

Probation Circular



DANGEROUS AND SEVERE PERSONALITY DISORDER (DSPD) PROGRAMME

PURPOSE

The purpose of this circular is to provide information about a new programme targeting dangerous offenders who have been assessed as suffering from a severe personality disorder, and to describe arrangements for making referrals to the DSPD Programme.

ACTION

All staff with responsibility for assessing and managing high-risk offenders should be aware of this programme. Appropriate referrals should be made in accordance with the guidance in this circular.

SUMMARY

The DSPD Programme is a new and innovative approach to assessing, managing and treating offenders who are dangerous as a result of a severe personality disorder. High secure services are now being piloted in two prisons (Frankland and Whitemoor) and two hospitals (Broadmoor and Rampton). This circular sets out the entry criteria, referral and assessment processes for these services and underlines the importance of early referral.

RELEVANT PREVIOUS PROBATION CIRCULARS

None

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Apendices A – D (part of Word
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BACKGROUND AND REQUESTED ACTION

1. The Dangerous and Severe Personality Disorder (DSPD) Programme brings together the Home Office, National Offender Management Service, Department of Health, Probation and Prison Services, and the NHS to deliver new mental health services for people who are dangerous as a result of severe personality disorder. The objectives of the programme are to protect the public from some of the most dangerous people in society, to provide high quality services to improve their mental health outcomes, and to understand better what works in the treatment of this group. New units have been built at HMP Frankland and Rampton Hospital and another should be completed at Broadmoor hospital in July 2005. An existing wing has also been converted at HMP Whitemoor. The four units provide 300 new places overall. Services for about 12 – 18 women are being developed at HMP Low Newton and should be available later in 2005.
2. All the high secure units now have prisoners / patients with most referrals being received from the high secure prison estate. Whilst life sentence prisoners constitute the majority of those admitted to date, high priority is being given to those serving determinate sentences who are assessed as high or very high risk of serious harm and likely to require management through the MAPPA level 2 or 3.
3. **ACTION:** Referrals should be made to the prison DSPD units from existing caseloads at the earliest opportunity following the imposition of a custodial sentence. The entry criteria are outlined below.

ENTRY CRITERIA FOR HIGH SECURE SERVICES FOR MEN

4. The DSPD Programme is based on three factors; risk of serious harm, personality disorder and the existence of a functional link between the two. 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 (defined in appendix C); and
 - There is a link between the disorder and the risk of offending

In practice, this means that a person is likely to be suitable if they are high or very high risk on OASys and have previously been assessed by a psychologist or psychiatrist as having a severe personality disorder. The 'severe' component will be reflected in a high score on the psychopathy checklist (PCL-R) and/or a diagnosis of two or more personality disorders. The units themselves will determine this. More information about personality disorder can be found in appendix A.

5. Referrals from the Probation Service will be to one of the two prison units and relate to current serving prisoners. Consideration will also be given to other offenders and the following referral principles should be followed:
 - Offenders in custody: A referral should be made at the earliest opportunity following the procedure described in paragraphs 6 & 7.
 - Offenders subject to licence conditions: Referrals can only be made in relation to a serving prisoner, so the offender must first have been recalled. The Breach Report should contain a full risk assessment, and a risk management plan that refers to the potential referral to the DSPD Programme. A referral should be made as soon as the offender has been returned to custody.
 - Offenders not subject to licence conditions with or without other supervisory arrangements cannot be referred to a Prison DSPD unit: The principle with this group of offenders is that the person should be treated at the lowest level of security commensurate with the risk they present. This will have to be determined by an appropriate medical practitioner (generally a psychiatrist) under the terms of the Mental Health Act and where the offender is not currently under the care of such a practitioner, offender managers should look to MAPPA mental health contacts for advice about referral.

