Treating dangerous and severe personality disorder in high security: lessons from the Regional Psychiatric Centre, Saskatoon, Canada

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ABSTRACT We describe the approach to risk reduction at the Regional Psychiatric Centre (RPC) in Saskatoon, Canada, making legal and institutional comparisons with the new Dangerous and Severe Personality Disorder (DSPD) Service to be established in high security hospitals in England and Wales. The RPC applies cognitive behavioural techniques to reduce recidivism, and current evidence suggests the same approach should form the core of the treatment regime in DSPD units. The key to success is the strict management of programme integrity, to deliver intensive treatment that is tailored to the individual's abilities and readiness to accept change. The Stages of Change model, derived from addictions, allows the planning, monitoring and evaluation of treatment. It plays an important role in maintaining staff morale by providing an objective measure of success within a reasonable timeframe. The DSPD service will require effective management and sophisticated information systems to support these developments. The RPC has the advantage of clear pathways through the service. Patients are able to return to an ordinary prison whenever they wish, and the average length of stay is about 2 years. The DSPD service will have to guard against beds becoming...
INTRODUCTION

Mental health services in the UK have been reluctant to treat patients with personality disorders and slow to evaluate interventions to reduce the risk of offending. The government is determined that these services should catch up with the rest of the world. A proposed new Mental Health Act would be permissive, allowing more scope for compulsory treatment by removing the treatability criterion (Department of Health and Home Office, 2000). However, the power to treat is useless without the means to do so and resources have been committed to develop a new service for individuals with a Dangerous and Severe Personality Disorder (DSPD) (Home Office and Department of Health, 1999).

Whilst DSPD is not mentioned in the proposed legislation, it will be the criterion for admission to a new service. The proposed definition consists of three components:

(1) A risk of greater than 50% of committing a serious offence, as measured by actuarial, standardized instruments.
(2) The presence of a severe personality disorder.
(3) An established link between the personality disorder and the risk of offending.

The threshold of risk for entry to the service is high, with a serious offence defined as one resulting in physical or psychological harm from which the victim is unlikely ever to recover. Psychopathy is an example of a severe personality disorder, the guideline range being a score of 25 or more on the Psychopathy Checklist (Hare, 1991).

PLANNING A SERVICE

The national service will have a core of 400 beds in high security, half in prison and half in hospitals (Broadmoor and Rampton). The first two authors lead the development of a 70-bed unit at Broadmoor and are developing a treatment model. The risks for a hospital PD service are spelled out in the Fallon Inquiry into the Personality Disorder Service at Ashworth Hospital (Fallon, Bluglass, Edwards and Daniels, 1999), which had amongst its principal criticisms a lack
of clarity about why patients were admitted, and the absence of treatment whilst they were there. The new service must avoid these mistakes.

Although DSPD is a new term, there is plenty of evidence relating to the assessment of psychopathy, and the reduction of risk in recidivist offenders (Hare, 1991, 2002; McGuire, 1995). Canada is a good place to start when looking for a service model, because it has a long history of providing and evaluating treatments for high risk offenders. The first two authors visited the Regional Psychiatric Centre (RPC) in Saskatoon, Canada where the third author is the Director of Research and the fourth author is the Executive Director of the Centre. Our aims were first to compare the legal and institutional approaches to risk reduction in the two countries, and then to identify aspects of the Canadian service that could be transplanted to a high security hospital in England.

THE REGIONAL PSYCHIATRIC CENTRE

The Regional Psychiatric Centre in Saskatoon was established in 1978. With 206 beds, it operates as a hospital under the Saskatchewan Mental Health Act and as a Penitentiary under the Corrections and Conditional Release Act. The Centre provides services to provincial and federal prisoners, to the Courts in the region, and to the Department of Health. Although operated by the Correctional Services of Canada (CSC), the Centre is situated on land owned by the University of Saskatchewan, whose position as landlord and full partner gives it influence over the running of the facility.

