
**A systematic exploration of informal mechanisms of change
on the Offender Personality Disorder Pathway across
prisons and probation**

Journal:	<i>Journal of Criminal Psychology</i>
Manuscript ID	JCP-04-2025-0036.R2
Manuscript Type:	Research Paper
Keywords:	personality disorder, pathway services, prisons, probation, informal change mechanisms, responsivity factors and barriers

SCHOLARONE™
Manuscripts

MANUSCRIPT DETAILS

TITLE: A systematic exploration of informal mechanisms of change on the Offender Personality Disorder Pathway across prisons and probation

ABSTRACT:

The Offender Personality Disorder Pathway (OPDP) in England and Wales provides around 3000 specialist prison and community-based treatment places annually. However, the efficacy of interventions remains unclear despite recent national quantitative and qualitative evaluations. This is partly because models of care are designed to be holistic and responsive, but measures of change capture formal treatment of the offender group only. The aim of this study is to qualitatively explore individual informal activities, relationships and support, alongside barriers and responsivity factors, that contribute to offender change in specialist services, as a first step to informing a comprehensive study of OPDP services.

Nineteen focus groups were conducted with 86 expert participants living and working across four male and two female prison sites and the London Probation Service. Framework analysis was used to systematically analyse all data.

Two main themes of “interactive informal mechanisms of change” and “internal and external factors interacting with mechanisms of change” with five further sub-themes were found to enable or inhibit successful pathway progression over time and provision.

The findings indicate a starting point for better capturing the full complexity of provisions and service participants in future evaluations of the OPDP services.

CUST_PRACTICAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

This study is the first to comprehensively explore all informal mechanisms of change on the OPDP across a whole partnership service, revealing their range, adaptability, interactive nature and integrality to models of care.

A systematic exploration of informal mechanisms of change on the Offender Personality Disorder Pathway across prisons and probation

Abstract

Purpose - The Offender Personality Disorder Pathway (OPDP) in England and Wales provides around 3000 specialist prison and community-based treatment places annually. However, the efficacy of interventions remains unclear despite recent national quantitative and qualitative evaluations. This is partly because models of care are designed to be holistic and responsive, but measures of change capture formal treatment of the offender group only. The aim of this study is to qualitatively explore individual informal activities, relationships and support, alongside barriers and responsivity factors, that contribute to offender change in specialist services, as a first step to informing a comprehensive study of OPDP services.

Design – Nineteen focus groups were conducted with 86 expert participants living and working across four male and two female prison sites and the London Probation Service. Framework analysis was used to systematically analyse all data.

Findings - Two main themes of 'interactive informal mechanisms of change' and 'internal and external factors interacting with mechanisms of change' with five further sub-themes were found to enable or inhibit successful pathway progression over time and provision.

Originality – This study is the first to comprehensively explore all informal mechanisms of change on the OPDP across a whole partnership service, revealing their range, adaptability, interactive nature and integrality to models of care.

Research implications – The findings indicate a starting point for better capturing the full complexity of provisions and service participants in future evaluations of the OPDP services.

Paper type – research paper

Key Words

Personality disorder, pathway services, prisons, probation, informal change mechanisms, responsivity factors and barriers

Introduction

The UK Offender Personality Disorder Pathway (OPDP) brings together the UK National Health Service (NHS) with His Majesty's Prison and Probation Services (HMPPS) to jointly deliver a set of psychologically informed services which operate across the entire criminal justice system. It focuses on individuals considered to pose a high or very high risk of harm to others whose psychological difficulties are associated with severe personality difficulties.^[1] The high level aims of the OPDP are to bring about a reduction in repeat high harm offending, to increase the psychological health, wellbeing and prosocial outcomes for service participants, and to increase the competence and confidence of staff (Joseph and Benefield, 2010). Although there are numerous models of service delivery within the OPDP, all commissioned services are bound together by a set of underpinning theories and principles, drawn from attachment and desistance theories, the 'what works' literature and the evidence underpinning the treatment of personality difficulties and complex trauma. Formal therapeutic interventions (such as schema focused therapy, mentalization based therapy and dialectical

behaviour therapy) are a standard component of the Pathways model and generally involve the current best available evidence (e.g. Katakis, P. *et al.*, 2023) for bringing about positive therapeutic change in those with severe personality difficulties. However, the OPDP model also includes a holistic approach to change, providing activities and support that are less readily assessed through traditional criminal justice methods of measuring change. Relationships are at the heart of this approach and are recognised as pivotal to desistance (Laub and Sampson, 2001). Within this relational model there is an explicit emphasis on the importance of establishing and maintaining supportive, boundaried and rehabilitative relationships. These relationships and the environments in which they take place are an explicit focus of the OPDP approach and seen as key mechanisms of change (NHS England, 2023).

At just over 15 years old, there now exists a developing literature about the effectiveness of various components of the OPDP. In the community, OPDP services have been shown to improve the confidence and competence of staff working with those with severe personality difficulties (Shaw *et al.*, 2012) and significantly reduce reoffending risk (Joliffe *et al.*, 2017a). Participation on the Pathway in prison settings has been associated with reductions in aggressive behaviours and non-compliance (Camp, Joy and Freestone, 2018) and self-injury (Forster and Shaw, 2018). The largest single evaluation of the Pathway to date was completed by Moran *et al.* (2022). This national evaluation of the OPDP found that service participants and staff reported how the development of trust and improved collaboration within positive relationships were central to pathway progression. Service participants reported a perception that their risk of reoffending had reduced, their psychological health had improved, and they felt safer overall. Staff also felt that the management of service participants had improved overall. Those accessing Pathways services in custody also had significantly fewer adjudications than a matched comparison group. A second national evaluation of community and prison based OPDP Psychologically Informed Planned Environments (PIPEs) with staff and residents found improved relationships, more pro-social behaviour by residents and less use of force by staff. PIPE staff also reported a higher sense of purpose and value in their work (Kuester *et al.*, 2022).

Despite these generally positive evaluations of specific components of the OPDP, the completed studies vary in methodological rigour and there are still important areas of the Pathway to be evaluated, both in terms of outcomes and services. Notably, it is recognised that those accessing the Pathway are a heterogeneous group with diverse personality and risk profiles and many fail to make consistent progress (Mathlin *et al.*, 2021). It is known that the road to desistance for people with severe personality difficulties is generally individual, winding and nuanced (Jarrett *et al.*, 2025) but it is not well understood what individual responsivity factors impact on progression on the Pathway and how these factors may interact with the elements of service delivery. Although the OPDP model of care emphasises the primacy of relationships between service participants and providers, what it is about the dynamics of these relationships that makes the difference, or how services might support or inhibit these relationships, is less well understood.

As the OPDP is a holistic programme of change, this study seeks for the first time to systematically identify mechanisms of positive change in OPDP services beyond formal treatment interventions, and what enables or inhibits equal access to change opportunities. Given this, the primary aim of this study is to comprehensively explore all non-treatment specific activities, relationships and support that impact OPD Pathway progression. A secondary aim is to explore barriers and responsivity factors that inhibit or enable progression. In doing this it will inform future holistic evaluations of the OPDP model.

