



## PC21/2008 – MANAGING HIGH RISK OF SERIOUS HARM OFFENDERS WITH SEVERE PERSONALITY DISORDER

**IMPLEMENTATION DATE:** Immediate

**EXPIRY DATE:** November 2011

**FOR ACTION:** Chairs of Probation Boards, Chief Officers/Executives, Secretaries of Probation Boards/Trusts

**FOR INFORMATION:** Board/Trust Treasurers, Improvement & Development Managers, Regional Offender Managers, Director's of Offender Management

### CONTAINS MANDATORY ACTIONS

**AUTHORISED BY:** Michael Spurr, Chief Operating Officer, NOMS

**ATTACHED:** Annex A - Personality Disorder – basic information  
 Annex B - Guide to decision making  
 Annex C - Geographical guidance for referrals to the DSPD programme  
 Annex D - DSPD assessment process  
 Annex E - DSPD Programme referral form  
 Annex F - Democratic Therapeutic Communities in Prison - entry criteria  
 Annex G - Democratic Therapeutic Communities in Prison referral form  
 Annex H: Equality Impact Assessment Form  
 Annex I: Resource Impact Assessment Form

### RELEVANT PREVIOUS PROBATION CIRCULARS

Replaces PC 40/2005

### CONTACT FOR ENQUIRIES

[Nick.Joseph@justice.gsi.gov.uk](mailto:Nick.Joseph@justice.gsi.gov.uk) or 020 7035 6911, DSPD Programme and TC Unit, Ministry of Justice

## PURPOSE

To provide guidance to Probation Areas on the assessment, management of, and strategic planning for severely personality disordered offenders who present a high or very high risk of serious harm to others. To provide guidance and referrals forms for the Dangerous and Severe Personality Disorder (DSPD) programme and Democratic Therapeutic Communities (TCs) in Prisons.

## MANDATORY ACTIONS

*Chief Officers should ensure that all relevant staff are aware of the guidance so that the instructions described in this PC are implemented with immediate effect. The decision making process described in annex B should be made available to assist in the management of all offenders who present a high or very high risk of serious harm to others.*

## SUMMARY

Offenders with severe personality disorder who present a high or very high risk of serious harm to others should be identified at the earliest possible opportunity and referred to appropriate programmes.

### Introduction

- 1 Between a half and two-thirds of prisoners have a personality disorder<sup>1</sup>. Their management often creates considerable challenges for the Probation and Prison Services. This guidance provides advice relating to personality disordered offenders who present a high or very high risk of serious harm to others and may require specialist treatment to meet their complex needs. A range of interventions are currently available for men and women through the Dangerous and Severe Personality Disorder (DSPD) Programme (300 places), Democratic Therapeutic Communities (TCs) in Prisons (538 places) and the NHS.
- 2 The DSPD programme (see paragraphs 5-18 below) brings together the Ministry of Justice, 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, reduce their risk related behaviours, and to understand better what works in the treatment of this group.
- 3 Democratic Therapeutic Communities in Prisons (see paragraphs 19-28 below) are a long-standing intervention and an accredited Offending Behaviour Programme. Whilst they are not exclusively a personality disorder service approximately 90% of prisoners in these programmes have at least one that is diagnosable.
- 4 The NHS provides forensic personality disorder services at a range of security levels and in the community. However, their availability and degree of development varies across England and Wales. Every NHS region has a multi-agency capacity plan for the development of personality disorder services.

### Dangerous and Severe Personality Disorder Programme

- 5 Admission to the DSPD Programme is based on three factors; risk of serious harm to others, personality disorder and there being a functional link between the two. A candidate for the DSPD high secure units can be admitted for treatment if assessment confirms that:
  - S/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
  - S/he has an identifiable severe disorder of personality (defined in Annex D); and
  - There is an evidential link between the disorder and the risk of offending.
- 6 In practice, this means that a person is likely to be suitable if they are very high risk of serious harm to others on OASys and have previously been assessed by a psychologist or psychiatrist as having a severe personality disorder or meet several of the criteria indicated in annex D. 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.

<sup>1</sup> Singleton et al (1997) Psychiatric morbidity amongst Prisoners ONS, London: The stationery Office

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The units themselves will determine this. More information about personality disorder can be found in Annex A, a guide to decision making in annex B and the DSPD assessment process in Annex D.