The RPC divides its beds into four units of 22 to 24 beds and one of 100 beds for men, as well as a 12-bedded unit for women. Security is the responsibility of uniformed correctional officers, whilst therapy is delivered by multi-disciplinary health teams, including nurses, psychiatrists, psychologists, occupational therapists, and social workers. Aboriginal elders, chaplains, and parole officers work with the teams to promote, reinforce and support interventions.

There is a strong emphasis on cognitive behavioural techniques, both group and individual. Rather than describe the details of treatment, we focus on philosophy and principles, beginning with the assumptions underlying the service.

The aim of intervention is to reduce the risk of offending

The treatment of mental disorder is a means to the end of risk reduction. This principle is alien to large sections of British psychiatry, where doctors claim that their role is to treat mental disorder and to alleviate suffering, with reduction of risk as an incidental benefit.
There have been dissenting voices in England. MacCulloch and Bailey (1991) argued that forensic services differ from other mental health services in that there is an expectation that their intervention will reduce their patients' dangerousness. It follows that recidivism rates are of greater importance in measuring the effectiveness of forensic psychiatric services, than are measures of clinical relapse. The authors believe that the truth of these statements is self-evident, and that it is unreasonable to expect public funding of a high-cost, low volume service, without a reciprocal and demonstrable reduction in risk to the public.

There is no room for ambiguity in respect of DSPD's aim of improving public protection. A failure in this respect would probably lead to the demise of the pilot projects. The speed with which mental health professionals will adapt to this explicit prioritization of risk is one of the uncertainties threatening the pilots. Early indications are that some senior psychiatrists remain uneasy but many others welcome a clear statement of an aim that has often been treated as if it were a dirty secret. As some time members of the public, the authors see nothing wrong with a clear commitment to their protection as a guiding principle for a service that will take some of the most dangerous offenders in the country.

Cognitive behavioural treatment (CBT) is the most effective means of reducing the risk of recidivism

A mass of empirical evidence supports the use of cognitive behavioural interventions to reduce the risk of re-offending (see Lösel, 1985). Other psychotherapeutic approaches may have their specific uses but there is no evidence to suggest that, used alone, they reduce risk.

Cognitive behavioural treatment is explicit in its aims and methods, setting clear behavioural targets and sharing information about assessment, treatment and progress. Skilled supervision of therapists is necessary, but training in some cognitive-behavioural techniques is less onerous than, for example, psychodynamic approaches. Standardization and the use of treatment manuals are strongly encouraged.

The empirical evidence on CBT is now so advanced that, as well as knowing that it is effective, we have estimates of just how effective it is in a range of offenders. It is worth summarizing this research here, partly because it has been given so little prominence in this context. One of the remarkable aspects of the development of DSPD, in a world preoccupied by evidence-based medicine, is that a large and expensive inpatient service has been commissioned without any explicit estimate of the likely benefit of treatment – or even a guarantee that treatment is effective in the target group.

Hanson et al. (2002) reviewed 43 studies that included at least an incidental matched untreated group. They involved a total of 9,454 sexual
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offenders (5,078 treated and 4,376 untreated) and meta-analysis showed a significant reduction in recidivism rates in the treated group. Treated vs. untreated recidivism rates were 12.3% vs. 16.8% for sexual offending and 27.9% vs. 39.2% for all offending. If the analysis includes only treatments meeting current standards, the results are even better: 9.9% vs. 17.4% for sexual recidivism, and 32% vs. 51% for all recidivism.

Coming first to the good news, the proven existence of an effective treatment in the management of sexual offenders fosters optimism. We can proceed with confidence to design a treatment programme that should have benefits for most offenders, even if those benefits may be less in a difficult population. The principles of programme design, delivery and support are well established and, if we are able to apply these principles in a new environment, we can expect some success. Refinements may be needed later, but we have a starting point.

