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The early years of the DSPD (Dangerous and Severe Personality Disorder) Programme: results of two process studies

This summary is based on two linked studies of an innovative programme which took place between 2006 and 2009. The first focused on the treatment delivered to and experienced by Dangerous and Severe Personality Disorder (DSPD) prisoners/patients. It was called IDEA (Inclusion for DSPD: Evaluating Assessment and Treatment). The second study was concerned with management and staffing of the four high-secure DSPD units for men. It was called MEMOS (Management, Organisation and Staffing of DSPD). More detailed reports on each of these studies are available on request through the Personality Disorder website <http://www.personalitydisorder.org.uk> (Burns et al., 2011a; Burns et al., 2011b); Trebilcock and Weaver, 2011a). The conclusions of the two studies are presented at the end of this summary.

Summary compiled by Malcolm Ramsay.

Key points

- There was a significant reduction in Violence Risk Scale (VRS) scores (which are known to be associated with subsequent violent offending) over time, but it is not possible to conclude that these were the result of treatment delivered under the DSPD programme.
- Sites delivered productive treatment, but organisational and therapeutic practice varied widely.
- Findings from both studies suggested that prison units were better placed to provide the right context for treatment delivery and with a lower ratio of staff to prisoners.
- Pathways out of the units were not well defined, and it was not clear how progress towards discharge was assessed.
- Good multi-disciplinary working was crucial to the success of the units. Good working relationships between staff and the treatment population helped reinforce the formal treatment provided.
- The units were successful in enabling the men to live well together, without resorting to institutional hierarchies, and irrespective of offending histories.

Context

Around the turn of the century, spurred on by at least one very high-profile case of a psychopath attacking members of the public, awareness increased that more needed to be done to provide treatment for such offenders – with a view, ultimately, to reducing this kind of reoffending. This led to the launch of the DSPD Programme. The term DSPD is administrative rather than medical: key criteria are:

- 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;
- Has a severe disorder of personality;¹ and
- A link can be demonstrated between the disorder and the risk of reoffending.

Four units were set up, each capable of housing some seventy male patients/prisoners: in Broadmoor and Rampton high-secure hospitals, and in Frankland and Whitemoor high-secure prisons. Setting up three of the units involved the construction of new buildings, which were not fully operational until 2005–7. The unit at Whitemoor was created out of a pre-existing prison wing. It began to receive relevant prisoners for assessment in 2001.²

The four DSPD units, which were the key elements of a pioneering programme, were operating in a field where the evidence base was not well advanced. New types of treatment and organisation needed to be developed, within both prison and secure hospital settings. It has always been possible to send offenders with mental health problems to appropriate hospitals, but those with personality disorder have not been high-priority cases until the set up of these units. Delivering such treatment to them in a prison setting, under the DSPD Programme, was altogether new. The types of treatment and organisation, which varied both within and across hospital and prison settings, are documented in detail in the IDEA and MEMOS reports. There was no consensus on

effective treatment; however the DSPD approach had several guiding principles:

- To address offending behaviour through the reduction of risk, by targeting criminogenic factors and meeting mental health needs.
- To be based on treatment models, grounded in evidence, susceptible to rigorous validation and external evaluation.
- To provide individualised treatment plans that were tailored and flexible, with regular progress reviews.
- To involve prisoners/patients in their treatment plans, gaining ownership of treatment outcomes, and having transparency of process.

While it was important to learn as quickly as possible about the effectiveness of the programme, reoffending outcomes were unlikely to be apparent in less than a decade. Treatment of this group of offenders was expected to take between three and five years, and even then few of them were likely to be released directly into the community. To some extent it has been possible to start to explore shorter-term outcomes, but this is not straightforward. The IDEA study identified a proportion of those referred to, but not accepted by, the DSPD units, who could potentially form a control group to be followed up alongside the DSPD programme leavers. There are plans for the IDEA data to be lodged in a specialist archive, so that, under appropriate governance, these data could be made available for evaluation.

¹ Criteria for severe personality disorder will have been met if the individual has a Psychopathy Checklist Revised (PCL-R) score of 30 or above; or a PCL-R score of 25–29 plus at least one Diagnostic and Statistical Manual of Disorders, edition IV (DSM-IV) personality disorder; or two or more DSM-IV personality disorder diagnoses.

