DANGEROUS AND SEVERE PERSONALITY DISORDER (DSPD)
HIGH SECURE SERVICES

PLANNING & DELIVERY GUIDE

DSPD Programme
Department of Health
Home Office
HM Prison Service

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Summary

This Planning & Delivery Guide covers the delivery of high secure DSPD services. The Government made a pledge, in its 2001 manifesto, to deliver 300 more places in high secure hospitals and prisons for the management and treatment of those whose risk of serious offending was linked to a severe disorder of personality. This document covers the development, delivery and management of pilot services to meet this commitment. Key points are as follows:

Legal Context

- DSPD services will operate within the ambit of current mental health and criminal justice legislation and do not require a change of mental health law. The Criminal Justice Act 2003 has introduced new indeterminate sentences for dangerous offenders whose eligibility for release will be dependent on the level of risk they pose in terms of violent or sexual reoffending.

Access to services

- Individuals will be considered to meet the criteria for admission to DSPD high secure services if they are assessed as being more likely than not to reoffend, resulting in serious physical or psychological harm from which the victim would find it difficult or impossible to recover. The risk of reoffending must also be linked to the presence of a severe personality disorder.

- Admissions to pilot services will be prioritised according to the level and imminence of risk to the public. Candidates for assessment do not need to volunteer, and work on motivation and engagement will be a key component of assessment and treatment programmes.

- Most referrals are expected to be serving prisoners or those detained under mental health legislation. Admissions to DSPD hospital units must satisfy the requirements of the Mental Health Act, 1983.

Assessment & Treatment

- Structured assessments will be carried out to inform clinical decisions about whether an individual meets the DSPD criteria, and to inform (and monitor progression through) treatment. Assessments will be carried out using an agreed set of psychiatric and psychological tools.

- Treatments delivered in units will be designed to reduce the risk of further serious offending, by targeting criminogenic factors and addressing mental health needs. Patients and prisoners will be actively encouraged to share in treatment planning and take ownership of treatment goals.
Evaluation

- The DSPD programme will be subject to external evaluation. Units will contribute to this process via the collection of data in an agreed format ("the minimum data set").

Governance, audit & inspection of services

- The interdepartmental DSPD Programme Board has overall responsibility for development and strategic management of DSPD services. The Mental Health Trusts and Prisons hosting the pilot units are accountable for the services delivered within the framework of their existing statutory and other responsibilities, and this guide.

- DSPD Services will be audited and inspected via the existing channels within the host organisations.
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1. Introduction

The purpose of this document is to set out advice about the planning and delivery of DSPD high secure services within the NHS and Prison Service. It describes those common elements that must be delivered in order that the service as a whole is coherent, in line with national policies and priorities, and achieves national objectives. The document therefore provides the background against which services are being funded, commissioned, performance assessed, and evaluated.

The guide is not intended to prescribe in detail how DSPD units are run or services are provided, either in hospital or in prison. Units will have discretion over the means of delivering services, within the framework set out in this document, and other relevant rules and procedures of the host prison or hospital in which they are located. In particular, decisions as to placement of patients within a DSPD Unit in a secure hospital should be taken in accordance with the policies of and procedures of the appropriate Mental Health NHS Trust.

2. DSPD Programme - Service Principles

The purpose of the DSPD Programme is to develop, pilot and deliver new services specifically for people who present a high risk of committing serious violent or sexual offences as a result of a severe personality disorder. The Government made a commitment, in its 2001 manifesto, to deliver 300 new DSPD places in high secure hospitals and prisons. The majority of these places will be available before the end of 2004.

The target outcomes of the programme are:

- Better public protection
- Provision of new treatment services improving mental health outcomes and reducing risk, and
- Better understanding of what works in the treatment of those whose severe personality disorder presents a high risk of serious offending.

The underpinning philosophy of the DSPD programme is that public protection will be best served by addressing the mental health needs of a previously neglected group.
The pilot services will cover England and Wales, and will be locally provided according to common, nation-wide standards. In addition to 300 high secure places for men, the programme will provide:

- 75 medium secure and community places, with community teams
- A pilot service for women
- A research & development programme

Separate guidance is being developed for the planning and delivery of new services in the medium secure and community sectors. The guidance set out in this document therefore refers primarily to high secure services for men and women, and to the provision of services for those moving on from high security.

3. Legislative Context

3.1 The Criminal Justice Act

The Criminal Justice Act 2003 includes two new sentences for dangerous offenders, an indeterminate sentence of imprisonment for public protection and an extended sentence. When in force they will replace the existing extended sentence for sexual and violent offences and the automatic life sentence for a second serious offence. The new sentences can only be imposed on offenders who pose a risk of serious harm to the public.

For the extended sentence, the Parole Board is required to take specific account of public protection in determining whether an offender can be released early. For the indeterminate sentence, the Parole Board will consider risk in the same way as it currently does for life prisoners.

The new sentences will put the work of DSPD units into sharper focus, since a prisoner’s eligibility for release will be explicitly and formally linked to evidencing a demonstrable reduction in level of risk. It can be anticipated that units will have a developing role, as their expertise grows, in providing risk assessments to help inform decisions around the management of dangerous offenders and the risks they might pose either in custody, or in the community, if released.

3.2 Mental Health legislation

DSPD services have been developed to operate in the context of current mental health legislation and are not dependent on a change of Mental Health law.
4. Admission to High Secure Services

A candidate for the DSPD High Secure units can be admitted if assessment (evidenced by previous and/or current offending behaviour) confirms that:

- He or she is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover; and
- He or she has a severe disorder of personality; and
- There is a link between the disorder and the risk of offending.