There are positive medico-legal implications also. The Mental Health Act 1983 has been seen as a barrier to the treatment of psychopathic patients, because of the requirement that treatment must be likely to 'ameliorate or prevent deterioration' in the patient's condition. Courts have sometimes interpreted this wording loosely, with treatment amounting to nursing care alone and incapacitation seen as synonymous with the prevention of deterioration, but there is now added ammunition for the service wishing to detain and treat such patients.

The evidence shows that, on the balance of probabilities, completion of a suitable CBT programme will decrease the risk of recidivism. Decrease in risk seems a reasonable synonym for treatment in this group, even if purists argue that the underlying disorder remains unchanged. This approach reduces the question of treatability to the offender's willingness to complete the programme. It seems unlikely that legislators intended the Act to allow high risk patients to be discharged simply because they refuse to undergo treatment, or because treatment would be a slow process, so the existence of effective programmes takes a lot of the heat out of the debate. Certainly, it should be possible to run a DSPD service in hospitals without changing the Mental Health Act, and this is now happening.

On the other hand, there is plenty of bad news for DSPD from existing research on effectiveness. Marshall and McGuire (2003: 654) point out that we do not know 'with which types of offenders' treatment is most likely to be effective. We may not know, but we can make a good guess. The meta-analytic studies included many whose offences were confined to a domestic setting, in the absence of personality disorder or an otherwise deviant lifestyle. Treatment is likely to be most difficult in predatory offenders, with 'stranger' victims and high psychopathy scores, which are precisely the characteristics needed to gain entry to DSPD services. It remains to be seen whether psychological treatments will have similar effects in the DSPD
population, where high PCL-R scores are the norm, even if the treatments are given intensively and attempts are made to address 'therapy-interfering behaviours'.

Indeed, this is the main scientific question addressed by the DSPD pilot service. As it is a pilot service, the fact that we do not yet know the answer should not be seen as a criticism, but as confirmation that we needed a pilot service. Even so, it would be the longest of long shots to gamble on DSPD services achieving results comparable to Hanson's figures, and the sensible assumption would be that the effect size will be a lot lower.

Marshall and McGuire go on to identify a further problem, in their calculation of effect sizes for sex offender treatment. They summarise results from meta-analytic studies, yielding treatment effects that range from 0.10 to 0.43, pointing out that these figures are comparable to those for the treatment of physical problems (including an estimate of 0.15 for the effect of coronary bypass surgery and 0.23 for AZT in AIDS). Whilst these figures may impress in that public health context, they are less reassuring for a hospital admitting high risk patients and hoping to reduce their risk to a point at which safe discharge will be possible. As DSPD patients will be more difficult than average, the best case scenario is an effect size at the lower end of the range quoted. Given the size of the initial risk, effective CBT would still leave most DSPD patients well above the range of risk considered acceptable for discharge from a high secure hospital. It may be that CBT is the most effective way to reduce recidivism in sexual and violent offenders, but that it is not effective enough to allow patients with the highest risk to move through the system.

**Standardized risk assessment is an essential adjunct to clinical assessment**

Actuarial instruments provide a standardized assessment of the type and level of risk, to guide therapeutic intervention and to measure progress. It is taken for granted that clinical assessments alone are insufficient. The DSPD programme shares this approach, but it remains exceptional in English secure hospitals.

These basic principles are applied in the following approaches to treatment and management.

**A focus on public protection and risk reduction**

Both services have a primary goal of public protection but DSPD clings to a medical model, insisting on a diagnosis, whilst the RPC deals only with risk. The latter approach derives from the principle that dynamic, criminogenic factors should be the targets for risk reduction (Andrews and Bonta, 1998). Criminogenic factors are those that have been linked with the individual's
offending in the past, so are likely to relate to future risk. Problems that are not criminogenic have a lower priority for treatment. By contrast, DSPD's medical model implies that the treatment of personality disorder should be a goal in its own right.

