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O'Loughlin, Ailbhe orcid.org/0000-0001-6850-5716 (2019) De-constructing Risk, Therapeutic Needs and the Dangerous Personality Disordered Subject. Punishment and Society. pp. 616-638. ISSN 1741-3095

https://doi.org/10.1177/1462474518811074

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De-constructing Risk, Therapeutic Needs and the Dangerous Personality Disordered Subject

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Abstract

The focus of this article is on the Dangerous and Severe Personality Disorder (DSPD) programme and its successor, the Offender Personality Disorder Pathway: two initiatives in England and Wales with the aim of protecting the public from dangerous offenders through a combination of preventive detention and therapeutic intervention in prisons and psychiatric hospitals. In this article, I first explore how the dangerous yet potentially redeemable DSPD subject was constructed by policymakers before turning to examine how the risks this group posed were translated into therapeutic needs under the DSPD programme. In so doing, I contend that prisoners' mental health needs are not only targeted for humane reasons but also as a means of facilitating the cost-effective management of difficult and disruptive individuals. Furthermore, meeting these needs can serve as an intermediate step towards drawing difficult prisoners into mainstream offending behaviour programmes explicitly targeting criminogenic risk factors. Ultimately, I conclude that, given that meeting prisoners' mental health needs is contingent on the compatibility of therapeutic regimes with the priorities of the prison, treatment programmes will ultimately yield to the overriding concerns of security and control in the event of conflict.

Keywords

rehabilitation, dangerousness, prison, personality disorder, mental health, risk, welfare

Introduction

[1] Ailbhe O'Loughlin is a lecturer in law at the University of York. Her current research examines the law and policy governing personality disordered offenders considered to be dangerous in England and Wales. Her first monograph, entitled *Personality Disordered Offenders: Risking Rights?,* will be published by Oxford University Press in 2020.

The last two decades have seen increased recourse to measures to incapacitate serious sexual or violent offenders who are perceived to be ‘dangerous’. Coercive methods such as lengthy prison sentences and civil commitment in mental health institutions can be seen not only in the UK but also in Germany, the Netherlands, the US and Australia (Malsch and Duker, 2016; Ashworth and Zedner, 2014). Reflecting on such trends, some have argued that penal systems have become increasingly concerned with the identification and ‘elimination’ (Rutherford, 1997) of dangerous ‘monsters’ (Simon, 1998) or criminal ‘others’ who threaten an innocent public (Garland, 2001). Conversely, a seemingly more progressive development is the revival of interest in rehabilitation and efforts to reintegrate even the most serious offenders into society. The therapeutic optimism of the ‘what works’ movement in offender rehabilitation (Cullen and Gendreau, 2001) has even begun to turn the tide of a long-held pessimism towards the treatability of psychopathy or antisocial personality disorders (Pickersgill, 2012).

Despite their diverging ideological connotations, David Garland argues that contemporary strategies of incapacitation and rehabilitation are unified by a fundamental preoccupation with protecting potential victims from harm (Garland, 2001). Thus, by contrast to the penal-welfarism of the mid-20th century, in ‘late-modern’ times, rehabilitative programmes are increasingly presented as being ‘for the benefit of future victims rather than for the benefit of the offender’ (Garland 2001: 176). For Gwen Robinson (2008: 432), this ‘disjunction of rehabilitation from welfarism’ is reflected in the distinction between ‘criminogenic’ and ‘non-criminogenic’ treatment needs in the dominant risk-need-responsivity model of offender rehabilitation (Bonta and Andrews 2007). In a similar vein, Kelly Hannah-Moffat argues that in ‘risk/need’ programmes, individuals’ subjective treatment needs that are not linked to a risk of recidivism are ‘considered a low priority in terms of intervention, except for “humane” consideration’ (Hannah-Moffat, 2005: 39). Consequently, in a context of limited resources, services that are ‘not readily amenable to evaluation or for which improvements may take a considerable length of time, like those that target […] psychiatric symptoms, are devalued and cut’ while services that have been proven to reduce recidivism are prioritised (Maurutto and Hannah-Moffat, 2006: 450).

