



Ministry of  
**JUSTICE**



**DANGEROUS AND SEVERE PERSONALITY  
DISORDER (DSPD)  
HIGH SECURE SERVICES FOR MEN**

**PLANNING & DELIVERY GUIDE**

DSPD Programme

Department of Health  
Ministry of Justice  
HM Prison Service

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## Summary

This Planning & Delivery Guide covers the delivery of high secure DSPD services for men. 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 men whose risk of serious offending was linked to severe personality disorder. This document covers the development, delivery and management of pilot services to meet this commitment. Key points are as follows:

### Legal context

- Pilot DSPD services are operating within the ambit of current mental health and criminal justice legislation. It is however an evolving picture. The Criminal Justice Act 2003 introduced new indeterminate sentences for dangerous offenders whose eligibility for release will be dependent on the level of risk they pose in terms of sexual and/or violent re-offending. Changes to the 1983 Mental Health Act made by the 2007 Act do not affect the fundamental principles underpinning the DSPD programme. We will keep under review how the treatment and management of dangerous offenders can be helped by changes in the law.

### Access to services

DSPD services have two distinct functions:

1. To carry out structured assessments, which seek to establish whether an individual meets the DSPD criteria
  2. For those who meet the DSPD criteria – to provide treatment that addresses mental health need and risk.
- An individual will be considered to meet the criteria for treatment in DSPD high secure services if he is assessed as being more likely than not to re-offend, resulting in serious physical or psychological harm from which the victim would find it difficult or impossible to recover. The risk of re-offending 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 of serving prisoners or those detained under mental health legislation. Admissions to DSPD hospital units must satisfy the requirements of the Mental Health Act.

### Assessment and treatment

- Structured assessments will be carried out to help 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.
- Individualised treatment 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 must contribute to this process via the collection of data in an agreed format (“the common data set”).

### Governance, audit and 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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# **DANGEROUS AND SEVERE PERSONALITY DISORDER (DSPD) HIGH SECURE SERVICES PLANNING & DELIVERY GUIDE**

## **1. Introduction**

This document sets out advice on the planning and delivery of DSPD high secure services for men within the NHS and Prison Services. 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 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 sexual and/or violent 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 target outcomes of the programme are:

- Improved public protection
- Provision of new treatment services improving mental health outcomes and reducing risk, and
- Better understanding of what works in the treatment and management of those who meet the DSPD criteria

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 cover England and Wales, and are 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 and development programme

Separate guidance has been developed for the planning and delivery of services in the medium secure and community sectors, and for high secure services for women. The guidance set out in this document refers primarily to high secure services for men, 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. These sentences 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 present 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 as it currently does for life prisoners. These are expected to have a significant impact upon the operation of DSPD units both in prison and hospital.

The new indeterminate sentence will put the work of DSPD units into sharper focus, since a prisoner's eligibility for release will be explicitly 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 the community, if released.

#### **3.2 Mental Health Legislation**

DSPD services in hospital operate within the context of mental health legislation.

## **4. Access to Services**

### **4.1 Capacity**

In order to meet the Government's 2001 manifesto commitment to provide 300 new high secure DSPD places, the following capacity is being developed:

- HMP Whitemoor: 70 places
- HMP Frankland: 86 places (up from the previous 80 places)
- Broadmoor High Secure Hospital: 70 places
- Rampton High Secure Hospital: 70 places

HMP Whitemoor began admitting prisoners to a converted wing of the prison in September 2000. Purpose built units have been built at the other 3 sites. The Westgate Unit at HMP Frankland and the Peaks unit at Rampton hospital both opened in spring 2004; and the Paddocks opened in Broadmoor in the summer of 2005.