The scientific literature provides little support for the latter position. First, the need to reduce risk, and the principles of doing so, are largely independent of diagnosis once major mental illness is taken out of the picture. Second, there is no evidence to suggest that treatment can alter the core condition of psychopathy. To the extent that risk reduction works in such patients, it does so by working around the personality disorder. Third, the concentration of psychopaths in a single unit may make it more difficult to apply interventions successfully.

The danger of the English approach is that the new service will suffer from the same woolly thinking that has characterized high secure psychiatric services in the past. Patients linger for a long time (the average length of stay is 8 years) and treatment goals may be poorly defined. Once the treatment of personality disorder starts, where and when does it stop? The Canadian answer is clear, and it is couched primarily in terms of risk reduction. Within the English system, it seems most likely that the courts will be left to decide, when patients ask Tribunals to release them.

**Discharge criteria and length of stay**

The RPC's focus on risk reduction encourages clarity about treatment, outcome and discharge. Patients come to the unit, they have individualized treatment tailored to reduce their risk, and they leave when it has been completed. There is no pretence at cure. Most patients return to ordinary prison accommodation, and it is from there that they will be released when appropriate. Release decisions by the parole board are informed by reports from the RPC, but patients do not wait at RPC for release decisions to be made. Beds are in great demand, and they are too valuable to be wasted on patients who are not having active treatment. Typical length of stay is a year or less.

RPC outcome data with follow-up of up to ten years have demonstrated reduction of sexual and violent recidivism by approximately 50% in both sex offenders and violent offenders (Nicholaichuk, Gordon, Gu and Wong, 2000; Wong, Gordon, Middleton and Polvi, in preparation). These results are very encouraging but must be qualified. The Nicholaichuk study was a matched case control study whose results may be contaminated by the method. Certainly the outcome is outside the range of the meta-analytic studies discussed above, and it may simply represent an outlier. Alternatively, the good results may be attributable to the quality of supervision and treatment during follow-up, a point explored at greater length below.
As DSPD beds in high security hospitals will be more expensive than those in prisons, the DSPD service should also aim for rapid discharge once treatment has been delivered. This poses few problems in offenders serving a sentence, but the same approach cannot be applied to 'civil' patients, including those prisoners whose sentence has expired. Experience in high security hospitals suggests it will be difficult to move such patients to lower security, and the most likely outcome is that they will linger for many years. The DSPD units will need to provide a long-term regime for these individuals, with less emphasis on active therapy and more on quality of life, without jeopardizing active interventions for other patients.

**Concentration of resources on those who present the highest risk**

The RPC targets offenders with the highest risk of recidivism to maximize efficacy and, therefore, to provide best value for money. It is easier to achieve and measure a significant reduction in risk when one starts high rather than low. The definition of DSPD ensures that patients present a high risk, but the insistence on a personality disorder restricts admission. High risk offenders without a severe personality disorder will be denied access to the service.

Both services assume that most psychopathic individuals will be particularly difficult to treat. The RPC deals with this problem by limiting the number of psychopaths on each unit, having found that too many such individuals disrupt treatment programmes. The DSPD programme has no guidelines but it is likely that it will adopt a similar approach, particularly because English services have so little experience in this area. Even in specialized personality disorder services, such as those at Rampton hospital or Grendon therapeutic prison, only a minority of existing patients would meet DSPD criteria.

All evidence favours dispersal or dilution of psychopaths in treatment facilities, the most authoritative statement being that the highest ratio of psychopaths to non-psychopaths should be 1:1, and then only within an established service with skilled and experienced staff (Wong & Hare, in press). The risk is that the restrictions needed to keep order in such a group will preclude useful therapy. Some evidence suggests that the presence of large numbers of manipulative psychopaths in a unit makes the impulsive patients worse (Rice, Harris and Cormier, 1989).

**Coercion vs. compulsion**

Most patients in the RPC are sentenced prisoners who choose to have treatment, although parole and similar considerations influence their choices, as does the superior physical environment. Their legal status is
that of prisoners, not detained patients, and they can return to ordinary prison location if and when they choose. Impulsive returns are discouraged by a wait of up to 2 weeks between prison transportation buses.