² Later, provision was made to house around a dozen women within Low Newton prison. This has not been covered in either the IDEA or MEMOS studies.

Approach

The IDEA study ran from July 2006 to December 2007 had four main aims:

- To describe key characteristics of those admitted to the four sites, primarily through the use of well-validated assessment tools, and also through one or more sets of follow-up interviews, at annual intervals (to assess potential change over time).
- To document the wide range of treatments in use across the sites, reducing them into a more limited and standardised set of categories – through a structured consensus (Delphi) process involving selected staff.
- To carry out qualitative interviews with a subsample of the men, to explore their views of the programme.
- To describe referral and acceptance processes across sites.

The IDEA research team had two members embedded in each of the four sites throughout the IDEA study period (July 2006 to January 2009). All 205 patients/prisoners in assessment or treatment were approached. Of these, 174 (86%) agreed to take part in a first assessment; 148 were assessed during the second wave a year later and 60 during the third wave (after another year, during a limited extension to the IDEA fieldwork). Two others left prior to their index date, and one withdrew consent prior to first assessment.

During the lifespan of the units up to and including the IDEA study period, 1251 referrals (reflecting 937 patients/prisoners, as some were referred more than once) were made to the four sites, of which 211 were accepted as meeting DSPD criteria, at a time when the sites were still endeavouring to reach their full capacity. From the remaining 1040 referrals, the IDEA team identified a systematic sample of 275 who were refused admission (including all the hospital referrals and a subsample of prison unit referrals). This sample was used to check that refusals were made according to the DSPD criteria. This group was not intended to be used as a comparator, as they may have been a very different group of offenders due to the fact that they did not meet DSPD criteria.

The MEMOS study was commissioned to help shape the development and operation of the DSPD units. It had five main aims:

- To describe workforce characteristics and measure clinical activity.
- To describe policies and practices relating to recruitment and training.
- To measure the psychological health of staff, and assess the role of staff support mechanisms.
- To identify the key ingredients of effective multi-disciplinary work.
- To describe changes in the legal status of DSPD patients/prisoners and operation of tribunals and parole boards.

In realising these aims, the MEMOS study drew not only on site records relating to staff (for instance, to investigate turnover, timetabling and multi-disciplinary team activity) but also on a cross-sectional staff survey and on qualitative staff interviews with 84 members of staff. The MEMOS study period varied across sites but was mainly in 2008.

As well as covering staffing issues within the sites, the same MEMOS team investigated the handling of current and future prisoner/patient progression from the sites. Hospital sites advised Mental Health Review Tribunals about the fitness of patients to leave the DSPD units. In much the same way, prison sites briefed the Parole Board. This differential processing of cases raised issues as many of those in the hospital units were being detained under mental health legislation, following the expiry of their determinate sentences (this applied to almost half the hospital patients at the end of the MEMOS study period, 49%: n= 37). There is a separate report, also available on the Ministry of Justice website, which explores the legal status of the prisoners/patients in greater detail (Trebilcock and Weaver, 2010b).

Results

This section starts by examining the delivery of the DSPD programme by the staff of the units, drawing initially on MEMOS. Then treatment is discussed, primarily from the perspective of the patients/prisoners. This covers treatment needs, levels and types of treatment, and initial responses on the part of the men. These all draw on IDEA, as does an account of the views of the men, based on qualitative interviews.

Staffing and organisation

The sites did not fill all their bed spaces (approximately 70 per site) to maximum capacity. During the twelve month MEMOS study period (broadly 2008), average occupancy figures were 36 and 52 at the Broadmoor and Rampton hospital sites, as compared with 75 and 64 at the Frankland and Whitemoor prison sites (not all those held in the Frankland unit were necessarily involved in the Programme). Senior staff at the hospital sites believed that, in part, their lower levels of occupancy reflected later start-up dates (while the prison sites were fully operational by 2005, this was not true of the hospital sites until 2007–8).

Another issue which linked with occupancy was the variable ability of the sites to recruit and retain suitable staff. At the start of the MEMOS study periods, the four sites employed nearly 790 staff. The hospital sites tended to have higher staffing levels: 190 at Broadmoor and 278 at Rampton, as compared with 178 at Frankland and 140 at Whitemoor. However, Broadmoor suffered a net loss of 22 staff during the study period, while the other sites kept virtually the same level of staffing.