5. Service provision

5.1 Men

Most of those meeting the admission criteria for DSPD high secure services are likely to be men with a history of very serious offending. The majority of these are also expected to be serving prisoners, or detained in hospital under the Mental Health Act 1983.

Pilot services are being developed in both the high and medium secure estates as well as in the community. The number of individuals moving on from secure services into community placements may initially be small. It will nevertheless be important to ensure that provision is made within community services for those who have made progress and could potentially move on from secure units. The DSPD programme is therefore committed to exploring how such services could work, and to ensuring that effective links between the various responsible agencies are in place.

Capacity is being developed as follows:

High security

- HMP Whitemoor: 80-92 places
- HMP Frankland: 80 places
- Broadmoor High Secure Hospital: 70 places
- Rampton High Secure Hospital: 70 places
Medium security

- 51 medium secure hospital places in London and Newcastle

Community Provision

- Development of 24 linked hostel places
- Four out-reach teams to be set up to support people living in hostels and the wider community

Separate guidance is being developed for the planning and delivery of medium secure and community services.

5.2 Women's Services

The group of women likely to meet the criteria for admission to DSPD high secure services is thought to be very small (10-15 persons) and currently almost exclusively within the prison estate. The key features and plans for the high secure women's service include:

- The development of a specialist clinical multidisciplinary team based at the National High Secure Women's Service, Rampton Hospital
- Once fully established, the service will offer a national assessment, management, and advisory service to the wider women's prison estate and related agencies. The service will include:
  - Consultations to Women's Prisons re prisoners currently held in segregation units
  - Sentence planning for appropriate cases
  - Assessments for Multi-Agency Public Protection Panels for appropriate cases
  - A provision for facilitating the transfer of prisoners in the programme to and from NHS provision who satisfy the appropriate criteria in the Mental Health Act 1983

The feasibility of developing a dedicated residential accommodation unit within the high secure prison estate, subject to appropriate considerations, will be explored. It is recognised that some of the issues affecting service provision for women may be different from those for men.

The aim is for a specialist in-reach service to be substantially established by December 2004.
5.3 Young Offenders

The age threshold for admission to DSPD services is 18 years and over. Below this age individuals will not be expected to have matured to the point where diagnoses of personality disorders could confidently be made, nor do the current diagnostic tools generally apply.

The DSPD Programme, however, recognises that young offenders, especially those who have convictions of a sexual nature, are an important group for whom services need to be further developed.

For prisons, care must be taken to ensure that any move into a high secure prison environment for prisoners aged 18-21 is fully justified. No such moves should be made without the agreement of the relevant Area Manager and the Deputy Director General of the Prison Service.

Similar considerations will apply to the admission of young people to high-secure DSPD services in hospital. There should be no admission of any individual under the age of 18, and admission of those aged 18-21 should be on an exceptional basis. Only rarely will it be in the interests of a Young Offender to be admitted to an adult service. Any such admissions must follow the standard practice set out in the High Secure Hospitals Admissions Procedures, including a comprehensive Social Care Assessment prior to admission, and preferably prior to the offer of a bed.

5.4 Diversity Issues

DSPD units must ensure that (prioritised) access to DSPD services is given to those who meet the DSPD criteria. However, no assumptions as to suitability should be made on the basis of ethnicity, race, or disability.

Treatment plans should take account of prisoner/patient ethnicity and cultural needs. Information about ethnicity will be part of the minimum data set used for evaluation, and the DSPD programme will be actively monitoring the ethnic mix of those referred, accepted, or rejected, to ensure that the criteria are being applied objectively.

Staff working within units should receive training in cultural awareness and sensitivity, and in tackling incidences of racism. Units should have a written policy, integrated with that of the host prison or hospital, dealing with racist abuse. Adherence to the policy should be regularly monitored.

Where appropriate, active steps should be taken to promote the recruitment and retention of suitably qualified black and minority ethnic staff, aiming to achieve workforces within units that are representative of the ethnic diversity in the community.
6. Access to Services and Service Delivery

6.1 General Principles

The planned 300+ high secure DSPD places will represent a limited resource. It is expected that the number of persons in prisons, for example, likely to meet the DSPD criteria will far exceed the number of treatment places available.

It will therefore be important that available places are utilised as effectively as possible. In essence, this will mean ensuring:

- That available places are allocated on the basis of priority (see 6.3)
- That treatment services are structured and focused around facilitating progression through reducing risk
- That viable through-care services are developed to facilitate movement on from DSPD units, for both those that benefit from the treatment and those who do not
- That case information is available at the point of referral

6.2 Hospital or Prison?

A high proportion of all DSPD admissions are likely to come from sentenced prisoners. Referrals to a hospital, rather than a prison DSPD site will be influenced by the following considerations:

- Detention beyond end of sentence is likely to be required to protect the public and provide treatment
- Specialised treatment needs that can be best met in hospital

In all cases, the requirements of the Mental Health Act will need to be met before a patient can be admitted to a hospital DSPD service.

6.3 Referral

DSPD services will be accessed through a process beginning with referral to a DSPD unit for the purposes of assessment. The possible sources for referrals are expected to vary between the prison and hospital DSPD units.

In planning their occupancy, DSPD units will be expected to manage the referral process. They will need to develop relationships with, for example, the DSPD link governors in high secure prisons. Since, in time, referrals are likely to exceed the number of places available for assessment at any given time,
units will need to establish a system for managing waiting lists and prioritising candidates. This again may vary between prison and hospital.

