

# Using Time, Not Doing Time

## Practitioner Perspectives on Personality Disorder and Risk

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# Chapter One

## Setting the Scene: National Developments in Services

John Milton and Gopi Krishnan

### Introduction

Changes to mental health legislation are relatively rare. The new Mental Health Act 2007 (in force from 3 November 2008) in England and Wales updated the 1983 Mental Health Act ‘to ensure it keeps pace with the changes in the way mental health services are – and need to be – delivered’ (Department of Health, 2008, p. 4). Arguably the most dramatic changes affect the detention and in-patient care of individuals with personality disorder which partly drove the government’s initial desire to update the legislation. From 1983 until the new Act was enforced, individuals with personality disorder who were assessed for formal detention in hospital were required to meet the legal criterion of ‘psychopathic disorder’ and also be deemed ‘treatable’. However, from November 2008 no separate legal category for personality disorder exists, merely the presence of ‘mental disorder’, and treatability has been sublimated into the ‘appropriate medical treatment’ being available in the hospital.

The legislative change from an individual needing to be ‘treatable’ to a service having treatment for them is a subtle but important distinction and arose from growing government frustration with the way professional practice had developed under the old Act. Although the original so-called ‘treatability clause’ was introduced into the 1983 Act partly to ensure that individuals who were admitted were able to benefit from the treatment available, critics (for example Hoggett, 1990) argued that it became a tool for use by psychiatrists to avoid admitting the ‘unmanageable’ on the grounds of ‘untreatability’. Instead the new Act now allows for the detention of individuals with personality disorder even though they may refuse to engage in treatment or the treatment may not initially be effective for them.

The purpose of this introductory chapter is to trace how and why these developments have arisen, the influence of other settings (such as offender management) on health services and treatment initiatives, the rise of specific services for higher risk individuals with personality disorder and the likely future agenda for service development.

## Precursors to change

A personality disordered individual's treatability was one of several areas which brought the issue of risk and personality disorder into sharp relief in the later 1990s. First, specific government criticism of the use of the 'treatability' criterion by psychiatrists arose in England following the 1996 murder of Lin and Megan Russell by Michael Stone, a man said to have 'untreatable' personality disorder (although this was later found to be erroneous). The then Home Secretary (now Secretary of State for Justice) Jack Straw complained that 'it is completely unacceptable that at present the detention of some very dangerous people depends on the random chance of whether a particular psychiatrist believes their condition is treatable' (Straw, 1998).

Second, in 1998 following concerns about patient mismanagement in the personality disorder service at Ashworth High Secure Hospital near Liverpool, an inquiry chaired by Peter Fallon (Fallon *et al.*, 1999) produced some wide-ranging recommendations, not just for high secure clinicians but for all working with personality disordered offenders. These included scrapping hospital order sentences for those with legal psychopathic disorder but maintaining transfers for sentenced prisoners and the creation of small, specialized units in prisons and hospitals. The recommendations were never fully accepted or implemented in a statutory way although they have been anecdotally acknowledged as helpful by clinicians working in the area of personality disorder.

Third, a large survey carried out for the Office for National Statistics in 1997 (Singleton *et al.*, 1998) found that, among those interviewed, over three quarters of men on remand and nearly half of those who were sentenced were considered to have a personality disorder. Problematically, however, only a minority of specialist places for managing offenders with personality disorder (PD) existed and these were mainly located in high security hospitals or in specialist prisons (such as Grendon Underwood prison). Due to some limited – and probably erroneous (D'Silva *et al.*, 2004) – research suggesting that some PD individuals with high psychopathy are 'made worse' (with negative reoffending outcomes) by traditional group approaches to treatment, many such individuals were excluded from interventions in prison to address violence or sexual reoffending.