The focus of this article is on a development in England and Wales that, at first glance, seems not to fit neatly with such accounts of contemporary policy and practice. Proposals put forward by the British government in 1999 to preventively detain a small group of individuals described as ‘dangerous and severely personality disordered’ (or ‘DSPD’) to protect the public received considerable attention from criminologists, who characterised the development as an

exclusionary risk management strategy aimed at neutralising a group of pathological 'monsters' (Rutherford, 2006; Seddon, 2007, 2008). Less attention has, however, been paid to the therapeutic ambitions of an initiative that used the language of health and wellbeing alongside narratives of risk and dangerousness (Home Office and Department of Health, 1999). These ambitions were to become more significant when a pilot treatment programme for the DSPD group began in prisons and secure hospitals in England in 2001. Despite the unclear impact of personality disorder interventions on participants' likelihood of reoffending, the capacity of the DSPD Programme has recently seen considerable expansion within prisons under the new title of the Offender Personality Disorder (OPD) Pathway. Following on from its predecessor, the OPD Pathway explicitly seeks not only to promote public protection but also to improve the psychological health and wellbeing of personality disordered offenders through the provision of tailored treatment and progression programmes within specially designed therapeutic environments (Department of Health and NOMS, 2011: para. 36).

By examining these developments in detail, I illuminate the place of mental health interventions with prisoners in the dominant 'risk/need' paradigm of offender rehabilitation (Hannah-Moffatt, 2005). The experience in England and Wales demonstrates that contemporary prison rehabilitation programmes are not only concerned with recidivism but also target the risks difficult and disruptive prisoners pose to themselves, to the safety of staff and other inmates, and ultimately to the integrity of the institutions that house them. By contrast to earlier commentators, I contend that the DSPD population was purposely constructed by policymakers as dangerous yet potentially treatable in an effort to address these longstanding and complex problems. This conceptualisation has allowed greater numbers of troublesome prisoners previously managed through strategies of detention and segregation to be assimilated into mainstream strategies for normalising and governing offenders 'at a distance' (Rose, 2000) under the OPD Pathway. Thus, the allure of programmes such as the DSPD programme and the OPD Pathway for policymakers is that they present a means for prisoners to move from 'circuits of exclusion' into 'circuits of inclusion' that promise a more humane and cost effective means of governing them (Rose 2000). For those who cannot be trusted to govern themselves, however, the possibility of preventive detention remains in order to ensure the public is protected.

I first demonstrate how and why the DSPD offender was constructed by policymakers as dangerous yet potentially redeemable before turning to examine how the risks this group posed were translated into 'intervenable' therapeutic needs (Hannah-Moffat, 2005: 31) under

the pilot DSPD treatment programme. In so doing, I contend that prisoners' mental health needs are not only targeted for humane reasons but also as a means of facilitating the cost-effective management of problematic individuals. Furthermore, meeting these needs can serve as an intermediate step towards drawing prisoners who were previously regarded as too disruptive or dangerous into offending behaviour programmes explicitly targeting criminogenic risk factors. Where efforts at rehabilitation fail, however, those subject to indeterminate sentences will remain in prison. For those whose sentences have expired, the diagnosis of personality disorder can serve to authorise preventive detention in psychiatric hospital to protect the public. In the final section, I draw out the reasons for the survival of the DSPD programme and its reconfiguration under the OPD Pathway and explore the tensions between the ethos of therapeutic units and wider prison culture. I conclude ultimately that, as meeting prisoners' mental health needs is contingent on the compatibility of therapeutic interventions with the priorities of the prison, treatment programmes will ultimately yield to the overriding concerns of security and control in the event of conflict.

