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Offender Personality Disorder Pathway Screening Tools Evaluation

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MANUSCRIPT DETAILS

TITLE: Offender Personality Disorder Pathway Screening Tools Evaluation

ABSTRACT:

The Offender Personality Disorder (OPD) Pathway faces the difficult task of identifying individuals who are eligible for their service from the entire probation caseload. The OASys Personality Disorder Screen (OASys PD) is a national screening tool used by the pathway to help with this task. This paper describes an evaluation of the effectiveness of this plus an additional screening tool currently used to identify eligible individuals for the OPD service in the South of England. Recommendations for improvements were made as necessary.

A mixed methods design used a quantitative analysis of data on the effectiveness of the OASys PD for correctly identifying individuals and a thematic analysis of a focus-group conducted with clinicians within the service.

Analysis revealed a positive predictive value of the OASys PD Screen of 72% and a negative predictive value of 91%. Key themes from the focus-group revealed what worked well about the screening process, what was difficult and what needed to be improved.

CUST_RESEARCH_LIMITATIONS/IMPLICATIONS__(LIMIT_100_WORDS) :No data available.

The OASys PD performed better than the clinicians had expected. It was recommended that the service continued to use the combination of the screening tool and the interviews with minor adjustments.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

This is the first research study of this kind on the effectiveness of the OASys tool.

Introduction

The prevalence of individuals who meet the diagnostic criteria for personality disorders is estimated to be around 5-10% in the general population (U.K) and in excess of 50% in western prison and forensic samples (Fazel & Danesh, 2002; Motz et al., 2015). A recent Swedish study reported the prevalence of Emotionally Unstable Personality Disorder (EID) to be 19.8% among male offenders on probation (Wetterborg, Långström, Andersson, & Enebrink, 2015). It has been suggested that offenders who meet the criteria for a diagnosis of personality disorder may be at a higher risk of committing serious crimes (Blackburn, 2000) and that those who meet the criteria for 'dangerous and severe personality disorder (DSPD)' have quicker reconviction rates for more serious offences (Coid et al., 2007). It should be noted that the DSPD term is not a clinical classification (Howells, Kirshnan, & Daffern, 2007) and the term is no longer used outside of the screening tool described below. The link between the presence of difficulties indicative of a personality disorder and offending has led to the provision of services that support high risk individuals on probation caseloads which aim to minimise both risk of harm and social costs.

Identifying Appropriate Individuals

In order to provide an effective provision these services first need to identify the individuals who meet their criteria from the National Probation Service (NPS) caseload. There are several ways to establish whether individuals might meet diagnostic criteria for personality disorder; unstructured clinical interviews, psychometric questionnaires and semi-structured interviews such as the International Personality Disorder Examination (IPDE). These are time consuming and require training to administer which makes them unsuitable for the volume of individuals on the probation caseload. A national tool called the Offender Assessment System Personality Disorder Screen (OASys PD) is used to identify those offenders with particularly complex and challenging needs to bring into the service to manage and minimise risk.

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3 The OASys PD consists of is a 10-item check-list (DSPD Score) and an
4 additional four criteria which staff complete (See Appendix A). The DSPD score
5 contains items indicative of diagnostic features of “Antisocial Personality Disorder and
6 Psychopathy” (London Pathways Partnership, 2017). The presence of seven or more
7 items should ‘indicate concern’ however over 30% of offenders within probation’s
8 caseload score at or above the suggested cut off (Motz et al., 2015). The OASys PD was
9 originally developed as a screen for Antisocial Personality Disorder (ASPD) with a
10 Positive Predictive Value (PPV) of 85% on the initial validation prison sample (Bui,
11 Ullrich, & Coid, 2016). Guidelines for the use of OASys highlight the limitation that
12 traits of other diagnoses e.g. EID may be missed (Motz et al., 2015). There is yet to be a
13 nation-wide evaluation of the effectiveness of this tool for correctly identifying
14 individuals who meet the criteria for the specialist offender services.
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25 There is limited research discussing the difficulty of identifying individuals with
26 difficulties indicative of personality disorder in probation samples. Minoudis, Shaw,
27 Bannerman, and Craissati (2012) found that using the DSPD score alone yields a
28 number too large to be meaningful and identification rates by probation officers vary
29 considerably from one individual to the next. However, combining markers of
30 personality problems, the DSPD items and offence severity alongside screening
31 meetings between probation officers and psychologists allows for high specificity and
32 sensitivity in identification. There is also evidence that providing psychological
33 consultation to probation staff can improve outcomes for the service (Clark & Chuan,
34 2015).
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46 **Service Context**