We believe that the DSPD programme should adopt a similar approach to sentenced prisoners, particularly lifers or those on long determinate sentences with a long period left to serve. In these cases the return to prison offers no risk to the public, and the provision of an element of choice helps the construction of a therapeutic alliance and is consistent with the general principle in the treatment of personality disorder, that the patient is encouraged to take responsibility for himself and his behaviour.

Different arrangements will be necessary for patients who cannot safely be returned to prison. Most of these will be close to, or beyond, the end of a determinate sentence, so that detention in prison is no longer an option in addressing their continuing risk. DSPD units will need some longer-stay accommodation, with a lower intensity of treatment, for patients who cannot return to prison but wish to opt out of therapy. The service will need incentives, such as increased privileges, to encourage participation in therapy.

The presence of long-stay patients in the DSPD unit will increase per bed costs and reduce programme efficiency. The detention of patients for compulsory treatment also implies frequent reviews of detention and all the associated paraphernalia of tribunals and legal representation. These procedures are a distraction from the core task of risk-reduction. They increase costs and reduce staff morale.

This discussion exposes the tensions between clinical priorities on the one hand, and the public protection imperative on the other. The Home Office has the power to direct sentenced prisoners to hospital, where they can be detained beyond expiry of their sentence, whereas this temptation is not available in Canada. The risk for DSPD services is that a large number of directed patients will make the units unmanageable, as the pressure of containing disruptive prisoners will preclude therapy for those patients who would like to have it. The success of the pilot projects in high secure hospital will probably depend on the successful negotiation of this tension, with a compromise between public safety and clinical priorities.

Separation of treatment and security

The RPC maintains a clear distinction between therapeutic and correctional staff, with the latter in uniform and taking prime responsibility for security. Therapists are conscious of safety issues, including the risk to themselves, but they function as a clinical team with a primary therapeutic purpose. Security staff are on the wards all the time, but they do not deliver therapy or form therapeutic alliances with the patients. This practice provides
important safeguards against some of the bad practices identified in the Fallon Inquiry.

Security departments have been given greater power within English high security hospitals since Fallon, but the Canadian system would be a step too far for many staff. Even so, we believe such a change to be desirable and probably inevitable in the longer term, bringing the UK in line with much of Europe, as well as Canada. The separation of treatment and security has many benefits. Therapeutic staff are forced to justify their salaries in terms of treatment delivered. Security becomes an essential support for treatment, but there is no pretence that maintaining a safe environment is, in itself, treatment.

Intensity of treatment

Cognitive behavioural treatment is available in English high security hospitals but the RPC programme is far more intensive. All patients should have at least 30 hours per week of treatment related activity, the principle being maximum therapy in the minimum time. It is easy to misinterpret this principle, and to imagine a service in which patients are exhausted by constant soul-searching. In fact, therapy is interpreted loosely, and may include low-level activities, work assignments or constructive leisure pursuits. Offenders tend to have disorganized lifestyles, so learning how to structure their days can represent a considerable achievement, and contributes to the goal of risk reduction.

Whilst the primary goal of providing high intensity, structured treatment is to produce change, there are important implications for security, as psychopathic patients left to their own devices find antisocial activities to occupy themselves (Harris, Rice and Cormier, 1989).

A corollary of the intensive daytime programme is that the night is a time for sleeping. Patients are locked in their rooms/cells between 10 pm and 7 am. This practice causes no controversy, as the RPC is similar to other prisons in this regard. Nursing care is provided at the RPC for those suffering from acute mental or physical disorders.

There has been widespread opposition to the suggestion that patients on the new DSPD units should be locked in their rooms at night. While there are substantial cost savings involved, the regime can be justified on therapeutic grounds alone. The DSPD service will not admit mentally ill patients, so the argument for 24 hour nursing care is weak. First, a model of nursing the sick around the clock conflicts with the need to encourage offenders to take responsibility for their own behaviour. Second, patients who are not acutely mentally ill are not, in fact, nursed throughout the night in any meaningful or useful way. Their night-time activities are more likely to undermine therapy and jeopardize security. Third, in the absence of any
demonstrable benefit, the cost of nursing care at night represents a drain on resources that should be contributing to therapy.