The Dangerous and Severely Personality Disordered (DSPD) Subject

The term 'dangerous and severely personality disordered' first appeared in a joint consultation paper published by the British Home Office and Department of Health in 1999. 'DSPD' was neither a medical diagnosis nor a legal category but a term created by policymakers for a small group of serious offenders who were presented as posing a significant risk to the public due to a serious form of personality disorder characterised by antisocial or psychopathic traits (Home Office and Department of Health, 1999). Toby Seddon acknowledges the inconsistencies between the 'apparent disregard for civil liberties' demonstrated by the government's plans to subject the DSPD group to preventive detention and the 'therapeutic innovations' that later developed in the pilot DSPD treatment units. Nevertheless, his account characterises the policy as an 'exclusionary response' to a group of 'monsters' that provoked public fears (Seddon, 2008: 309-10). In a similar vein, Andrew Rutherford saw the DSPD initiative as stemming from a 'vigorous renaissance of positivism towards offenders' under New Labour (Rutherford, 2006: 51) and an example of 'risk thinking' in which measures are taken to 'neutralize' the 'intractably risky' (Rutherford, 2006: 82, quoting Rose, 2000). According to Nikolas Rose, however, 'whilst confinement without the aspiration of reformation is certainly on the increase in […] new control practices, it would be a mistake to think that the logics of control pay no attention to the transformation of the excluded individual' (Rose 2000: 334).

Drawing on the work of Rose (2000), I argue that the seeming contradictions within the DSPD strategy may be best understood as a response to two distinct subjects constructed by policymakers: dangerous individuals who had the potential to be redeemed through treatment, and the irredeemably dangerous who required indefinite detention. By revisiting the history of the DSPD proposals, I demonstrate how a set of longstanding, complex and seemingly intractable problems came to be translated into discrete 'risks' posed by a small group of individuals. As I argue further below, this conception of the DSPD group has allowed for ever-greater numbers of previously excluded individuals to be assimilated into more cost-effective normalising strategies for governing offenders 'at a distance' under the pilot DSPD programme and its successor, the OPD Pathway.

From the early to mid-1990s, a series of highly publicised cases of serious violent and sexual offenders being released from prison and killings by current and former psychiatric in-patients raised public concerns about dangerous individuals slipping through the cracks between the mental health and criminal justice systems (see Pickersgill, 2012). This led to calls for something to be done, and a newly-elected New Labour government seeking to establish its reputation as tough on crime appeared eager to respond (see Rutherford 2006). The problems they sought to address were not new, however. Government officials had been aware as far back as 1975 of 'the legal obligation to release, at the end of determinate prison sentences, a small number of men who are probably dangerous but who are not acceptable for treatment in hospital' (Home Office and Department of Health and Social Security, 1975: para. 4.34). Under the Mental Health Act (MHA) 1983, such individuals could not be detained in psychiatric hospitals on the grounds of 'psychopathic disorder' unless two psychiatrists certified that treatment was 'likely to alleviate or prevent a deterioration of [their] condition' (MHA 1983, former Section 3(2) (b)). Coupled with a paucity of evidence for effective treatments and the refusal of some psychiatrists to take responsibility for difficult patients, this 'treatability' criterion was presented by New Labour as impeding the protection of the public from dangerous individuals (Home Office and Department of Health 1999).

Two policy proposals were put forward to address these problems. Option A proposed removing the 'treatability' criterion from the MHA 1983, encouraging judges to make greater use of discretionary life sentences and improving joint working between the mental health and criminal justice systems. Under the more radical Option B, a new institution separate from the existing prison and secure hospital systems would be established and new powers created to detain DSPD individuals there for as long as they posed a risk. Detention would be authorised

by a court under a 'DSPD order' which would not depend on a criminal conviction or the amenability of the individual to treatment but would instead fall within the state's powers to detain persons on the grounds of 'unsound mind' under Article 5.1(e) of the European Convention on Human Rights (ECHR) (Home Office and Department of Health, 1999). The DSPD group would not merely be detained, however, but would also be 'helped and encouraged to co-operate in therapeutic and other activity designed to help them return safely to the community' (Home Office and Department of Health, 1999: 9). In this manner, the government aimed to strike a 'balance' 'between the human rights of individuals and the right of the public to be protected from these very dangerous people' (Boateng and Sharland, 1999: 7).