47 The specialist offender service described here is a psychologically led service
48 which is contracted to provide the National Personality Disorder Strategy (OPD
49 Pathway) within three local delivery units of the National Probation Service in the
50 South of England. The community strand of the OPD pathway is commissioned to
51 deliver five core services within probation: early identification of PD offenders;
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3 workforce development; case consultation; case formulation; and joint casework
4 (Knauer, Walker, & Roberts, 2017) . The OPD pathway uses the OASys PD screen to
5 identify eligible individuals from the probation caseload. The tool is viewed by many
6 clinicians in the OPD pathway to be too simplistic and to be producing too many errors
7 (false positives and false negatives). Until now the above perception had just been
8 anecdotal and no evidence for the accuracy of the screening tool in identifying eligible
9 individuals existed. The service hypothesised that the OASys PD was missing 10-15%
10 of individuals who needed the service.
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17 In response to the perception of the OASys PD tool being too simplistic the
18 OPD pathway implemented an additional screening process in the form of an
19 interview/consultation. Clinicians who work within the OPD pathway (e.g. Clinical
20 Psychologists) interviewed probation officers about their caseload to identify those with
21 complex/challenging needs that could be considered to reflect a diagnosis of personality
22 disorder. The screening interview is a lot more time consuming than the OASys PD
23 tool, taking 1-2 hours plus additional admin time (per probation officer caseload). The
24 screening interview also fulfills many of the core roles of the OPD strategy as
25 mentioned above so, if effective, can serve multiple functions. An evaluation of this
26 new process was indicated so that the most time-effective and accurate process for
27 identifying eligible offenders is used.
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37 The need to accurately screen for individuals with difficulties reflective of
38 personality disorders does not ignore the many problems associated with the diagnostic
39 construct. The diagnosis can pathologise an individual's response to early relational
40 trauma and is associated with significant stigma. The OPD pathway recognises this and
41 does not require a formal diagnosis for individuals to be eligible for their service,
42 however a screening tool associated with this diagnostic construct is necessary in order
43 to provide an effective service to the correct individuals.
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50 The project was split into two stages. The aims, and any associated research
51 questions, of these stages are listed below. Recommendations were made to the service
52 based on the findings from both stages.
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- 1) Establish how the OASys PD tool compared to clinical judgement about appropriateness of an individual for the OPD service
 - How accurate is the OASys tool at correctly identifying individuals who need the service?
- 2) Establish clinicians experience of the screening interviews
 - Are the screening interviews helpful and can they be improved?

Method

Part 1: OASys Analysis

Sample and data collection.

Both Research and Development (R&D) approval from the NHS trust and ethical approval from the University of Bath were gained for both part 1 (quantitative) and part 2 (qualitative) of this evaluation. Anonymous data on the outcome of the screening tool was provided by the service e.g. the individual was screened in when they met seven or more of the items on the DSPD checklist or the presence of two of the four additional criteria, and otherwise screened out. This was compared to data provided on the subsequent pathway of the individual (e.g. whether they were actually brought into the service or were screened out at a later date). The data, which is routinely collected by the service, came from 1368 individuals from four geographical areas covered by the service.

For each case the researcher determined whether it was a true positive, false positive, true negative or false negative (see Table 1 for definitions). The researcher double checked 10% of data to ensure integrity. Table 2 shows the total numbers of each screening outcome. This information was then used to calculate the Positive Predictive Value (PPV) and Negative Predictive Value (NPV) of the OASys PD screen based off the formulas below. In the medical literature, the PPV of a test refers to the probability that an individual with a positive screening test truly has the 'disorder'. In this research, a positive result meant that the individual met criteria for the service and were appropriately screened in. PPV was calculated using the following equation; Total

1
2
3 true positives/(total true positives + total false positives). Similarly, in the medical
4 literature the NPV of a test refers to the probability that an individual with a negative
5 screening test truly does not have the 'disorder'. In this case, a negative result would
6 mean that the individual had appropriately been screened out of the service as they
7 didn't meet the criteria and didn't need the service. NPV was calculated using the
8 following equation; total true negatives/(total true negatives + total false negatives).
9

14 **Part 2: Clinician's View of Screening Process**

18 **Participants and data collection.**

19 A pool of 14 clinicians from the OPD service were invited to participate in a
20 focus-group on the experience of the screening interviews and the screening process.
21

22 Eligibility criteria were that the individual was a member of the OPD service
23 who had experience of conducting screening interviews with probation officers; all 14
24 invited clinicians met this criteria. Clinicians were provided with information on the
25 purpose of the group and the proposed interview schedule by email and were asked to
26 confirm their interest in participation before the day of the focus-group. Six individuals
27 confirmed their interest in the focus-group prior to participation and five individuals
28 took part on the day.
29

30 The focus-group lasted one hour and took place at the end of a Team Away Day.
31 The focus-group was facilitated by the lead researcher (ZM) using a semi-structured
32 interview protocol and was audio-recorded. Written consent was obtained from all
33 individuals.
34