Method

Design

The study employed an exploratory qualitative design, utilising focus groups with expert service participants and providers both NHS and HMPPS staff working in jointly run OPDP services across a whole OPDP partnership, to gain a comprehensive view of the OPDP holistic model of care beyond formal treatment. The study excluded formal treatments defined in the national evaluation of the Dangerous Severe Personality Disorder (DSPD) programme, the forerunner of the OPDP, as “interventions with an explicit agreement between therapist and patient to work together with an agreed process and goal. Treatments usually (but not always) had a predicted duration and frequency” (Burns *et al.*, 2011, p413). The study aimed to identify *all* informal activities, relationships and support interactions that occur outside formal treatment sessions but within OPDP settings or with OPDP staff and *all* pre-existing individual characteristics and circumstances known as responsivity factors and explore how they affect progression on the OPDP. To ensure the comprehensive and transparent categorisation and analysis of all data a framework analysis method (Green and Thorogood, 2004) was used, and a full item list was developed to check findings with participants.

Participants

Participants were purposively sampled as expert service participants and providers working and living across OPDP services in the London area, including the London Probation Service, two women’s prisons and four men’s prisons (see Table I). Purposive selection criteria included a minimum of one year experience of the relevant pathway service for staff. Known experts were identified by two members (XX, XX) of the research team holding leadership roles in the services. Service providers included clinicians who lead and deliver services, and key operational staff, both prison and probation officers, employed in the OPDP services whose relationships with service participants, both prisoners and people on probation, have been found to be pivotal to change (Auty and Liebling, 2020; Beck and McGinnis, 2022). Service participant experts represented those with first-hand experience of informal mechanisms of change, drawn from a minimum of six months direct experience of accessing OPDP services. This group also included lived experience peer mentors, working in supportive roles with their peers but also still concurrently engaged in OPDP services themselves. The sample consisted of 86 experts with the distribution of service providers and participants across services and focus groups presented in Table I. The National Research Committee (NRC) provided ethical approval for the study (Ref 2021-218). Further approval was granted from the individual prison governors within each prison and from the research committee of the Probation Service London. The researchers shared study information with all participants, through local clinical teams, in a standardised or easy read format 24 hours prior to each focus group. At the start of each focus group participants had the opportunity to ask questions prior to giving written informed consent, which reiterated rights to not respond and withdraw, research phases, confidentiality, and anonymity protocols. Debriefs and signposting for further support were provided post-focus group. The research was completed in conjunction with clinical leads in each site to ensure participant wellbeing was monitored and attended to following participation. It is of note that it was not possible to recruit expert service participants in the community owing to access limitations.

INSERT TABLE I AROUND HERE

Focus groups

Focus groups were selected to engage sufficient experts across sites (Ogunbameru, 2003). Focus groups have been found (Kitzinger, 1995) to generate more critical explorations of topics and were employed to facilitate comprehensive identification and interrogation of informal mechanisms of change over time, as well as factors that inhibit or enable change on the OPDP. Focus groups varied in size between three and 10 participants with an average of five to six, meeting the rule of thumb guide of between four and 12 participants per focus group, erring towards smaller groups owing to the exploratory (Tang and Davis, 1995) nature of the research. Focus groups were held separately for service participants and providers and conducted in-person with notes taken throughout, added to on completion of sessions and typed up within a day of data collection to facilitate completeness. This method was assessed as sufficient to capture short verbatim quotes, removed the inhibition of tape recording and met the pragmatic needs of a large-scale qualitative study. Consistency in data collection was maintained using a topic guide that asked open questions on non-treatment activities, support and relationships and personal attributes that commonly, positively or negatively make a difference and trigger change on the OPDP as well as asking what signifies change and exploring positive and negative responses to the Pathway. The topic guide was developed with OPDP service providers and piloted in an OPDP NHS facility with service participants where it was identified that concepts such as progression were too abstract and led to the simplification of the schedule. Focus groups work well in health settings across staff and patient groups and have been used effectively elsewhere with service participants on the OPDP (Blagden *et al.*, 2023).

Framework analysis

Framework analysis was developed to do applied research, to systematically identify, describe and interpret themes and maintain the integrity of cases (Ritchie and Spencer, 1994) across large datasets (Goldsmith, 2021). The method requires the non-selective and transparent management and analysis of all data through the early identification of a deductive framework but is flexible to inductive additions and refinements based in subjective accounts. This fit the aims and design of this large-scale qualitative study to firstly identify and describe all informal mechanisms of change and responsivity factors and to secondly interpret differences across service provision, expert groups, and time. The identification phase of the analysis included a member checking exercise wherein lists of all informal mechanisms of change and responsivity factors, with brief descriptions, were shared with participants as a transactional validity check on accuracy and completeness (Cho and Trent, 2006). No additional items were identified. The interpretative phase of the analysis is reported in explicit topic summaries (Braun and Clarke, 2021), that can be readily applied to practice (Ritchie and Spencer, 1994), to inform service provision and future evaluations.

Findings

This comprehensive exploration of informal mechanisms of change and responsivity factors on the Pathway progresses previous thematic analysis of the OPDP lived experience to develop a holistic descriptive understanding of what makes a difference on the OPDP beyond formal interventions. An iterative and systematic analysis of the focus group data^[2]

led to the identification of two main themes, *informal interactive mechanisms of change* and *internal and external factors interacting with mechanisms of change*, with three sub-themes of *activating activities*, *relationships that matter* and *supportive interactions*, and two sub-themes of *barriers to change* and *responsivity factors* respectively. Figure 1 illustrates how the themes and sub-themes interact and indicates the number of separate items identified under each sub-theme. Supplementary tables contain a full list of exemplified items under each sub-theme for future exploration. This section exemplifies the interactive nature of the two main themes and five sub-themes in the progression narrative. Service and expert differences and similarities are reported throughout. [3]

INSERT FIGURE 1 AROUND HERE

Theme 1: Informal interactive mechanisms of change

The theme *informal interactive mechanisms of change* include the three interactive mechanisms of *activating activities*, *relationships that matter* and *supportive interactions* that worked together in multiple ways across settings to facilitate positive change.

Activating activities were found to initiate *supportive interactions* and enable the development of *relationships that matter*. These differed across settings owing to service variation although the nature of *supportive interactions*, *relationships that matter* and progression impact overlapped suggesting activity type alone was not the trigger for change.

In prisons the most frequently cited *activating activities* were supported and in-cell 'creative activities' (n = 13 FGs) and 'food and drink activities' with staff and peers (n = 11 FGs) identified across all prisons by providers and/ or participants. 'Creative activities' were described as 'feeding the creative brain' and enabling 'shared goals' (Pris-7, 11, 12, 13). 'Food and drink activities' were linked to having the 'time and space to break down barriers' and 'create community' (Pris-2, 6, 7, 9, 13, 14, 16). Other regularly named activities across expert groups were 'sporting activities' (n = 7 FGs) and 'informal social activities' (n = 8 FGs). All activities, except 'informal social activities' were linked to positive progression. 'Informal social activities' were instead linked to being occupied in the moment. The converse, not being occupied, was experienced as discouraging and led to boredom, identified as a negative trigger in two male prisons (Pris-2,10,12) by providers and participants.