Partly because of structural and organisational constraints, none of the sites found it straightforward to recruit staff with appropriate qualifications who were capable of responding well to the challenges (such as highly manipulative behaviour) posed by the DSPD men, or so managers reported. At Broadmoor an attempt was made to create a new class of 'therapy assistants', alongside the larger group of nurses customarily employed in hospitals. However, this innovation was only partly successful: it may also have blurred expectations and fostered divisions among staff.

Table 1: Composition of the baseline workforce at the hospital and prison DSPD units

Staff	Hospitals n=468		Prisons n=318	
	n	(%)	n	(%)
Senior Management	6	(1)	7	(2)
Administration & Clerical	28	(6)	26	(8)
Psychiatry	11	(2)	2	(1)
Psychology (Qualified)	15	(3)	13	(4)
Psychology (Trainee)	8	(2)	23	(7)
Nursing	212	(45)	15	(5)
Occupational Therapy	9	(2)	2	(1)
Social Work or Probation	5	(1)	2	(1)
Healthcare (Other qualified)	3	(1)	2	(1)
Non-Qualified Healthcare	145	(31)	0	(0)
Prison Officer	0	(0)	202	(64)
Operational Support	6	(1)	12	(4)
Education and technical	14	(3)	9	(3)
Research	5	(1)	3	(1)
Chaplain	1	(<1)	0	(0)

While all four sites were multi-disciplinary, the composition of the staff varied (see table 1), as did precise roles. In the hospitals, nurses were the largest group, accounting for over a third of all staff. At the prison sites, prison officers were the largest group, accounting for almost two-thirds of all staff. The two hospital units had between them 11 DSPD psychiatrists (as opposed to 2 in the prisons), while the two prisons had between them more psychologists (36 as opposed to 23 in the hospitals). Despite these contrasts, almost half the staff at every site had at least some involvement in the delivery of treatment, while around one in ten were 'core therapists'.

Using data about the employment start and end dates of all staff employed during the study period, staffing levels for each of the four staff groups at each unit were calculated (see table 2). These were expressed as a mean number of staff employed on an 'average day' and as a proportion of the number of staff employed at baseline. Staffing levels for most groups at all sites either exceeded baseline levels or remained within 90% of baseline levels. The exception to this was Broadmoor where mean frontline staffing levels over the study period were only 85.1% of baseline. Broadmoor was also the only unit where mean core therapy staffing levels over the study period fell below baseline levels.

Table 2: Mean staffing levels for each unit and sub-group of staff

	Broadmoor		Rampton		Frankland		Whitemoor		Total	
	Mean n of staff	% of baseline pop	Mean n of staff	% of baseline pop	Mean n of staff	% of baseline pop	Mean n of staff	% of baseline pop	Mean n of staff	% of baseline pop
Core therapy team	18.7	(94)	26.6	(116)	27	(108)	19.9	(117)	92.2	(102)
Secondary therapists	77.4	(102)	87.1	(98)	60.9	(96)	42.2	(103)	268	(100)
Frontline staff	66.4	(85)	147	(104)	76.8	(99)	56.9	(93)	347	(97)
Management/Admin	16.8	(105)	22.2	(111)	12.7	(106)	19.5	(93)	71.3	(103)

Although staff across the sites tended to express broadly favourable views about multi-disciplinary team working, there was some variation in levels of staff satisfaction, which were not uniformly high.

- Hospital-based staff were not as positive as those in prison sites. Instead, they articulated more of an ‘us and them’ division between clinical and other staff in hospital settings (also acknowledged by the clinicians). Frontline staff in the hospitals tended to feel clinicians were not particularly visible, and that they were not consulted purposefully by clinicians. This attitude was particularly apparent at Broadmoor, where it may have reflected a range of staffing/turnover issues, including the attitudes which staff on the unit may have brought with them from previous posts elsewhere.
- Two-thirds of frontline staff agreed that they were satisfied with the work they did. There were some contrasts between hospital and prison staff and, in particular, a significantly lower proportion of Broadmoor staff, as compared with those in the other sites, reported that they experienced job satisfaction. Similarly, while there were some indications of workplace stress and burn-out across all the sites, staff at Broadmoor had ‘psychological demand scores’ (used to measure psychological stress) that were significantly higher than for those in the other three sites.
- Despite the demanding nature of their work, those members of staff who were more closely involved with the clinical team and believed they were making a difference were the most positive about their employment. In particular, some prison officers who were involved in the delivery of therapy described a sense of achievement that came from an additional role over and above their normal custodial work.