Work on the process of admitting a prisoner or patient, as well as gathering all relevant documentation should start, if possible, before the candidate arrives on the unit. Candidates do not need to volunteer in order to be referred for assessment. Work upon motivation and engagement will be a key component of both assessment and treatment.

Prisons

The placement of prisoners and the operation of prison-based DSPD units must be in accordance with prison rules. It is expected that the majority will be prisoners (mostly Category A or B) from within the Directorate of High Security Prisons (DHSP). Referrals of prisoners from outside of the DHSP can also be considered where there is clear, emerging evidence that the prisoner is likely to meet the DSPD criteria.

Priority for allocation of places should be given in the first instance, to those prisoners who present the most serious and immediate threat to public protection, most likely in the cases of high-risk prisoners serving determinate sentences. Where a life-sentenced prisoner is referred to unit, public protection considerations (tariff and length of time to possible release) should be a significant factor in determining the prisoner’s priority for admission.

In all cases, units will be expected to evidence decisions taken on referrals on the basis of meeting prioritised need, ensuring the safe and effective functioning of the unit as a whole, which may mean striking a balance between the numbers of determinate and life sentence prisoners.

Hospitals

Admission to DSPD units in high-secure hospitals will be possible if a patient satisfies the criteria for detention under current mental health legislation. As with the prison units, admissions to a DSPD unit must be on the basis that the patient meets the DSPD criteria.

Priority will be determined by degree and imminence of risk to the public, the latter often depending on when and if a dangerous offender is due to be released, and clinical need. Good practice dictates that prisoners serving determinate sentences likely to meet the DSPD criteria should be identified as early as possible in the course of their prison term, and that their assessment and treatment plans are, so far as possible, developed in consultation between the prison and hospital based units.

Other sources for referral to hospital units will include:

- Those already detained in or on the waiting list for hospital (high and, to a lesser extent, medium secure).
- Referrals from criminal courts under Mental Health legislation
- In certain, exceptional, circumstances, referrals from the community (via the MAPPPA), where past offending history and current behaviour indicate a high risk of further offending.

Maintaining a manageable mix of patients on the units will be a factor in considering referrals to health establishments just as it will be for referrals to prison.

Referrals of serving prisoners to DSPD hospital units can be made direct by the referring establishment. There should be sufficient case information to indicate that referral to hospital would be appropriate, and it would generally be helpful to discuss the issues with the hospital DSPD unit concerned where there is any doubt. In such cases, suitability of the referral would be validated by the receiving DSPD unit as a first stage of the assessment process.

Prisoners whose DSPD needs could be adequately met within a prison unit should be referred on to the appropriate prison site. Similarly, prison units receiving referrals more appropriate to health should refer on to the appropriate hospital site.

Where difficulties arise, decisions around appropriate referral should, as far as possible, be reached via a process of discussion and agreement between the units themselves. In exceptional instances where this proves not to be possible, the case will be considered by the DSPD Service Management Group (SMG) in order to determine the appropriate site for full assessment and potential admission to take place.

The casework for the transfer of prisoners or restricted patients to the hospital based DSPD Units (and, where appropriate, their remission back to prison) will be managed by the Home Office Mental Health Unit (MHU), as part of its role in administering the Home Secretary's responsibilities under the Mental Health Act 1983. Transfers of restricted patients between DSPD hospital units and other health placements (e.g., a move to a medium secure unit) will be managed under the "trial leave" arrangements as currently administered by the MHU.

6.4 Screening

The option of developing a tool for screening of the prison population to help identify potential candidates for referral has been discussed and explored with various stakeholders. It was concluded that systematic screening, as a component part of the referral and assessment process, was currently neither viable nor desirable given existing constraints and the relative scarcity of available treatment places.

Responsibility for identification of potential DSPD referrals from within the prison population will lie primarily with the referring establishments. Guidance notes will be available via the Prison Service Intranet and hard copy referral
packs, and DSPD unit teams will continue to act as a source of expertise for prison staff considering making a referral.

6.5 Catchment areas

Candidates will be referred for assessment to a specific DSPD site. Geography will determine whether prison referrals are made to Whitemoor or Frankland, and hospital referrals to Rampton or Broadmoor. The catchment areas will be:

- For prison based DSPD places, based on home probation area as set out at appendix A
- For hospital based places, based on existing catchment areas as set out at appendix B

This approach can be varied in cases where there are clear, agreed management or clinical needs, or transfer between units at a later stage to meet specific treatment needs. In these cases:

- There will be bilateral discussion between the units to establish the terms of the transfer (including, where appropriate, return of the prisoner/patient to the original host unit)
- Where needed the DSPD Programme will organise case reviews to help arbitrate on disagreements. The DSPD units, relevant NHS Commissioners, Home Office Mental Health Unit and senior prison service staff would be expected to attend to enable decisions to be made.

6.6 Non-admissions

Prisoners/patients who are assessed for DSPD services, but not selected for admission, will normally return to their place of referral within prison or hospital. In such cases, the unit which carried out the assessment should prepare a management plan, which covers:

- Full details of the assessment and why the individual was considered unsuitable or not admitted
- Recommendations for the future management and care of the individual
- (If appropriate) recommendations on referral back to DSPD at a later date

The assessing unit should agree with the receiving hospital/prison what aspects of the management plan can practically be provided, and within what time-scale. Arrangements should be put in place to monitor future outcomes.
in respect of each such prisoner/patient, in order to provide further information on the effectiveness of the assessment process.