44 **Analysis.**

45 The focus-group was transcribed and analysed using the Classic Framework
46 Analysis Approach described by Krueger and Casey (2009). This approach was chosen
47 due to the advantages of a systematic approach to analysis that was designed
48 specifically for focus-groups. The epistemological stance of the researcher conducting
49 the analysis was of Critical Realism. After transcription, the whole interview was cut
50 into individual quotes by each participant and then they were organised following
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3 Krueger's framework under each of the focus-group questions they answered. The
4 quotes were given a rough code/summary and then these were grouped into categories.
5
6 As the categorising was being completed it became clear that there were similar
7
8 themes/categories across the questions, so although the analysis started by analysing
9
10 each focus group question individually, the themes were then arranged in relation to
11
12 three overarching questions; what works well, what needs to be improved and how
13
14 could this be done? Once the main themes and sub-themes had emerged these were
15
16 checked with a second researcher and shown to individuals in the service with the
17
18 opportunity to comment/feedback on them.
19
20
21
22

23 **Results**

24 **Part 1: OASys Analysis**

25
26 Data from one of the four probations areas was excluded due to the extensive
27
28 number of data gaps. Data gaps occurred where there was not sufficient information
29
30 recorded to identify the pathway of the individual in or out of the service. Data gaps
31
32 from the other three areas equated to 17% of the total data points. Data from a total of
33
34 1179 individuals, from three probation areas, was used in the final analysis.

35 Analysis revealed a Positive Predictive Value of the OASys PD Screen of 72%.
36
37 This means that 72% of the time the clinician interview agreed with the screening tool
38
39 that a person should be included in the OPD service. The Negative Predictive Value
40
41 was calculated to be 91%. 91% of the time the clinician interviewed agreed with the
42
43 screening tool that a person should not be included in the OPD service. Table 2 shows
44
45 the total numbers of True Positives, False Positives, False Negatives and True
46
47 Negatives respectively.
48

49 **Part 2: Clinician's View of Screening Process**

50
51 Analysis of the focus groups revealed a number of key findings which are
52
53 summarised in relation to three questions. The themes in relation to Question 1 (What
54
55 works well about the screening interviews?) were; providing reflection on cases,
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increasing awareness of probation staff and fulfilment of core roles of the service (see Figure 1).

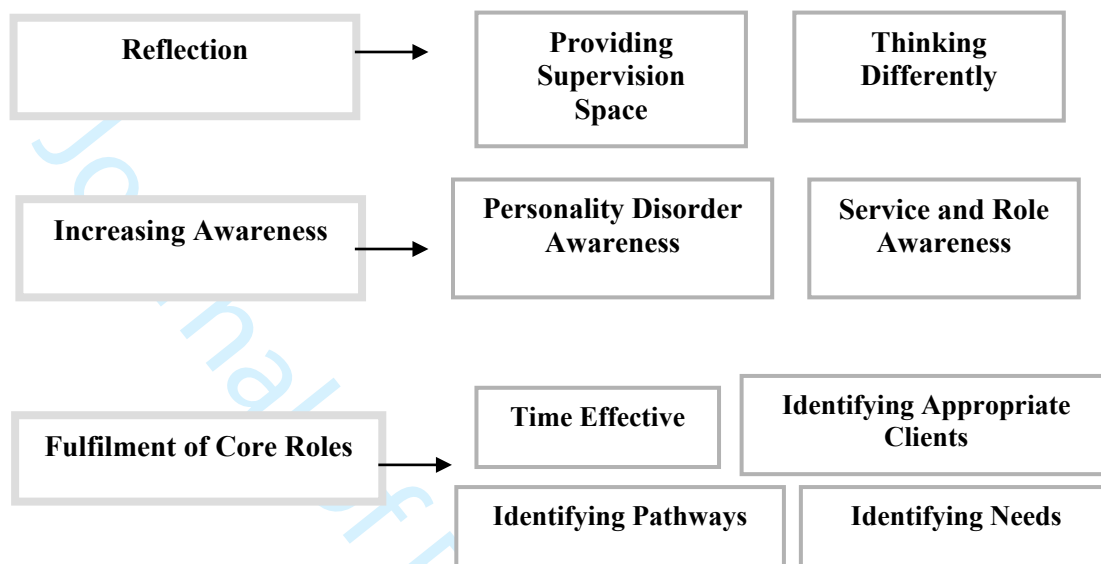


Figure 1. Diagram of Themes (Left) and Subthemes (Right) in relation to Question 1