Activating activities with *supportive interactions* were linked to all stages of prison progression. Initially experts described activities as supporting 'positive interaction' and the 'development of social skills' like engaging in 'mutual conversations' which in turn led to the development of 'healthy relationships' and the skills 'to safely challenge peers' (Pris-3, 4, 8, 7, 12, 14, 15, 16). *Activating activities* with *supportive interactions* changed how participants felt about themselves, 'more human' and 'valued' (Pris-3, 4, 7, 8) in turn leading to a greater 'sense of purpose', 'agency and hope' (Pris-7, 10, 11, 12, 16). This led to 'better engagement' in formal treatment (Pris-3, 4, 7, 10, 11, 12, 16), encouraging service participants 'out of their comfort zone' (Pris-7, 8, 12, 14, 16). Overtime, this translated into greater 'social skills', the ability 'to pick yourself up' and become 'more involved' and 'autonomous' (Pris-5, 8,10, 13). This led to a 'change in mindset', 'to think about the future' and 'prepare for release' (Pris-6, 7, 8, 9, 11, 14).

In the community (Prob-17, 18, 19) *activating activities* were an essential first step for some service participants towards engagement in formal OPDP services being 'non pressurised, non-prescriptive' spaces in which 'trust' and 'rapport' could build 'organically' in a 'social', 'unstructured' space. This in turn 'eases anxiety' and shifts negative perceptions of the service, triggers 'a sense of purpose' and 'responsibility', and participants start to feel 'less isolated' and 'open-up more to professionals', being able to 'express how they feel'. Overtime this led to 'greater engagement' across the service and 'independence building'.

Relationships that matter were linked to positive change on the OPDP in combination with *activating activities* and *supportive interactions* and negative change in combination with *barriers to change* and *responsivity factors*. The latter will be discussed separately under the second theme of *internal and external factors interacting with mechanisms of change*.

Service participant relationships with unspecified frontline providers include both operational and clinical staff where they were not clearly differentiated in the data. There were more opportunities identified for informal contact in prisons than in the community. In prisons these relationships were largely described as being experienced through proactive and reactive crisis management, support-related activities (Pris- 1, 2, 3, 5, 7, 8, 10, 11). These were more widely noted in the male estate across expert groups. In the community general conversations and joint OPDP-probation sessions were identified as opportunities for relationships to develop.

Service participant-provider relationships were linked to a significant range of *supportive interactions*. These were both environmental and individual. It was recognised that relationships took time and fluctuated over time. The environmental support described by experts across the male and female estate included, a 'relaxed social environment', where staff were 'present', provided 'a safe space' through 'working as a team' and 'showing a willingness to go above and beyond' (Pris-1, 2, 3, 4, 5, 7, 8, 11).

The incremental building of relationships through individual *supportive interactions*, described by experts in men's prisons and providers in probation, started with rapport building:

'Treating as people not patients', 'showing a genuine interest and willingness to engage', 'taking time to build trust before doing anything official' (Pris-1, 2, 3, 5, 7, 10, 13; Prob-19).

Staff needed to maintain and convey their belief in service participants, through sustained emotional support in the face of resistance and identify achievable goals in the face of self-doubt. Experts described the need to demonstrate:

'High levels of empathy, find the reasons behind behaviour, understand and have patience' and 'persistence, not writing them off if they behave poorly, give people a chance when others don't' to 'help service participants build confidence, present solutions, believe service participant capable of achieving things' (Pris-1, 2, 3, 4, 5, 7, 8, Prob-18).

Service participants' early responses were described by experts as the development of positive emotional states and healthy relationships with other service participants and in therapy as they:

'Feel understood', 'build trust, respect and confidence' and 'reduce anxiety'; 'learn to open up', develop 'positive relational styles' and 'tolerate daily frustrations' (Pris-2, 4, 5, 7, 8, 10, 11, Prob-17, 18).

Overtime, experts across prison sites further reported relationship shifts from negative to positive emotional attachments leading to a strengthening of therapeutic work and personal responsibility as they:

'Breakdown barriers', 'don't want to let staff down', 'develop a sense of autonomy' and 'discover better ways of handling things' (Pris-1, 2, 3, 7, 8, 10, 13, 16).

Ultimately, experts in one male prison identified service participants were 'happier by the time they leave' and ready for progression (Pris-5, 9).

More specifically, *service participant relationships with clinicians* were recognised as almost exclusively positive in the community but mixed in prisons. *Supportive interactions* with clinicians across services largely occurred in the *activating activities* of ad hoc check-ins or spontaneous conversations, sometimes over food and drink (Pris-1, 3, 7, 8, 10, 11, 12, 13, 14, 16, Prob- 18). Phone calls, support groups and practical support were additional points of interaction in the community (Prob-18, 19). The *supportive interactions*, and service participant responses found in these relationships are captured above.

Service participant relationships with prison officers were largely viewed as a positive mechanism of change across prisons. Similarly to clinicians, organic conversations were a core *activating activity* for informal relationships (Pris-7, 10, 11, 12, 13, 16). However, specific to these relationships were the non-OPDP specific, semi-formal activities of keyworker and shadow keyworker sessions, five-minute check-ins and peer mentor training (Pris-1, 8, 9, 10, 12, 13, 14, 15, 16). The *supportive interactions* described above in *relationships with unspecified frontline providers* cover service participant-prison officer relationships. It is of note that these support dynamics were explicitly identified as mechanisms of positive change (Pris-7, 8, 10, 12, 13, 14, 16) in the context of these relationships but not *service participant-clinician relationships* where non-treatment specific interactions were less explicitly linked to change.

Additionally, specific to prison officers, experts across prisons, identified the importance of 'breaking down barriers as screws' (an informal and derogatory term for more punitive prison officers), through a 'non-punitive', 'non-authoritarian' approach (Pris-7, 8, 10, 12, 13, 14, 16). This was identified as being of particular importance for IPP (Imprisonment for Public Protection sentenced) prisoners on one male site (Pris -9). Keyworker sessions and relationships, and the flexibility to change keyworkers, were described across prisons as an opportunity to continue treatment work on 'building knowledge and understanding of personality disorder and triggers' as well as a safe space to both 'seek advice' and 'vent' (Pris-7, 9, 10, 12, 13, 14, 15). These unique opportunities within these relationships were described by two provider groups on one male site as supporting progression overtime owing to the greater frequency of interaction, wherein service participants 'stopped seeing operational staff as authority figures, become comfortable opening up and engage more' (Pris-7, 8).

Service participant relationships with probation staff were only identified in the community but were largely viewed positively. *Activating activities* here were solely classed as informal conversations. Relationships mattered positively where probation officers bought into the OPDP, recognised service participant needs and recalled less. *Service participant relationships with external specialist services* were again only discussed in the community and were linked to the provision of differing levels of practical support around finances, housing and employment also identified under *service participant relationships with clinicians* in the community. The bottom line here was facilitating basic stability and relieving associated anxieties were a necessary first step to engagement.