- Finally, across all the various sites, 69% of staff expressed confidence that, for men completing the treatment programme, this would reduce their eventual risk of reoffending.

Treatment

The 174 men who consented to take part in the IDEA research substantially matched their administrative designation of ‘dangerous and severe personality disorder’. Records accessed by the IDEA team showed that:

- 80% were assessed as more likely than not to commit an offence leading to serious physical or psychological harm.
- 79% had either a very high measure of psychopathy/personality disorder – that is, they either had a score of 30+ on the PCL-R; or they had two or more personality disorders as calibrated by the IPDE (International Personality Disorder Examination); or else they had an intermediate PCL-R score of between 25 and 30 and additionally at least one personality disorder other than antisocial disorder.
- 60% were noted as having an explicit link between their personality and their offending.

These psychopathy/personality disorder scoring processes all involved administrative guidelines, with some room for manoeuvre, rather than strict medical criteria needing to be followed precisely. However, it is of concern that there was a lack of full documentation across the sites, as to whether the men were within the DSPD parameters. Another descriptive study of the DSPD population has confirmed that the criteria are guidelines rather than rules, and has also noted that one of the sites was calibrating personality disorder conservatively (Kirkpatrick, 2009). With an average PCL-R score of 28, and 40% scoring in the top range (30+), these

are higher scores than any previously reported in the literature from high-secure settings. Over half had previously experienced some in-patient psychiatric treatment. One in three reported a family history of mental illness.

The men were serious offenders. Apart from those held under mental health legislation (generally because their sentence had expired and they were still judged to be dangerous), more than three quarters were detained under life sentences. The index offence³ of over nine-tenths of the men was homicide or other violence or a sexual offence. Their median age at first conviction was 15; their median number of convictions was 12; and their median number of years previously in custody, before being admitted to the DSPD unit, was 13.

In its early days, fears had occasionally been expressed that relatively 'ordinary people' might be detained under the DSPD Programme. These figures about offending and psychopathy suggest otherwise. On the one hand, the men were strongly in need of the programme, as the site records reveal; on the other hand, as noted earlier, there were also many others believed by their referring prisons to be suitable cases for treatment, but not accepted by the sites. Those accepted and those rejected had certain broad similarities. However, there was a statistically significant difference in terms of levels of previous psychiatric inpatient admission (relevant figures were 38% for those accepted and 30%, for refusals). Not surprisingly patients in the hospital units were nearly all detained under the Mental Health Act, with only one in the prison units.

The treatment packages delivered by the four sites varied considerably. One underlying factor was that the sites did not hold identical populations: those in the hospitals held proportionately more sex offenders and those in the prisons more violent offenders. Another factor was the lack of an evidence base, or of other obvious examples on which to base a singular treatment package. In the face of a wide variety of approaches to treatment, the IDEA team carried out a 'Delphi' process of structured dialogue with selected staff from the sites, involving a sequence of consensus-building meetings to develop a clearer treatment typology.

An initial listing of 115 actual or potential types of treatment across the four sites was reduced to 50 important types of treatment; these were then allocated to a shortlist of eleven main categories of similar treatments: psycho-education, motivation, psychological skills, sexual offending programmes, violent offending programmes, general offending programmes, psychopathy programmes, cognitive therapies, psychodynamic therapies, vulnerability to relapse and trauma. Different sites prioritised specific types of programme: for instance, one of the hospitals (Broadmoor) and one of the prisons (Frankland) focused strongly on motivation; the other two sites did not have any programmes explicitly about motivation. All of the sites used a mixture of individual and group sessions.