Opposition to both plans was vociferous and widespread. As Jill Peay remarked at the time, 'proposals which can unite in opposition MIND, the Law Society, Liberty and the Royal College of Psychiatrists suggest that the Government may need to reflect further' (Peay, 1999: 23). Psychiatrist Paul Mullen (1999) described the proposals as 'glaringly wrong - and unethical' given the diagnostic difficulties surrounding personality disorder and uncertainties regarding treatment. Despite the emphasis placed on 'balancing' rights in policy documents, Nigel Eastman (1999) expressed the concern that the government sought to use mental health legislation to circumvent human rights protections against detention without trial.

Following sustained resistance, Option B was quietly dropped. Instead, the MHA 2007 was introduced, replacing the treatability test with the less stringent requirement that 'appropriate medical treatment' be 'available' and that its 'purpose' be 'to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations' (MHA 1983 as amended, Section 145(4)). Thus, the test became 'not predictive but aspirational' (Peay, 2011: 238), lowering the threshold for involuntary commitment. A parallel development was the introduction of the Dangerous Offender provisions of the Criminal Justice Act (CJA) 2003, which created the indeterminate sentence of imprisonment for public protection (IPP). Like the DSPD proposals, the aim of the IPP was to tackle the problem of dangerous offenders released from determinate prison sentences (Annison 2015). Similar to a life sentence, the IPP was composed of a punitive tariff followed by a period of preventive detention that would continue until the Parole Board was 'satisfied that it [was] no longer necessary for the protection of the public that the prisoner should be confined' (Crime Sentences Act 1997, Section 28(6) (b)). The IPP could be imposed on newly convicted offenders who had a previous conviction for a listed offence and who were judged to pose a 'significant risk' of 'serious harm' to the public

(CJA 2003, Section 225(1) (b)). Following its abolition by the Legal Aid, Sentencing and Punishment of Offenders Act 2012, the IPP has been replaced with the life sentence for a second serious offence which applies to offenders with a previous conviction for a serious violent or sexual offence listed in Schedule 15B to the CJA 2003 who are being sentenced for a second such offence.

While awaiting legislative change, a pilot assessment and treatment programme for the DSPD group was established in the early 2000s. Commentators were surprised when a policy that had seemingly begun as 'an ill-conceived attempt to hide the imposition of preventive detention and indefinite sentences behind the veneer of respectability provided by a mental health context' seemed to become 'a genuine attempt to address the psychological and interpersonal difficulties of recidivist violent offenders' (Mullen, 2007: s.3; see also Seddon, 2008). However, it is clear from the 1999 proposals that these therapeutic ambitions were present from the beginning. Placed in their historical context, the seeming inconsistencies in DSPD policy, in which a 'self-conscious "toughness" [...] sat alongside a more conventionally progressive faith in the transformative potential of interventions with offenders' (Seddon, 2008: 301) may best be understood as an effort to reformulate and address a set of seemingly intractable problems facing the prison and secure hospital systems.

While the DSPD proposals were under development, the Fallon Inquiry into allegations of misconduct at the Personality Disorder Unit (PDU) at Ashworth Special Hospital shone a light on the difficulties psychiatric hospitals encountered in managing personality disordered patients. While the psychiatric profession was split on the question of whether personality disorder was inherently 'untreatable', it was clear that there was a paucity of available treatment options and a weak evidence base for their effectiveness (Fallon, 1999). Pressure to take individuals who were thought to be dangerous but whose prison sentences were close to expiry therefore often resulted in the Special Hospitals acquiring patients who could not be released but for whom little positive could be done (Fallon, 1999; see also Dell and Robertson, 1988). Overall, evidence from nine patients at the Ashworth PDU 'gave a sense of time passing with precious little progress' and 'an atmosphere of inertia [...] in which poor practice, apathy and corruption [could] flourish' (Fallon, 1999: para. 1.25.34).