Hence, spurred on by the Stone case in particular, a joint paper by the Department of Health and the Home Office in England and Wales was issued in 1999 on *Managing Dangerous People with Severe Personality Disorder* (Department of Health, Home Office, 1999). In the executive summary accompanying the paper the stated intention was described as 'a co-ordinated package of arrangements that offer better protection to the public in a way which strikes the right balance between the interests of the individual and society'. Embedded within this was the development of a specialist service, partly in prison and partly in hospitals,

to manage offenders who came to be labelled as having dangerous and severe personality disorder (DSPD).

## **The genesis of newer secure services for personality disorder**

Although the initiation of the DSPD project in 1999 appeared to be a somewhat sudden reaction to the Michael Stone case, its origins can arguably be traced through concerns about the unstructured approach to health-based PD services but also the coincidental convergence of a number of criminal justice developments through the 1990s including research about assessment tools, such as the influence of Hare's Psychopathy Checklist (Hare, 1991), and greater understanding of cognitive-behavioural risk-reducing interventions which became known as the 'what works' movement (Andrews & Bonta, 2003; McGuire, 1995). This is worthy of greater elaboration.

### **Developments in health-based PD services**

So what was the position regarding NHS-based secure PD services in the early 1990s and where were the problems that could have culminated in the Fallon Inquiry? The first issue is that, until recently, PD services in forensic settings were essentially clinical and academic backwaters. There was little focus on health-based PD services which have traditionally been the poor relation of services managing individuals with psychosis. This lack of focus was not novel to health settings however. Even within the criminal justice system, risk-reduction initiatives rarely singled out offenders on the basis of their specific mental disorder, more on account of their offence type such as sexual or violent offenders.

Despite legal psychopathic disorder (then defined in the 1983 Mental Health Act as 'a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct' generally equating to clinical personality disorder) being maintained as a separate clinical category, only a minority of patients with PD were (and still are) admitted under the Mental Health Act to non-forensic settings such as acute psychiatric wards – even within forensic settings following the 1983 Act, from almost 15% of all admissions in 1983 to 0.04% by 1993 (Home Office Statistical Bulletin, 1995). However high secure hospitals (such as Broadmoor, Ashworth and Rampton hospitals) have tended to maintain a greater proportion of such patients, with almost 26% labelled with PD uncomplicated by comorbid psychosis or learning disability in a three-hospital survey of the hospital population conducted in 1993 (Taylor *et al.*, 1998). Hence, high security hospitals became areas of relative experience and expertise in the management of disordered offenders with PD.

By the mid-1990s approximately 400 beds were occupied within high secure hospitals by patients with primary personality disorder while units in lower security, such as regional secure units, usually only had a handful of patients with PD as their primary problem. However, there were a number of unanswered questions such as (a) how did such patients come to be selected to be admitted to high security, (b) what treatment did they require or receive and (c) what was their

outcome? As one author put it, 'What is special about those classified and accepted for admission by a special hospital psychiatrist? Tens of thousands of men are convicted of violent crimes every year; a handful find their way into Special Hospitals – how do they get selected?' (Chiswick, 1992).

The first question of how offenders were selected for admission to high security also intrigued Collins (1991) at Rampton Hospital who compared those referrals with psychopathic disorder who were accepted for admission with those who were rejected. He was unable to find any discriminating factors across a range of demographic, offence or clinical domains and concluded that the admission process was 'arbitrary'. Even today clinicians assessing offenders with PD for admission, for example to a medium secure PD unit, find little to differentiate those accepted for admission from those rejected (Milton *et al.*, 2007).

Regarding the second question of what treatment patients with PD actually receive, for several years it seems that no systematic treatment approach was described for the in-patient treatment of PD in high security. However, the so-called therapeutic 'milieu' effect was regarded as a significant factor. Although ill defined in high secure hospitals, similar approaches within hospital, such as the Henderson Hospital, and prison-based therapeutic communities (with, for example, community meetings and structured activities in addition to group and individual therapies) were given weight by follow-up studies, albeit in a slightly different format (Chiesa & Fonagy, 2003; Lee *et al.*, 1999), with positive clinical outcomes.