### **4.2 Access to Services**

A candidate for the DSPD High Secure units can be admitted for treatment if assessment confirms that:

- He 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 has a severe disorder of personality; and
- There is a link between the disorder and the risk of offending

It is expected that the number of men in prisons alone likely to meet the DSPD criteria will far exceed the available treatment capacity. The current places must therefore be utilised as effectively as possible. In essence, this will mean ensuring:

- That available places are allocated on the basis of priority
- 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, both for those that benefit from the treatment and for those who do not

### 4.3 Referrals

A referral to a DSPD unit should be considered for any person that might meet the DSPD criteria. Most of these will be of sentenced prisoners or patients already detained under mental health legislation. Anyone who has been in regular contact with a potential candidate for assessment can initiate a referral. In due course most referrals will be triggered through regular sentence planning and/or CPA (Care Programme Approach) arrangements.

It is expected that the majority of referrals will be prisoners (mostly Category A or B) from within the Directorate of High Security (DHS). Referrals of prisoners from outside of the DHS and lower category prisoners can also be considered where it is clear that the prisoner is likely to meet the DSPD criteria. Re-categorisation, if needed, should only be done following completion of the assessment process (i.e. after confirmation that the prisoner meets the dangerousness criteria).

Other sources for referrals 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 may be accepted from the community (via the MAPPA and local forensic mental health services) where past offending history and current behaviour indicate a high and increasing risk of further offending, and the individual requires management in high security. Parallel pilot services are operational in medium secure units and in the community for the management and treatment of those whose assessed level of risk does not require management in a high secure environment. The Planning & Delivery Guide for Forensic PD Medium Secure and Community Pilot Services gives more information on these services and how they may be accessed.

Referrals of serving prisoners should be made using the standard Prison Service DSPD referral form. Where the referring agent is from a prison with a DSPD liaison manager, the form should be authorised by them before being submitted.

If a home probation officer is making a referral of a serving prisoner, the referral form should be completed with the assistance of the prison's probation officer.

If a referring agent is unclear as to the suitability of a particular referral, they should discuss the case by phone with one of the units before the form is sent in. The consent of an individual is not required for a referral to be made. However the individual must be informed of their referral by the referring agent before the referral can be accepted. Units should offer advice and

support about how best to do this in sensitive cases. In all cases, it is good practice for referring agents to give a copy of the referral form (minus security details) to the individual being referred, to give them the opportunity to make any comments on matters of fact before the referral is considered.

All referrals – whether to a prison based or to a health based unit – must be supported as far as possible by background file information which evidence the referral in terms of risk and personality disorder. If available an up to date psychiatric report should also be supplied. Responsibility rests with the referring agent to supply all supporting evidence available at the time of making the referral. The referring agent must provide an explanation in cases where file evidence is missing or cannot be supplied at the time.

Responsibility for admitting someone onto one of the units, and for assessment against the DSPD criteria, rests with the unit's management and not the referring agent.

#### **4.4 Hospital or Prison?**

Each of the units will broadly be taking similar groups of people based on the admission criteria. There may be instances however when a hospital rather than a prison setting is more appropriate. This will be decided by the units themselves on a case by case basis and will be influenced by the following considerations:

- The individual has mental health treatment needs that can be best met in a hospital environment
- An individual is near the end of their sentence and is likely to require continued detention under mental health legislation in order to complete treatment.

In the latter case, every effort should be made to identify the prisoner as early on as possible within the course of their prison term. Assessment and treatment plans should, so far as possible, be developed in collaboration between the prison and hospital DSPD units. As a general guideline, anyone with less than 12 months to serve of their sentence should be referred directly to one of the hospital units for assessment. For referrals of individuals from within the prison estate with more than 12 months left to serve, the referral should be made in the first instance to one of the two prison DSPD units, who will liaise directly with the relevant hospital unit to determine if, and when, a referral on to hospital would be most appropriate.

Planning for the potential transfer of determinate sentence prisoners to hospital in order to extend treatment at end of sentence should commence at the earliest possible opportunity, with both the referring and receiving units actively involved in the planning process from the outset.

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 unit for full assessment and potential admission.

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. 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 Ministry of Justice Mental Health Unit (MHU), as part of its role in administering the Secretary of State's responsibilities under the Mental Health Act. 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.