Formal treatment, as defined strictly in terms of pre-arranged sessions fitting into the eleven main categories just outlined, only took up a modest proportion of the weekly timetable. Averaged across the sites, and totalling between 57 and 58 hours (from Monday to Friday), the weekly timetable for each prisoner or patient included:

- three hours a week for formal treatment;
- one and a half hours for milieu therapy (informal treatment and interaction involving mutual accountability of staff and patients, as in therapeutic communities);
- half an hour for assessment (preparation for treatment, or monitoring of progress); and
- nine hours for structured activity/work (possibly with a loosely therapeutic aspect, although this aspect was not greatly emphasised by the sites).

The allocation of three hours a week for formal treatment was aspirational. In reality, less than two hours a week was generally devoted to treatment. For those in their first IDEA year, the median was 1.3 hours of formal treatment per week; for those in year two, it was 1.8 hours, and for those in year three, it was 2.4 hours a week. While this was less than had been timetabled, or had originally been expected by staff, it may not have fallen too far short of relevant international norms for the treatment of this kind of incarcerated population in, for instance, the Netherlands (de Boer-van Shaik and Derks, 2010).

³ The index offence is the offence the person was convicted of which led to their current detention.

In addition to this spectrum of wholly or partly therapeutic activity, site timetables also included more mundane activities:

- fourteen and half hours for recreation; and
- close to thirty hours for staying in own room/full lock-down.

These were high-secure settings where it is normal for men to be confined to their rooms/cells for an appreciable proportion of their time – and the DSPD group was particularly high-risk. It is not altogether surprising that, in their qualitative interviews, the men emphasised that a good deal of their time was spent ‘waiting’.

To determine whether or not treatment was having an immediate impact, the IDEA team relied mainly on a psychometric instrument, the VRS (Violence Risk Scale), which is reasonably widely used in settings of this kind internationally, with a view to predicting reoffending on release. The men were retested each year, although the numbers reduced (from 151 to 111 and finally 41, although only 40 individuals had all three VRS assessments). The results showed that there was a statistically significant reduction from 64.8 for the first test to 62.3 to the second; and then another statistically significant reduction to 57.7 in the third test (in each case, $p < 0.01$). Reassuringly, this change was largely accounted for by a reduction in the ‘dynamic’ score⁴ (from 47.9 to 46.2 and then 43.0). There was also a statistically significant association between time in treatment and reduced VRS scores, both between the first and second tests (Spearman’s rho = 0.3, $p < 0.01$) and between the second and third tests (Spearman’s rho = 0.3, $p < 0.05$).

Assessment of the 40 people with all three VRS assessments pointed to broadly similar results. The same pattern of weak global improvement was found, which in principle confirms the changes found in the wider group, although statistical significance was reduced because of the smaller sample size.

These results suggest that, at least in the short term, treatment across the sites may have been beneficial. However, these reductions in the VRS scores could conceivably have occurred whatever the men’s circumstances, given the lack of data for any

untreated comparison group. The VRS changes were not matched by reductions in officially recorded behavioural violations, but the IDEA team, which had two researchers in each site throughout the study period, believed that official recording was not a reliable guide to behavioural change.

The views of the men

To identify aspects of the programme perceived as inhibiting or facilitating their progress, 60 of the men were interviewed, on a qualitative basis. The sample reflected the different sites, time in the programme, IQ and level of engagement.

Key themes were as follows, starting with treatment, broadly defined:

- Overall, the men in the prison units were more satisfied with their treatment and reported less coercion.
- Similarly, those in the hospital sites were more likely than those in the prisons to consider ‘waiting’ to be a major issue – even though those in the hospitals spent less time locked up on their own. Likewise, the men in the hospital sites were more critical of the limited opportunities to do a range of activities, when in reality such opportunities were better in the hospitals.
- Relationships with staff were very important across all the sites. The vast majority of the interviewees highly valued those individual staff that they perceived as being professional, did their best to fulfil reasonable requests and were willing to help with problems. Despite their own troubled personality constructs, the men respected staff who treated them in a kind, constant and empathetic way, as was clearly often the case.
- The men recognised that treatment was not just something that took place in the formal treatment sessions, and that it was not delivered simply by clinical staff. This kind of acknowledgement was apparent to some extent across sites, although more clearly at Whitemoor.
- In the hospitals, there were some complaints about staff not following through on tasks they had agreed to do; and about inconsistencies in the behaviour of different members of staff.

⁴ Dynamic items, such as criminal attitudes, emotional control and insight into violence, are those that are amenable to change. They are used to record where the individual lies on a continuum between ‘pre-contemplation’ and ‘maintenance’.