- 7 Treatment is complex and requires a demanding programme of therapy to enable a reduction in the potential risks the person poses to other people. It is likely to take a minimum of three years so early identification and referral is essential.
- 8 The DSPD programme operates in high security at Whitemoor, Frankland and Low Newton (for women) prisons and Broadmoor and Rampton Hospitals. Referrals from the Probation Service will be to one of the three Prison units and relate to current serving prisoners. The following referral principles should be applied:
  - Offenders in custody: All prisoners who are considered for the DSPD programme are in the scope of phases II or III of offender management, because of their OASys high or very high risk category. The Offender Manager is responsible for sentence planning for these groups and should consider a referral at the initial sentence planning (ISP) meeting held within 16 weeks for offenders serving over 2 years in custody. It is vital that following the ISP, if assessment for a DSPD programme is part of the sentence planning objectives, a referral is made at the earliest opportunity. The procedure is described in paragraphs 10-16.
  - Offenders subject to licence conditions: Referrals can only be made in relation to a serving prisoner, so the offender must first have been recalled. Reports recommending revocation should state that a DSPD referral is recommended and this should be initiated as soon as the offender has returned to custody.
  - Offenders not subject to licence conditions, with or without other supervisory arrangements: They 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 be determined by an appropriate medical practitioner under the terms of the Mental Health Act 1983<sup>2</sup>. 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.

### Services for women – the Primrose Programme

- 9 It is recognised that the issues affecting service provision for women are different from those of men. However, the programme incorporates the underpinning philosophy of the national DSPD programme, that public protection will be best served by addressing the mental health and offending behaviour needs of a previously neglected population. The Primrose Programme/DSPD Women's Services has a maximum of 12 residential places available on the 40-bedded F wing of HMP & YOI Low Newton.

### Making a referral to a DSPD unit

- 10 Referral should be initiated at the earliest possible point post-sentence. The completion of a full OASys assessment should trigger the need for a further assessment; if this is the situation then the Offender Manager should first discuss any potential referral with their line manager. Following the sentence planning meeting and discussions with the prisoner, referral should be initiated as soon as possible. Referral is a detailed process as a substantial amount of information is required to undertake a full assessment. A DSPD referral can and should be made even when the offender is not co-operative. When it is agreed that the individual should be referred the case should be discussed by telephone with the appropriate prison DSPD unit. For men, England and Wales are split according to home Probation area and these are listed in Annex C. The Prison units can be contacted on the following telephone numbers:

Fens Unit, HMP Whitemoor

01354 602811

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<sup>2</sup> **Mental Health Act 2007** – Generally a psychiatrist, however, under the MHA 2007 this is an “approved clinician”.

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Westgate Unit, HMP Frankland            0191 375 6950

Primrose, HMP Low Newton            0191 376 4127

- 11 If it is agreed that the referral should proceed, the Offender Manager should complete the form attached as Annex E. This is a universal referral form used by all agencies. It is best completed on a multidisciplinary basis. Best practice would for the Offender Manager and the Offender Supervisor to organise a meeting so that all involved in working with the prisoner can contribute to the referral. It is likely that not all the information will be known. However, it should 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 any recall to Prison should be added. The form, together with a full OASys, should then be sent to the appropriate Prison DSPD unit and the offender management unit in the Prison holding the prisoner.
- 12 Prisoners should know about and be involved in the referral to the Programme to the fullest extent possible and be given a copy of the referral form, minus any confidential or sensitive security information. If s/he is reluctant to co-operate, the prisoner should be advised orally by the Offender Manager or an appropriate member of Prison staff.
- 13 A person can be referred whether they consent or not. The reluctance or resistance of the prisoner should not be regarded as a factor in considering referral. 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.
- 14 An early referral enables a scarce resource to be properly managed and prioritised. For those prisoners serving very long sentences the annual sentence planning process and three yearly full reviews will give consideration to the appropriate timing and sequencing of interventions. If the DSPD prison 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, they will initiate a referral to a hospital under the terms of section 47 of the Mental Health Act 1983.
- 15 Referrals late in a prisoner's sentence are unlikely to be accepted as they may present severe management difficulties. This will increase the likelihood that the person will either have to be managed in the community or transferred to hospital at the end of their sentence. Transfers to hospital at the end of sentence are unlikely to be an effective way to manage risk because:
  - The offender is less likely to be motivated to engage in treatment, and
  - The Secretary of State's powers under the Mental Health Act 1983 lapse at the end of sentence with release decisions made by the responsible doctor or a Mental Health Review Tribunal. The tribunal must discharge irrespective of risk if it cannot be satisfied that detention is justified on clinical grounds.
- 16 Once a referral has been made:
  - a. A multi-disciplinary panel at the DSPD unit will consider it.
  - b. The prisoner will be interviewed at his/her 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. Priority for allocation of places will be given to those prisoners who present the most serious and immediate threat to public protection. For others, consideration will also be given to the current prisoner/patient mix and length of time on the waiting list.
  - c. The detailed assessment is 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.
  - d. If the individual is accepted for treatment It is anticipated that they will remain in the unit initially for at least three years - another reason why early referral is important.

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Progress reviews will usually take place annually. The Offender Manager has a lead role to play in these reviews to ensure continuity in the overall sentence plan and to update OASys. The Offender Manager will then be able to ensure that the learning from the therapy, and any post therapy objectives, are carried on through the rest of the sentence and on release into the community. Offender Managers should make every effort to attend these annual reviews and at a minimum participate by telephone or video conferencing, where available.