#### **4.5 Catchment Areas**

Admission to a specific prison or hospital DSPD unit will also be dependent on catchment area. Broadly speaking, HMP Frankland and Rampton hospital cover the northern half of the country and HMP Whitemoor and Broadmoor hospital the southern half.

- For the prison units, catchment area is based on home probation area as set out at appendix A
- For the hospital units, catchment area depends on where they are registered with a GP by area as set out at appendix B

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

Where difficulties in relation to catchment area arise, the case should be referred in the first instance to the DSPD SMG for arbitration. NHS Forensic Commissioners and the NOMS Agency will be invited to join the meeting as appropriate.

#### **4.6 Prioritising Admission for Assessment**

In planning their occupancy, DSPD units will be expected to manage their referral process. They will need to develop relationships with, for example, the DSPD liaison managers in high secure prisons. Since, in time, demand for places is 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 may vary between prison and hospital.

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 to be high-risk prisoners serving determinate sentences. Where an indeterminate prisoner is referred to a unit, public protection considerations (tariff and length of time to possible release) should be a major factor in determining the prisoner's priority for admission.

Units should however also take into account other criteria when allocating places, such as the existing population mix of the unit and the amount of time someone has already spent on the waiting list. In all cases, units will be expected to evidence decisions taken on referrals on the basis of meeting prioritised need, and ensuring the safe and effective functioning of the unit as a whole.

#### **4.7 Engagement with Assessment and Treatment**

Not all patients/prisoners 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. Units will not be required to seek the formal consent of patients/prisoners before they are admitted to a Unit for assessment.

Non-compliance with the assessment process, or refusal to engage with treatment, will not in itself constitute a reason to hold someone back from admission into a unit. Work on motivation and engagement will form a key part of the assessment and treatment process. Considerations of need and public safety should remain primary in considering and prioritising admissions.

If a patient/prisoner refuses to engage with the assessment process, the assessment should be based, as far as possible, on observed behaviour and collateral information.

Only in exceptional circumstances, when the physical safety of staff or prisoners is at risk or where admission might lead to a serious disruption of the work of the unit, should an admission be deferred. In such circumstances the matter should be brought to the attention of the referring prison or other institution, then to the SMG and central team. A management plan should be formulated, in consultation with the referring agency, to address issues of treatment need and public protection.

#### **4.8 Age**

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.

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 NOMS Offender Manager and the Director of High Secure Prisons. The appropriate Regional

Specialised Secure Services Commissioners and DSPD Central Team should also be notified.

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. It will rarely 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.

There is no upper age limit for admission to DSPD services. While it is accepted that those over a certain age may well be less responsive to treatment, this alone should not form the basis of exclusion from services.

#### **4.9 Learning Disability**

A low level of IQ should not in itself preclude assessment or admission. Units should look at each case on its individual merits and attempt to adapt their procedures accordingly. An onward referral to a specialist learning disability service should only take place where it is felt that the person referred will be unable to engage with the assessment and treatment processes because of a learning disability.

#### **4.10 Mental Illness**

Mental illness can reduce someone's ability to respond to psychological intervention. If a referral meets the DSPD criteria, but the individual has an active mental illness that would impact on their ability to engage in the therapeutic process, the symptoms would need to be controlled before admission. Advice on appropriate treatment should be given to the referring agent and a management plan agreed to facilitate referral back to DSPD services following completion of treatment.

#### **4.11 Referrals Not Admitted**

Prisoners/patients who are referred to 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 initial assessment should write to the referring agent explaining why the individual was not considered suitable for admission and giving recommendations for the future management and care of the individual.

### **5. Service Delivery**

#### **5.1 Assessment**

The assessment process has a number of 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
- To facilitate the measurement of change

### ***Meeting the DSPD Criteria***

The judgement about whether someone meets the DSPD criteria 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 informed and evidenced through application of the following set of tools:

### ***Assessment Tools***

#### Violence

- VRS
- HCR-20

#### Sexual offending

- Risk matrix 2000
- Static 99
- VRS-SO

#### Personality Disorder

- PCL-(R)
- IPDE

#### Mental Illness

- SCID-1

For the purpose of DSPD assessments, the criteria for *severe personality disorder* includes:

- 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.