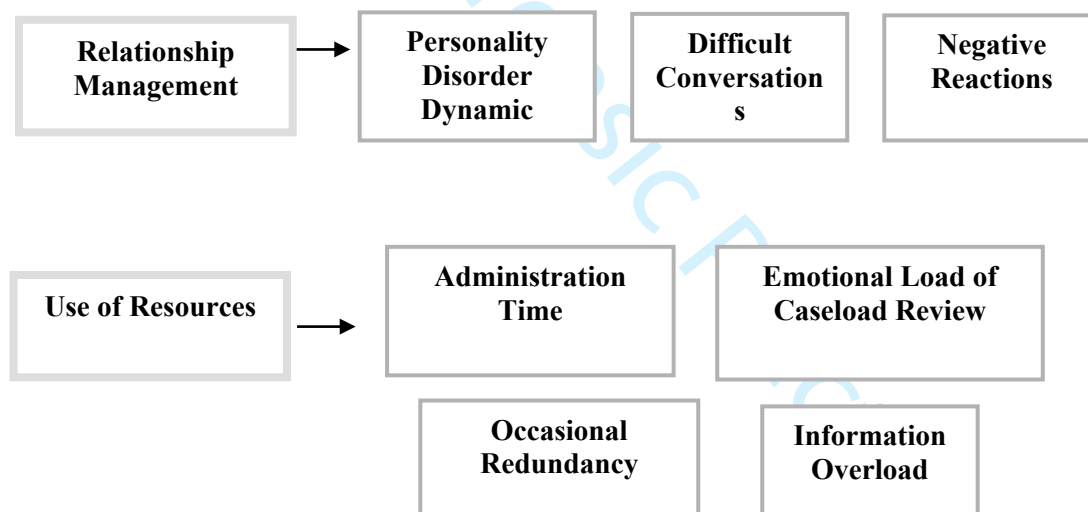


Figure 2. Diagram of Themes (Left) and Subthemes (Right) in relation to Question 2

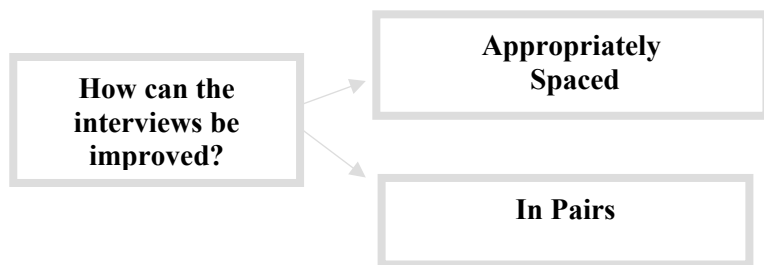


Figure 3. Diagram of Questions 3 and themes

The themes identified in relation to Question 2 (What is difficult about the screening interviews?) were; use of resources and relationship management (see Figure 2). The themes identified in relation to Question 3 (How could these be improved?) were appropriate spacing and conducting the interviews in pairs being suggested as improvements (see Figure 3). These themes are elaborated and discussed, with reference to quotes from the focus-group, below.

What Works Well about the Screening Interviews?

Theme: Reflection

Providing supervision space.

Clinicians reported that the addition of the screening interview adds value to the screening process as it provides time and space for Offender Managers (OMs) to reflect on their caseloads in a supervision setting that they may not otherwise have access to.

PP1: "I think it's the space to reflect as well, it's a proper time out. They've booked two hours out to sit with us so they're literally having that two hours to think about the cases rather than answering the phone or somebody is coming and they just have that time, and they don't get that in supervision"

PP2 "they're (OM) appreciative of that time and space, it's a little bit forced upon them, that time and space to actually think about the individual and think about what their needs are and their pathway"

Thinking differently.

This space for reflection allows for thinking in a different way about the offender, or about different ways to engage or work with offenders, which participants said can help to bring about change in cases that can otherwise appear stuck.

PP3: "with certain cases they have just got a bit lost and not being progressed through. People can start thinking about them [cases] again in a slightly different way to maybe 'Are they just messing up?'"

PP4: "and it just enables that space to sit down and think outside the box about how to deal with things, rather than going through the same motions."

Theme: Increasing Awareness

Personality disorder awareness.

A major theme reported by the clinicians was the upskilling of OMs in terms of their knowledge and understanding of working with the client group (individuals with symptoms indicative of a personality disorder).

PP5: "it was a positive experience, the OM (was newly qualified. It felt good to engage her in understanding what PD is, so it felt like you were giving over information."

PP1: "I think if you are adding that value as well that's what our project should be about and kind of raising awareness for the OM to understand more about personality disorder and how it might manifest itself or how it might show itself"

PP4: "...you're actually up skilling people and helping them to think about their caseloads, just for those who are less used to talking about PD"

Service and role awareness.