Non-admissions will normally be on the basis that the individual either

- Does not meet the agreed criteria for DSPD, or
- Meets the criteria, but is not considered suitable for admission to the unit at that time (and no other place is available in any other unit)

In the latter case, the reasons for non-admission should be clearly evidenced. Explanation should be given as to why the care and management needs of the prisoner/patient should, for the time being, be met elsewhere. Where a non-admitted prisoner/patient has been identified as having mental health needs, the assessing DSPD unit will have a responsibility to develop links with the referring establishment in order to facilitate provision of appropriate care.

6.7 Consent

Consent to participate in assessment

Not all prisoners/patients admitted to units will have been referred on a voluntary basis. It is to be expected that willingness to participate in assessment or treatment will be a continuum, with some patients/prisoners more motivated to engage than others (see also sections 6.9 and 6.12 below). Units will not generally be required to seek the formal consent of prisoners/patients before they are admitted to a Unit for assessment.

However, units should ensure, as far as practicably possible, that individuals admitted are made fully aware of what assessment and in due course, if selected, treatment will involve, and what their expectations may be in terms of participation in the programme. Patients/prisoners should clearly understand why they have been referred, and what the goals of their particular treatment plan are.

Consent to use of data

It is not envisaged that units seek the formal consent of individual patient/prisoners before utilising data (anonymised as appropriate) for the purposes of research and evaluation. Units should nevertheless take appropriate steps to ensure that patients/prisoners are made aware of the nature of any research, the type of any personal data required, how the data will be used, and the extent to which it will be anonymised. Where data is to be collected from hospital sites, particular care should be taken to ensure that the process meets the appropriate requirements of health service research guidelines.
If an individual is not happy about their data being used, they will need to know with whom they can discuss their concerns. That concern, and the outcome of any subsequent review or enquiry, should be recorded.

6.8 Assessment

Individuals referred to DSPD units will be assessed to see if they meet the agreed DSPD criteria and current admission priorities. DSPD units may have different approaches - subject to those common core elements described below - about the process and content of the assessment.

Because of the limited total capacity of the units it may be advantageous for as much of the initial assessment as is possible - particularly the initial work linked to deciding whether they are likely to meet the DSPD criteria - to be carried out before candidates are admitted to a unit. This may not always be practicable, particularly for non-volunteers, when a longer period of observation may be needed before an informed view can be taken.

Assessment will have several functions:

- To establish whether an individual referred to DSPD services meets the entry criteria
- To identify their treatment needs and to inform the development of a care plan (in the DSPD unit if admitted, or from other services if not)
- To facilitate the measurement of change, particularly whether there has been a reduction in risk following treatment (i.e. establishment of a baseline for evaluation)

The judgement about the above will, so far as possible and within the present state of knowledge and practice, be objective and evidence based. In this respect both static and dynamic tools will be used to help inform a structured clinical judgement.

Assessments will be carried out using (as a mandatory minimum) the following set of tools:

**Risk assessment tools**

**Violence**

- VRS
- HCR-20

**Sexual offending**

- Risk matrix 2000
- Static 99
- SARN
Personality Disorder

- PCL-(R) / PCL-(SV)
- IPDE

Mental Illness

- SCID-1

For the purpose of DSPD assessments, the criteria for severe personality disorder will have been met if the individual has:

- a PCL-(R) score of 30 or above (or the PCL-SV equivalent); or
- a PCL-(R) score of 25-29 (or the PCL-SV equivalent) plus at least one DSM-IV personality disorder diagnosis other than anti-social personality disorder; or
- Two or more DSM-IV personality disorder diagnoses.

PCL-(R) thresholds will be kept under review in the light of evaluation data.

Other tools may be used, at local discretion, to augment the core assessment tools. Where this is done, DSPD units should explain the rationale behind their use; how they help improve the assessment and/or treatment processes, and how their use will be evaluated.

The application of structured clinical judgement implies that the results of these tools, along with other information, are used to make judgements about whether individuals meet the DSPD criteria, and their treatment needs. It is recognised that these tools, either individually or collectively, will not always be capable of discriminating between those presenting different forms and levels of risk. There may be circumstances where a clinical override will need to be exercised, where it can be shown that an individual would be excluded by reliance upon the tools alone, but for whom there is other compelling clinical evidence that points to them posing a high risk. The use of an override should be an exceptional measure, and clear reasons for its use recorded in each case.

The process of assessment must as far as possible be transparent. There is a need to ensure that the process of selection for DSPD units does not operate in such a way that the most difficult or challenging candidates for treatment are excluded from the system.
6.9 Treatment

The treatments or interventions offered or being developed by DSPD units will aim to address and reduce the risk of serious offending presented by DSPD individuals. Development of treatment services will be the responsibility of individual units.

Each DSPD unit will set out:

- The treatments or range of interventions offered
- The evidence on which they are based, and
- Any evaluation being conducted to assess their effectiveness.

In the prison-based units, while the placement itself can be involuntary, prisoners will continue to have the legal right not to participate in treatment.

Given that the hospital-based units operate within the ambit of mental health legislation, it would legally be possible to provide treatment under compulsion. However, current evidence points to patient involvement and active participation in the treatment programmes as a necessary condition for a positive therapeutic effect.

In practice, therefore, hospital-based DSPD units will also need to rely very heavily on patient participation in treatment. This means that all units need to develop strategies for managing prisoners/patients who do not engage, or are disruptive. Often these will be the very people who pose the highest risks and who are in most need of the treatment services offered by the Programmes.