However, when considering personality disorder the single most important factor for assessment is the probable impact of the pathology upon the individual's offending behaviour. To this end, the above criteria should be seen as guidelines rather than rigid boundaries for admission to a service.

Data drawn from application of the above tools will contribute to the Common Data Set (see 5.8 below), which will inform the evaluation of the DSPD programme. Other tools may be used, at local discretion, to augment these 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.

In terms of assessing against the entry criteria, units should keep in mind the requirement to ensure that services are prioritised for those presenting the highest risk of serious offending. DSPD is not a diagnosis, and application of the tools cannot in itself be expected to deliver an exact assessment of who should be admitted to services, and who should not. Application of the tools will provide clinicians with a framework within which to reach a view as to which referrals are suitable for admission to the unit, as well as a basis of evidence for those decisions.

There may be occasional instances where reliance on the tools alone would be insufficient; for example, where an individual who would be excluded by reference to the core tool data is admitted on the basis of other clinical evidence indicating a high level of risk.

Such cases must be carefully documented, and the basis of the clinical decision clearly evidenced in terms of risk. 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.

### ***DSPD Assessment Report***

On completion of this part of the assessment process, each unit will prepare a DSPD assessment report. This should include a summary of how the clinical team has reached its conclusions, a formulation on their understanding of the presenting behaviour(s) and whether the individual meets or does not meet the DSPD criteria from the tools, observed behaviour and other collateral information. It is expected that a full social and criminological history will underpin all assessments and those referred to DSPD services. This report should be shared with the individual who has been assessed and its implications discussed.

Where an individual is found not to meet the assessment criteria, the individual will, in most circumstances, be returned to the referring establishment together with recommendations for his future management. Where mental health needs have been identified, the DSPD unit should support the original referring establishment in facilitating the provision of appropriate care.

### ***Preparation of Individualised Treatment Plans***

Once it has been established that an individual meets the DSPD criteria and has been accepted for treatment, units will need to develop individualised treatment plans based on their assessment and formulation. These will detail the person's treatment needs and set out goals against which progress will be measured. It is against this treatment plan that change will be measured, particularly whether there has been any reduction in the risk of further offending.

## **5.2 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 patients / prisoners. 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.

In practice, however, work on building and maintaining motivation will be equally important for both prison and hospital units, in order to ensure that patients and prisoners engage as productively as possible with the therapeutic regime. All units will need to maintain and 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 service offered by the Programme (see 5.6 below).

Certain principles and goals will 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 evaluation
- To provide individualised treatment plans that are tailored and flexible, with regular progress reviews using the CPA approach
- To involve prisoner/patients in treatment planning, encouraging them to share ownership of treatment outcomes. Treatment goals should be open and transparent.

### **5.3 Length of Stay**

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

DSPD places however represent a scarce resource. Length of stay in, and movement through, units must be actively managed to ensure that available places continue to be put to the most effective use. Individual treatment plans should be goal-focused and time-constrained. Progress and discharge plans should be regularly reviewed through the CPA process. Planning for exit pathways, and communication with potential receiving agencies, should be commenced at an early stage so that move-on can be managed in an appropriate way through the preparation of a progression plan.

No later than 3 years after the commencement of treatment there should be a formal meeting where an individual's case and progression plan is discussed. A clear case, in terms of treatment need, admission priorities and public protection, must be made where an individual is to remain on a unit longer than 3 years after commencement of treatment. Where appropriate, other placement options for the continuation of treatment after leaving the unit should be thoroughly explored.

Patients/prisoners arriving on units should have a clear understanding that their stay on the unit will be time-constrained, and will, optimally, last no longer than five years in total. Time in treatment and overall duration of stay on DSPD units will be kept under review in the light of evidence emerging from the programme.

### **5.4 Progression and Continuity of Care**

In order for the progress made on the units to lead to a long-term reduction in re-offending, patients and prisoners leaving the units will need a degree of continuing aftercare in order to help ensure that treatment gains are generalised and maintained in the longer term.