The picture within the prison system was similarly bleak. Disruptive prisoners, many of whom showed traits of personality disorder, were 'transferred from segregation unit to segregation unit' with 'little or nothing in the way of constructive activity or opportunity to

address their behaviour' (Fallon, 1999, para. 1.35.8). Paradoxically, as the Butler Committee noted in 1975, some prisoners were excluded from pre-release home leave and employment schemes as they were thought to be too dangerous, and this had the effect that many were released from determinate sentences without prior socialisation (Butler, 1975). A similar trend in the 1990s was the exclusion of offenders with high psychopathy scores from prison treatment programmes due to studies purporting to show that treatment could enhance their risk of recidivism (e.g. Rice et al., 1992; see D'Silva et al., 2004). In 1999, then Home Office Minister Paul Boateng described a visit to HMP Durham where prison officers told him about a 'highly dangerous' man who was shortly to be released from a special unit. Although the prisoner had spent a long time in prison, his condition remained unchanged and officers 'were absolutely convinced' he would reoffend. (Home Affairs Committee 2000, Minutes of Evidence, 30 November 1999: para. 115).

By developing treatment techniques for personality disorder, it seemed that the problem of untimely release could be avoided by working to reduce the risks dangerous individuals posed while in prison. The DSPD group was not only portrayed as dangerous, however, but were also adept at manipulating others and undermining management regimes, posing 'significant management challenges' and a 'constant threat' to staff and other inmates in institutional settings (Home Office and Department of Health, 1999: 12). Furthermore, by constructing personality disorder as something that caused 'immense distress' to the sufferer (Home Office and Department of Health, 1999: 49), developing effective interventions could be presented as a humanitarian duty as well as a means for responding to the problems distressed, frustrated or merely bored individuals posed for the internal management of prisons and secure hospitals. Despite the scepticism of some psychiatrists, the evidence base left some room for a more optimistic view. A review commissioned by the Home Office concluded that overall there was 'no evidence that "DSPD" can or cannot be treated' (Warren et al. 2003: 120). This allowed the government to take the position that a lack of robust evidence that the available treatments *worked* did not prove that *nothing worked*. Rather, 'more research was needed', and significant funding was to be dedicated to the cause (Pickersgill 2012: 41).

Given the myriad of problems they posed, the DSPD group was not conceived by policymakers as homogenous, and while developing new treatments was seen to be the way forward, it was recognised that not all could be expected to respond. This is demonstrated by the evidence given by Mike Boyle, a senior Home Office civil servant, to the House of Commons Select Committee on Health on 18 May 2000:

> […] we think we can do an awful lot better than we currently do in identifying new treatments and providing those treatments so that individuals who currently receive totally inadequate management across the system can be helped to make the changes in their behaviour, if not in their personalities, that will let them return to the community safely. We are reasonably confident and we certainly feel an obligation to put much greater effort into investigating that possibility but we do recognise there will be individuals who will be drawn into the system who will not be amenable to any kind of intervention of that kind and who may end up spending the rest of their lives in that system (Select Committee on Health 2000: para. 634).

Following Nikolas Rose (2000), therefore, the proposals may be understood as a response to two dangerous groups: redeemable, treatable subjects and irredeemable, untreatable subjects.

Rose argues that contemporary control strategies deploy processes 'that affiliate or expel individuals from the universe of civility, choice and responsibility, best captured by the dichotomy of inclusion and exclusion' (Rose, 2000: 324). For Rose, 'circuits of inclusion' 'seek to regulate conduct' while 'circuits of exclusion' 'seek to act upon pathologies' (Rose, 2000: 324). This model leaves open the possibility for the excluded to move into the circuits of inclusion (Rose, 2000: 325). Through the techniques of 'remoraliz[ation]' and 'responsibilization', re-inclusion strategies seek 'to reconstruct self-reliance in those who are excluded' (Rose, 2000: 334). Through the process of normalisation, the individual internalises norms and comes to govern himself, meaning that the state can govern its citizens 'at a distance' (Rose, 2000: 337). Conversely, for 'those who cannot or will not be included, and who are too risky to be managed in open circuits – the repeat offender, the irredeemably anti-social, the irretrievably monstrous, the paedophile, the psychopath – control will take the form of more or less permanent sequestration' (Rose, 2000: 335).