Certain principles and goals are expected to be common to treatment programmes in all units. In particular, treatment services will need:

- To address offending behaviour through the reduction of risk, by targeting criminogenic factors and meeting mental health needs
- To be based on treatment models, grounded in evidence, susceptible to rigorous validation and external evaluation
- To provide individualised treatment plans that are tailored and flexible, with regular progress reviews
- To involve prisoner/patients in their treatment plan, gaining ownership of treatment outcomes, and having transparency of process.
6.10 Length of Stay

Patients and prisoners in DSPD units will present with differing treatment needs, and with different attitudes towards, and capacity for, treatment. It is inevitable that length of stay, and the amount of progress that can be expected over any given period, will vary between individuals.

This means that individual treatment plans should be goal-focused and time-constrained. Patients/prisoners who remain on a unit beyond three years should be subject to a review, which should consider:

- The progress made by the individual on the unit to date
- The reasons why a move at 3 years is not appropriate
- Realistic goals for the remaining period of treatment
- A plan for moving on (see also section 6.13 below)

Patients/prisoners should have an expectation of remaining on the unit for no more than 5 years in total. Beyond this period there would need to be exceptional reasons for extending someone's stay in a unit.

6.11 Secure Working Environments

Patients and prisoners in DSPD units can be challenging, confrontational and manipulative in their behaviour. They can be expected to test boundaries and to identify and exploit any weaknesses that may exist in the operational system, or in working relationships on the unit. This can pose a significant risk to the health and safety of all staff working in DSPD units, and to the security and integrity of the units themselves.

Security within DSPD units should be maintained at levels commensurate with the assessed risk. The provision of appropriate care and clinical treatment must be balanced against the safety of the public, the staff and of the prisoners/patients.

Units should regularly review security protocols to confirm that they are sufficiently robust to meet the particular demands of a DSPD population. In particular, they should ensure that:

- Operational policies and procedures are open, clear and regularly reviewed
- Systems are in place to record and analyse information on security incidents and "near-misses"
o All staff on units have access to regular supervision and staff support services

o Staff absences (especially levels of sick leave) and patterns of recruitment and retention are actively managed and monitored

o Units operate on an integrated, multi-disciplinary basis

o A management culture of trust and openness is developed – with an emphasis on positive exploration of error and learning from mistakes

6.12 Control Problem Patients/Prisoners

For the DSPD units to operate within a secure, therapeutic environment, it will be necessary to ensure that they maintain a safe and manageable mix of patients/prisoners. DSPD patients/prisoners will by their nature present a diverse range of challenges to the management of a unit. Addressing and managing these challenges will be a fundamental part of the process of treatment.

However, there may be instances where the level of disruption and/or interfering behaviour by a patient/prisoner poses an unacceptable risk to the integrity and/or security of the unit. In such cases it may be necessary to consider removal of the patient/prisoner, on either a temporary or a permanent basis.

Units will be expected to make every endeavour to ensure that individuals gain the necessary motivation to participate positively in treatment. Maintenance of a manageable working environment must not be allowed to dilute or deflect from the core aim of the units, which is to work creatively and constructively with some of the most difficult and dangerous people within society. Where a decision is taken to move an individual out because they have become disruptive or impossible to manage, units should be able to specify:

o The exact reasons why the individual is being moved

o The options which have been explored in an attempt to achieve engagement or modify unacceptable behaviour

o How the units will be monitoring or supporting the continuing care of the individual who has been moved, and recommendations for future care, together with options for return to a DSPD unit at a later date.
6.13 Continuity of Care

The DSPD Programme will promote the creation of suitable facilities and the means of progression for those leaving DSPD high secure units. This will include both those who move on as part of a planned progression, and those who leave for other reasons (e.g. respite, or no longer able to engage effectively with treatment).

To support this process, units will need to provide:

- Profiles of prisoners/patients who will be leaving the units
- Information on clinical and other needs
- Recommendations as to future management and care
- Flow information mapping out the numbers leaving the units

Facilities will need to be developed based upon predictions from the units as to throughput. These will need to be amended over time. Other issues which will need to be addressed include:

- Continuing management of care plans
- Expected volume of after-care services needed
- Suitable training of staff

It is anticipated that the medium-secure, hostel and community support facilities under development in health will offer one potential pathway for progression from high-secure DSPD units. The DSPD programme will also support the development of aftercare services within the prison service for those who move from DSPD units to a lower level of security or return to high secure settings. It will work with probation services to develop appropriate community services for those ultimately released from prison.

6.14 Evaluation

The DSPD programme represents an innovative approach in an area with considerable uncertainties, especially in the design and delivery of effective treatment programmes. External evaluation and validation of treatment delivery, and of the outcomes achieved, will be a key component of the programme. External evaluation will be commissioned centrally. It will be informed by a minimum data set and by the advice of an independent Expert Group established to provide guidance in relation to the research and evaluation aspects of the DSPD programme.
Beyond the process of external evaluation, it is expected that DSPD units will develop processes to evaluate and validate their own facilities, treatments or interventions. The DSPD Programme will offer any appropriate support in this process, but the mechanisms for internal evaluation will be at the discretion of the units.