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, positive 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 prepare viable progression plans for all patients/prisoners leaving the units, including:

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

Prison units should appoint progression leads who will coordinate the preparation of progression plans and help find suitable onward placements.

While some of this role is already carried out by forensic case managers in relation to moves from high secure hospital units to other NHS settings, they have no current involvement in the arrangement of moves back to the prison service. Previously, it has been standard practice that when a patient is remitted to prison from hospital, they return to the establishment they were in prior to their original transfer.

There may be occasions however that such a move is not desirable. For example, if a move to one of the high secure prison DSPD units or a move to a prison with a lower level of security or a specialised aftercare regime is more appropriate. In such cases the responsible medical officer from the hospital unit should liaise with one of the progression leads of the two high secure DSPD prison units to help facilitate a progressive move within the prison service.

In the case of formerly Category A prisoners being returned to prison and for whom recategorisation is being recommended, the Responsible Medical Officer and the progression lead should work together in preparing the relevant security report for the Head of Category A Section in DHSP so that the case for recategorisation can be considered while the patient is still at the hospital DSPD unit.

## **5.5 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.

Dynamic/relational security within DSPD units should be maintained at levels commensurate with the assessed risk, rules and procedures. 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”
- All staff on units have access to regular supervision and staff support services
- Staff absences (especially levels of sick leave) and patterns of recruitment and retention are actively managed and monitored
- Units operate on an integrated, multi-disciplinary basis
- A management culture of trust and openness is developed – with an emphasis on positive exploration of error and learning from mistakes
- That the balance between security requirements and therapeutic conditions is continuously managed and regularly reviewed.

## **5.6 Control Problem Patients/ Prisoners**

### ***Working with Difficult or Disruptive Individuals***

The over-riding purpose of DSPD units is to provide effective treatment services for high risk, severely disordered patients and prisoners. This will include those who, as a result of their pathology or through their institutional behaviour, have hitherto avoided, or been excluded from, other treatment services.

Some of these individuals can be expected to be disruptive, difficult to manage, and may be highly resistant to participating in therapeutic activity in the unit. Often, however, these same individuals will represent the highest priority in terms of treatment need and risk to public protection – the critical cases which DSPD units will be required to manage.

Units should develop innovative and creative but operationally secure ways of working with such individuals. This will include detailed plans for motivating non-compliant patients / prisoners, and strategies for maintaining therapeutic

engagement with those refusing to participate within the formal treatment programme.

### ***Temporary or Permanent Removals***

There may nonetheless be instances where the ongoing level of disruption and/or interfering behaviour poses an unacceptable risk to the integrity and/or security of the unit. Occasionally it may be necessary to consider removal of the patient / prisoner, either on a temporary or a permanent basis. In such cases, units should consider how and where the interests of public protection are best served, and the individual's continuing care needs will best be met.

Refusal or reluctance to engage with treatment would not in itself be sufficient justification to remove a patient/prisoner from a unit, unless it could be demonstrated that treatment and public protection needs could be better met elsewhere. Breach of a conduct agreement (such as a zero-tolerance of violence) may well warrant application of sanctions, but these should not include permanent removal from the unit except in the most extreme cases. Temporary removal may, however, be an option. Examples of temporary removals would include life sentence prisoners returned to prison for further, longer-term work to be done on issues of motivation and engagement before (potentially) referral back to a DSPD unit at a later date.

Where removal from the unit is both appropriate and necessary, units should also consider the option of a move to another DSPD unit – in prison or in health – either for respite purposes, or where the environment and/or therapeutic regime may be more appropriate for the safe and effective management of the individual.

In all cases, a management plan should be drawn up making it clear why the individual is being moved, and identifying treatment needs and targets for the individual whilst off the host unit. The plan should also specify the likely duration of the move, and the circumstances under which return to the host unit would be appropriate. As far as possible, the contents of the plan should be shared with the individual being moved. Additionally, for hospital sites, all cases involving potential removal of a patient from a DSPD unit must be managed in accordance with section 117 of the MHA.