Peer relationships impacted progression positively in prisons and the community. In prison peer relationships were identified as supportive in the high security and local male prisons only and both women's prisons (Pris- 6, 8, 9, 10, 11, 12, 13, 14, 16). *Activating activities* where support was experienced were peer mentor schemes, and food and drink activities and post-session support in the women's estate only. These activities facilitated both model and learn, and share and support opportunities, including modelling 'healthy relationships', 'sharing experiences' and 'providing hope and validation' amongst men and women (Pris- 8, 9, 10, 11, 12, 13, 14), additionally 'creating safety and preventing bullying' for men (Pris- 8) and 'reinforcing skills', 'opportunity to voice feelings' and develop 'friendship' for women (Pris-11, 15, 16). These dynamics initially led to service participants developing 'confidence', 'a sense of belonging', 'healthy relationships' and 'interpersonal skills' (Pris- 10, 14, 15). Men were also found to 'open up' (Pris- 8) whilst women reported 'attending groups because of friends' and developing 'perspective taking skills' (Pri- 11, 14). 'Mixing and engaging with other residents' and 'sharing experiences' were identified as helping men get through their sentence, 'feeling more contained' and moving towards progression (Pris- 12, 13). 'Attempting to instill learnt skills in others' was reported as having a similar impact on women (Pris- 11).

In the community the Hub (a community social support facility) was identified as a social space where peers could 'socialise', provide mutual support and 'share information', and more specifically 'meet others in a similar position but at different stages' and 'positively influence others' (Prob- 17, 18, 19). Overtime, this translated into 'building trusting relationships with staff, observing their positive interactions with others' (Prob- 17, 18, 19). Older service participants were particularly strong role models, demonstrating 'it is in their best interest to engage', either because of 'burn out' or 'life experience' or both.

Service participant relationships with friends and family enabled Pathway progression across all services. Providers across prisons and probation described relationships with friends and family, and more specifically intimate partners and children, as a source of 'continuous', 'positive support', 'prosocial influence', 'accountability and motivation' (Pris- 7, 8, 9, 10, 11, 13, 13, 15, 16; Prob-17, 18, 19). Friends and family received limited recognition from service participants in one women's prison, and one men's local and open prison only. Although, rarely discussed, they were considered an active trigger for change. Initially as a 'motivation to engage and improve relationships on the unit' or as a motivation 'to step up and be there for children' in the community. Overtime in the community they helped 'create a network' and 'enable progression' and in prisons at the point of transition to lower security facilities or release, family and friends were identified as providing 'motivation, purpose and preparation'.

Relationships between service providers were recognised as positively impacting service participants by providers only across all services. Activities that supported relationships were non-treatment information sharing activities in prisons, and joint clinical and operational led activities with service participants on one prison site and in probation. Both services identified the importance of team relationships' (Pris-11, 13, Prob-19), 'discussing service participant needs' (Pris-7, 11, 13, Prob-19) and 'modelling healthy relationships' (Pris-1, 8, 11, Prob-18) through being 'consistent' (Pris-7, 13 Prob-17, 19), 'good communication' (Pris- 1, 7, 8, 11, Prob-17, 18, 19) and 'learning from each other' (Pris-13, Prob-19). The most frequently identified relationships were between clinical and operational staff both in prison and probation.

Theme 2: Internal and external factors interacting with mechanisms of change

Responsivity factors and *barriers to change* reported under this theme included individual, OPDP and service factors that were largely found to negatively interact together and/ or with *relationships that matter* to disrupt progression. Although many responsivity factors were identified, few were explicitly linked to progression, however awareness was positively linked to *relationships that matter* and *supportive interactions*.

Responsivity factors that inhibited *activating activities* across prisons and probation were substance and medication misuse or getting medication wrong (Pris-6, 7, 8, 9, 10, 12, 13, Prob-17, 19) with the converse abstinence and getting medication right identified as enabling positive change in prison (Pris- 8, 9, 10, 13, 16). Misusing substances at best limited engagement with services across settings (Pris-7, 8, 9, 10, 13, 16 Prob-17, 19) and at worse induced active psychosis, as well as risking 'debt, threat, increased vulnerability and behaviour deterioration' in prisons (Pris-8, 14). Dealing substances was also linked to violence (Pris-8). Either set of circumstances could result in removal from the service. Some substance misuse in prisons was tied into a negative chain of events through peer influence, poor staff treatment, loss of privileges and a downward spiral of behaviour. Alternatively, 'honesty', 'appropriate staff support' and 'trust' could trigger positive change (Pris-12).

In men's prisons, providers observed staff awareness of *responsivity factors*, including 'developmental maturity', 'neurodiversity' and 'gender needs' supported relationships (Pris-1, 5, 8) whereas staff oversensitivity to perceived PD traits was disruptive (Pris-8). Initially and overtime some service participants, were described by experts across services, as developing an over-reliance on individual relationships and/ or the service, that manifest in PD related traits, including 'avoidance', 'entitlement', 'over-expectation' or 'acting out to get support' (Pris-7, 10, 13, 15, 16, Prob-18). Ultimately, 'trust' for some was described by providers in two men's prisons as highly fragile or insurmountable and could lead to service withdrawal (Pris-2, 7).

Barriers to change within *provider-service participant relationships* were identified by experts across prison sites, as the converse of *supportive interactions* - poor, forced or inconsistent communication and inconsistent staffing (Pris-1, 4, 5, 6, 7, 8, 15). Such dynamics could lead to service participant mistrust, although it is of note that this could also be an initial response to *supportive interactions* where providers identified service participants 'find the fact that the staff listen and give them time difficult to understand' (Pris-7, 9). One provider group observed this may be because of the sentence related *responsivity factor* of 'previous history of poor experiences with staff' (Pris-9).

An additional *barrier* described in one service participant group regarding *service participant-clinician relationships* was that 'service participants refuse to engage' with clinical staff perceived to be 'punitive' (Pris- 8). Again, previous negative experiences of staff were problematic, particularly for Black and Minority Ethnic service participants (Pris-8). A small number (n = 5 FG) across services identified initial negative responses to clinical staff, related to the perception that 'all encounters are regarded as therapy and therefore threatening' and a largely female clinical team, that for some could be triggering. Overtime, staffing inconsistency was identified by one group as 'triggering abandonment issues' and behaviour deterioration.

The pros of the unique prison officer role could also be experienced as negative, where again 'past history', 'incidents' and 'trust issues with officers' could ultimately result in 'a refusal to work with operational staff' (Pris-7, 6, 8, 10, 11, 12) and resource *barriers* with staff movement and shortages undermine the principles of 'consistency' and 'planned endings' (Pris-7, 8, 10, 14). Poor past experiences of Black and Minority Ethnic service

participants as well as current negative responses from officers who 'treated them differently' and expressed the belief service participants were 'only accepted onto the unit owing to their ethnicity' (Pris-8, 13) were identified on one male prison site by service providers.

Barriers to change linked to provider-provider relationships were identified by service participants at the open prison site, as 'not enough communication and feedback between staff' (Pris-5). Specific difficulties were identified around progression and the different ways of working between OPDP services and wider organisational changes, including parole in prisons and governance in probation. In the community the 'stigmatising language of the Pathway', 'staff inconsistency' and some probation officers 'not buying into' or supporting service engagement were barriers that could ultimately lead to recall. This was exacerbated by the barriers of an overstretched service and frequent changes to probation officers that initially 'prevent the development of trust' and later 'destabilise' service participants (Prob-17, 18, 19). Limited resources and procedural obstacles also created *barriers* to external specialist support.