MAKING A REFERRAL

6. Referral should be initiated at the earliest possible point post sentence and when there has been a full OASys. The offender manager should first discuss any potential referral with their line manager. Referral is a detailed process, as a substantial amount of information is required to undertake a full assessment. This is especially so where the offender is not co-operative. When it is agreed between the offender manager and their line manager that the individual should be referred the case should be discussed by telephone with the appropriate Prison DSPD unit. England and Wales are split according to home Probation area and these are listed in appendix B. Contacts at the prison units are:

HMP Whitemoor	DSPD Referrals	01354 602811
HMP Frankland, Westgate Unit	DSPD Referrals	0191 375 6950

7. If it is agreed that the referral should proceed, the offender manager should complete the form attached as appendix D. This is the same as the one completed by the Prison Service, therefore not all information will be available or known to the Probation Service. It should, however, be completed as fully as possible, including all supporting documentation and, where appropriate, details of the offender's behaviour in the community, any work/treatment undergone, and the reasons for recall to prison should be added. The form, together with a full OASys, should then be sent to the appropriate prison DSPD unit and a Probation Officer in the Prison holding the offender.
8. Prisoners should be told of the referral to the Programme and be given a copy of the referral form, minus any sensitive security information. Best practice, given the likely reluctance to co-operate, would be for the prisoner to be advised verbally by the Offender Manager or an appropriate member of prison staff.
9. As stated, the referral should be initiated at the earliest possible opportunity, preferably immediately following sentence at Court. This enables a scarce resource to be properly managed and prioritised. If the prison DSPD unit is of the view that the person should be detained beyond the end of their sentence, or treatment can best be provided in the NHS, then a referral may be made to a hospital unit under the terms of section 47 of the Mental Health Act 1983. Late referrals, that is to say those where the person only has a short period to serve, should be avoided as they may present severe difficulties in their management and increase the likelihood that the person will have to be managed in the community.
10. Once a referral has been made:
- A multi-disciplinary panel at the DSPD unit will review it. This usually consists of a psychiatrist, psychologist, psychiatric nurse, prison officer and prison probation officer.
 - The prisoner will be interviewed at his current location. If a decision is taken to admit, the individual will be transferred to the DSPD unit for a full assessment. This can take up to 20 weeks from date of arrival.
 - The first step is a detailed assessment to confirm that they meet the DSPD criteria (expected to be the vast majority of cases admitted for assessment), to assess treatment needs and plan appropriate interventions.
 - It is anticipated that an individual will remain in the unit for about 3 years - another reason why early referral is important. The home Probation area will be kept informed of the person's progress throughout and invited to attend reviews.
11. A person can be referred whether they consent or not. The Prison Service can place a person at any location it wishes and can then undertake an assessment. Work on motivation and engagement is a key component of treatment in all DSPD units.

MANAGING HIGH RISK CASES WITH PERSONALITY DISORDER WHO DO NOT MEET THE DSPD CRITERIA

12. The Probation Service works with many high-risk offenders in the community and has significant skill and experience in their effective management. There will be considerable numbers who are managed at MAPPA levels 2 and 3, present a high risk of re-offending and have a personality disorder, but are not suitable for a DSPD unit. This may be because they fall short of the criteria or are inappropriate for the service, for example, where there is an active mental illness.
13. Prisoners who are assessed for DSPD services, but not selected for admission, will normally return to their place of referral within the Prison Service. In such cases, the unit which carried out the assessment will 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
 - or recommendation for referral to the relevant local medium secure services

The plan will be shared with the Offender Manager and should be incorporated into future sentence planning and MAPPA processes.

CONCLUSION

14. The DSPD Programme is a new and innovative way of managing people who are dangerous as a result of severe personality disorder. Referrals from the Probation Service should be made at the earliest opportunity to enable the most effective management of the individual and help reduce the risk to the public in the long-term.

Personality Disorder

Personality disorder is relatively common in society as a whole. It is estimated that it is present in 10-13% of the general population, 10-30% of people who present to primary care services and 30-50% of those presenting to secondary care. The incidence of Personality Disorder is significantly higher in the prison population, with estimates ranging from 60-80%.

For a Personality disorder to be present, symptoms must be chronic or persistent (continuing for a long time or frequently recurring) and pervasive (affecting numerous areas of their life, for example, social, employment, personal life, etc.). Personality disorders are usually classified using one of two internationally recognised systems: ICD-10 or DSM IV. Diagnosis is based on information held in existing records, clinical interviews and self-report questionnaires. These are not applied to young people, as it is believed that ones personality continues to develop through late teens.