### ***Liaison and Case Discussion***

Problematic cases should be brought to the attention of the DSPD central team at the earliest opportunity. This will allow discussion of the case in the context of the broader DSPD programme, including the provision of any appropriate support. Where a unit has a particularly difficult or sensitive case to consider, it may be appropriate for a representatives from the central team, the Forensic Case Manager and the responsible Commissioner to attend CPA or other assessment/treatment review meetings.

In cases where consideration must be given to moving a patient / prisoner before end of treatment, units should consult relevant stakeholders from an early stage, in order that any resultant move can be planned and managed in an appropriate way.

Stakeholders will generally include:

- The DSPD central programme team
- The Ministry of Justice Mental Health Unit (in the case of restricted patients)
- The original referring establishment
- The potential receiving establishment(s) (where different)

### ***Continuity of Care***

In any case where an individual is to be moved before end of treatment (either temporarily or permanently) units must record:

- The exact reasons why the individual is being moved (including why care and management needs can be better met elsewhere).
- What has been done to attempt to achieve engagement or modify behaviour.
- How the unit will be supporting the continued care of the individual being moved (this should be incorporated within a management plan for the guidance of the receiving establishment).
- The options for returning the individual to the unit (or - as appropriate - another DSPD unit) at a later date.

### **5.7 Diversity Issues**

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

Treatment plans should take account of prisoner/patient ethnicity and cultural needs. Information about ethnicity will be part of the common data set used for evaluation. The DSPD programme will be actively monitoring the ethnic mix of those referred, accepted or rejected, and will investigate further any significant patterns or trends that emerge.

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, so aiming to achieve workforces within units that are representative of the ethnic diversity of the wider community.

## **5.8 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 all aspects of service 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 the common 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.

### ***Research Forum***

The DSPD Research Forum will draw representation from the four high secure DSPD units and the central programme team. The forum will facilitate a co-ordinated approach to the internal and external programmes of research, and will ensure that research is:

- Well-planned, and incorporated within the business planning of the units
- Supportive of, and congruent with, the aims of the wider DSPD programme
- Informed and (where appropriate) co-ordinated by a cross-site view
- Quality assured.

The research forum will also act as a knowledge-sharing forum and provide a central point of referral on research matters and dissemination of international research evidence in this field.

### ***The Common Data Set***

The common data set will be collected by all units. These data will facilitate the evaluation of the units by providing a common format describing all those entering treatment at the units. It is the responsibility of the lead clinician to ensure that these data are recorded and provided to the Common Data Set project in the approved format (see Appendix D). The data set comprises:

### Demographic factors

- Date of Birth
- Ethnicity
- Legal status, immigration status, life/determinate sentence prisoner, length of 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)
- Nature of risk – general, sexual, other
- VRO - SO

### Mental disorder

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

### Treatment

- What treatments have been delivered over what duration

The common data set will continue to be reviewed in light of experience. It will be augmented by the wider range of site-specific data collected by units relating to assessment, treatment, and clinical and behavioural observations and outcomes.

## **5.9 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 are 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.

In the case of recorded material of assessment or treatment sessions where the patient/prisoner might readily be identifiable, the material should be kept only for the minimum period necessary (i.e. to assess, supervise, wipe etc.) unless retained with patient/prisoner's consent (i.e. for staff training, research etc.).

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.

The DSPD Programme is a pilot initiative and access to anonymised data, profiling separate DSPD Units, will be required by the central DSPD team on a quarterly basis.

## **5.10 Management Information Database**

The Programme central team maintains a Management Information Database, covering all the high secure DSPD units, to supply service management and audit information, including the facility to track individual progress across sites if necessary. High secure units are required to supply regular updates to the information on this database. This must include the Police National Computer (PNC) identifier, which will serve as a unique identifier.

## **6. Service Management**

### **6.1 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.

## **6.2 Finance, Business Planning and Commissioning**

### ***Finance and Business Planning***

The finance and business planning processes for the DSPD units differs, depending on whether they are hospital or prison based. Hospital based DSPD units 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 must meet the planning requirements of the prison high secure directorate. In all cases, business plans also need to be approved by the DSPD programme manager.