Despite resistance from some staff, we recommend that patients on the DSPD units should be locked in their rooms at night, with compensatory privileges to make the regime more tolerable, and to minimize adverse comparisons with other parts of the hospital. For example, the Rampton DSPD business case would allow personal computers (without internet access) and televisions within rooms.

Stages of change, treatment responsivity and motivational interviewing

The concept of stages of change developed from the treatment of addictive behaviours (Prochaska, Di Clemente and Norcross, 1992) but it is central to the treatment of offenders at the RPC. This approach uses operational measures to place individuals at one of five stages of treatment readiness: pre-contemplation, contemplation, preparation, action and maintenance.

The stages of change are independent of diagnosis, so the model applies as well to a normal individual wishing to give up smoking as to a man with a severe personality disorder who is receiving treatment to give up sexual offending. It encourages staff to engage the resistant patient in treatment by using techniques appropriate to the level of treatment readiness (see Wong and Hare, in press).

Within the stages of change model, outcome measures are relative. Success may amount to getting a patient to acknowledge that he has a problem he has been denying (i.e. progress from the pre-contemplation to the contemplation stage). For some men, this shift would be a worthwhile achievement for a 2-year therapeutic programme. The model helps to maintain staff morale, by providing markers of progress in treatment, when the ultimate goal of reducing re-offending lies in the distant future.

A related concept is responsivity, the principle that treatment should be tailored to the individual's abilities and capabilities, including intellectual ability and readiness for treatment (Andrew and Bonta, 1998). It is no use attempting to do relapse prevention work with someone who is not yet prepared to acknowledge that he has a problem. Also, programme material should be tailored to the literacy level and ability of the participant.

The main technique used to engage resistant clients in treatment is motivational interviewing (Miller and Rollnick, 1991). This approach is non-confrontational, with the therapist assisting the patient in developing a better understanding of his situation and of his own reasons for change. It works best if all therapeutic staff are trained and committed to it.

We believe that these principles must be at the heart of a DSPD service in high security, but it will not be easy to introduce them. In contrast to this
sophisticated approach, British psychiatry is accustomed to a crude, 'take it or leave it' approach to treatability. A comprehensive training and supervision package will be necessary, as one member of staff's confrontational approach to a resistant client can wreck gains that took others months to achieve.

The therapeutic alliance and programme management

The RPC assumes that there is nothing magical about cognitive behavioural interventions, and the key to success is a well-managed programme that delivers treatments within a good therapeutic alliance. The quality of that alliance is measured by asking the patient, in periodic surveys, as the patient's perspective is what matters (Horvath and Luborsky, 1993).

Good management needs effective quality assurance and audit. The integrity of treatment delivery is measured using indicators such as the number of therapeutic sessions delivered against the number planned, and the number of treatment drop-outs over a particular period. Routine collection of such data means that any problems come to light at an early stage. Staff morale benefits from rapid feedback of success in treatment delivery.

Such a process is only possible if supported by good information management, superior to that which exists in British high security hospitals. Ordinary wards do not need such sophisticated information technology, so the DSPD programme should not be tied to developments elsewhere in the hospitals.

The system needs a programme manager, to whom all staff are accountable. This key clinical post requires familiarity with the programme and a presence on the unit, in order to provide leadership and direction. The manager's role is critical in ensuring that different disciplines do not highjack treatment objectives, and drift off in their own directions. This seems straightforward, and many Canadian services are accustomed to programme managers who are not doctors, and to whom all disciplines are accountable. Proposals for a new Mental Health Act in England and Wales floated the idea of a lead clinician, who need not be a doctor, to replace the traditional responsible medical officer, but the reception was mixed. It will not be easy to introduce programme management in English high security hospitals, which are still getting to grips with the idea of any form of effective management.