'Negative dynamics between residents' were identified as a *barrier* by prison experts. Individual 'residents not settling and leaving can upset others' as well as 'one negative person' or 'bullying' behaviours (Pris- 5, 6, 7, 8, 14). In terms of group dynamics, experts called out 'cliquey wings', 'wrong' and 'difficult' groups resulting in units feeling 'unsafe' (Pris-10, 13, 15). Other issues included the perceived misuse of peer support 'to get out of cell not support others' (Pris - 13). Antisocial 'personality traits' (such as impulsivity and an exploitative stance towards others) were also identified as *responsivity factors* that negatively impacted peer relationships (Pris -7, 8, 15). Additionally, in one prison, 'ethnic minority individuals' were reported as 'doing less well as they are treated differently by their peers' (Pris- 8). Negative peer dynamics could limit progression. For women they could lead to 'resentment of others poor emotion regulation' and 'lead to withdrawal and self-isolating' behaviour or be 'a bad influence' (Pris- 14, 15). Similar examples were given for men as well as 'making it hard to be vulnerable, open up' (Pris- 6, 8). Overtime poor peer dynamics led to 'relationship breakdowns', 'behaviour deterioration' and 'violence' which could end in deselection.

'Unstable family networks' were a *responsivity factor* that inhibited progression in multiple ways across services, owing to historical 'family dysfunction', 'past trauma' and 'domestic violence', and current 'family problems', including 'illness', 'bereavement', 'relationship breakdowns', 'abusive relationships', 'unwanted pregnancies' and 'loss of custody'. 'Lack of family support' and 'physical distance' were problematic as were the perceived 'stigma' and 'lack of understanding' of the OPDP (Pris- 5, 8, 9, 11, 13, 14, 16; Prob-17, 18, 19). Only two participant groups, one female and one male open prison identified difficulties. Family difficulties were identified as a catalyst for negative change in prison and the community. 'Difficulties where children are involved evoke a lot of emotion' and these and other problems could lead to an immediate 'deterioration in behaviour'. Overtime service participants 'struggle with focus and engagement', and experience 'anxiety' and 'emotional instability' that can lead to 'negative behaviours', 'relationship breakdowns' and 'self-harm' (Pris-8, 11, 14, 16; Prob-17, 19). Negative responses were largely identified in women's prisons and the community.

Discussion

The relatively large scale, multi-site, service and expert nature of the sample in this exploratory qualitative study allow for some transferability of the findings across the OPDP.

Nevertheless, clear limitations were the study focus on the London area only, the lack of scope to provide detailed descriptions of individual services which differ significantly across England and Wales, the relatively small community sample that did not include expert service participants and the potential for others to define experts differently. It is recognised that differentiating formal and informal interventions is not straightforward and capturing *all* non-treatment activities, support and relationships is a challenge. A member checking exercise was conducted to help validate the accuracy and completeness of the lists of informal mechanisms and responsivity factors generated. However, these cannot be exhaustive and list length may have limited engagement in the checking process, particularly for service users with literacy difficulties. The importance of items and the nature of progression were only explored within focus group narratives which limit the opportunity for detailed, personal explanations, and it was beyond the scope of the study to consider interaction with formal treatment, all require further empirical testing.

The primary aim of the study was to comprehensively explore all informal activities, relationships and support that impact OPDP progression. A secondary aim was to explore responsivity factors that inhibit or enable progression. The intended outcome to contribute to an evidence-based understanding of the theoretical model of holistic and responsive care (Craissati, 2017), including the psychologically-informed relationship-focused PIPE model (Bolger and Turner, 2015), operating across prison and community Pathway services (NHS England, 2023).

The primary aim was met through the identification of the main theme *informal interactive mechanisms of change* that contained separate activities, relationships and supports within the sub-themes of *activating activities*, *relationships that matter* and *supportive interactions* that worked in combination, beyond explicitly agreed treatments, to enable progression. The study illustrated the value of informal activities as a core opportunity to model, provide and access a range of support and develop and maintain healthy relationships with operational and clinical staff, peers and family and friends that were enhanced through relationships between service providers. Ultimately although not straightforwardly, space and safety, empathy and persistence led to respect and rapport, trust and openness, and involvement and agency. These informal mechanisms aided progression through the practice and action of cognitive, emotional and behavioural change and facilitating engagement in formal treatment. Additionally, 'informal social activities' were identified as important to being occupied in the moment contributing to the safe and contained environment needed for change, with the absence of such activities conversely being detrimental in the male closed estate reflecting earlier findings in the OPDP high security predecessor service (Sinclair *et al.*, 2012).

Overall, the findings build on the national evaluations of OPDP (Moran *et al.*, 2022) and OPDP PIPE services (Kuester *et al.*, 2022) and others (see Turley *et al.*, 2013; Minoudis and Kane, 2017; Blagden *et al.*, 2023) that have identified but not comprehensively explored the importance of positive interactions, supportive and trusting relationships with clinical and operational staff, and the wider social environment to psychological well-being and behavioural change on the OPDP. The findings also reflect the wider penology literature on the crucial nature of prison officer-prisoner relationships to personal development and successful release (Auty and Liebling, 2020), that similarly indicate the importance of 'present' officers (Crewe, Liebling and Hulley, 2014), 'right' relationships (Liebling, 2011a), and a 'moral' climate (Liebling, 2011b). There is limited evidence that PIPEs can contribute to such climates (Liebling *et al.*, 2019). Our research expands this to suggest that the holistic OPDP model operating across men's and women's prisons can deliver the officer-

prisoner informal and semi-formal activities, support and relationships, and requisite climate needed for change.

Several further areas for exploration were identified through the study. Probation practice literature similarly illustrates the pivotal nature of supportive probation practitioner-supervisee relationships to desistance. However, there is a lack of evidence about what works best (Beck and McGinnis, 2022). Our findings are also limited owing to lack of access to people on probation, however service participant relationships with frontline providers and between service providers in the community appear to map onto the concepts identified above. The contribution of family ties to desistance are argued in the Farmer Report (2017) and were widely recognised by service providers not participants in our study requiring further investigation. Male peer relationships are contentious in the criminological literature owing to their known antisocial influence, similarly to that of families (Farrington, Ttofi and Piquero, 2016). Both featured as inhibitors in our study, however service participants and providers more often found peer relations across services to be a great strength to progression except in the men's open and training prisons. The prosocial influence of peers for adult men and women in prisons and probation outside mentoring schemes, where support is positively received but only partially understood (Brierley *et al.*, 2025), demands further exploration.