All Units are required 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, are being implemented.
- The key risks to delivery of the programme, and how they will be managed
- Other requirements set by the central team.

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 must not be diverted to areas outside the business plans without prior agreement from the DSPD Programme Manager and the Prison Service or NOG as appropriate.

Any budget tensions or concerns likely to impact upon delivery of the programme should also be reported to the high secure project managers and/or 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.

### ***Annual Report***

Each DSPD unit will also produce an annual report which details progress made against agreed delivery targets and milestones for the preceding financial year. The report should contain narrative on:

- The key challenges faced by the unit during the course of the year, and the steps taken to address them
- Successes – what has gone well during the year
- Areas identified requiring further development / improvement
- Lessons learned for the unit and/or the programme as a whole
- Other requirements set by the central team

### ***Commissioning Arrangements***

The transfer of commissioning responsibility for prison health care to PCTs was made in 2006.

The DSPD programme will develop and maintain links with PCTs 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

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](#).

The DSPD central team oversight will be maintained through bi-monthly Project Steering Groups which will be established by the relevant Trust and will be attended by members of the central team. Membership of the Steering Groups will include the relevant secure commissioner and high secure performance manager.

## **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.

The transfer of commissioning arrangements for prison health services to PCTs is now complete. Case management arrangements for prison DSPD units will be integrated into existing secure services case management arrangements. Procedures should mirror those for hospitals, and the responsible Commissioner and the Forensic Case Manager should in the interim be kept advised of all admissions to units and invited to CPA meetings.

### **6.3 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. The guidance of the Department of Health Capabilities Framework should be used to inform the recruitment and development of staff on the basis of the competencies required to work safely and effectively with a DSPD population.

Health professional staff will, as a minimum, need to carry out continuing professional development in order to maintain professional registration. Opportunities to share learning across units, and to gain professional accreditation for training programmes should be fully explored. 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 continue to facilitate regular DSPD Learning and Development Forums to provide opportunities for networking and sharing of information and good practice between service providers and other stakeholders within the Health and National Offender Management Services. Units will be expected to contribute and play an active part in these events.

### **6.4 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). All units will be expected to develop and maintain a recruitment strategy, which addresses the challenges of recruiting and retaining adequate numbers of appropriately skilled staff, in line with agreed business plan occupancy targets.

The DSPD Programme will address any critical HR problems that would benefit from a national, rather than a local, approach (for example, the development of the Core Behavioural Skills).

## **6.5 Construction**

Where new or refurbished accommodation has been provided for DSPD services, the units have been responsible for the development, design and delivery of such accommodation. Units will bring any issues or concerns relating to facilities to the attention of the central DSPD Programme at the earliest possible opportunity.

## **6.6 Communications Plan**

The DSPD Programme will produce and deliver an annual 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 the DSPD website and supporting literature targeted at stakeholders and other key players
- Effective engagement with the media

Proactive engagement with appropriate media sources is important if key messages on DSPD are to be communicated successfully.

## **6.7 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 whom 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.

## **6.8 Allowances and Entitlements**

Units 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.

## **6.9 Role of Audit and Inspection Bodies**

Inspection of the work of the DSPD units falls to the Chief Inspector of Prisons (and successor Inspectorate for NOMS) or the Healthcare Commission as appropriate. The roles performed by the NHS in the delivery of clinical services in prisons will also fall within the remit of Healthcare Commission. Healthcare 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 - is the responsibility of the Probation Service Inspector (and successor Inspectorate for NOMS) for probation supervised services, and the Healthcare Commission 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 the prison or in the Trust.

## **6.10 Clinical Governance**

Clinical governance for delivery of assessment and treatment services within the units rests within the appropriate NHS 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. Clinical governance 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.

## **6.11 Relationship with Mental Health In-Reach**

DSPD units should work with 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.