However, the difficulty in determining a suitable and methodologically valid treatment approach was not unique to high secure PD settings and perhaps not surprising as a review of treatments for PD found no conclusive evidence of benefit from any specific approach (Dolan & Coid, 1994). Again, a recent systematic review of treatment for borderline personality disorder found few methodologically robust studies to give guidance to clinicians in determining any evidence-based psychological approach (Binks *et al.*, 2006) although guidance about suitable treatment approaches has recently been issued to clinicians regarding both anti-social (NICE, 2009a) and borderline PD (NICE, 2009b).

Regarding the third question of outcome, this has generally been regarded as criminological outcome, that of reoffending by patients after discharge into the community. Although no specific studies were commissioned to follow PD patients in particular after discharge from hospitals in England and Wales, research data have confirmed that patients categorized with legal psychopathic disorder tend to have a poorer criminological outcome (for example Buchanan, 1998) although this may be tempered by a more favourable psychosocial outcome compared with patients suffering from mental illness (Steels *et al.*, 1998). A lack of outcome data remains a significant concern within the research community although may eventually be addressed, albeit with quasi-clinical outcomes, as those who commission services will require financial answers about their cost-effectiveness.

Despite these problems, and concerns about the 'elastic' nature of the psychopathic disorder concept which it was argued could allow almost any violent offender to be classified for admission (Chiswick, 1992), a majority of forensic psychiatrists at that time continued to support the inclusion of personality disorder within mental health legislation and that there should be specific treatment facilities within prisons and high security to support this (Cope, 1993). However, there

was confusion about assessment, including how treatability (required for legal psychopathic disorder) might be determined.

This area was helpfully addressed by an important report produced by a Working Group on Psychopathic Disorder (Reed, 1994). It argued for much greater clarity and structure to assessment for personality disorder to 'promote the adoption of multi-method criteria for categorizing severe personality disorders'. It recommended the use of standard diagnostic instruments for Axis II categorization (from structured interview), a measure of psychopathy, a dimensional assessment of personality and a psychodynamic formulation.

Reed's findings regarding assessment were endorsed by the Royal College of Psychiatrists in 1999 although another report on diagnostic and assessment criteria in PD (Meux & McDonald, 1998) also acknowledged that assessment methods remained inadequate and recommended establishing research projects to develop customized assessment tools, neurocognitive instruments and outcome measures. Adopting assessment protocols with congruence between individual healthcare units and specialist prison services would have been an important starting point. Such information would also 'promote a greater consistency among future clinical and research studies' (Reed, 1994). However, a subsequent survey of all secure forensic units in England and Wales (Milton, 2000) found that there was still a degree of idiosyncratic use of assessment tools in practice.

## Developments in criminal justice settings

Within the criminal justice services, both in prison and probation, the 1990s saw a number of important developments which would lead to them stealing a march on health services in the area of risk assessment and intervention. Although this initially began in relation to psychopathy, there were general implications for personality disorder and related services and later for the structure of DSPD assessment and interventions.

The development of the Psychopathy Checklist – Revised (PCL-R) by Hare (1991), as an empirical descriptor for the characteristics of psychopathy noted by Cleckley (1976), was an important addition to the assessment armamentarium. The discovery that a higher PCL-R score (equating to the presence of more psychopathic traits) was correlated with recidivism was highly notable (Hart *et al.*, 1988). This was followed by the development of further tools, such as the HCR-20 (Historical, Clinical, Risk Management-20; Webster *et al.*, 1997), for the assessment of risk.