The secondary aim was met through the exploration of two interactive themes of *barriers to change* and *responsivity factors* – with the key finding that OPDP progression can be inhibited when specific barriers to change combine with specific responsivity factors. *Barriers to change* matched those found in previous studies (Jarrett *et al.*, 2025; Kuester *et al.*, 2022; Turley *et al.*, 2013). *Responsivity factors* mapped less closely with an earlier quantitative study (Jolliffe *et al.*, 2017) of factors associated with OPDP progression in the community where offence type and risk levels were included. Neither were identified in the current study. However, Jolliffe *et al.* viewed progression differently to the current study with the end point being service start, the beginning point for the current study. Factors associated with progression to service start were therefore linked to the OPDP target population criteria of risk level and offence type (NHS England, 2023). It may be that neither of these factors were identified in the current study as these were not differentiating factors for the in-service group. Jolliffe *et al.* did find that referrals of Non-White ethnicity were less likely to commence services despite being proportionately represented throughout the referral process. The current study tentatively indicates this may be because of negative past or current experiences with peers and providers partly supporting Jolliffe *et al.*'s reflections on systemic discrimination (see Lammy, 2017). Ultimately buy-in and trust of service participants and providers were essential to progression and could be won or lost in service but severely disrupted through *responsivity factors* and *barriers to change*.

In conclusion, the findings provide qualitative evidence to support the OPDP (NHS England, 2023) and PIPE (Bolger and Turner, 2015) theoretical models of change that centralise the importance of relationships. In comprehensively exploring informal mechanisms for change – both the enablers and inhibitors – the findings have the potential to further inform these models if the mechanisms can be narrowed down and their link to progression tested. This focus group study will inform the first phase of a Delphi study to meet the first objective. The research helps demonstrate that any evaluation of the OPDP model needs to capture informal mechanisms of change alongside formal treatment interventions and to recognise responsivity factors to comprehensively measure the complexity of the OPDP. This is the evidence base needed to meet the system level ambitions of the national strategy of 'supporting a whole system response' and 'prioritising a relational practice culture' (NHS England, 2023). This study will therefore inform the development of a new multiple,

embedded case study design to capture individual services and service user progression across informal and formal Pathway services.

References

- Auty, K. M. and Liebling, A. (2020), "Exploring the Relationship between Prison Social Climate and Reoffending", *Justice Quarterly*, Vol.37 No.2, pp.358-381, doi: 10.1080/07418825.2018.1538421.
- Beck, P. and McGinnis, E. (2022), "An exploration of the relationship between probation supervision and desistance: a systematic narrative review", *Irish Probation Journal*, No.19, pp.97-118.
- Blagden, N., Evans, J., Gould, L., Murphy, N., Hamilton, L., Tolley, C., and Wardle, K. (2023), "“The People Who Leave Here Are Not the People Who Arrived.”: a qualitative analysis of the therapeutic process and identity transition in the offender personality disorder pathway", *Criminal Justice and Behavior*, Vol.50 No.7, pp.1035-1052.
- Bolger, L., and Turner, K. (2015), "*Psychologically Informed Planned Environments - model description document*", National Offender Management Service.
- Braun, V. and Clarke, V. (2021), "Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches", *Couns Psychother Res*, Vol.21, pp.37-47.
- Brierly, A., Best, D., McDermott, D. and Woodfield, R. (2025), "Peer Mentors and Desistance: a systematic literature review and synthesis". *Criminal Justice and Behaviour*, Vol.52 No.7, pp.1128-1147, doi: 10.1177/00938548241313387.
- Burns, T., Yiend, J., Fahy, T., Fitzpatrick, R., Rogers, R., Fazel, S., and Sinclair, J. for the IDEA Group (2011), "Treatments for dangerous severe personality disorder (DSPD)", *Journal of Forensic Psychiatry and Psychology*, Vol.22 No. 3, pp.411-426.
- Camp, J., Joy, K. and Freestone, M. (2018), "Does "Enhanced Support" for Offenders Effectively Reduce Custodial Violence and Disruption? An Evaluation of the Enhanced Support Service Pilot", *International Journal of Offender Therapy and Comparative Criminology*, Vol.62 No.12, pp.3928-3946.
- Cho, J., and Trent, A. (2006), "Validity in qualitative research revisited", *Qualitative research*, Vol.6 No.3, pp.319-340.
- Craissati, J. (2017), "The clinical development of the London pathways partnership", *Criminal Behaviour and Mental Health*, Vol.27, pp.265-268.
- Crewe, B., Liebling, A. and Hulley, S. (2014), "Heavy–light, absent–present: rethinking the ‘weight’ of imprisonment", *The British Journal of Sociology*, Vol.65 No.3, pp.387-410.
- Farmer, M. (2017). "*The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime*", Her Majesty's Stationary Office, London.
- Farrington, D.P., Ttofi, M.M. and Piquero, A.R., (2016), "Risk, promotive, and protective factors in youth offending: results from the Cambridge study in delinquent development", *Journal of Criminal Justice*, Vol.45, pp.63-70.

- Forster, O. and Shaw, J., (2018), "Self-injury group psychotherapy intervention for young offenders: a pilot study", *The Journal of Forensic Psychiatry & Psychology*, Vol.29 No.5, pp.733-743.
- Goldsmith, L. (2021), "Using framework analysis in applied qualitative research", *The Qualitative Report*, Vol.26 No.6, pp.2061-2076. doi:10.46743/2160-3715/2021.5011.
- Green, J. and Thorogood, N. (2004), *Qualitative methods for health research*, Sage, London.
- Jarrett, M., Trebilcock, J., Weaver, T., Forrester, A., Cambell, C.D., Khondoker, M., Vamvakas, G., Barrett, B. and Moran, P.A. (2025), "The Offender Personality Disorder (OPD) pathway for men in England and Wales: A qualitative study of pathway user views about services, perceived impact on psychological wellbeing, and implications for desistance", *Criminal Justice and Behavior*, Vol.52 No.1, pp.98-118.
- Jolliffe, D., Cattell, J., Raza, A., and Minoudis, P. (2017a), "Evaluating the impact of the London Pathway Project", *Criminal Behaviour and Mental Health*, Vol.27 No.3, pp.238-253.
- Jolliffe, D., Cattell, J., Raza, A., & Minoudis, P. (2017b), "Factors associated with progression in the London pathway project", *Criminal Behaviour and Mental Health*, Vol.27 No.3, pp.222-237.
- Joseph N., Benefield N. (2010), "The development of an offender personality disorder strategy", *Mental Health Review Journal*, Vol.15 No.4, pp.10–15.
- Katakis, P., Schlieff, M., Barnett, P., Rains, L.S., Rowe, S., Pilling, S. and Johnson, S., (2023) "Effectiveness of outpatient and community treatments for people with a diagnosis of 'personality disorder': systematic review and meta-analysis". *BMC psychiatry*, Vol.23, pp.1-29.
- Kitzinger, J. (1995), "Introducing Focus Groups", *British Medical Journal*, Vol.311, pp.299-302.
- Kuester, L. Freestone, M., Seewald, K., Rathbone, R. and Bhui, K. (2022), "*Evaluation of Psychologically Informed Planned Environments (PIPES) Assessing the first five years*", HMPPS, MoJ Analytical Series, London.
- Lammy, D. (2017), "*The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System*", Lammy Review, London.
- Laub, J. H., and Sampson, R. J. (2001). "Understanding desistance from crime". *Crime and Justice*, Vol.28, pp.1-69.
- Liebling, A. (2011a), "Distinctions and distinctiveness in the work of prison officers: legitimacy and authority revisited". *European Journal of Criminology*, Vol.8 No.6, pp.484-499.
- Liebling, A. (2011b), "Moral performance, inhuman and degrading treatment and prison pain". *Punishment and Society*, Vol.13 No.5, pp.530-550.
- Liebling, A., Laws, B., Lieber, E., Auty, K., Schmidt, B.E., Crewe, B., Gardom, J., Kant, D. and Morey, M., (2019), "Are hope and possibility achievable in prison?" *The Howard Journal of Crime and Justice*, Vol.58 No.1, pp.104-126.