Rose identifies three groups subject to circuits of exclusion: those who 'have refused the bonds of civility and self-responsibility', those who are 'unable to assume them for constitutional reasons', and those who 'aspire to them but have not been given the skills, capacities and means' (Rose, 2000: 331). While a conception of 'DSPD' as 'an unchanging characteristic' or of the DSPD group as pathological 'monsters' (Seddon, 2008: 309) would have helped to justify the incapacitation of this group through preventive detention, it would not have helped to address the multifaceted problems they posed to the institutions that housed them. Conversely, redeemable subjects could be imbued with the skills needed to exercise the 'responsible and prudent self-management' and ultimately become part of a modern, civilised

society (Rose, 2010: 96-7). Under the DSPD proposals, the process of assessment would, theoretically, allow for dangerous personality disordered offenders to be identified, and the process of treatment would allow for a distinction to be drawn between treatable subjects and those who were resistant to or incapable of change. The latter would demonstrate the limits of normalising strategies and require indefinite detention to protect the public (see Home Office and Department of Health, 1999: 9). As scientific expertise was not yet able to offer a means of distinguishing between these groups, preventive detention was deployed for all while the prospect of reform was left open. The DSPD subject, therefore, may be best understood as dangerous but potentially redeemable through normalising interventions.

As I argue further below, this conception of personality disordered offenders as potentially amenable to treatment has allowed greater numbers of difficult and disruptive prisoners and patients to be assimilated into mainstream control strategies through the OPD Pathway. For those who are unable or who refuse to engage with efforts at their rehabilitation, however, the prospect of indefinite detention, whether on an indeterminate prison sentence or in a hospital under the MHA 1983, remains open.

Treating the DSPD Subject

In this section, two DSPD prison treatment programmes are examined to explore in further detail how the treatable DSPD subject was conceived of under the DSPD programme and how treatment for personality disordered offenders may be understood in light of theories of contemporary rehabilitation practices. Rather than being conceived as a pathological subject, I argue that those in the DSPD group are seen either as the 'disadvantaged or poorly socialized' subjects of penal-welfarism (Garland, 2001: 137) or as rational individuals who can be taught how to manage their own risks 'by acquiring the requisite skills, abilities, and attitudes needed to lead a pro-social life' (Hannah-Moffat, 2005: 42). However, in practice both conceptions are deployed with the ultimate aim of integrating difficult individuals into the mainstream. Adding an important nuance to existing accounts, I argue that mental health needs, including personality disorders, are not only intervened with where these are linked with a risk of recidivism but also to stabilise prisoners, making them easier to manage and preparing them for interventions focused on criminogenic risk factors.

The pilot DSPD assessment and treatment programme began in 2001. By June 2009, there were 12 women and 216 men in high secure DSPD services spread across five units: two

high secure prison units for men (HMP Whitemoor and HMP Frankland), one unit for women in a closed women's prison (HMP Low Newton) and two secure hospitals units for men (Broadmoor and Rampton) (Department of Health, 2011: 4; Trebilcock and Weaver, 2010a). The DSPD cohort was largely drawn from the existing prison and secure hospital populations and candidates were referred to the units by their host institutions and assessed on arrival for admission. Three entry criteria were established. First, the 'dangerousness' criterion required that the candidate be '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'. Second, he or she had to be diagnosed with a 'severe' personality disorder. Finally, a 'link' between the disorder and the risk of offending was required (DSPD Programme et al., 2008, 2006).

While the 1999 consultation paper claimed that the risks the DSPD group posed to others resulted from their disorders (Home Office and Department of Health, 1999: 12), it was not clear whether the third criterion required causation or merely co-occurrence to be established between the candidate's personality disorder and the risk of reoffending (Duggan and Howard, 2009). According to the clinical literature, while there is some association between personality disorder and violence, establishing a causal relationship is fraught with difficulty due to a multiplicity of confounding factors, including comorbid substance abuse, mental illness and post-traumatic stress disorder (Duggan and Howard, 2009; see also Ministry of Justice, 2014). Consequently, it was recognised that the treatment of personality disorder itself may not lead straightforwardly to a reduction in offending (Duggan and Howard, 2009; Howard, 2015).