Around this time psychologists working in criminal justice settings began to tease out the components of effective offender rehabilitation, leading to the 'risk–need–responsivity' principles (Andrews & Bonta, 2003). This essentially described how treatment would be most effective when services are matched with the offender's risk of reoffending; that services should be targeted towards higher risk offenders; that criminogenic needs are generally 'dynamic' factors which may be altered as opposed to static risk factors which are unchangeable; and that interventions should be responsive by providing treatment that addresses an offender's individual characteristics, such as learning style and personality. Overturning the 'nothing works' nihilism of 1970s offender rehabilitation, this became summated as the 'What Works' approach (McGuire, 1995).



Using the above principles, many of the subsequently developed treatment approaches adopted a cognitive-behavioural emphasis, with group-based manual-oriented interventions with high adherence to the treatment model. Thus several risk-reducing group approaches were developed for criminal justice settings. One such example is the Sex Offender Treatment Programme (SOTP) which was developed and initiated nationally in the early 1990s. Ongoing evaluations have yielded positive results indicating reductions in recidivism for some groups (Friendship *et al.*, 2003). More recently there has been recognition within offender management services that there is greater scope still for enhancing rehabilitative approaches. The emergence of a 'Good Lives' strategy (for example Ward *et al.*, 2006), where risk avoidance is added to by development of active rehabilitation and skills-based approaches, is predicted to produce encouraging results.

Despite the positive aspects to offender management in prison and probation settings, there have still been some notable problems. For example, there is a (perhaps understandable in view of a manualized approach) rigidity to some programme-based interventions which can lead to treatment 'drop-out' by a significant proportion of higher risk individuals. Analysis of the characteristics of 'drop-out' offenders has revealed a significant number have unaddressed mental health needs, often in the domain of personality disorder (Jones, 2002). In addition, based on the early and potentially erroneous research that individuals with high psychopathy cannot benefit from treatment as usual (or that their risk could be made greater), such individuals have been excluded from many risk-reducing interventions. This has led to either 'drop-outs' serving determinate sentences coming to the attention of supervising services just prior to their community release which have little to offer as positive interventions or being considered too psychopathic to be offered treatment.

### **Developments in interventions for personality disorder**

Following on from Dolan and Coid's (1994) exposure of the dearth of evidence of effective treatments for personality disorder, a number of psychological treatment approaches developed during the 1990s which were to become equally relevant to forensic settings. Although interventions such as 'Reasoning and Rehabilitation' (Ross & Fabiano, 1991) had been used in offender settings and often addressed traits associated with common personality disorders such as impulsivity or paranoid thinking styles, several interventions emerged which specifically targeted personality disorder symptom or trait areas such as dialectical behaviour therapy (DBT; Linehan *et al.*, 1991), cognitive analytic therapy (CAT; Ryle & Kerr, 2002) and schema therapy (Young *et al.*, 2003). For example, DBT's use of techniques to address the emotional dysregulation of borderline personality disorder could allow an indirect influence on impulsive violence. In the case of schema therapy, allowing individuals to understand their 'mistrust/abuse' schema may assist in reducing the hypersensitivity associated with paranoid personality disorder and hence reduce some forms of instrumental violence. What these therapy modalities shared was a tendency to be structured, systematically delivered by trained staff, time-limited and with relative treatment fidelity, in many ways mimicking the developments in the criminal justice arena.

On the heels of the adoption of specific treatment approaches into forensic settings was a national, governmental recognition that individuals with PD were effectively being excluded from generic as well as forensic services. The imaginatively titled *Personality Disorder: No Longer a Diagnosis of Exclusion* from the National Institute for Mental Health in England (NIMHE, 2003) provided guidelines for all health services providing management of individuals with PD and made funding available over a three-year period. Although this raised the profile of the treatment needs for those with personality disorder, not just in forensic settings, it remains unclear how much influence the 'Exclusion' document has had on service strategy and development.

At this point it is important to mention that there have historically been pockets of expertise within health settings for individuals with personality disorder. Specifically a major evidence base which helped to inform the early drive towards developing the therapeutic milieu for DSPD services and the 'Exclusion' initiative came from the therapeutic community movement (for example Lee *et al.*, 1999) and led to an expansion of a network of therapeutic community services.