Evaluation will be informed by data collected via the minimum data set which will be common to all units. This will comprise:

**Demographic factors**
- Date of Birth
- Ethnicity
- Legal status, immigration status, life/determinate sentence
- Employment, education - when education left, highest levels of achievement.
- Date, reason and source of referral
- Date of arrival to and departure from the unit
- Date of departure, and reason

**Criminal history**
- Total convictions, index offence, PNCID number, institutional misconduct
- Adult - age, number and type of offences (charges, convictions, arrests etc) (major violence, minor violence, sexual violence)
- Juvenile/youth - offending history

**Risk factors**
- Static tools (Static 99, Risk Matrix 2000)
- Dynamic tools (VRS, HCR-20, SARN)
- Nature of risk - general, sexual, other

**Mental disorder**
- Axis I - Mood, Psychotic, Organic, Substance misuse (drug and alcohol), IQ
- Axis II - personality disorder(s) - PCL-(R) / PCL-(SV)
- Trauma
- Number of previous admissions to hospital

**Treatment**
- What treatments have been delivered over what duration

The minimum data set will continue to be reviewed in light of experience.
7. Service Management

7.1 Governance and accountability

DSPD high secure services are organised as follows:

- The interdepartmental DSPD Programme board has overall responsibility for development and strategic management of services.

- The local Mental Health Trusts via their chief executives and boards, and the Prison Service through the Governors of the prisons involved are accountable for the services delivered in their respective organisations, within the framework set out in this guide.

- DSPD units are responsible for delivery of the service.

- Performance management above that level will be via the existing structures in the parent organisations: Strategic Health Authorities in the NHS; Directorate of High Security in the Prison Service.

- DSPD units will provide reports to the DSPD Programme Board on a range of issues. The content of these reports will be guided by this document, or as otherwise agreed.

7.2 Finance, Business Planning and Commissioning

Finance and business planning

The finance and business planning processes for the DSPD units will differ, depending on whether they are hospital or prison based. The hospital based DSPD units will need to comply with the business planning requirements of the hospital in which they are based, and report as appropriate to the relevant Strategic Health Authority, and to the National Oversight Group (NOG) for NHS high secure services. The prison-based units should meet the planning requirements of the prison high secure directorate. In all cases, business plans will also need to be approved by the DSPD Programme Board.

Units will be expected to produce an annual business plan, detailing:

- The full cost of administering the DSPD programme at each site for the year, including any specific in-year targets.

- How the processes and mechanisms for local delivery of the DSPD programme, as set out in this document, will be implemented.
The key risks to delivery of the programme, and how they will be managed

Units will provide regular reports on expenditure against budget, explain any variances and project the year-end position.

Funding for DSPD will be committed to the areas of spend set out in the business plans. Under-spends should not be diverted to areas outside the business plans without prior agreement from the Prison Service or NOG as appropriate. Such changes of use should be reported to the DSPD Programme Manager.

Any budget tensions or concerns likely to impact upon delivery of the programme should also be reported to the DSPD central finance team at the earliest opportunity.

Business planning requirements for health units will be designed to fit with existing NHS Trust planning cycles.

Commissioning Arrangements

By April 2006 Primary Care Trusts (PCTs) will have become fully responsible for the commissioning of health services in prisons. During 2004/5 and 2005/6, prisons and PCTs will be expected to work in partnership to develop local Prison Health Delivery plans to facilitate the progressive transfer of commissioning responsibility for prison health care to PCTs by 2006/7.

The DSPD programme will develop and maintain linkages with the health commissioning bodies to ensure that (for DSPD units in both prisons and health)

- There are clear, agreed lines of accountability and responsibility that take account of any transitional activity

- Funding streams for prisoners/patients to be admitted to DSPD units are clearly mapped

- Units are adequately resourced to meet projected operational needs

Commissioning arrangements for the DSPD units at Broadmoor and Rampton will be the same as those for other high-secure services, as outlined in "The Future Management & Commissioning of High Security Services 2002." Lead commissioning structures are in place. As with other high-secure services, the lead commissioners for DSPD will be accountable through the Cluster Groups to NOG. Clear lines are in place between NOG and the DSPD Programme Board.
Case Management

Case management arrangements for patients in DSPD hospital units will be the same as those for other high security patients. On receipt of a referral, the DSPD unit will contact the appropriate NHS Regional Commissioner. Responsibilities under case management will be equivalent to those for any other high security patient, and current processes will apply to all patients managed within DSPD services.

Until the transfer of commissioning arrangements for prison health services to PCTs (see above) is complete, case management arrangements for prison DSPD units will be kept under review. Where practicable, procedures should mirror those for hospitals, and Regional Commissioners should in the interim be kept advised of all admissions to units.

7.3 Training, Learning & Development

Each unit will put in place policies and practices that enable its staff to develop and maintain the necessary levels of competency and experience to work safely and effectively with patients/prisoners. Health professional staff will, as a minimum, need to carry out continuing professional development in order to maintain professional registration.

The high secure units and the central DSPD Programme have produced a learning and development strategy. Induction, training and ongoing development of staff at all units will be in accordance with that strategy. By July 2004, all units will have:

- Developed induction programmes
- Established a set of measurable and attainable core staff competencies
- Conducted a training needs analysis

The design and development of individual training programmes will be at the discretion of the units, and should be covered in annual business/delivery plans.

The DSPD Programme team will also facilitate regular "DSPD Forums" (held approximately each quarter) which will provide opportunities for networking and sharing of information and good practice between units and other parts of the Prison and Probation Services (and future National Offender Management Service) and the NHS. Units will be expected to contribute and play an active part in these events.
7.4 Human Resources

It is recognised that staffing the DSPD units will present significant challenges. Units will be required to recruit and retain adequate numbers of suitably skilled staff, drawing upon limited resources and a labour market that has insufficient qualified staff. The demands placed upon people employed within DSPD will also be considerable. Staff - at all levels - will be required to work with some of the most difficult and challenging individuals in society.

- HR issues will be managed by the units (as informed and constrained by their respective parent organisations)
- The DSPD Programme will address any critical HR problems that would benefit from a national, rather than a local, approach.