### Referred prisoners who are not offered a place

- 17 There will be a number of prisoners managed by the probation service at MAPPA levels 2 and 3, who 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.
- 18 Prisoners who are assessed for DSPD services, but not selected for admission for treatment, 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 re-referral to DSPD at a later date;
  - Or recommendation for referral to the relevant local NHS services.

The plan will be shared with the Offender Manager and should be incorporated into future sentence planning and MAPPA processes. On returning to a prison establishment the Offender Manager and Offender Supervisor should organise an early sentence planning review meeting to set new sentence planning objectives incorporating any relevant objectives from this report.

### Democratic Therapeutic Communities in Prison

- 19 Democratic Therapeutic Communities in Prison (TCs) are not services exclusively designed for a personality-disordered population, however, there is some evidence that this is an effective intervention<sup>3</sup>. Research indicates that 88% of the population referred for assessment has a diagnosable personality disorder<sup>4</sup>. There are 538 places across Grendon, Dovegate, Gartree, Blundeston and Send (for women) prisons.
- 20 Accredited in March 2004, democratic therapeutic communities in prisons are aimed at those for whom a shorter intervention may be inadequate or where particular emotional or psychological needs may hinder engagement in other programmes. They tend to be most effective with prisoners who have a sense of their own disturbance, a degree of self-awareness, are self-critical, aware of their needs, and can receive feedback. Unlike the DSPD programme, prisoners must consent and self-refer using the form in Annex G.
- 21 TCs provide a living learning experience using a holistic approach to complex needs and offending. Community structures and boundaries are established in order to encourage identified treatment needs to emerge and to be addressed by the community within the forums of exploring, learning about and feeding back on member's behaviour. This setting also provides the opportunity for residents to demonstrate and reinforce new skills acquired. The multi-disciplinary staff teams operate in a multi-modal way using a combination of theoretical therapeutic approaches. The staff teams are led and supervised by therapy managers specialising in social therapy. The treatment model includes formal group work five days a week.

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<sup>3</sup>Warren et al (2003) Review of treatments for severe personality disorder *Home Office on-line report 30/03*

<sup>4</sup>Birtchnell, J. and Shine, J. (2000). Personality disorders and the interpersonal octagon. *British Journal of Medical Psychology*. 73 (4): 433-48

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- 22 It is likely that some offenders will appear to meet the criteria for both the DSPD programme and a therapeutic community. In the first instance, the referral should be discussed with a therapeutic community.

### Services for women

- 23 HMP Send is a closed female training Prison in Woking, Surrey. However, it is a national resource, taking prisoners from all over the country. The TC is located on A wing, a 40 bedded unit, within the main prison. It is also accredited and based on the same model operating in the male prison TCs.

### Making a referral to a therapeutic community in Prison

- 24 Referrals can be made to any TC and consideration should be given to the prisoner's category and the entry criteria described in Annex F. Additionally, potential applicants may wish to consider that, at Grendon and Dovegate prisons, the prisoners only mix with others on the TC. At the other prisons residents will sometimes spend time with non-TC residents. A referral form is attached at Annex G. The prisoner must complete this, as far as it is possible.
- 25 As with the referrals to the DSPD units early identification of the potential to attend a therapeutic community is important. This should be discussed at the initial sentence planning meeting within the first 16 weeks of sentence and a referral put in as an objective in the initial sentence plan.
- 26 A number of studies have indicated that treatment requires a minimum of 18 months to reduce reconviction rate<sup>5</sup> (12 months for women). However, this may vary depending on the individual. Three years is normally the maximum time recommended though this can be extended for those with multifaceted needs who are continuing to engage in and respond to this therapeutic environment.
- 27 Progress reviews will usually take place annually. The Offender Manager has a lead role to play in these reviews to ensure continuity in the overall sentence plan and to update OASys. The Offender Manager will then be able to ensure that the learning from the therapy, and any post therapy objectives, are carried on through the rest of the sentence and on release into the community. Offender Managers should make every effort to attend these annual reviews and at a minimum participate by telephone or video conferencing, where available.
- 28 The referral form and an up to date OASys should be sent to the preferred TC by the Offender Supervisor, Personal Officer or 'Governor's Representative'. Individual TCs will then begin the process of gathering further information and, when appropriate, transfer to the host establishment for assessment.

### Working with the NHS

- 29 The funding for the DSPD programme also led to the development of a number of forensic and non-forensic medium secure and community pilot personality disorder services. Additionally, many PCTs have recognised the need for such services and are developing new provision, however, these are at varying stages. Each region has a capacity plan. Some information about these plans and services can be found at: <http://www.personalitydisorder.org.uk>. However, this is not comprehensive and managers with responsibility for liaison with mental health services should ensure they are aware of local developments and contribute to local planning.