Clinicians also described that the screening interviews allowed the OMs to learn about the Pathfinder service and the roles of the clinicians and what they can offer. As this knowledge has been given over time the screening interview process has been described as becoming easier.

PP1: "when we were first going in to do screenings with probation officers and they didn't quite understand it so, and they haven't experienced actually what a

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3 *consultation, what a formulation, what other sort of pathway planning stuff actually*
4 *could add to the supervision of their cases.”*

5
6 *PP4: “So it’s actually a really good opportunity for them to start understanding what*
7 *we can offer in terms of a service and I think that’s always a bit of a relief to people; to*
8 *go away thinking someone, in a way, is going to take something off my hands, or I don’t*
9 *have to think about this case on my own”*

13 14 15 16 **Theme: Fulfilment of Core Roles**

17 18 **Identifying appropriate clients.**

19
20 The opinion emerged that the identification of individuals with personality
21 disorder is improved using the screening interviews compared to screening just using
22 the screening tool.

23
24 *PP2 “[The OASys PD] kind of misses a lot, I mean relationships isn’t- there’s nothing*
25 *on relationships which is kind of an obvious thing like what would be an issue for*
26 *somebody with personality disorder.”*

27
28 *PP3: “I’m just thinking in terms of a tool, if you just do them as tick box it doesn’t*
29 *really have, it doesn’t tell you a wealth of information..... Personally in terms of tick*
30 *box and the score I just do it because we have to, I wouldn’t say that I have confidence*
31 *that it always gets it right”*

32 33 34 35 36 37 **Identifying pathways.**

38
39 Clinicians reported that the screening interview can provide a wealth of
40 information from which can help to identify the individual’s pathway earlier.

41
42 *PP3:” we are trying to get as much done in that screening process as*
43 *possible... so we can do a bit of consultation, we can identify a pathway for the*
44 *person that’s been screened in, we can start to identify where they are going”*

45 46 47 48 **Identifying needs.**

49
50 The screening interviews were seen to provide an opportunity for OMs
51 to recap their entire caseloads and for clinicians to gain a sense of the needs of
52 both the service users (e.g. needs of an offender being screened in) and the
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3 OMs (e.g. where an OM might need support to understand and recognise signs
4 that an offender is eligible for the service).

5
6 *PP4 “I think that that’s probably the key thing with screening; it identifies
7 that caseload but it also helps us identify exactly what the needs are.”*

8
9
10 *PP3 “It’s also a bit of an opportunity for them (OMs) to have a recap on their
11 cases. So actually it can be a bit of reassurance of actually knowing where
12 everybody is at ‘cause I’ve had that recap of it. I think that’s a really
13 functional aspect of it”*
14
15
16

17 18 19 20 **Time-effective.**

21 Whilst the screening interviews take longer than just using the
22 screening tool, the process is described to be time-effective as the identification
23 of pathways/consultations can occur earlier. Clinicians also reported their
24 experience that if the process is done well the piece of work can have enduring
25 value.
26
27

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29
30 *PP2 “And the screening meeting will feed into pretty much all but one of our objectives
31 for commissioning, so it’s a major piece of work that if you’ve done it effectively, I hate
32 using this term, but it ticks boxes. So yeah it can be very effective but also time
33 consuming”*
34
35

36
37 *PP3 “Yeah I do think that if you do it to a certain level actually that piece of work on its
38 own with that case can then last for potentially 12 months until the next review”*
39

40 The participants in the focus-group described their overall experience of the
41 screening interviews as positive and helpful, but made reference to the below
42 difficulties.
43
44

45 46 47 **What is Difficult About the Screening Process?**

48 49 **Theme: Relationship Management**

50 51 **Personality disorder dynamic.**

52 Clinicians described that the working relationships between the pathfinder
53 clinicians and the OMs to be difficult to manage at times. Clinicians described that
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3 transference of the dynamics between the offender and the OM could be mirrored in the
4 relationship between the OM and the clinician.

5
6 *PP4 "I think the thing that I would find most difficult, and most worrying in*
7 *terms of if we were leaving some people to it, I suppose in that way is those*
8 *who very clearly have a PD dynamic going on in the relationship that they*
9 *have with the offender but that is not clear to them in any way shape or form*
10 *because they've become so immersed in it and so blind to what is going on"*

11 12 13 14 15 **Difficult conversations.**

16
17 Having difficult conversations, such as bringing a dynamic to the OM's
18 awareness or highlighting an area where perhaps the OM lacks some knowledge, were
19 described to be challenging by the clinicians due to the need to be sensitive and non-
20 shaming.