7.5 Construction

Where new or refurbished accommodation is required for DSPD services, the units will be responsible for the development, design and delivery of such accommodation - subject to funding approval. Progress on construction will be managed and monitored via local Steering Groups. Units will bring any issues or concerns relating to construction (e.g. timetable slippage or budget tension) to the attention of the central DSPD Programme via the construction advisor at the earliest possible opportunity.

7.6 Communications

The DSPD Programme will produce and deliver a communications plan. Units will contribute to delivery of the plan as appropriate, in particular providing clinical and operational input. Core components of the plan will include:

- Seeking and identifying opportunities to explain the DSPD Programme and key messages
- Engaging with key stakeholders through meetings and attendance at relevant events
- Development and maintenance of a website and supporting literature targeted at stakeholders and other key players
- Effective engagement with the media

As the units become operational, media interest in the DSPD Programme can be expected to increase. Proactive engagement with appropriate media sources will be important if key messages on DSPD are to be communicated successfully.
7.7 Complaints procedures

The process by which patients/prisoners in units can make a complaint or register a request should be open and transparent. Patients/prisoners should be given clear information on who to contact and the procedures involved. As a general principle, units will be expected to follow a procedure of local investigation followed (where the issue cannot be resolved to the complainant’s satisfaction) by an external review.

Complaints made within DSPD Units in health will be investigated in accordance with the NHS complaints procedure.

In prisons, non-clinical complaints that cannot be locally resolved can be referred to the Prisons Ombudsman. Where a complaint relates to clinical practice, and cannot be locally resolved, prisoners should be offered the option of having the matter referred for external peer review. The process would provide the opportunity for a further look by clinical expert(s) from outside the unit. The review would offer non-binding advice on the basis and resolution of a complaint to the complainant and the unit.

All units – including those in health – are encouraged to make use of the peer review process in instances where a complaint cannot be resolved at unit level. Referral to peer review would not in any way compromise the complainant’s right to escalate the complaint through other available avenues.

7.8 Allowances and entitlements

Units will have discretion to develop prisoner/patient rewards and incentives which are compatible with, and complementary to, the scope and aims of the treatment regime.

Overall, however, the level of and scope for earnings, allowances or entitlements awarded to prisoners and patients in DSPD units should remain broadly in line with (and be comparable to) the standard arrangements for the prison or hospital in which they are located.

7.9 Role of Audit and Inspection Bodies

Inspection of the work of the DSPD units will fall to the Chief Inspector of Prisons (and successor Inspectors for NOMS) or the Commission for Healthcare Audit & Inspection (CHAI) as appropriate. The roles performed by the NHS in the delivery of clinical services in prisons will also fall within the remit of CHAI. CHAI inspections will generally encompass all activity within a NHS Trust and will not be limited in scope to DSPD services.

Inspection of DSPD-related services provided in the community – aftercare and supervision of dangerous offenders with severe personality disorder – will
be the responsibility of the Probation Service Inspector (and successor Inspectorate for NOMS) for probation supervised services. And CHAI or (as appropriate) the Commission for Social Care Inspection (CSCI) for the NHS.

Teams conducting inspections should take account of the advice and guidance set out in this document, so that they are aware of DSPD policy and service expectations. Where relevant, e.g. in prisons, inspections should be conducted jointly so that the whole service may be assessed.

Investigation of any serious incidents occurring within DSPD Units – suicides, other deaths or serious injury etc – will be carried out in accordance with the current policies and procedures of the parent organisation in prison or health.

7.10 Clinical Governance

Clinical governance for delivery of assessment and treatment services within the units rests within the appropriate Trust for the High Secure hospital units. In the case of the prison-based units it is jointly held by the local partner NHS Trusts and the Governor of the prison. It is distinct and may be separate from the lines of formal management operating within the DSPD units. It means that:

- All staff – whether working within prison or hospital DSPD units – whose role includes the delivery of treatment services must have appropriate access to professional supervision
- Clinicians may – by local agreement – be line-managed within the prison structure, provided that clinical management/supervision is available from an appropriately trained and qualified person. This may be internally, or through an external agency.
- Ultimate responsibility for governance on clinical issues (i.e. those relating to treatment with an impact upon the mental or physical health of the patient / prisoner) will rest with the health service.

7.11 Relationship with Mental Health in-reach (Prisons)

The Prison Mental Health In-reach Collaborative has been developed in partnership with the National Institute for Mental Health in England (NIMHE) and the Regional Development Centres. The aim of the collaborative is to improve the mental health care provided to prisoners who need it, and to help in providing the correct numbers of appropriately trained and skilled staff. In particular, it has the following objectives:

- To establish a process for the implementation of the Care Programme Approach (CPA) in prisons
The DSPD units should work with key prisons and their in-reach teams to ensure the continuity of care and treatment of prisoners who have moved on or out of units, or who have been returned to their place of origin following initial assessment. Where possible, the care plans of those returning to mainstream prison health services should be discussed with the receiving in-reach team.

7.12 Links with Probation and wider PD services

It is important that the DSPD programme operates in a way which is congruent with the wider Personality Disorder Strategy in health, and forms effective linkages with arrangements in place for the management and supervision of offenders in the community (e.g. the MAPPPA and the Assertive Outreach mental health services facilitated through NIMHE).