### Training and workforce development

- 30 The Ministry of Justice, Department of Health and the Care Services Improvement Partnership (CSIP) have commissioned the development of the Forensic and Non-Forensic Knowledge and Understanding Frameworks (KUFs). The key purpose is to develop practitioner attitudes, skills and behaviours in relation to people with personality

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<sup>5</sup> Shine J. (2001) Characteristics of Inmates Admitted to Grendon Therapeutic Community Prison and their Relationship to Length of Stay *International Journal of Offender Therapy and Comparative Criminology* 45; 252

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disorder. This builds on 'Breaking the Cycle of Rejection, The Personality Disorder Capabilities Framework'.

- 31 The development of the KUFs is to be completed by spring 2009 when a range of PD training and education packages, accredited and delivered by the Personality Disorder Institute University of Nottingham and the Open University, will become available.

### Linked guidance and resources

32 The following resources may be useful:

- DSPD Programme website: [www.dspdprogramme.gov.uk](http://www.dspdprogramme.gov.uk)
- Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework NHS National Institute for Mental Health in England:  
<http://www.personalitydisorder.org.uk/assets/Resources/57.pdf>
- National Personality Disorder website: [www.personalitydisorder.org.uk](http://www.personalitydisorder.org.uk)
- The Personality Disorder Institute: <http://www.pdinstitute.org.uk> The Personality Disorder Institute (PDi) is geographically based at the University of Nottingham and aims to build multi-disciplinary research and development capacity capable of driving the field.

## PC21/2008 - Annex A - Personality Disorder – basic information

Personality disorders are 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 usually applied to young people, as it is believed that personality continues to develop through late teens. Personality disorder is defined as<sup>1</sup>:

*“An enduring pattern of inner experience and behaviour that deviates markedly from the individual’s culture.”*

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 emotion 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
- Borderline – pervasive instability of mood, interpersonal relationships and self-image associated with marked impulsivity, fear of abandonment, identity disturbance and recurrent suicidal behaviour and/or other self-harm

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

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). They must also cause the individual or those around him or her clinically significant distress or impairment.

The Royal College of Psychiatrists (1999) suggested that ‘severe’ should be defined as “gross societal disturbance” plus “gross severity of personality disorder within the flamboyant group and a personality disorder in at least one other cluster”. The criteria for the DSPD programme are described in Annex D.

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)<sup>2</sup> describes psychopaths as “grandiose, egocentric, manipulative, dominant, forceful and cold-hearted ... they display shallow and labile emotions, are unable to

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<sup>1</sup> **American Psychiatric Association (1994)** The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

<sup>2</sup> **Hare, R. (1991)** The Hare Psychopathy Checklist-Revised (PCL-R) *Toronto, Ontario: Multi-Health Systems*

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. The Mental Health Act 2007 amended the 1983 Act to remove the categorisation of mental disorder. The legal category of psychopathic disorder, therefore, no longer has significance with the implementation of the act in November 2008. Liability for compulsion under the amended Act will depend on clinical evidence of “mental disorder”, defined as “any disorder or disability of the mind”.

### **Prevalence**

Estimates of the prevalence of personality disorder in community samples vary between 4 and 13%<sup>3</sup>. Almost half of people with a personality disorder will have at least one other<sup>4</sup>. However, it is significantly higher in the Prison population - 73% of male remand, 64% of male sentenced and 50% of female Prisoners<sup>5</sup>. The most common is anti-social personality disorder, 63%, 49% & 31% respectively. For men paranoid is the second most prevalent and for women borderline. A small study which included high tariff offenders attending a probation centre found that, where personality disorder was diagnosable, the average was four<sup>6</sup>.

Personality disorder is also more prevalent in substance-misusing populations. Estimates vary, however, in drug services approximately a third of clients have a personality disorder, the most common being cluster B. In alcohol services this increases to just over half of clients with cluster C more prevalent<sup>7</sup>. Assessments need to be undertaken with particular care in these settings as the presentation may be masked or affected by the substance misuse.

Given the high prevalence rates it is clear that the Probation and Prison Services have worked with personality disordered offenders for many years. A significant proportion will not require specific interventions beyond Offending Behaviour Programmes. However, for some, referral to more specialist provision should be considered. These include the DSPD programme, therapeutic communities in Prison and the NHS.

Whilst research indicating what might be effective interventions regarding personality disorder and offending is limited<sup>8</sup>, 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.