21
22 *PP3: "...you have to be quite skilled about not shaming OMs about their*
23 *knowledge about their cases."*

24
25 *PP4 "That can sometimes be a very difficult balance to strike and having to*
26 *tread very carefully sometimes, particularly I think where there are people who*
27 *really don't know an awful lot about PD, but unfortunately know so little about*
28 *it that they also don't realise that they know so little about it, and that's where*
29 *the difficulties arises"*

30 31 32 33 34 35 **Negative reactions.**

36
37 Staff-burnout and lack of capacity due to ever increasing demands was
38 described as one of the reasons that OMs could sometimes have a negative reaction to
39 the screening process. Reactions experienced include OMs being defensive about their
40 caseloads, not being open to suggestions and devaluing the OPD clinician's role.

41
42 *PP2 "Yeah I've had a couple of people like that who are quite defensive about their*
43 *cases, it was hard. And I've had people that have devalued our role....so they have felt*
44 *that they really don't want to give their time to screening because they are so busy*
45 *doing important stuff."*

46
47 *PP1: "You get a sense of 'none of my cases are PD, leave them alone, they're all mine'*
48 *kind of thing. Just kind of presents a bit defensive."*

1
2
3 *PP4 “I think its when people have got to the point that they’ve become very cynical or*
4 *very burnt out or whatever.”*
5
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7

8
9 **Theme: Use of resources**

10 **Occasional redundancy/over-resourcing.**

11
12 It was noted by participants that there is of course variation in the experience of
13 the screening interviews, for example there are OMs who already have a lot of
14 knowledge of personality disorder/the service or where the screening interview isn’t
15 deemed useful.
16
17

18
19 *PP2: “ the others it was kind of almost obvious when you’re looking through, you just*
20 *think this is really obvious and you almost think is it worth taking up like an hour and a*
21 *half or two hours of their [OM] time to have them in a room when you could just be*
22 *doing it yourself”*
23
24
25

26 **Administration time.**

27
28 Clinicians reported that whilst the screening as a whole is time-effective in the
29 long run, the process is resource heavy and that the associated administration time is
30 time-consuming and not cost-effective.
31
32

33
34 *PP3: “I suppose the thing is that for us as clinical staff... there is a lot of admin so I*
35 *think It does feel like a laborious process because there is big admin aspect to it. And*
36 *you tend to think ‘I shouldn’t be doing admin I should be doing something else”*
37
38

39 *PP4 I think the meeting itself is time effective, it’s all the admin that goes around it that*
40 *we’ve all been struggling with....”*
41
42

43 **Emotional load of caseload review.**

44
45 The screening interviews were also described as resource heavy and draining
46 from a personal point of view for both OMs and OPD clinicians. The volume and nature
47 of information that is being given over in the 2-hour interviews was described to be
48 draining.
49
50

51
52 *PP3: “I do sometimes get concerned that as you go through you can chat*
53 *about 20-25 cases all high-risk offenders, all committed quite- sort of yeah*
54 *nasty offences, and personally sometimes going through doing the screening*
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3 *stuff you're like that's a lot of information to hold, I think probation officers*
4 *sometimes they don't want to hold all that information for all their cases they*
5 *are responsible for at the same time... sometimes yeah if you're brining it up*
6 *and going through sometimes it can be quite a draining process again."*
7
8
9

10 **Information overload.**

11
12 The repetitive/similar nature of many of the cases can mean that information is
13 forgotten or confused if too many are done together.
14

15
16 *PP2: "So we're screening in, giving them information that they probably don't*
17 *even want to hold in their head, so it can be a bit of an obstructive process for*
18 *them"'"*
19

20
21 *PP1 "You can even start to forget which case is which as you are doing them.*
22 *You're talking about somebody a minute ago who was a [convicted of]*
23 *domestic violence and you might still have the [man convicted of] domestic*
24 *violence (man) in your head because you've done so many that day"*
25
26
27
28
29

30 **How Could These be Improved?**

31 **Theme: Appropriately Spaced**

32
33 Spacing out the interviews was seen to allow for enough time to write up the
34 notes and to reduce the draining impact/information overload effects.
35

36
37 *PP2: "I think you've got to be organised in how many you allocate yourself because if*
38 *you're not doing it right it becomes ineffective. So if you're doing lots of screening and*
39 *you are not able to upload that data then you forget."*
40

41
42 *PP1: "you need to have a few breaks in between. That's probably why it works*
43 *well in pairs because you switch over."*
44
45
46
47

48 **Theme: In Pairs**

49
50 Conducting the screening interviews in pairs, as they have sometime been done
51 in the past, was suggested by clinicians to help reduce the negative impact of the
52 volume and type of information being discussed, help with having the difficult non-
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2
3 shaming conversations with OMs and allow for two people's heads to be thinking about
4 the same person.