Therefore, a number of the newer initiatives for personality disorder have been employed in forensic areas with mentally disordered offenders. What is now needed is evidence of their efficacy in these transferred settings and how they might be integrated as a treatment package or strategy with, for example, other interventions with different end goals such as violence reduction. Although many of the treatment principles, such as being of cognitive-behavioural orientation, may be related to those used in offender management, evidence needs to be gathered demonstrating that they can be married together successfully.

## **High-risk PD services: A service waiting to happen or a driven political agenda?**

At face value, it would appear that a minister's 'riposte' to psychiatry in the wake of some high profile murders led to a top-down, new agenda to develop a cutting-edge, novel service to meet the public protection demands posed by dangerous offenders with a difficult-to-manage personality disorder. While that might have been partly true, we believe in retrospect that there may well have been a groundswell leading to similar developments, either within health or criminal justice settings, even without the Stone case. For example, the new thinking arising from Fallon, the need to demonstrate effective treatments and to develop a systematic approach within health services for PD, the success of the 'what works' approach in offender management and the potential to transfer it to health settings, the recognition of the size of the problem within prisons but also that a significant minority of offenders, potentially with PD, were being excluded or dropping out of offence programmes, might have led to the development of specific initiatives for such a subgroup. We believe that the Stone case acted as the 'tipping point' (to borrow from Grodzins, 1958, and recently Gladwell, 2000) which galvanized somewhat unusually two government departments and allowed the development of a broad range of pilot initiatives with a high level of clinical and research funding for a group of offenders who might otherwise not get a service.

Following the launch of the DSPD proposals in 1999, critics (for example Mullen, 1999) argued that there are considerable concerns attached to developing a service specifically to detain individuals with PD who are deemed to be high risk but potentially of equivocal treatability. Some of these are philosophical although some are born out of research interests. For example, fundamentally there has been unease amongst many clinicians regarding the prominence of the public protection agenda at the apparent expense of a treatment component, potentially using a medical approach to circumvent any breach of human rights legislation. Some have argued that the medicalization of risk management for this group of offenders resulted from the government's dissatisfaction at the perceived inadequate response of the criminal justice system to sentence such individuals, where an offence has been committed, to sentences offering greater post-release supervision such as discretionary life sentences for qualifying offences (Eastman, 1999).

In addition, although the vision of Philip K. Dick's (1956) *Minority Report* short story (recently a film) where mutant 'Precogs' preventatively identify 'Pre Crimes' is compelling, the reality of the sensitivity and specificity of DSPD's chosen instruments is far from science-fact. Based on research such as a systematic review by Buchanan and Leese (2001) of the proposed DSPD assessment measures, they reported that six DSPD individuals would need to be detained in order to prevent one violent act over a one-year period. They noted that the number needing detaining, for example in a community setting, would probably be even greater if more conservative base rates for violence, such as 5%, are used.

On the other hand, some have argued that the DSPD initiative is an opportunity to provide a service for some high-risk individuals with mental disorder who were clearly not having their needs met. Others such as Coid and Maden (2003) have suggested that such work clearly falls within the risk management role of mental health clinicians who should be more influential in assisting a multi-agency approach to risk management, particularly in community settings.

## **DSPD services: A challenging outlook**

As for any new initiative, there are inevitably challenges which can be seen either as necessary detours or as insurmountable obstacles. Perhaps in response to previous criticism of the loose or overly flexible concept of legal psychopathic disorder, admission to a new bespoke (DSPD) service has been subjected to greater 'gate-keeping' by its clinicians. In order to ensure that only the most dangerous are admitted (what has been termed the 'critical few'), and coincidentally to assist in research endeavours (a quasi-experimental design with defined parameters), individuals thought to be worthy of admission have to undergo a detailed observational and psychometric evaluation to determine the presence of so-called dangerous (relating to risk) and severe (relating to highly pathological) personality disorder. This perhaps brave attempt at operationalizing criteria for admission to a mental health service is unusual although it will be interesting to assess how determined the clinicians and administrators are at maintaining such a threshold in the face of potential clinical expediency or public ('the greater good') protection. A further proposal, which formed part of the original Department of Health Mental Health Bill (Department of Health, 1999), of mental health tribunals to sanction lengthier

admissions would have added a layer of quasi-judicial legitimacy to the assessment process.