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<sup>3</sup> **De Girolamo G. & Dotto P. (2000)** Epidemiology of personality disorders *New Oxford Textbook of Psychiatry, 1<sup>st</sup> Edition* Chapter 4.12.5

<sup>4</sup> **Coid J. et al (2006)** Prevalence and Correlates of Personality Disorder in Great Britain *British Journal of Psychiatry* 186, 423-431

<sup>5</sup> **Singleton et al (1997)** Psychiatric morbidity amongst Prisoners *ONS, London: The stationery Office*

<sup>6</sup> **Dolan B. et al (1995)** Multiple axis-II diagnosis of personality disorder *British Journal of Psychiatry* 166: 107-112

<sup>7</sup> **Bowden-Jones O. et al (2004)** Prevalence of personality disorder in alcohol and drug services and associated co-morbidity *Addiction* 99 1306-1314

<sup>8</sup> **Duggan et al (2007)** The use of psychological treatments for people with personality disorder: A systematic review of randomized controlled trials *Personality and Mental Health* 1: 95-125

### Guide to decision making – Annex B

This is a guide to offenders who may have severe personality disorder who should be considered for an intervention designed to meet their complex needs. When appropriate, during sentence-planning, consideration should be given to a TC or the DSPD programme or further discussions with local mental health professionals.

This does not cover all potential referrals. Others who may be suitable for the programmes include lifers (including IPPs) serving their first prison sentence and, for TCs, those presenting a medium risk of serious harm and non-violent offenders, for example, persistent fraud. If in doubt, contact the relevant unit for advice.

**Personality disorder:** None of the following are, on their own, indicators that an offender has a severe personality disorder. However, the presence of several of these factors should lead to further consideration of a referral to the NHS, the DSPD programme or a TC. For a personality disorder to be present, the 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.) They must also cause the individual or those around him or her clinically significant distress or impairment:

Diagnosed with Personality Disorder or Conduct Disorder;

Experiences emotional distress persistently to a debilitating degree (not due to depression or bereavement). Struggles to manage the intense emotions appropriately. May respond by blaming others or by making excessive demands on others or by blocking them out through, for example, substance misuse, self-harm or acting destructively to other people or property;

Reported experiencing physical or sexual abuse in childhood (or this may be suspected);

Criminally versatile;

A history of self-harm;

History of contact with a range of service providers e.g. NHS, CJS, Child & Adolescence, etc.

Grandiose behaviour or fantasies, deceitful in his or her relations with others, or a lack of empathy for others;

Low self esteem or unstable sense of identity. (An example of this may be past name changes.);

Previously failed to complete Offending Behaviour Programmes or completed them but this has not led to a change in behaviour.



**If yes:** The presence of several of the following characteristics should assist in determining whether a referral is better made to a Democratic Therapeutic Community or a DSPD unit:

#### Democratic Therapeutic Communities

Assessed as medium, high or very high risk of serious harm to others and a medium or high risk of reconviction;

Willing to work as part of a community, participate in groups and be subject to the democratic process;

**AND**

Willing to commit to staying for at least 18 months (12 months for women);

**AND**

Reached the point in their lives when they say they are ready to change and appear so;

**AND**

Has an offending history which includes violence (including robbery) and/or sexual offences (other offending is also considered);

**AND**

Deficits in two or more of the following:

- Self-management, coping, and problem solving
- Relationship skills/ inter-personal relating
- Anti-social beliefs, values and attitudes
- Emotional management and functioning

#### DSPD Programme

Assessed as high risk of re-conviction and very high risk of serious harm to others;

A history of serious violent and/or sexual offences;

If in the community would present an imminent risk of serious harm to others;

Unable to fully acknowledge the degree of harm to others or minimises the impact on others; tends to blame others for their problems or circumstances;

Abuses trust or friendships, exploits others;

Has breached parole licence, bail conditions or community based sentences;

Requires a more intense intervention from clinically trained staff – change is unlikely to happen without it;

Not likely to be very motivated, but likely to benefit from work to increase their motivation and engagement;

Excessively violent or sadistic aspects of offending;

Ideally, a minimum of three years still to serve.

**PC21/2008 – Annex C - DSPD referrals for men - Probation Area by Region**

<b>HMP Frankland</b>	<b>HMP Whitemoor</b>
<p>NORTH-EAST</p> <p>County Durham</p> <p>Northumbria</p> <p>Teesside</p>	<p>EAST OF ENGLAND</p> <p>Bedfordshire</p> <p>Cambridgeshire</p> <p>Essex</p> <p>Hertfordshire</p> <p>Norfolk</p> <p>Suffolk</p>
<p>NORTH-WEST</p> <p>Cheshire</p> <p>Cumbria</p> <p>Greater Manchester</p> <p>Lancashire</p> <p>Merseyside</p>	<p>SOUTH-WEST</p> <p>Avon &amp; Somerset</p> <p>Devon &amp; Cornwall</p> <p>Dorset</p> <p>Gloucestershire</p> <p>Wiltshire</p>
<p>YORKSHIRE &amp; HUMBERSIDE</p> <p>Humberside</p> <p>North Yorkshire</p> <p>South Yorkshire</p> <p>West Yorkshire</p>	<p>SOUTH-EAST</p> <p>Hampshire</p> <p>Kent</p> <p>Surrey</p> <p>Sussex</p> <p>Thames Valley</p>
<p>EAST MIDLANDS</p> <p>Derbyshire</p> <p>Leicestershire &amp; Rutland</p> <p>Lincolnshire</p> <p>Northamptonshire</p> <p>Nottinghamshire</p>	<p>LONDON</p> <p>All areas</p>
<p>WEST MIDLANDS</p> <p>Staffordshire</p> <p>West Midlands</p> <p>Warwickshire</p> <p>West Mercia</p>	
<p>WALES</p> <p>Dyfed-Powys</p> <p>Gwent</p> <p>North Wales</p> <p>South Wales</p>	