5
6 *PP3: "I think when you're done you feel exhausted afterwards, whereas it's not that*
7 *level of exhaustion in a pair, cause you do tag team naturally."*

8
9
10 *PP4 "I actually really valued doing them in a pair, because partly of what PPI was*
11 *saying about kind of the objectivity and stuff about it but sometimes you do get cases*
12 *that you are discussing when it isn't really very clear sometimes its just to have that*
13 *additional person to check in... and again I think that's where its really helpful to have*
14 *two people doing it rather than one because there may be times when you really need to*
15 *pause to think about how you say things and how you approach things. "*
16
17
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21

22 **Feedback and Recommendations to the Service**

23
24
25 The results (Table 3) of the evaluation were fed back to the service in a
26 presentation at a team away day. The results were discussed and the team drew up an
27 action plan for recommendations. The results suggest that the additional screening
28 interview will at most pick up a potential extra 3%. It is not certain that the screening
29 interview actually picks these cases up; the service did not record how false negatives
30 were eventually identified, so although it is likely to be through screening interviews,
31 this is not definitive.

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34 The team reflected that the results and feedback discussion were extremely
35 helpful and that they had been shocked to hear that their hypothesis that the screen was
36 missing 10-15% of eligible individuals was not confirmed. A potential reason for this
37 discrepancy was highlighted to be due to the complexity of the cases that the screen
38 might miss (e.g. individuals with traits indicative of EID). These cases were described
39 to feel 'bigger' in some way, e.g. take up a 'big space' in the mind due to added
40 emotional weight of the case, so clinicians felt they may have over predicted the
41 number of cases to reflect this. Table 4 shows the recommendations discussed and the
42 action points the service agreed to take forward.
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Discussion

Summary

Contrary to team expectations the resource-intensive screening interviews were not identifying as many extra cases as predicted, although the false negatives were believed to be significantly emotionally intensive. The screening interviews were seen to be valuable in a number of other ways and the team has taken forward recommendations based on these results to refine the process whilst managing some of the challenging elements.

Implications

The analysis of the tool's ability to correctly identify individuals who clinicians feel meet the criteria for the OPD service offers an initial piece of evidence towards the validity of the use of this tool. The National Offender Management Service note that of the number of screening tools available only one (the Standard Assessment of Personality- Abbreviated Scale [SAPAS]) has been tested for validity and that screening tools must be used with extreme caution (Craissati et al., 2011). When tested in a probation sample, using the recommended cut-off score of 3, the SAPAS has a positive predictive value of 96% (Pluck, Sirdifield, Brooker, & Moran, 2012) which is slightly higher than the OASys PD result described here. However, the results described here suggest that the OPD team use a screen (OASys PD) with caution (the addition of the screening interviews) which creates a useful and effective process for tackling the very difficult task of delivering the service to the target population. Most importantly the OASys PD rarely identifies false negatives and therefore the risk of a potentially dangerous individual not receiving the service that they need is very low.

Although the service felt that the PPV and NPV of the OASys screen were adequate, and in fact exceeded their expectations, it is important to note that this evaluation is subjective. The generally accepted guide to classifying the accuracy of a diagnostic test is the traditional academic point system (Tape, 2001); where 90-100 = excellent (A), 80-90 = good (B), 70-80 = fair (C), 60-70 = poor (D) and 50-60 = fail (F). Thus, based on this system the PPV would be considered 'fair' and the NPV 'excellent.'

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3 The team feedback session highlighted the difficulty that the OASys screen has
4 for picking up difficulties indicative of the entire range of personality disorders, e.g.
5 Dependent Personality Disorder, due to the development of the screen stemming from
6 the identification of antisocial personality disorder. Whilst an important limitation to
7 consider, the OASys is not alone in its difficulty to identify all types of personality
8 disorder equally well. The SAPAS is noted to correlate less well with antisocial,
9 narcissistic, and histrionic personality disorder traits (Hesse & Moran, 2010). This may
10 reflect the heterogeneity of the traits which fall within the differing personality disorder
11 constructs. It may therefore be best practice to use a tool which correlates highly with
12 the type of traits that are prevalent in the population, as the OPD team does, and hold in
13 mind these limitations.
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24 **Limitations**