Mathlin, G., Freestone, M., Taylor, C. and Shaw, J. (2021), "Offenders with Personality Disorder who Fail to Progress: A Case Control Study using PLS-SEM Path Analysis", *JMIRx Med*, Vol.2, No.4.

Minoudis, P. and Kane, E. (2017), "It's a journey, not a destination-From dangerous and severe personality disorder (DSPD) to the offender personality disorder (OPD) pathway". *Criminal Behaviour and Mental Health*, Vol.27, pp.207-213.

Moran P., Jarrett M., Vamvakas G., Roberts S., Barrett B., Campbell C., Khondoker M., Trebilcock J., Weaver T., Walker J., Crawford M. and Forrester A. (2022), "*National evaluation of the male offender personality disorder pathway programme*", HMPPS, MoJ, London.

NHS England (2023), "*The offender personality disorder (OPD) pathway: a joint strategy for 2023 to 2028*". Reference: PRN00321.

Ogunbameru, O. A. (2003), "Focus groups: Issues and approaches", *The Anthropologist*, Vol.5 No.1, pp 1-8.

Ritchie, J., and Spencer, L. (1994), "Qualitative data analysis for applied policy research", Bryman, A. and Burgess, R. (Ed.s), *Analysing qualitative data*, Routledge, pp.305-329.

Shaw, J., Minoudis, P., Hamilton, V. and Craissati, J. (2012), "An investigation into competency for working with personality disorder and team climate in the probation service", *Probation Journal*, Vol.59 No.1, pp.39-48.

Sinclair, J., Willmott, L., Fitzpatrick, R., Burns, T., Yiend, J., and IDEA group. (2012), "Patients' experience of dangerous and severe personality disorder services: qualitative interview study". *The British Journal of Psychiatry*, Vol.200 No.3, pp.252-253.

Tang, K. C. and Davis, A. (1995), "Critical factors in the determination of focus group size", *Family Practice*, Vol.12, pp.474-475.

Turley, C., Payne, C., and Webster, S. (2013), "*Enabling features of Psychologically Informed Planned Environments*". Ministry of Justice, London.

[1] Suitability for the OPDP is ascertained through comprehensive screening of all individuals within the English and Welsh criminal justice system and hence a formal diagnosis of personality disorder is not required.

[2] Frequency of mention across focus groups is indicated by n = number of focus groups (FG).

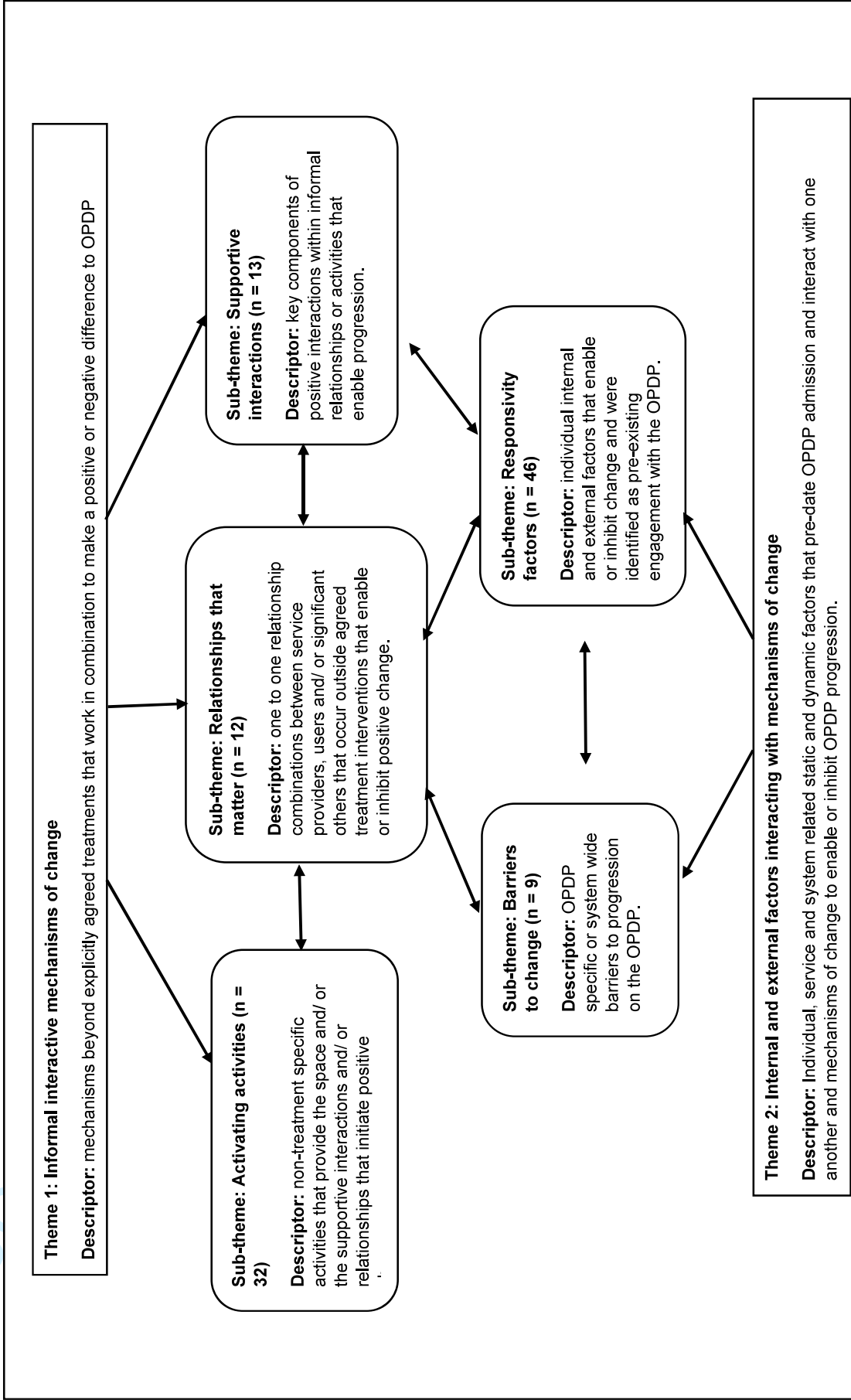
[3] Each focus group is identified through a number (1-19) with prison service groups indicated by Pris and community service groups indicated by Prob. Expert differences are indicated in the prose.

Table I Expert participants across OPDP service location, focus groups and area of expertise.