## PC21/2008 - Annex D - 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 one of the following. This is assessed using the Psychopathy Checklist – Revised (PCL-R) and a DSM-IV diagnosis through the International Personality Disorder Examination (IPDE):

Entry Criteria	Men	Women
PCL-R score	30 or more	25 or more
PCL-R score	25-29 and one or more personality disorders (PDs), other than antisocial (ASPD)	18-24 and two or more PDs other than ASPD
Multiple PDs (DSM-IV)	Two or more	At least three

The criteria for **risk** are 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
VRS (Violence-Risk Scale)	Risk assessment in violent offenders	Strong dynamic element supports measurement of change and formulation of treatment plans
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-SO (Violence-Risk Scale – sex offender version)	Sex offender version of the VRS	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 (Psychopathy Checklist)	Used to measure the presence and level of psychopathy in an individual	Tool also proven effective predictor of violence risk
IPDE	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	Semi-structured interview used to assist clinicians in the	Axis 1 includes all mental health conditions except

DSM-IV-TR)	diagnosis of axis 1 clinical disorders	mental retardation and PD
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**Ministry of  
JUSTICE**



**Dangerous & Severe Personality Disorder  
Programme (DSPD)**

**Referral Form**

Please complete this form as fully as possible. The boxes will expand as you type into them. In the Sources of Information boxes please indicate both the source and the person who can be contacted should any clarification be required.

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

Current sentence:

Earliest date of release:

**TRIGGER FOR REFERRAL:**

What prompted this referral?

Sentence planning meeting

OASys review

MAPPP meeting

MH in-reach

Self-referral

Other (please give details).....

**SECTION 1 - OFFENDING HISTORY**

From Offender Management Unit, Psychology Dept., LIDS, Sentence Planning documents and/or core records

**INDEX OFFENCE/CURRENT OFFENCE:**

Please give details of all charges as well as convictions. If there is insufficient space please attach additional sheets.

Date of Sentence	Offence(s) including dates	Sentence	Date of NPD or end of tariff

**DESCRIPTION OF INDEX OFFENCE:**

Please describe the index offence(s) and/or attach any Pre Sentence Reports or Post Sentence Reports and CPS papers, if available

**SOURCE OF INFORMATION**

**APPEAL PENDING?**  YES  NO

If yes: against sentence  Against conviction

**NEXT SENTENCE PLANNING BOARD DATE:**

<b>DATE OF NEXT PAROLE REVIEW:</b>		
<b>ATTITUDE TOWARDS INDEX OFFENCE (S)</b> Where possible please include prisoner's own words.		<b>SOURCES OF INFORMATION</b>
<b>PREVIOUS CONVICTIONS:</b> Please attach a photocopy of up-to-date list of previous convictions.		<b>SOURCES OF INFORMATION</b> Attached <input type="checkbox"/>
<b>SECTION 2 - BEHAVIOUR IN PRISON</b> From Offender Supervisor, Personal and Wing Officers, Probation Dept., Psychology Dept., Education, Workshops and/or core records		
<b>INCENTIVE LEVEL</b>		
<b>RESPONSE TO AUTHORITY:</b> Please describe prisoner's attitude to 'the system' and those in authority.		<b>SOURCES OF INFORMATION</b>
<b>RELATIONSHIP WITH PEERS:</b> Please comment of prisoner's relationship with other prisoners.		<b>SOURCES OF INFORMATION</b>
<b>ADJUDICATIONS:</b> Has the individual a history of adjudications?		<b>SOURCES OF INFORMATION</b>
<b>Date</b>	<b>Location</b>	<b>Details of the adjudication</b>
<b>SELF-HARM/SUICIDAL INTENT/ OPEN ACCT</b> Has the individual a history of self-harm?		<b>SOURCES OF INFORMATION</b>
<b>SECTION 3 - OFFENCE RELATED WORK</b> From Offender Management Unit; Psychology Dept.		
<b>ACCREDITED PROGRAMMES AND OTHER OFFENCE RELATED WORK IN PRISON:</b> 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.		<b>SOURCES OF INFORMATION</b>
<b>SECTION 4 – MEDICAL HISTORY</b> From Healthcare, Psychiatry and Psychology Dept.		
<b>CONTACT FOR CPA:</b>		