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26 The results described above only represent how likely that a positive result
27 represented a true positive, and vice versa, for the population analysed; if the OASys
28 screen was used on a different population, the PPV and NPV would change. The PPV
29 and NPV are directly influenced by the prevalence of the disorder in the population
30 (Parikh, Mathai, Parikh, Sekhar, & Thomas, 2008) and it is noted that the OASys is a
31 probation tool.
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36 It is also necessary to comment on the noticeable limitations that this medical
37 model analysis presents by classifying personality disorder as a 'clinically present
38 disorder' that is present or not. There are the aforementioned difficulties with the
39 diagnostic construct however there needs to be a way to filter out those less likely to
40 have difficulties indicative of a personality disorder from the large number of high risk
41 of harm individuals.
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47 Evaluating a single service means that there are limits to the generalisability of
48 these results, however it is also important to note that the OPD pathway is a relatively
49 new national approach and thus an understanding of how it works is both important and
50 emerging (Knauer et al., 2017)
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54 The missing information that resulted in certain areas and data points being
55 excluded from analysis appeared to be related to different individuals/localities
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3 recording different amounts of information in different ways on the database. The data
4 gaps highlight the need for the entire service to populate the database in a uniform way
5 should future research be pursued.
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8 The focus-group was completed with five individuals however only four
9 contributed significantly to the interview. The fifth individual had less experience of
10 screening, was new to the team and had less established working relationships with the
11 others which may explain their reduced participation. Whilst the results of the focus-
12 group naturally only reflect the views of those involved, other team members were
13 present at the feedback session and no concerns or challenges were raised.
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21 **Conflicts of Interest**

22 None.
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28 **Implications for practice**

- 29 • The OASys PD is an effective screening tool- for the population analysed, the
30 tool alone accurately identified individuals who were eligible for the service
31 72% of the time.
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- 33 • Consultation between the OPD service and probation team has value in addition
34 to identifying possible cases that require the OPD service; allows for reflective
35 space, increases awareness and help to fulfil core roles (e.g. commissioned
36 duties including providing a psychologically informed service for challenging,
37 high risk group).
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- 39 • Using a screening tool such as the OASys PD with some caution (e.g. the
40 addition of consultation) creates a useful and effective process for tackling the
41 very difficult task of delivering the service to the target population.
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Table 1

Definitions

	Definition
True Positive	Where the OASys PD screened the individual in and they were deemed suitable/remained in the service
False Positive	Where the OASys PD screened the individual in but they were later screened out/not deemed suitable for the service
False Negative	Where the OASys PD screened the individual out but they were later brought into service/deemed suitable by a different process e.g. screening interviews
True Negative	Where the OASys PD screened the individual out and they remained out of the service/not suitable

Table 2

Total numbers of screening outcomes

Type	Number identified	% of Total
True Positive	556	47
False Positive	214	18
False Negative	35	3
True Negative	374	32
<i>Total</i>	<i>1179</i>	<i>100</i>

Table 3

Summary of Results fed back to the service

Key Results
<ul style="list-style-type: none"> • For the population analysed, the tool alone accurately identified individuals who were eligible for the service 72% of the time • 3% of individuals were 'missed' by the screen (false negatives). • 18% of the individuals were screened in when the tool was over-inclusive (false positives) • The screening interviews do have value in addition to identifying possible false negatives; they allow for reflective space, increase awareness and help to fulfil core roles (e.g. commissioned duties including providing a psychologically informed service for challenging, high risk group)

Table 4

Summary of recommendation and agreed actions from the service

Recommendation	Rationale	Action Points
<p>A further piece of work be undertaken to track where the false negatives are picked up (e.g. whether they are being screened in or highlighted in the screening interviews or not) and the profile of these individuals. The database should be completed in a uniform way across all areas for any future analysis.</p>	<p>This would provide evidence for whether discussing the false negatives in the screening interview has any value, whether the false negatives are high-risk and could help build an understanding of the OASys blind spots.</p> <p>Previously data had to be excluded due to missing information.</p>	<p>Passed on to the service lead</p>
<p>Continue running the screening interviews but streamline them by initially only discussing individuals with a 'positive' screened in result from the tool.</p>	<p>The screening tool is over-inclusive and correctly identifies true negatives more often than true positives. Therefore the positive results should be discussed during screening to identify which are true and which are false. This recommendation allows the benefits of the screening interview to continue but will require less resources</p>	<p>Agreed to take this recommendation forward and initially discuss those individuals with a positive screen</p>
<p>In line with the above recommendation, offer the OM the chance to bring any other individuals to the screening interview that they are concerned about, in addition to the 'positive' screened results</p>	<p>This will allow for any possible 'false negative' individuals to be discussed and maintains discussions of individuals who may not be eligible for the service, but the OM requires help with (which improves good working relationships)</p>	<p>Agreed to take this recommendation forward and will /offer the chance for the OM to contact the clinician about other cases that are concerning as needed.</p>
<p>A guideline of one hour to one and a half hours of screening per session be recommended to clinicians</p>	<p>This will reduce the chances of information overload so that the clinicians can be time-effective</p>	<p>Agreed to set this guideline but recognise that staff may choose to do more or less when it suits their diary</p>
<p>Run the screening interviews in pairs where possible</p>	<p>To reduce the emotional load, information overload and help with difficult conversations during the screening interviews</p>	<p>Agreed to run the screening interviews in pairs where possible</p>

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