The 'Dangerous and Severe Personality Disorder' programme: a view from inside

Martin Kettle explains the 'DSPD' definition of some people who have committed a violent offence, and reviews the operations of the service in prisons and hospitals.

The notion of a 'Dangerous and Severe Personality Disorder' service was born in controversy, and is unlikely ever to be free of it. The political impetus which brought the programme into being, and sustains the will to fund it in spite of question marks raised by the press against the cost, comes from public concern about the most serious and apparently random crimes of violence, including sexual violence. Some dangerous offenders are mentally ill to the extent that they can be held indefinitely in hospital; a few have committed such appalling acts that they are sentenced to life with a whole-life tariff. For some, the risk of reoffending can be significantly reduced through established offending behaviour programmes, or through the well-developed therapeutic communities in prisons and elsewhere.

There remains a significant group – potentially around 2000, according to the available research – who have previously been regarded as clinically untreatable. Many of them have high levels of psychopathy by the currently accepted measures. The growing body of knowledge (chiefly in mental health related research) about personality disorder has provided a rich new set of concepts for understanding the behaviours of this group, and their aetiology. The crude mad/bad disjunction, which has been institutionally reinforced by the contrasting cultures of the State systems for health and criminal justice, is challenged in new and suggestive ways by the development of understandings of personality disorder.

Four DSPD units are now operational in high secure institutions – in Broadmoor Hospital, HMP Frankland, Rampton Hospital and HMP Whitemoor. To these have being added a number of DSPD services in medium secure hospitals, and in low secure and community contexts, as well as follow-on services planned in Category B and C prisons. It is now possible therefore to speak in practical as well as theoretical terms about a DSPD service, as it develops in parallel with the much larger-scale growth of Personality Disorder services in the NHS.

Does DSPD exist?

Despite the increasing recognition of the DSPD brand, there is of course no such thing as a dangerous and severe personality disorder. A major aim of the DSPD project is to explore under what circumstances people with severe personality disorders come to be at high risk of serious violent offending, and how that risk can be reduced. If there were a way of reducing the risk of offending without addressing the personality disorder at all, that would (in terms of the overall political aim) be satisfactory. There has been much discussion of the effects of labelling people as 'DSPD' – this has already happened to a number of offenders, including those who have been assessed as meeting the DSPD criteria, and (whether through disengagement from treatment, or other reasons) are not now in DSPD services. The criteria for admission to a DSPD unit are threefold: a high risk of serious offending, evidenced chiefly by past offending history; the presence of complex and severe personality disorder, described chiefly in terms of the taxonomy laid down in DSM-IV; and evidence of a functional link between the two (Dept of Health, 2005 and APA, 2000). This last criteria is the most controversial: there are no well-established assessment tools for measuring this link, because there are no clear research outcomes to support such tools. The very labelling of an offender as 'DSPD' (which, to reiterate, is not a description of a person nor the identification of a well-established clinical syndrome) involves, therefore, the assumption that that link is established in the case of this offender.

The problematic nature of the DSPD brand is matched in the operational realities of the programme. It is a pilot programme, with the twin purposes of achieving actual change in the risk profile of the offenders admitted to the DSPD units, and contributing to the building of an evidence base as to what is effective. There is a substantial governance infrastructure, with an expert advisory group comprising leading academics in the field, and a project board pitched at a very senior level in health and criminal justice. It is a truism that research always impacts the process which it is researching; there is, it often seems, no part of the

DSPD programme which is not being evaluated and researched throughout the (sometimes necessarily tentative and exploratory) process of service development. This continuous scrutiny, combined with the acute risks associated with any publicly perceived failure (in particular, the so far unrealised risk of very serious offending either within a DSPD unit or by an ex-DSPD offender), places many constraints on those managing the services; it is possible that, paradoxically, the chief risk in the programme could be risk aversion, fettering the freedom of pioneering clinicians and other staff to test experimental methods.

Will it work?

The evaluation of outcomes is notoriously difficult with the kind of offenders who find their way into a DSPD service. Randomised trials have been tried, but are impractical for a number of reasons. For example, the process of assessment within the DSPD programme is complex and extended; to assess and then not offer treatment to a control group would be ethically problematic, but to identify a control group on the basis of a simple paper-based assessment would be of doubtful value. Again, to reduce the number of variables to a manageable level would be difficult and expensive – the DSPD units are mainly new builds to a high standard, and they all have high staffing levels, so these conditions might have to be duplicated for a control group if the treatment itself is to be tested. Two-year reconviction rates, the commonest currency of treatment effect research, scarcely apply to a group many of whom will remain in secure environments for a considerable time after DSPD treatment, and many of whom have a pattern of offending – sexual offending, notably – where very serious offences may occur after a period of apparent compliance.

Evaluation is therefore likely to focus on the measurement of change, partly through observations of behaviour change and partly through the before-and-after application of well-accepted assessment tools. What can be said at this early stage – and any such assertion is a hostage to fortune, in view of the potential destructive impact of any serious offence by an offender currently or formerly in a DSPD service – is that the cause of public protection is already being strongly served by the DSPD Units. The claim is largely dependent on the assumption that those working and those living within prisons and secure hospitals are members of the public – and the level of assaults and damaging behaviours is anecdotally evidenced to be much reduced, in comparison with the behaviours of these offenders in their previous custodial contexts. Some small-scale research in this area in HMP Whitemoor already bears out this conclusion.

It is fair to assume that the effectiveness of treatment in the high secure DSPD units can only be consolidated, and safely tested, in services which continue or at least reinforce the treatment and learning gained in the intensive DSPD treatment programmes. For this reason the growth of the lower-security DSPD services is vital, as also is the development of constructive operational interfaces between these services and others which, explicitly or implicitly, manage and/or treat personality disordered people, whether in health or criminal justice contexts.

What are they doing?

The operational DSPD services are putting into practice a fascinating variety of treatment approaches and methods, within the common framework of the overall programme. Some are based on well-established manualised interventions grounded in forensic psychology, largely within the cognitive behavioural tradition. These are being extended in scope, notable in the Chromis programme developed within the Prison Service to facilitate change in those with high levels of psychopathy. Others reach more widely into the role of emotion and the effects of trauma in the aetiology of PD and offending behaviours, and so draw as much on clinical as on forensic psychology. In all the units, a multidisciplinary ethos brings together psychiatrists, psychologists and other professions (nursing, occupational therapy, probation, education...) with front-line operational staff in a common endeavour – the atmosphere of common commitment to a pioneering endeavour is apparent in each of them.

The DSPD programme originated in a political atmosphere which seemed to be preparing the way for detention of people identified as dangerous, before rather than after they offended. That huge legislative step has not been taken. In a society where anxiety about serious violent and sexual offending runs as high as in ours, the national DSPD programme is a serious and internationally significant attempt to address these terrifying risks.

■

Martin Kettle *is Head of Special Units (including the DSPD Unit) at HMP Whitemoor. The views expressed here are his own, and do not represent the official views of the government departments involved.*

References

American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, (fourth edition). American Psychiatric Publishing.

Department of Health, Home Office, HM Prison Service (2005) *Dangerous and Severe Personality Disorder (DSPD) High Security Services: Planning and Delivery Guide*. London: Home Office.