<p><b>PSYCHIATRIC HISTORY:</b> As far as you know has the prisoner <b>ever</b> had contact with psychiatric services? Please give details and attach reports if available.</p>	<p><b>SOURCES OF INFORMATION</b></p>
<p><b>PSYCHOLOGY:</b> As far as you know has the prisoner <b>ever</b> had contact with psychological services? Please give details and attach reports if available.</p>	<p><b>SOURCES OF INFORMATION</b></p>
<p><b>PSYCHOLOGICAL TESTING:</b> Please give past psychological testing results e.g. PCL-R, HCR-20, VRS, any psychometric tests, personality disorder assessment, outcome measures for offending behaviour programmes:</p>	<p><b>SOURCES OF INFORMATION</b></p>
<p><b>INTELLECTUAL ABILITY:</b> Is there any record of intelligence testing e.g. WAIS, WASI, Quick Test? Please give scores if completed</p>	<p><b>SOURCES OF INFORMATION</b></p>
<p><b>CURRENT MEDICAL ISSUES:</b> 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.)</p>	<p><b>SOURCES OF INFORMATION</b></p>
<p><b>SECTION 5 – SECURITY INFORMATION</b> From Security Dept.</p>	
<p><b>(NOT FOR DISCLOSURE)</b></p>	
<p><b>SECURITY INFORMATION OR INTELLIGENCE:</b> 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><b>SOURCES OF INFORMATION</b> (Please indicate whether information is based on evidence or intelligence)</p>
<p><b>BULLYING/ANTI INTIMIDATION STRATEGY (AIS):</b> Please list and describe any occasions when the prisoner has been subject to an AIS or has been a victim of bullying</p>	<p><b>SOURCES OF INFORMATION</b> (Please indicate whether information is based on evidence or intelligence)</p>

<b>HOSTAGE TAKING:</b> Has the prisoner ever been involved in (as perpetrator or victim) or threatened hostage taking.	<b>SOURCES OF INFORMATION</b> (PLEASE INDICATE WHETHER INFORMATION IS BASED ON EVIDENCE OR INTELLIGENCE)
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**SECTION 6 – AUTHORISATION**

<b>IS THE PRISONER AWARE OF THIS REFERRAL?</b> All prisoners being referred must be told of the referral before this form is submitted. 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.	<b>SOURCES OF INFORMATION</b>
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Date Referral Form Completed	
Name of Referrer	
Designation and Grade of Referrer	

Some establishments have DSPD liaison managers. Where applicable, 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 all attachments:**

**PC21/2008 - Annex F - Democratic Therapeutic Communities in Prison – summary of entry criteria**

	<b>HMP Blundeston, Suffolk</b>	<b>HMP Dovegate, Staffordshire</b>	<b>HMP Gartree, Leicestershire</b>	<b>HMP Grendon, Buckinghamshire</b>	<b>HMP Send, Surrey</b>
Prison type	Male category C training	Male category B training; also takes C cat	Male category B training; indeterminate sentence prisoners only	Male category B therapeutic community; also takes C cat	Closed female training
No. of places	40	200	23	240	40
Contact no.	01502 734500	01283 829400	01858 436600	01296 443000	01483 471000
Minimum time commitment	18 months (Research indicates that this is the minimum period for effective treatment. However, some may require longer.)				12 months
Current location/categorisation	C cat, currently in any prison	B cat, currently in any prison	At HMP Gartree	Not A cat for 6 months	Any women's prison
Appeals or offences	No offences outstanding; not appealing against conviction				
Drug dependency	It is fairly common for prisoners referred to TCs to have used drugs. However, a TC is not a drug rehabilitation programme. Prisoners are expected to not have failed a Mandatory Drug Test for at least two months.				
Index offence of a sexual nature	Not taken	Yes	Not taken	Yes	Yes
Mental illness	No current diagnosis of an active mental illness				
Self-harm	None for two months				
IQ	Must have the intellectual capacity to participate in the programme. This usually equates to an IQ of 80. If in doubt, please discuss with the TC.				
Psychopathy	Psychopathy is an indicator of significant levels of disruptive behaviour in treatment and failure to stay in treatment when compared to other offenders <sup>1</sup> . Highly psychopathic offenders are better referred to the DSPD programme.				
Motivation	Must be motivated to participate in a programme based on therapeutic community principles. Indicators of offenders who do less well and are less likely to be motivated are current poor institutional behaviour, for example, serious adjudications, drug dealing, instrumental violence, threatening behaviour and bullying.				