## **6.12 Links with Probation and Wider Personality Disorder 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 MAPPA 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 & Humberside

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

|                 |   |
|-----------------|---|
| <b>CPA</b>      | Care Programme Approach                                 |
| <b>DHS</b>      | Directorate of High Secure (Prisons)                    |
| <b>DSM-IV</b>   | Diagnostic & Statistical Manual IV                      |
| <b>DSPD</b>     | Dangerous and Severe Personality Disorder               |
| <b>HCR-20</b>   | Historic – Clinical – Risk (assessment tool)            |
| <b>IPDE</b>     | International Personality Disorder Examination          |
| <b>MAPP</b>     | Multi-Agency Public Protection Panel                    |
| <b>MAPPA</b>    | Multi-Agency Public Protection Arrangements             |
| <b>NIMHE</b>    | National Institute for Mental Health in England         |
| <b>NOG</b>      | National Oversight Group                                |
| <b>NOMS</b>     | National Offender Management Service                    |
| <b>OASys</b>    | Offender Assessment Systems                             |
| <b>PCL-(R)</b>  | Psychopathy Check List (revised)                        |
| <b>PCL-(SV)</b> | Psychopathy Check List (shortened version)              |
| <b>PCT</b>      | Primary Care Trust                                      |
| <b>PD</b>       | Personality Disorder                                    |
| <b>RMO</b>      | Responsible Medical Officer                             |
| <b>SARN</b>     | Structured assessment of risk and need                  |
| <b>SCID</b>     | Structured clinical interview for personality disorders |
| <b>SMG</b>      | (DSPD) Service Management Group                         |
| <b>SHA</b>      | Strategic Health Authority                              |
| <b>VRS</b>      | Violence Risk Scale                                     |

## Appendix D - Protocol for completion of Common Data Set items

The Common Data Set (CDS) includes the following compulsory instruments, which should be completed within the timescales indicated.

| Instrument         | When completed   | Notes  |
|--------------------|--|--|
| HCR-20             | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   | To be repeated at least annually from date of first administration   |
| VRS                | Criteria assessment or treatment needs analysis phase<br>To be completed within 16 weeks of commencement of needs assessment | To be repeated at least annually from date of first administration   |
| VRS-SO             | Criteria assessment or treatment needs analysis phase<br>To be completed within 16 weeks of commencement of needs assessment | For those deemed sex offenders <sup>1</sup>  |
| STATIC 99          | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   | For those deemed sex offenders <sup>1</sup>  |
| RM2000             | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   | For those deemed sex offenders <sup>1</sup><br>'Not applicable' should be entered for the Final Risk Classification where sex offender assessment is not appropriate |
| PCL-R <sup>2</sup> | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   | Must be administered as a separate instrument, and not converted from PCL:SV scores  |
| IPDE               | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   | Scores entered must take appropriate account of collateral information that may override interview data  |
| SCID-I             | Criteria assessment phase<br>To be completed within 12 weeks of commencement of assessment                                   |  |

Scores for all instruments must be entered onto the unit's electronic CDS database within one month of finalising the score (e.g. within one month of MDT/case conference meeting when final score is agreed).

Each unit should establish a protocol for the quality assurance of the assessment process and of input to the Common Data Set.

[1] For the purposes of the CDS, a prisoner/patient should undergo assessment for risk of sexual violence if it is the collective decision of the team that he or she is eligible for the sex offender treatment programme. This means that those who have index or historical convictions for sexual offences will undergo a sexual violence risk assessment. It also means that where there is agreement across the team that an individual's offence was sexually motivated, even if they were not convicted of an actual sexual offence (e.g., their conviction was for murder), this person will also undergo assessment of sexual violence risk. Additionally, sexual offenders could include those who have committed sexually motivated behaviour in custody that would normally result in a sexual offence conviction if committed in the community (eg a prisoner with proven adjudications for indecent exposure to prison staff).

[2] In exceptional circumstances and where there is an overriding need (eg where there is no prior offending history), the PCL:SV may be substituted for the PCL-R. In this situation, the scores must be entered in the PCL:SV section of the CDS and not converted to PCL-R scores.