As well as exploring treatment, the qualitative interviews also addressed the shared lives of the men:

- While there was an element of tension between men with different levels of engagement in treatment, there was very little sign of the dangerous tension that often occurs in custodial settings between men with different offending histories. The mixing of sex offenders with other types of offender seems from the qualitative research to have worked well: there were even some men who acknowledged that this had meant they had needed to overcome some of their own stigmatising attitudes.
- Similarly, there was very little sign of the traditional hierarchies that often exist among groups of incarcerated males.

These findings could have reflected a wide range of underlying factors including relatively generous staffing of comparatively small-sized therapeutic units. Given the high-risk character of the men, there were remarkably few security incidents.

Finally, the qualitative interviews explored the views of the men about their progression through the units and on towards their release.

- Pathways through and out of the programme were not fully clear for many of the men. This seemed to have a negative impact on their engagement.
- The men in the prisons seemed particularly concerned about their progression out of their units and towards eventual release. Those in the hospital units were not as worried, although some of them were still concerned about how they would sustain the gains they had made from treatment, once they moved on from their unit.

Conclusions

Integrating the results of the two studies, the key conclusions are as follows:

- While it is much too soon to say whether treatment is having any long-term effect, it may be helping the men, to judge from their own testimony; from the results of risk evaluation (the VRS scores); and from the views of staff.

- There is a wide variety of organisational and therapeutic practice across the sites, stemming from the rapid early development in four different settings of a highly innovative programme. These variations between sites, which are particularly obvious in terms of the many different types of treatment in use, need to be reviewed, with an eye to greater though not absolute standardisation. Treatment fidelity and practice should be audited across the service, not just within individual units. There are other examples of inconsistent practices which should be reviewed, including training and security, both of which vary considerably.
- Staffing practices should be altered to ensure greater reliability of treatment provision.
- It would make sense to clarify clinical subgroups within this population, to help justify any differences in treatment regimes (and also to ensure targeted assessments of progress).
- More attention needs to be paid to determining and recording the place of structured activities.
- The IDEA and MEMOS studies both tend to suggest that the units in prisons seem to have been better placed to provide the right kind of context for the delivery of treatment (and with a lower ratio of staff to prisoners/patients) than the hospital-based units. However, while it is important not to over-emphasise this contrast (not least for reasons mentioned below, in terms of progression), it may have some long-term implications.
- Given that the sites are receiving many more referrals than they are able to accept, it would make sense to review priorities. Re-referrals should be discouraged, without clear supporting evidence. In addition, it is also important to make sure that documentation about those accepted/rejected is more readily and comprehensively available within the sites than it was to the IDEA researchers. In particular, any exercise of clinical discretion should be recorded and explained.
- Pathways out of the units also need to be clarified and improved, partly because these are currently affecting the men's engagement with treatment. This is more true of the prison sites, from which progression routes are less well defined.

- Linked to this, a clearer indication of how progress towards discharge is assessed should be developed, and communicated to the patients/prisoners.
- The staffing of the units is not straightforward. This research has highlighted the value of recruiting people who not only have relevant qualifications but are also able to relate well to the men, and also to interact effectively with other staff. Good multi-disciplinary working is crucial to the success of this type of unit.
- The testimony of both the staff and the men shows that these innovative units are working well. The good working relationships that exist quite widely across all the sites have helped to reinforce the formal treatment that is provided. This tends to imply that the units should look more explicitly to learn lessons from other relevant settings such as therapeutic communities.
- A final conclusion is that, in addition to delivering treatment, the units are successful in enabling the men to live well together, irrespective of their offending histories, and devoid of damaging hierarchies. There is however a need to clarify policy about disclosure of offences within the units.

As well as these conclusions bearing directly on the development of the DSPD Programme, there is also a need to consider the scope for further research, so as to guide and support the Programme in future. In principle this points to the need for a comparator group, not allocated to the DSPD units: ideally this should be done on a randomised basis. The Programme itself continues to evolve. One source of up-to-date information can be found in a 'Consultation on the joint Department of Health / NOMS Offender Personality Disorder Pathway Implementation Plan' published on the Department of Health website in spring 2011: <http://www.dh.gov.uk/en/Consultations>

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