On the one hand, the suggestion that there is nothing magical about cognitive behavioural therapy for high risk offenders is good news for the DSPD programme. On the other, tight management has not been the most noticeable strength of either high security hospitals or prisons.
The aim and end point of treatment

The RPC aims to produce a reduction of risk and to return most patients to prison within about 2 years of admission. It is assumed that some will return later in their sentence for further treatment but the underlying assumption is that prisoners will spend time in ordinary prisons when not receiving intensive treatment at the RPC.

The risk reduction programme is closely allied to a system of community supervision and surveillance, with probation taking the lead role. There is close cooperation with mental health, to allow the continuation of maintenance and booster CBT during the follow-up period. The provision of maintenance treatment and supervision is seen as an essential continuation of the core treatment programme, rather than an optional extra or luxury. The expectation would be that many of the gains in treatment at the RPC would be lost without the benefit of this continuing treatment.

The situation is more complex in England, where many patients will be rehabilitated entirely through the mental health services because they cannot be returned to prison. Community supervision and maintenance treatment will still be crucial to the success of the programme and mental health services are not equipped for this task at present. There are firm plans to develop both medium secure and community DSPD services. In an ideal world their development would have come before the building of high security inpatient units, but the world is not ideal and late is better than never.

The fate of proposed changes in mental health legislation remains uncertain, but there can be no doubt that the single legal change that would most benefit DSPD services would not concern treatability. Rather, it would be the introduction of a community treatment order that would allow mandatory supervision and treatment of high risk patients after discharge, without the necessity that a court should have imposed a restriction order. There is little evidence in the research literature to show that CBT will produce enduring changes in the DSPD population, without the benefit of such supervision, so it may be that the apparent success of the high secure project will be determined ultimately by the quality of specialized community services.

This reasoning leads inevitably to an answer to the vexed question of when patients admitted to a DSPD unit will ever be ready for discharge. The criterion must be that the patient is ready for safe supervision in the community. This standard has the advantage over any simple measure of the level of risk, in that it is qualitative and linked intimately to the management of risk. It accepts that DSPD patients will always pose a significant risk, but it assumes that it will be possible to manage that risk outside hospital, given adequate preparation of the patient and adequate community services. This
fundamentally optimistic approach is the only realistic alternative to indefinite institutional care.

CONCLUSIONS

(1) The core of the DSPD service should be the application of cognitive-behavioural interventions to reduce risk. The techniques are well established but the main challenge is to manage these interventions within hospitals that are used to a different way of working.

(2) The main problem for the DSPD project, compared to the RPC, is the lack of established pathways through the system. The cognitive behavioural approach relies on explicit goals for patients, who are entitled to expect that they will move on once they have met their treatment targets. Life sentence prisoners can move back to prison, but patients stuck in the hospital system will present a challenge to programme integrity and staff morale.

(3) The maximum estimated effect size of cognitive-behavioural treatment for sexual offenders is a reduction in recidivism rates approaching 50%. Whilst there is a possibility of further improvement given a mandatory programme of structured, community supervision, DSPD is never likely to match this standard because it will be dealing with much more difficult cases. A new service needs optimism and a spirit of enterprise but we should not be led into making unrealistic claims for the new service, however great the political pressure. On present evidence, it is likely that many patients who present the high risk needed to meet the DSPD admission criteria will never reach the low level of risk normally required for discharge from a high security hospital to the community.

(4) The ultimate goal of treatment should be readiness to be supervised safely in the community, and priority should be given to development of community services. Only when the nature of the community service is settled, will it be possible to prepare patients for it, and inpatient beds will become blocked by long-stay patients.

DISCLAIMER

The views expressed in this article are solely the authors’ and may not reflect the views of Broadmoor Hospital, the Department of Health, the Correctional Service of Canada or the Regional Psychiatric Centre.
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