There are additional risks for developing a service with the DSPD parameters as described above. First, most obviously, and yet unproven, is the need for the interventions to work, either to reduce severity or frequency of the facets of personality disorder which cause subjective distress or 'damage' to others. Maden (2007) has cautioned against any over-optimistic claims about CBT-based initiatives with this population. Importantly, there is a significant research component to the DSPD project to answer questions about outcome although the real question, that of 'is offending reduced?', will inevitably take time to become clear. At the very least, investigators will have some idea about 'what doesn't work' or what initiatives cannot be transported into this population. Some may see the need for such evaluation as unfair for DSPD as, unlike the built-in evaluation of offender programmes in prison, few psychiatric services so far have been required to evaluate, even broadly, their treatment or programme management arrangements.

Second, the assembled patient population, deemed by some as the 'unmanageable', is difficult to work with. In addition to the deliberate collection of individuals with likely lower motivation, such patients are likely to exhibit greater subversion to hospital systems and the planned treatment approaches for psychopathy are experimental. Thus, although there are the lessons learned from the Fallon Inquiry (1999) which have undoubtedly influenced the environmental and operational design, clinicians in this service can expect substantial challenges in a range of clinical and security-related domains and an efficient public relations strategy may be required to manage any media fall-out.

Third, there are likely to be 'attacks', either legal challenges by patients or sniping by colleagues from the establishment. Legal challenges by patients about what constitutes appropriate medical treatment in relation to their own clinical treatability may follow for some cases with lower motivation or for those transferred to hospital towards the end of determinate sentences. Challenges to the Scottish Assembly's equivalent of such detention was held to be compatible with the European Court of Human Rights (*Hutchinson Reid v. UK* 50272/99 [2003] ECHR 94).

In addition, there may well be those within 'traditional' services, certainly within the Prison Service, who may see the novelty of DSPD (apparently deemed by some prison officers as the 'Darts Snooker Pool Department') as a 'too-soft' response to offenders who are felt to require a greater punitive approach to their broader rehabilitation. A more passive but insidious problem may be a labelling effect of being a DSPD individual which more generic PD and other forensic services may shy away from, encouraging a parallel PD service framework to develop rather than an integrated one.

Lastly, there is the need for the authorities to consider the likelihood of these pilot services creating a DSPD legacy of individuals on 'notional' mental health orders, detained in a health system essentially by default after their determinate sentences have expired following transfer from prison. Although a number of such transfers are effected deliberately at the end of a sentence where multiple community agencies are alarmed about unmanageable community risk (often referred to as 'directions' to hospital regardless of the receiving clinicians' views), such individuals and many of the DSPD cases are likely to require long-term placements

due to their undiminished risk. This ‘legacy’ could well prove problematic if the DSPD pilot is deemed to be ineffective or not cost effective and such patients require assimilation into the wider hospital population. Recently a case challenging the transfer of a prisoner with personality disorder at the end of their sentence has led to the view from the Ministry of Justice that it will no longer consider such late transfers without clear grounds for mental disorder and the likely benefits of treatment (*R [TF] v. SSJ* [2008] EWCA Civ 1457).