OPDP service location	Total focus groups per service location	Providers		Service participants	Total participants per service location
		Clinical ¹	Frontline operational		
London Probation Service	3	11	7	0	18
HMP Downview	2	3	0	4	7
HMP Send	2	1	2	6	9
HMP Swaleside	4	7	6	5	18
HMP Brixton	2	2	3	5	10
HMP Aylesbury	4	6	4	8	18
HMP Stanford Hill	2	2	2	4	8
Total	19	32	24	32	88

¹ Two clinical providers attended two focus groups working across HMP Brixton and community OPDP services

Figure 1 – Themes, sub-themes and descriptors: the figure indicates the two main themes and five interactive sub-themes of analysis and the number of individual items that were identified under each sub-theme (see supplementary tables for full list). The arrows indicate the relationship between the themes and sub-themes and the interactive nature of the sub-themes.



A systematic exploration of informal mechanisms of change on the Offender Personality Disorder Pathway across prisons and probation

32 non-treatment specific activities identified across prison and probation OPDP services/ experts

Category	Item	Examples
Onsite indoor activities	1. Relaxation activities	e.g. yoga, breathing exercises
	2. In-house supported creative activities	e.g. music, creative writing, craft activities, making podcast
	3. In-cell creative activities	e.g. fine cell work, hobbies
	4. In-house group sports	e.g. sports events, football, darts
	5. Informal solo activities	e.g. crosswords
	6. Informal social activities	e.g. watching films together, card games
	7. Informal organised activities	e.g. quiz, bingo
	8. Celebratory events	e.g. birthdays, holidays, Christmas, noticing small wins
	9. Food and drink activities with staff	e.g. food and drink together
	10. Advanced warnings	e.g. cancellations, staff changes, planned ending
	11. Spontaneous activity with clinicians	e.g. general conversation/ laugh/ informal check ins
	12. Spontaneous activity with operational staff	e.g. general conversation/ laugh/ informal check ins
	13. Semi-formal activity with operational staff	e.g. KW sessions, 5 minute check ins
	14. Therapy breaks	
	15. Peer mentor training	
	16. Open door policy	
Onsite service user led activity	17. Service user led meetings	e.g. community meetings, landing meetings
	18. Service user initiated groups	e.g. creative group, debates
	19. Peer mentor jobs	
	20. Semi-formal peer mentor activity	e.g. active listeners, buddy system
	21. Informal peer mentor activity	e.g. help in between sessions, general conversations
Onsite external provision	22. Food and drink activities with peers	e.g. cooking, baking, washing up, breakfast club
	23. Outside providers	e.g. speakers, workshops, lived experience talks
Onsite outdoor activity	24. Prison wide activities	e.g. education, OMU engagement
	25. Farms and gardens	
Off site preparation for release	26. Temporary release activities	e.g. ROTL, time accompanied, time unaccompanied
	27. Engaging with community services	
Substance related	28. Illegal substance abstinence	
	29. Getting medication right	
Provider to provider activities	30. Non-treatment specific on-site activities	e.g. staff debriefing, meetings
	31. Informal cross site activities	e.g. progress check ins
	32. Informal support	e.g. WhatsApp groups

12 relationships identified across prison and probation OPDP services/ experts

Category	Items
----------	-------

Relationships between Pathway and other service providers	1. Pathway clinical staff with Pathway operational staff
	2. Pathway clinical staff with governor(s)
	3. Pathway staff with probation
	4. Pathway staff with OMU (Offender Management Unit)
	5. Pathway services with other services
Service user relationship with peers, families and/ or friends	6. Service user with peers on Pathway
	7. Service user with friends/ family
Service user relationship with Pathway staff	8. Service user with Pathway operational staff
	9. Service user with Pathway clinical staff
Service user with non-Pathway site service providers	10. Service user with governor(s)
	11. Service user with OMU (Offender Management Unit)
	12. Service user with probation

13 interactions identified across prisons and probation OPDP services/ experts

Category	Item	Examples
Provider	1. Joint working	e.g. clinical and operational staff, specialist services
Reciprocal	2. Collaborating with SU	e.g. shared responsibility, co-production of service
	3. Persistence of staff/SU	e.g. breakdown barriers, build trust, address ruptures
Peer	4. Peer to peer sharing of experiences	
Staff to service user	5. Pro-social modelling	e.g. healthy relationships
	6. Safe and supportive environment	e.g. able to vent, staff present
	7. Consistency	e.g. continuity of care/ communication/ staffing
	8. Limit setting	e.g. containing
	9. Staff flexibility	e.g. adapt to needs, open door policy
	10. Staff sincerity/ honesty	e.g. genuine
	11. Staff empathy/ validation	e.g. emotional support
	12. Curiosity	e.g. willing/ interested to look under the surface
	13. Treating as human beings	e.g. use of first names, informal conversations

9 barriers identified across prisons and probation services/ experts

Category	Item	Examples
Pathway specific	1. Stigmatizing language of Pathway	
	2. Intervention overwhelming	
	3. Staff inconsistency of approach	e.g. too punitive vs too soft
	4. Negative dynamics between residents	e.g. bullying, cliques
System wide	5. Resourcing	e.g. staff shortages/ burnout, changes, lack of purposeful activity, housing difficulties, limited services for women
	6. Confidentiality limitations	
	7. Knock backs	e.g. parole, new charges, limited ROTL, loss of enhanced, recall, negative media attention
	8. Too many partners	e.g. bureaucracy, differing policies
All	9. Communication	e.g. lack of, inconsistent

46 responsivity factors across prisons and probation services/ experts

Category	Item
----------	------

Personality traits	1. Stable antisocial
	2. Insecure attachment
	3. Avoidant
	4. Chaotic antisocial
	5. Emotionally unstable
	6. Paranoid
	7. Narcissistic
	8. Secure attachment
	9. Being empathic
	10. Being respectful
	11. Being determined
	12. Being internally motivated
	13. Being externally motivated
Attitudes and skills	14. Hope for better self
	15. Stop caring about reputation
	16. Ability to self reflect
	17. Healthy coping mechanisms
	18. Stop caring about reputation
Mental health	19. Limited/ insincere engagement with the Pathway
	20. Post traumatic stress disorder (PTSD)
	21. Past trauma leading to trust issues
	22. Substance/ medication misuse/ dependency
Neurodiversity	23. Active psychosis
	24. Specific learning difficulties (SpLD) , e.g. dyslexia, dyspraxia
	25. Autism
	26. Attention Deficit Hyperactivity Disorder (ADHD)
	27. Learning difficulty/ low cognitive functioning
Age-related	28. Brain injury
	29. Biological maturity
Ethnicity	30. Greater life experience
	31. Black
	32. Asian
	33. Mixed
	34. White
Sentence related	35. Other (please specify)
	36. IPP (imprisonment for public protection)
	37. Previous experience of criminal justice professionals
	38. Determinate sentence
Behaviour related	39. Indeterminate - Mid tariff
	40. Indeterminate - Post tariff
	41. Involvement in gang culture
Background related	42. Debt problems
	43. Substance dealing
	44. Socio-economic deprivation
	45. History of being in care
	46. Unstable family network