<sup>1</sup> **Hemphill & Hart (2002)** *Motivating the unmotivated: Psychopathy, Treatment and Change Motivating Offenders to Change: A guide to Enhancing Engagement in Therapy Chapter 12* J. Wiley and Sons, Ltd)

	<p><b>Democratic Therapeutic Communities Application Form</b></p>	 <p><b>Ministry of JUSTICE</b></p>
<p>Please complete this form as fully as possible. If you need help please ask your Personal Officer. If you do not know the answers to any of the questions please say so on the form. It can still be sent to the Therapeutic Community of your choice.</p>		
<p><b>Section One - Basic Information:</b></p>		
Name:		
Home address: (if you are homeless please tell us your home probation area)		
Current prison, prison number & categorisation:		
Offender Manager (and the office in the community):		
Offender Supervisor:		
Personal Officer:		
Do you have at least 18 months to serve? (12 months for HMP Send)	YES <input type="checkbox"/> NO <input type="checkbox"/>	
How long is your current sentence?		
What is your earliest date of release?		
What are the offences for which you are serving your current sentence?		
Are you appealing against conviction or length of sentence?	Conviction: <input type="checkbox"/> Length of sentence: <input type="checkbox"/> When is this likely to be heard? _____	
<p><b>Section Two – Democratic Therapeutic Community in Prison (TC)</b></p>		

**Which TC would you like your application considered by?**

Blundeston:  Grendon:  Dovegate:  Gartree\*:  Send^:

\* you must be a lifer and apply for transfer to the prison first

^ Women Only

Why do you want to go to a Democratic Therapeutic Community?

Have you previously been in therapy at a TC? YES  / NO

If **yes**, where:

**Section Three – Personal Information:**

Are you currently on an offending behaviour, educational or drug programme?

If **yes**, which ones?

Which programmes have you attended in the past? Please include those run by the Prison and Probation Services.

How many adjudication reports have you had in the last year?

Please tell us about any medical or psychiatric treatment you have received in the last year.

Please tell us about any drug or alcohol problems you may have.	
<b>Date:</b>	<b>Signed:</b>
<b>Please ask your Personal Officer or Offender Supervisor to send this form to the Therapeutic Community of your choice. As soon as it is received the TC will contact you to explain what will happen next.</b>	

## A. INITIAL SCREENING

**1. Title of function, policy or practice (including common practice)**

*This Probation Circular provides guidance to Probation Areas on the management of, and strategic planning for severely personality disordered offenders who present a high or very high risk of harm to others. It provides information and referrals processes for the DSPD programme and Therapeutic Communities in Prison.*

**2. Aims, purpose and outcomes of function, policy or practice**

*This probation circular intends to ensure that offenders with a mental disorder, severe personality disorder, and who present a high risk of harm to others, are identified and referred to appropriate services.*

**3. Target groups**

*Who is the policy aimed at? Which specific groups are likely to be affected by its implementation? This could be staff, service users, partners, contractors.*

Equality target group	Positive impact – could benefit	Negative impact - could disadvantage	Reason for assessment and explanation of possible impact
Women	Will benefit women as the PC provides information about specialist services.		There have been a number of studies considering the prevalence of personality disorder in male and female prisoner populations, for example, by Coid (2006) and Singleton (1997). These identify the extent and nature of the personality disorders and indicate the need for specialist provision. The PC provides information about two specialist services for women with severe personality disorder.
Men	Provides information about specialist services		As above
Asian/Asian British people			No specific impact
Black/Black British people			No specific impact

Chinese people or other groups			No specific impact
People of mixed race			No specific impact
White people (including Irish people)			No specific impact
Travellers or Gypsies			No specific impact
Disabled people	Provides information and advice for a specific type of mental disorder, personality disorder.		This Probation Circular is intended to have a positive impact on offenders with personality disorder who are unlikely to be suitable for other interventions. It provides information about services that may address their mental health needs and risk of re-offending.
Lesbians, gay men and bisexual people			No specific impact
Transgender people			No specific impact
Older people over 60			No specific impact
Young people (17-25) and children			No specific impact
Faith groups			No specific impact

4. Further research/questions to answer  
A full impact assessment is not required

**Initial screening done by: Nick Joseph**

**Name/position:      Date: 01/07/08**

## Probation Resource Impact Assessment Template

### A. SCREENING DETAILS

1. Title of Probation Circular (PC) 21/2008  
Managing high risk of harm offenders with severe personality disorder

2. Notes on the reliability of the costing below and issues for the Probation Coherence Group to consider.

There are no cost implications relating to the implementation of this PC. It replaces an existing circular with up to date information and advice about managing this population. If the advice is implemented it may lead to savings as prisoners will be referred to the most appropriate interventions earlier in their sentence and less will be referred to programmes that may be unsuitable.

### 3. Method

Identification of Task	(a) Additional /Reduced Time to Perform Task (hours)	(b) Number of Times Task Performed Annually Nationally	(c) National Increase /Decrease in Hours (a x b = c)	(d) Hourly Cost (determined by grade of staff) £	(e) National Annual Total Cost/Saving (c x d = e) £
<b>Total for PC</b>					