Personality disorders can be described in terms of clusters. DSM-IV identifies three cluster classifications:

Cluster 'A' – 'odd' or 'eccentric'

- Paranoid – interpretation of people's actions as deliberately demeaning or threatening
- Schizoid – indifference to social relationships and restricted range of emotional experience and expression
- Schizotypal – deficit in interpersonal relatedness with peculiarities of ideation, odd beliefs and thinking, unusual appearance and behaviour

Cluster 'B' – 'dramatic'

- Histrionic – excessive emotionality and attention seeking, suggestibility, and superficiality
- Narcissistic – pervasive grandiosity, lack of empathy, arrogance, and requirement for excessive admiration
- Anti-social – pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15
- Borderline – pervasive instability of mood, interpersonal relationships and self-image associated with marked impulsivity, fear of abandonment, identity disturbance and recurrent suicidal behaviour

Cluster 'C' – 'anxious' or 'inhibited'

- Obsessive-compulsive – preoccupation with orderliness, perfectionism and inflexibility that leads to inefficiency
- Avoidant – pervasive social discomfort, fear of negative evaluation and timidity, with feelings of inadequacy in social situations
- Dependant – persistent dependent and submissive behaviour

To be assessed as 'severe' an individual may have more than one personality disorder, or there may be personality disorder (other than antisocial) associated with high levels of psychopathy.

Psychopathy is not, in itself, one of the DSM-IV or ICD-10 classifications. However, high scoring psychopaths present a particularly high risk of serious offending. Hare (1991) describes psychopaths as "grandiose, egocentric, manipulative, dominant, forceful and cold-hearted. ... they display shallow and labile emotions, are unable to form long-lasting bonds ... and are lacking in empathy, anxiety, and genuine guilt and remorse. Behaviourally, psychopaths are impulsive and sensation seeking, and they readily violate social norms. The most obvious expressions of these predispositions involve criminality, substance misuse and a failure to fulfil social obligations and responsibilities".

Psychopathy should not be confused with "Psychopathic disorder" as defined within the Mental Health Act 1983 as "...a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct." This is a legal rather than a medical definition, which encompasses a range of personality disorders, including psychopathy.

Whilst research indicating what might be effective interventions regarding personality disorder and offending is limited, it is unlikely that the focus will be on 'curing' the disorder rather, finding effective means of managing the effects of the disorder, through targeting offending behaviour, mental health problems and social functioning.

H M P F R A N K L A N D	H M P W H I T E M O O R
<i>Probation Area by region</i>	<i>Probation Area by region</i>
<p>NORTH-EAST County Durham Northumbria Teesside</p>	<p>EAST OF ENGLAND Bedfordshire Cambridgeshire Essex Hertfordshire Norfolk Suffolk</p>
<p>NORTH-WEST Cheshire Cumbria Greater Manchester Lancashire Merseyside</p>	<p>SOUTH-WEST Avon & Somerset Devon & Cornwall Dorset Gloucestershire Wiltshire</p>
<p>YORKSHIRE & HUMBERSIDE Humberside North Yorkshire South Yorkshire West Yorkshire</p>	<p>SOUTH-EAST Hampshire Kent Surrey Sussex Thames Valley</p>
<p>EAST MIDLANDS Derbyshire Leicestershire & Rutland Lincolnshire Northamptonshire Nottinghamshire</p>	<p>LONDON All areas</p>
<p>WEST MIDLANDS Staffordshire West Midlands Warwickshire West Mercia</p>	
<p>WALES Dyfed-Powys Gwent North Wales South Wales</p>	

DSPD Assessment Process

The process is intended to assess whether an individual meets the entry criteria and to plan treatment interventions. The criteria for 'severe' Personality Disorder are that s/he:

1. has a PCL-R (Psychopathy Checklist – Revised) score of 30 or greater
2. has a PCL-R score of 25-29 and one or more personality disorders (other than antisocial personality disorder)
3. has two or more personality disorders

This is assessed using the PCL- R and DSM-IV diagnosis through the IPDE.

The criteria for risk is based on information gained from the tools outlined below, with the exception of the last two. These are used to form a structured clinical judgement.

The table below is intended only to give a brief overview of the tools used in the DSPD assessment process.