## **DSPD and ‘higher risk’ community PD services: Future horizons**

Despite acknowledgement that the management of individuals with PD was previously under-resourced (NIMHE, 2003), recent investment has been unprecedented. As well as the DSPD programme for hospital places (such as the Peaks Unit at Rampton Hospital and the Paddocks Unit at Broadmoor Hospital), in December 2007 the Department of Health and Ministry of Justice commissioned the development of the National Knowledge and Understanding Frameworks on Personality Disorder ([www.pdinstitute.org.uk/downloads/upload\\_7504.pdf](http://www.pdinstitute.org.uk/downloads/upload_7504.pdf)) to support people to work more effectively with personality disorder.

Although an economic evaluation has been built into the research portfolio mainly addressing the costs of setting up and running the new prison and hospital services, searching longer-term questions are likely to be asked about outcome in the face of a service that is two or three times more expensive than a generic prison place.

Community-based clinicians, while welcoming a repository for the secure management of higher risk individuals with PD at critical times, may well look on jealously at the concentration of financial resources for the ‘critical few’ when arguably such resources could be maximized by offering briefer interventions to a greater number of similar individuals with PD who are, say, about to be released under probation supervision. Initial DSPD plans had provision for ‘step-down’ and community-based services although whether there will be a cross-flow of DSPD-labelled individuals and other forensic patients to established or new services remains to be seen. However, this is likely to become more important as some patients make sufficient progress to warrant placements in the distal part of the DSPD service arrangements such as medium security or supported hostels. There will need to be an urgent expansion of community and low secure provision, and linking with other agencies, to ensure the opportunity for patients to progress and particularly to offer hope to some sceptical patients that discharge from hospital remains feasible.

As long as a project as expensive as the DSPD initiative (particularly the hospital-based service) remains a pilot with only limited ‘proof’ of efficacy, within a changing geopolitical landscape it is likely to be at risk of funding cuts or diversion of resources to the ‘next big thing’ unless preliminary criminological or other psychosocial data can demonstrate success. There is also a lesson to be considered for big projects such as DSPD, which are initially based on ‘best-guess’ evidence of what works to reduce offending, from SOTEP (Sex Offender Treatment Evaluation Project) in the US (Marques *et al.*, 1994) which had some interesting

parallels with the DSPD project. The SOTEP in-patient programme at Atascadero State Hospital in California, through its design, was probably the most ambitious research programme for treatment and evaluation of sex offenders ever undertaken. It was highly resourced, research and evaluation focused and even involved changes in the state law to allow participants to be mandated there for treatment. Despite employing a 10-year prospective, randomized controlled trial approach to interventions, the programme showed minimal treatment efficacy. Therefore the DSPD data are likely to be awaited with interest.

In the meantime systematic reviews of the limited evidence for both psychological and pharmacological interventions for a variety of subtypes of personality disorders (analogous to that of Binks *et al.*, 2006), including schizoid, dependent and narcissistic PD, continue and are likely to report to the Cochrane database in the coming months. This will be of assistance to the bulk of clinicians working with lower risk individuals with primary or comorbid PD in community or non-secure settings as well as those in forensic services.

Ultimately the future for community management of higher risk individuals with PD may lie in the public protection agenda, perhaps focused upon by Multi-Agency Public Protection Panels (MAPPPs). The involvement of mental health professions as already described by Coid and Maden (2003) could, with sufficient vision and political will, take an even broader step forward by considering the primary prevention arm of higher risk PD services, i.e. the use of the public health agenda for managing or even the prevention of psychopathy or risk-related personality disorder. As Coid (2003a, 2003b) has previously described, this is a logical step within the public protection agenda in addition to other social policy measures. For example, adopting strategies identifying high risk individuals at an earlier stage, particularly in adolescence or even childhood, may be fruitful and economically viable (Scott *et al.*, 2001) and several potential research initiatives already have been identified (Harrington & Bailey, 2003) which may have important implications for public health approaches. Evaluation of high risk patients with PD, such as the DSPD service, will hopefully provide useful pointers to prevent the high risk PD cases of tomorrow.

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