DSPD units will be expected to:

- Support continuity of care through assessment of ongoing and long-term risk, and recommendations for future treatment
- Maintain effective links with aftercare providers in order to monitor and review the (longer-term) effectiveness of assessment and treatment services provided in DSPD units.
Appendix A

DSPD Prison referrals by probation area

**Frankland:**

**North East**
County Durham, Northumbria, Teesside

**North West**
Cumbria, Cheshire, Greater Manchester, Merseyside, Lancashire

**Yorkshire & Humber**
Humberside, South Yorkshire, West Yorkshire, North Yorkshire

**East Midlands**
Derbyshire, Leicestershire & Rutland, Lincolnshire, Northamptonshire, Nottinghamshire, Warwickshire, West Mercia

**West Midlands**
Staffordshire, West Midlands

**Wales**
Dyfed-Powys, Gwent, South Wales, North Wales

**Whitemoor**

**East of England**
Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk, Suffolk

**South West**
Avon & Somerset, Devon & Cornwall, Dorset, Gloucestershire, Wiltshire

**South East**
Hampshire, Kent, Surrey, Sussex, Thames Valley

**London**

All areas
Appendix B – High Secure Health Catchment Areas
(By Strategic Health Authority)

Rampton:

Trent:
Trent, Leicestershire, Northamptonshire, Rutland, South Yorks

Northern & Yorkshire

West Yorks, North & East Yorks, Northern Lincolnshire, County Durham & Tees Valley, Northumberland, Tyne & Wear

Eastern

Essex, Bedfordshire & Hertfordshire, Norfolk, Suffolk & Cambridgeshire

North West

Cumbria & Lancashire, Greater Manchester, Cheshire & Mersey

West Midlands

Coventry, Warwickshire, Hereford & Worcestershire, Birmingham & the Black Country, Shropshire & Staffordshire

Wales

Bro Taf, Dyfed Powys, Gwent, Lechyd Morgannwg, North Wales

Broadmoor

South East

Thames Valley, Hampshire & Isle of Wight, Kent & Medway, Surrey & Sussex

South West

Avon, Gloucestershire & Wiltshire, South West Peninsula, Dorset & Somerset

London

North East, North West, North Central, South East, South West
# Appendix C - Glossary of terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CHAI</td>
<td>Commission of Health Audit &amp; Inspection</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CSCI</td>
<td>Commission for Social Care Inspection</td>
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<tr>
<td>DHSP</td>
<td>Directorate of High Secure Prisons</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic &amp; Statistical Manual IV</td>
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<tr>
<td>DSPD</td>
<td>Dangerous and Severe Personality Disorder</td>
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<tr>
<td>HCR-20</td>
<td>Historic - Clinical - Risk (assessment tool)</td>
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<tr>
<td>IPDE</td>
<td>International Personality Disorder Examination</td>
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<tr>
<td>MAPPP</td>
<td>Multi-Agency Public Protection Panel</td>
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<tr>
<td>MAPPA</td>
<td>Multi-Agency Public Protection Arrangements</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act (1983)</td>
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<tr>
<td>MHU</td>
<td>(Home Office) Mental Health Unit</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
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<tr>
<td>NOG</td>
<td>National Oversight Group</td>
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<tr>
<td>NOMS</td>
<td>National Offender Management Service</td>
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<tr>
<td>OASys</td>
<td>Offender Assessment Systems</td>
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<tr>
<td>PCL-(R)</td>
<td>Psychopathy Check List (revised)</td>
</tr>
<tr>
<td>PCL-(SV)</td>
<td>Psychopathy Check List (shortened version)</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PD</td>
<td>Personality Disorder</td>
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<tr>
<td>SARN</td>
<td>Structured assessment of risk and need</td>
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<tr>
<td>SCID</td>
<td>Structured clinical interview for personality disorders</td>
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<tr>
<td>SMG</td>
<td>(DSPD) Service Management Group</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>VRS</td>
<td>Violence Risk Scale</td>
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# Appendix D – The Assessment Tools

The table below is intended only to give a brief overview of the tools used in the DSPD assessment process. It should not be used for definitive advice on the use or application of any of the tools. Readers requiring more detailed information should consult the appropriate technical specification.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SARN (Structured Assessment of Risk and Need)</td>
<td>Dynamic tool for working with sex offenders.</td>
<td>For use in development of treatment plans and measuring change</td>
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<tr>
<td>STATIC 99</td>
<td>Actuarial tool for measuring risk in sex offenders</td>
<td></td>
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<tr>
<td>HCR-20 (Historic - Clinical - Risk)</td>
<td>Risk assessment in violent offenders</td>
<td>20 fields combine static and dynamic factors - supports the development of risk management plans</td>
</tr>
<tr>
<td>VRS (Violence-Risk Scale)</td>
<td>Risk assessment in violent offenders</td>
<td>Strong dynamic element supports measurement of change and formulation of treatment plans</td>
</tr>
<tr>
<td>Risk Matrix 2000</td>
<td>Risk assessment tool that categories sexual and violent offenders from low to very high risk</td>
<td></td>
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<tr>
<td>PCL-R and PCL-SV (Psychopathy Checklist)</td>
<td>Used to measure the presence and level of psychopathy in an individual</td>
<td>Tool also proven effective predictor of risk. Short (SV) version can also be used in non-forensic populations</td>
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<tr>
<td>IPDE (International Personality Disorder Examination)</td>
<td>Measures personality disorder using DSM-IV (Diagnostic &amp; Statistical Manual of Mental Disorders) or ICD-10 (International Statistical Classification of Diseases and Related Health Problems) criteria</td>
<td>Use of this tool is a component part of the structured clinical diagnosis of personality disorder</td>
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<tr>
<td>SCID-1 (Structured Clinical Interview for DSM-IV-TR)</td>
<td>Semi-structured interview used to assist clinicians in the diagnosis of axis I mental illnesses</td>
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