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



Dangerous & Severe Personality Disorder Programme (DSPD)

Referral Form

NAME	
FORMER NAMES/ALIASES	
PRISONER NUMBER	
DATE OF BIRTH	
CATEGORISATION	
ETHNICITY	
CURRENT LOCATION (state prison and internal location)	
HOME PROBATION DETAILS	
INITIAL REFERRAL TO?	Whitemoor <input type="checkbox"/> Frankland <input type="checkbox"/>
REASON FOR REFERRAL	
Please give reasons as to why you think the individual might meet the DSPD criteria. (please call one of the units if you would like to talk this through)	

TRIGGER FOR REFERRAL

What prompted this referral?

Sentence planning meeting

OASys review

MAPPP meeting

MH in-reach

Self-referral

Other (please give details).....

<p>ATTITUDE TOWARDS INDEX OFFENCE (S) Where possible please include prisoner's own words.</p>	Sources of information
<p>PREVIOUS CONVICTIONS: Please attach a photocopy of up-to-date list of previous convictions.</p>	Source of Information
<p>Attached <input type="checkbox"/></p>	

SECTION 2 - BEHAVIOUR IN PRISON

From Personal and Wing Officers, Probation Dept., Psychology Dept., Education, Workshops and/or core records

INCENTIVE LEVEL

RESPONSE TO AUTHORITY:

Please describe prisoner's attitude to 'the system' and those in authority.

Sources of Information

RELATIONSHIP WITH PEERS:

Please comment of prisoner's relationship with other prisoners.

Sources of Information

ADJUDICATIONS:

Has the individual a history of adjudications?

Sources of information

SELF-HARM/SUICIDAL INTENT/ 2052SH:

Has the individual a history of self-harm?

Sources of information

SECTION 3 - OFFENCE RELATED WORK

From Psychology Dept. and Probation Dept.

ACCREDITED PROGRAMMES AND OTHER OFFENCE RELATED WORK IN PRISON:

Please list any programmes that the prisoner has been nominated for, refused access to or dropped out of, attended or completed whilst in prison, summarising course results.

Sources of Information

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SECTION 4 – MEDICAL HISTORY

From Healthcare, Psychiatry and Psychology Dept.

PSYCHIATRIC HISTORY:

As far as you know has the prisoner **ever** had contact with psychiatric services?
Please give details and attach reports if available.

Sources of
Information

PSYCHOLOGY:

As far as you know has the prisoner **ever** had contact with psychological services?
Please give details and attach reports if available.

Sources of
Information

PSYCHOLOGICAL TESTING:

Please give past psychological testing results e.g. PCL-R:

Sources of
Information

INTELLECTUAL ABILITY:

Is there any record of intelligence testing e.g. WAIS, WASI, Quick Test? Please
give scores if completed

Sources of
information

CURRENT MEDICAL ISSUES

Does the prisoner have any current medical issues that might affect his intake on
to a DSPD unit? (receiving medication, awaiting surgery, hospital appointments,
etc.)

Sources of
information

SECTION 5 – SECURITY INFORMATION

From Security Dept.
(NOT FOR DISCLOSURE)

<p>SECURITY INFORMATION OR INTELLIGENCE: Please comment on any security information or intelligence relating to this prisoner. Has there ever been any involvement in drug networks or victim protection issues. Are there any prisoners with whom this prisoner should not mix? Please comment on any issues that may be relevant to this prisoner transferring to a DSPD Unit.</p>	<p>Sources of Information (Please indicate whether information is based on evidence or intelligence)</p>
<p>BULLYING/ANTI INTIMIDATION STRATEGY (AIS): Please list and describe any occasions when the prisoner has been subject to an AIS or has been a victim of bullying</p>	<p>Sources of Information (Please indicate whether information is based on evidence or intelligence)</p>
<p>HOSTAGE TAKING: Has the prisoner ever been involved in (as perpetrator or victim) or threatened hostage taking.</p>	<p>Sources of Information (Please indicate whether information is based on evidence or intelligence)</p>

high

SECTION 6 – AUTHORISATION

IS THE PRISONER AWARE OF THIS REFERRAL?

If so, does the prisoner want to come to the unit and why? What is the prisoner's attitude to this referral? Please also comment on motivation.

Sources of Information

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Date Referral Form Completed

--

Name of Referrer

--

Designation and Grade of Referrer

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We would be grateful if the DSPD Liaison Manager completes this section when s/he is satisfied with completeness and accuracy of the form.

Authorised by (DSPD Liaison Manager)

Signed

Date authorised

Please list attachments: