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Working with people with personality disorder

DSPD ten years on at Broadmoor

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This article looks at the lessons learned from the Dangerous and Severe Personality Disorder (DSPD) service at Broadmoor. The staffing, policies and management practices that were implemented are discussed, many of which are still in place today after the decommissioning of the DSPD service in 2011. Our treatment and assessment model is described in comparison to the other DSPD units. It might be said that the DSPD service at Broadmoor was never really fully tested, with lower than anticipated referral numbers and limited options for moving patients on. The challenges of decommissioning and where to place our DSPD patients are discussed and how, if it were today, moving patients on would be easier within the national offender PD pathway. However, whilst Broadmoor may have been operationally more vulnerable than expected, lessons learned in the course of DSPD programme development have made lasting changes in the ethos of patient engagement, treatment delivery and risk management at Broadmoor.

Introduction

Following a number of national concerns about the unsafe management of Personality Disorder patients, a joint initiative from Department of Health and Home Office resulted in the development of the DSPD (Dangerous and Severe Personality Disorder) programme. Its objective was to meet the equal concerns of providing treatment and public safety.[1] Key events that led to this development included: (i) the Fallon enquiry into Ashworth's treatment and management of Personality Disorder (ii) the 1983 Mental Health Act requirement for the treatability of 'psychopathic disorder' and (iii) cases like that of Michael Stone who as an 'untreatable psychopath' was excluded from forensic mental health services and remained in the community free to kill Lynne and Megan Russell. This highlighted the inadequacy of evidence-based treatment for severely personality disordered patients. The case of Robert Oliver who declined admission by Broadmoor on the grounds that his paedophilic-motivated kidnapping, assault and killing did not constitute a mental disorder only fuelled the debate.

The DSPD challenges were twofold: to manage and alleviate personality disorder, including psychopathic traits, and to address criminogenic needs and reduce risk. Its development was controversial from the outset: some felt that the possibility of detaining a determinate sentenced prisoner beyond the expiry of sentence undermined basic human rights, and others argued that DSPD was not a clinical diagnosis nor a medical condition. In practical terms the new proposals were not substantially different from the prevailing Mental Health Act provisions other than treatability would be less restrictively interpreted.

To meet the DSPD criteria, there would need to be evidence of a severe personality disorder(s) and severe past offending (refer to table 1) with the two being functionally linked. The initial working definition of DSPD was set out in terms of an individual presenting with: (i) a significant risk of serious physical or psychological harm from which it would be difficult or impossible for the victim to recover; (ii) a significant disorder of personality; and (iii) the risk presented is functionally linked to the personality disorder. A series of guidelines were developed to support these criteria which included the use of DSM or ICD diagnosed personality disorders and/or high scoring on the PCL-R and use of empirically sound risk assessment instruments for quantifying risk of sexual or violent offending.

The origins of DSPD

The introduction of DSPD at Broadmoor

The national DSPD strategy was set up in two prison units (HMP Whitemoor and HMP Frankland) and two high secure mental health units (Broadmoor and Rampton). Two of the original architects of the DSPD proposals were Broadmoor staff: Dilys Jones then Consultant Forensic Psychiatrist acted as a Department of Health advisor and Derek Perkins, the then head of Psychology was seconded to the national DSPD planning

1. *Dangerous and Severe Personality Disorder (DSPD) High Security Services: Planning and Delivery Guide*. Home Office, 2004.

group. This group was tasked with drafting national guidelines for the four proposed units which were encouraged to develop individual identities and treatment regimes. On Broadmoor's part national and international visits informed the decision to adopt a Cognitive Behavioural Therapy (CBT) approach. This was based on the evidence base for this approach, that it did not require 'experts' and it was already developed and did not require a huge investment of time to design a new treatment model.

An outreach team consisting of a senior manager and clinical staff visited several high secure prisons to seek volunteers for the new service at Broadmoor. A small trial ward was set up in the main hospital (Bicester Ward) to receive the new patients as they were to have no contact with other patients in the main hospital and a new specifically designed unit 'The Paddock' was built and policies and procedures developed in close consultation with the staff group. The DSPD design group was always aware that the project may have a time-limited life and there was therefore much discussion about not only making the Paddock safe to accommodate this challenging DSPD cohort, but flexible enough to be reused for other types of patients should the service not continue.

There was an initial fear that these patients were very unusual and dangerous, partly no doubt because of their 'DSPD' label. However, with regard to day-to-day risk to self or others, the challenges were no greater than with other PD patients within the main hospital; DSPD patients' risk lay more in their risk to the public than in their day-today management. Due to a slow pace of admissions Broadmoor was not able to generate sufficient numbers of DSPD patients to form the relevant therapy groups and DSPD patients began to be placed in centralised therapy groups or treated individually on a bespoke basis and segregation gradually relaxed for general activities such as education, recreation and general rehabilitation groups.

Staffing, Management and Policy

Staff working in the DSPD unit required a high degree of personal resilience to maintain boundaries, survive hostility and manage conflict in a high secure setting. The early service at Broadmoor had a specific staff recruitment assessment centre solely for this purpose. A new strategy included recruiting Assistant Psychologists as well as Health Care Assistants into a new category of Therapy Assistants to work alongside the larger group of nurses. This innovation was only partly successful and resulted in tensions between Therapy Assistants and Staff Nurses. Despite efforts to ensure all clinical staff were involved in delivering therapy the new therapy assistants were not qualified to perform daily mandatory nursing duties which fell to the Staff nurses to complete and prevented them being as involved in therapy as the more junior Therapy Assistants. As the DSPD service became more embedded within the wider hospital such tensions dissipated and the later service operated more in line with the main hospital's recruitment procedure of 'recruit and place hospital-wide'.

Not only was the DPSD population difficult to treat, it also presented challenges with regard to their safe management and containment. Clinicians were presented with the risk of allegations and litigation, the threat of clinical boundary violations, and significant difficulties with therapeutic engagement. Broadmoor developed clear policies and procedures to ensure clinical work was supported, including enhanced communications between the clinical team and the security department to deliver effective intelligence gathering and risk management. We also adopted a harm minimisation approach and a learning culture which promoted open discussion and analysis of mistakes as well as successes, and this was regarded as essential in safeguarding both staff and patients.

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Multidisciplinary teamwork (MDT) was developed to a high level to manage the particular challenges of the DSPD population. Teams were required to include, amongst others, a psychiatrist, a nurse, a psychologist, a social worker, an occupational therapist, a therapy assistant and a security liaison nurse. It was imperative that the staff understood the imortance of team working, sharing information, being effective team players and feeling comfortable working as part of an MDT. Lessons from this continue to be used throughout Broadmoor to ensure all aspects of a patient's needs are reviewed and to support the staff who address them.

Another gain in working practices from our experience of working with DSPD has been the role of supervision and reflective practice in maintaining the effectiveness and healthy functioning of the team. Regardless of the format of therapy (1:1 or group format), each staff member received a minimum of one hour of formal clinical supervision and one hour of

management supervision per month; practices that continue today. Clinicians working with DSPD were continuously exposed to challenging interpersonal dynamics resulting in potential boundary breeches, vulnerability, team polarisation and splitting. Facilitated multidisciplinary team supervision and reflective practice enhanced team effectiveness and helped them to resolve conflict and disagreements. These forums, and a daily shift de-brief allowed teams to take 'protected time' to reflect on shared experiences of patient work and their approaches to clinical practice. This reduced professional isolation and allowed staff the space to explore problematic feelings and attitudes which had the potential to split the team.

Admissions into the new DSPD unit

The early DSPD patients recruited from their original prisons were keen to come to Broadmoor. Some were genuine volunteers seeking enhanced treatment and others saw Broadmoor as a better alternative to prison. Others were lifers well over their tariff who saw the move as a potential route out of confinement. This was a stark contrast to the later patients who were admitted involuntarily and sometimes near the end of their sentences. They were often antagonised by the circumstances of their admission and less cooperative.

The new system had a very clear and challengeable process of defining (i) Personality Disorder and Risk and (ii) the functional links between them. Despite the original guidance on establishing links between personality disorder and offending, it was not clear how a functional link could be determined beyond identifying that that patient belonged to two overlapping populations (personality disorder and serious violent/sexual offending). Demonstrating the presence of a functional link required clinical evidence that either treatment of the personality disorder led to a reduction in their violent or sexual offending, or that a period of deterioration in mental state (personality disorder presenting) was associated with more obvious offence paralleling behavior. Attempts were made to elucidate and standardise the identification of this functional link by means of an 'Aid to Decision Making' document *(refer to Table 1).*

Early on in the DSPD project, Broadmoor developed a policy of seeking to admit child sexual abusers and other sex offenders on the basis that (i) this group, especially child sex offenders, was of maximum concern to the public (ii) Broadmoor had expertise and facilities in working with such cases and (iii) such offenders would be less disruptive in the unit than other offenders. This view was possibly ill conceived as, although sex offenders typically posed little control problem in prison, the criteria for admission into DSPD treatment were a high PCL-R score or two PD diagnoses, disorders that are associated with high levels of interpersonal challenging behaviours. Although as the DSPD service at Broadmoor developed this over-representation of personality disordered sex offenders was challenged by national management in an attempt to better 'share the load' of difficult patients. Whilst this did reduce the number of DSPD sex offenders, Broadmoor still had a high proportion (76%) in comparison with the Rampton (44%), HMP Whitemoor (50%) and HMP Frankland (46%) units.

Unlike the other DSPD units, Broadmoor did not have a formal inpatient assessment process but assessed referrals in prison prior to making a selection decision (by means of the PCL-SV[2] and HCR-20[3]) by an outreach group of a psychologist, a psychiatrist and a nurse. In

Table 1: The criteria for admission to a DSPD unit.

To be meet the criteria, an individual needs to fulfil either criterion A or B and/or Criterion C

Criterion A	A score of 30 or above on the Revised Psychopathy Checklist (PCL—R; Hare, 1991) or
Criterion B	A PCL—R score of 25—29 plus at least one DSM—IV personality disorder diagnosis other than antisocial personality disorder
Criterion C	Two or more DSM—IV personality disorder diagnoses

Table 2: The minimum assessments required for admission to a DSPD unit

Domain	Assessment tool
Violence	Violence Risk Scale (VRS; Wong and Gordon, 1999—2003) Historical, Clinical and Risk Management (HCR—20) scale (Webster et al, 1997)
Sexual Offending	Risk Matrix 2000 (Thornton et al, 2003) Static 99 (Hanson and Thornton, 2000)
	Structured Assessment of Risk and Need (SARN; Thornton, 2002)
Personality disorder	The Revised Psychopathy Checklist (PCL— R; Hare, 1991) Psychopathy Checklist — Screening Version V (PCL—SV; Hart et al, 1995) International Personality Disorder Examination (IPDE; World Health Organization, 1997)

Source: Howells, Krishnan, and Daffern (2007). Challenges in the treatment of dangerous and severe personality disorder.

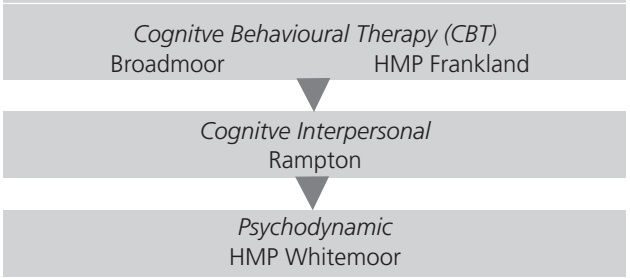
2. Hart, S., Cox, D. & Hare, R. (1995) *The Hare PCL:SV Psychopathy Checklist: Screening Version*. Multi-Health Systems.
3. Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997b). HCR-20: Assessing the Risk for Violence (Version 2). Vancouver: Mental Health, Law, and Policy Institute, Simon Fraser University.

addition to being cost-effective, this integrated approach had the benefits of creating more confidence that patients coming in would be suitable and allowing access to treatment at the three month point of the initial Care Programme Approach (CPA), if not sooner. Broadmoor maintained this 'outreach' assessment team to complete a comprehensive initial assessment and formulation even after the 'Aid to Decision Making' document was introduced. This consisted of using semi-structured interviews and a standardized battery of structured assessments *(refer to Table 2)*.

Treatment

The different DSPD units were encouraged from the outset to develop different models of treatment (pending approval from the national board and compliance with a common core of requirements; *(refer to Figure 1)*.

Figure 1: The spectrum of therapeutic models used across the DSPD units.



Given the multidimensional nature of Personality Disorders and psychopathy, Broadmoor identified the need for a multifaceted but integrated treatment approach, consistent with Livesley's (2003) recommendations.[4] In keeping with the key elements of the DSPD strategy the psychological therapies used at Broadmoor attempted to integrate both the personality disorder and the offending behaviour/criminogenic needs (refer to figure 2 and 3) and an integrative cognitive behavioural treatment (CBT) approach was adopted. CBT has the advantage of capitalising on the cognitive strengths associated with the DPSD population and not requiring introspection or emotional experience. Guidance suggests that as it is the deficient interpersonal and affective facets of psychopathy and not the behavioural facets that present the poorest treatment prognosis.[5] More specifically CBT's collaborative 'personal scientist' approach empowers patients and is likely to appeal to the grandiose nature of psychopaths, their self-interest and their desire for novelty and control.[6]

As not all the DSPD population was anticipated to be high PCL-R scorers, we needed to ensure the therapeutic style was responsive to the whole spread of PCL-R scorers, and the CBT approach at Broadmoor was therefore shaped by a number of additional influences and therapies, including the phases of the Violence Reduction Programme,[7] Dialectical Behavioural Therapy,[8] the 'what works' literature,[9] Integrative and milieu therapy and Livesley's 4-stage process of change,[10] the 'Good Lives' principles,[11] the 'Risk Needs and Responsively' model,[12] and Schema focussed therapy.[13] The National Institute of Clinical Excellence (NICE 2003) service-user perspective were also incorporated into the delivery of therapy.

As the DSPD service developed, the profile of the DSPD population changed from a preponderance of antisocial and psychopathic traits for which the literature recommends CBT to more borderline traits, for whom the cognitive model was insufficient *(refer to table 3)*. As a result the treatment strategy changed to include approaches that included introspection such as Mentalization-Based Therapy[14] and the emotional domain such as Dialectical Behavioural Therapy (see footnote 8).

Motivation and Engagement

The nature of the DSPD criteria (high-risk, prior significant therapy interfering behaviours and high levels of resistance) together with the psychopathic traits of most of the patients (lack of insight, lack of therapeutic

4. Livesley, W. J. (2003) Diagnostic dilemmas in the classification of personality disorder. In *Advancing DSM: Dilemmas in Psychiatric Diagnosis* (eds K. Phillips, M. First & H. A. Pincus), pp. 153–189. American Psychiatric Association Press.
5. Hemphill, J.F., & Hart, S.D. (2002). *Motivating the unmotivated: Psychopathy, treatment and change*. In M. McMurran (Ed.), Motivating offenders to change: A guide to enhancing engagement in therapy (pp. 193-219). Chichester: Wiley.
6. Farr, C and Draycott, S (2007) "Considering Change": A motivational intervention for severely personality disordered patients. *Issues in Forensic Psychology, Special Edition,* 7, 62-69.
7. Wong, S. (2004) *The Violence Reduction Program*. Correctional Services Canada.
8. Linehan, M. M., Schmidt, H., Dimeff, L.A., et al (1999) Dialectical behaviour therapy for patients with borderline personality disorder and drug-dependence. American Journal on Addictions, 8 (4), 279-92.
9. McGuire, J. (ed.) (2002) *Offender Rehabilitation and Treatment: Effective Programmes and Policies to Reduce Re-offending*. John Wiley & Sons.
10. Livesley, W.J, (2003). *Practical Management of Personality Disorder*: New York: The Guildford Press.
11. Ward, T. & Brown, M. (2004) The good lives model and conceptual issues in offender rehabilitation. Psychology, Crime and Law, 3, 243–257.
12. Andrews, D. A. & Bonta, J. (2003) *Psychology of Criminal Conduct* (3rd edn). Anderson Publishing.
13. Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: a practitioner's guide*. New York: Guilford Press.
14. Fonagy, P. & Bateman, A. (2006). Mechanism of change in mentalization based treatment of borderline personality disorder. Journal of clinical Psychology, 62, 411-430.

Table 3: Demographics and Clinical Assessment of Broadmoor's DSPD in compared to other DSPD population

	Broadmoor	Other high secure DSPD population
Demographics		
Mean Age (sd)	38.2 (9.4)	36.7 (9.3)
% White	89 %	88 %
Clinical Assessment		
PCL-R Total Score	27.4 (4.8)	27.8 (5.2)
PCL-R Factor 1 Score	10.8 (2.8)	10.7 (3.0)
PCL-R Factor 2 Score	14.3 (3.2)	14.9 (3.2)
% Diagnosis		
Paranoid	48.1	26.7
Schizoid	3.8	7.0
Schizotypal	11.5	7.3
Antisocial	76.9	75.2
Borderline	46.2	43.7
Histrionic	9.6	6.0
Narcissistic	17.3	17.3
Avoidant	21.2	16.2
Dependent	1.9	1.8
Obsessive-compulsive	7.7	6.8

attachment, manipulative interpersonal style, and lack of personal responsibility) was a challenge to clinicians in terms of enabling patient motivation. These patients had anti-social interpersonal and cognitive skills but lacked the necessary motivation and/or ability to apply these pro-socially. Subsequently, one of the primary approaches to engage the DSPD population in therapy, using the theoretical model of the Considering Change programme, became early intervention to use the skills the patient already had to reduce the discomfort of cognitive dissonance produced by the interplay of self-evaluations, cognitive mechanisms, behavioural and outcome expectancies, personality traits, and aspects of the environment.

Such attempts were in keeping with recommendations that the cognitive skills of psychopaths should be utilized to enable them to understand the rationale underpinning their treatment (see footnote 5). Due to the challenging nature of the population, the reasons they cited for wanting to change, often extrinsic motivators, were represented as important stepping-stones towards making the change. In the same way, internalising the desire to change was, and still is, regarded as a therapeutic process rather than a treatment target in itself.

Broadmoor remains very much aware that the systems in which treatment programmes are embedded are important in establishing and maintaining motivation. All ward based staff were trained in core motivational skills as a means of mitigating a potentially hostile and coercive environment. To motivate the patients, further attempts were made to examine the costs and benefits of changing offending behaviour with reference to self and others. Despite the restricted empathic responses of the DSPD patients, referring to 'significant others' was also important in achieving change. Using a meaningful role-model had the advantage of levering self-interest as did working with general behaviours that they wanted to change in preference to their offence-paralleling behaviour (or inter-personal aggression).

The high levels of psychopathy associated with DSPD were viewed as responsivity factors in terms of the RNR model.[15] Treatment targets were represented as 'strengths', such as the psychopathic tendency to desire a sense of control and to seek sensation (be comfortable with novel situations). Utilising a personal-scientist approach and independent between-session tasks helped to create a sense of control, resulting in increased self-efficacy and personal responsibility for change. Equally, the patients' desire for status and their facility with impression management were capitalised upon through group declarations of change 'targets'.

Treatments outcomes

Positive changes did occur in response to treatment for the DSPD patients, but not for all. Change scores were developed at the point of leaving Broadmoor (for example of the 47 patients for whom repeat HCR-20 data was available, 68 per cent showed positive change on the dynamic (Clinical and Risk) items, 15 per cent showed no change, 17 per cent showed negative change and 28 per cent showed a change greater than 5. A striking difference between the DSPD patients and the patients in the main hospital was how well developed they were in talking about their diagnosis and offences, reflecting the transparent approach to treatment and significant investment made in orientating and engaging patients in treatment that included for example patients being actively involved in rating their own VRS and HCR-20.

Related to this, a seemingly paradoxical pre and post measure change occurred: as the DSPD patients progressed in therapy they gained insight and appeared to become more honest in their behaviour and attitudes, yet on paper this gave the impression that they had got worse. The Violence Risk Scale[16] and Violence Risk Scale: Sexual Offender version (VRS-SO)[17] were used as

15. Risk, Needs, Responsivity model, see footnote 12
16. Wong, S. C. P. & Gordon, A. (1999–2003) *Violence Risk Scale.* Department of Psychology, University of Saskatchewan. http://www.psynergy.ca
17. Wong, S.C.P. & Olver, M. (2010). The Violence Risk Scale and the Violence Risk Scale- Sex offender version. In R. Otto and K. Douglas (Eds.), *Handbook of Violence Risk Assessment.* Routledge.

measures of change on a six monthly basis, but this transpired to be too frequent. A pattern emerged in which progression through 'pre-contemplation' and 'contemplation' to 'preparation' were being evidenced by all, but at the point of 'preparation' the majority of patients flat-lined, and those who were able to progress on to the 'action' stage were unable to proceed to the 'maintenance' stage as this required them to be able to demonstrate their newly acquired skills in higher risk situations, opportunities that were not available within a high secure environment. The VRS and VRS-SO were probably not the best suited for such a high frequency of assessment, suggesting that either alternative tools more sensitive to change were required, or that such entrenched enduring presentations as severe PD do not readily lend themselves to change. These assessments were shared transparently with patients and completing them was very much a collaborative process, but this eventually became demotivating due to this being interpreted by patients as a lack of progress.

Whilst there was some improvement in motivation level, only a limited behavioural change was observed in DSPD patients. Due to their desire for novelty it may have been that these patients were willing to engage in the therapy when it was relatively new but less so as the treatment progressed. It was identified that to achieve this, individual consolidation sessions and opportunities for generalising skills to a broader environment was necessary. Therapy groups that offered a less formal 'skills workshop' style and more approaches that employed behavioural skills rather than cognitive restructuring were introduced. During this time, treatment recommendations were emerging in NICE guidelines re ASPD that where there is a high risk and a high need, the dosage of treatment also needs to be higher, as does the need for consolidation and opportunities for generalising skills to a broader environment (NICE 2009). This practice-based evidence and more formalised NICE recommendations continue to underpin the application of skills-based CBT to our PD population, particularly with patients who display high levels of psychopathic traits.

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Patients moving on

At the time of commissioning the DSPD service at Broadmoor, and only slightly remedied at the point of its decommissioning, the processes and resources for a patient to either 'step down' to lower security or across high security were limited. This made it very difficult for a patient, especially those on a Section 47/79 to move on from the DSPD unit. Medium Secure Units (MSUs) were resistant to taking on these patients and it was felt that this was due to their sexual offending history (sex offenders being the maximum concern to the public) and the DSPD label that was now attached to the patient. This was even more disquieting as it was not intended to be used as a diagnosis but as a term describing a patient at the point of entry into treatment. By definition therefore they would not be considered 'DSPD' at the point of exit.

Notwithstanding, Broadmoor was able to discharge 24 (31%) of their DSPD patients due to treatment progress prior to its decommissioning in 2011. Now, with the introduction of the Offender Personality Disorder pathway many of the issues that prevented patients from successfully moving on no longer exist. Clear 'step across' pathways are now in place as are pipelines to facilitate patients' downward pathway from a high secure setting up and eventually into the community.

Learning Points

In the nine years that DSPD was at Broadmoor, many lessons have been learned. First and foremost the lack of a continuous pathway from DSPD in a high secure setting to lower security was an issue. At that time the pathways that were in place were limited to MSUs which were very sceptical about accepting Broadmoor DSPD patients. Now, ten years on the National OPD Pathway Directory of Services (2014) addresses this key issue. At the time of writing, Broadmoor's PD patients have recently been given access to this Pathway Directory which lists a range of step-down services, including Psychologically Informed Planned Environments (PIPEs); probation approved premises and medium secure healthcare settings.

At Broadmoor it has now become established that our patients undergo a group therapy pathway in three phases (i) Therapeutic engagement that addresses a patients coping and cognitive skills; (ii) an 'active' treatment phase that restores mental health and addresses the risk behaviour(s); and (iii) relapse prevention in preparation for moving on. The benefits of being upfront with patients about the assessment process and its implications (for example sessions on understanding the nature of personality disorder) were identified in the DSPD project and still stands today.

Furthermore lessons have been learned about the clinical characteristics of psychopathy that would previously have generated therapeutic pessimism but that are now regarded as responsivity features, with some regarded as

strengths that can be channelled and optimised through a CBT approach rather than being exclusion criteria, as was the case in the years prior to DSPD.

There have also been lessons about engagement and the importance of integrating 'formal' treatment with the less formal parameters of a therapeutic milieu. Day-to-day interactions on the wards play out the PD-linked patterns of relating to others, and therefore these daily interactions in themselves offer opportunities for corrective experiences. Integrating this with more formal psychological therapy enables a more holistic service and one that helps to integrate a sense of self. This is akin to the Enabling Environments approach, something that the current Broadmoor PD service is seeking to gain accreditation in. The lessons learnt from our early DSPD experience have been central to our thinking around fulfilling the Enabling Environment criteria.

Finally, the decommissioning of Broadmoor's DSPD service was a contentious decision that was challenging in itself. Not all patients could be returned to prison. For some their determinate sentence had expired, while others who had made significant progress were unable to move on progressively. Only five of the DSPD cohort that needed to be placed in another service due to the decommission were admitted into the newly developed Personality Disorder directorate at Broadmoor (and a further two into the main hospital). Several were transferred to the Peaks Unit at Rampton, but for most of the rest the decision was whether to return them to prison or into the community. Ultimately, only two patients were discharged to the community following Mental Health Review Tribunals as after a cut-off date the decision came down to: if the patient was not suitable to be released into the community they would have to be sent back to prison regardless of how well they had progressed in DSPD treatment.

Did DSPD work?

Very early on at the national multi-agency level there was a rigid requirement that DSPD treatment should be located in high secure settings. Perhaps operationally Broadmoor was more vulnerable than expected and not up to the challenge of working in such as way with a range of a Personality Disorders. But the learning from these challenges, such as the importance of pro-active supervision, good teamwork and specific training in working with Personality Disorders, has been integrated into Broadmoor practices and continues to benefit current PD patients. It was the first of all the commissioned units to close, being decommissioned before it really began. It never received enough referrals, contrary to our original Clinical Director's assertion that 'if you build it they will come'. Experience proved that they will not unless they are sufficiently different to warrant detention in a specialist service, and it has become increasingly apparent that they were not. The commonalities between DSPD patients and the rest of the Broadmoor patients have far outweighed the differences, which suggests that a flexible clinical/forensic PD pathway across services and through into the community is actually what is required.