In this context, the DSPD units were encouraged to develop their own treatment models and therapeutic environments based on the existing evidence base (Saradjian et al., 2010; Tew and Atkinson, 2013; Tennant and Howells, 2010). Under the dominant risk-need-responsivity model, antisocial personality traits may be conceptualised as 'criminogenic needs' linked to a risk of recidivism or as 'responsivity factors' that interfere with treatments targeting criminogenic needs (Bonta and Andrews, 2007: 13). Consequently, two separate treatment programmes emerged in prison units for men with different conceptions of the 'link' between personality disorder and offending: the Chromis programme at HMP Frankland and the trauma-focused programme at HMP Whitemoor. Nevertheless, both programmes have the same goal: to draw personality disordered prisoners into mainstream strategies for governing prisoners both within and beyond the prison walls.

The Chromis programme regards psychopathic traits as responsivity factors. Thus, it assumes that offenders with high levels of psychopathy are affected by the same criminogenic risk factors as ordinary offenders but are more resistant to engaging with treatment due to traits such as mistrustfulness and a low tolerance for boredom (Tew and Atkinson, 2013). Therefore, Chromis does not aim to change personality traits but works with them to reduce participants' risk of violent offending (Tew and Atkinson, 2013: 417). Rather than undertaking in-depth exploration of the past, Chromis is 'future-focused' and seeks to encourage prisoners to change their thinking patterns and behaviours, learn objective decision-making based on the consequences of their choices, exercise self-responsibility and pursue their goals in a 'pro-social' manner (Tew and Atkinson, 2013).

By contrast, the early part of the treatment programme at HMP Whitemoor specifically targets trauma and attachment disorders, common aetiological factors in the development of personality disorders, and seeks to modify problematic personality traits themselves (Saradjian et al., 2010). The programme takes a holistic approach and aims to enhance overall functioning and wellbeing as well as to reduce reoffending risk. Treatment is based on a cognitive interpersonal model and begins with individual psychoanalytic psychotherapy focusing on the origins of the individual's personality disorder. The developers of the programme argue that such interventions can be expected to lead to more fundamental and longer-lasting change than those focused more narrowly on offending behaviours (Saradjian et al., 2010).

The Chromis programme appears to fit well with David Garland's account of 'late-modern' rehabilitation, which holds that rehabilitative programmes are increasingly presented as 'for the benefit of future victims rather than for the benefit of the offender' (Garland, 2001: 176). Furthermore, the emphasis placed on individual responsibility and choice indicates that the DSPD offender is conceptualised under the Chromis programme as someone who can learn the skills needed to become a 'prudent and rational risk managing subject' (Hannah-Moffat, 2005: 42; 40). Conversely, the holistic approach taken by the HMP Whitemoor programme appears to have more in common with the practices of penal-welfarism in seeking to remedy defects in the offender's personality or social relationships and seeing offending as a symptom within a broader picture of disadvantage and dysfunction (Garland, 2001: 176). Thus, personality disorder is not regarded straightforwardly as a criminogenic need, but as something that can affect the whole person. This would seem to differ from Canadian 'risk/need' programmes described by Hannah-Moffat in which non-criminogenic needs 'are considered a

low priority in terms of intervention, except for "humane" consideration' (Hannah-Moffat, 2005: 39, see also Robinson, 2008).

The theoretical differences between the two programmes are not so clear-cut in practice, however. While HMP Whitemoor starts with a holistic approach, interventions targeting offending behaviour are also deployed in the later stages of treatment (Saradjian et al., 2013). Furthermore, policy at HMP Frankland dictates that mental health issues that interfere with treatment, such as depression or anxiety, must be addressed before prisoners enter Chromis (Tew and Atkinson, 2013). Thus, while the DSPD programme demonstrates the enduring relevance of holistic and welfare-oriented interventions in prisons in England and Wales, targeting mental health needs plays a role in stabilising prisoners so that they can engage with programmes geared more explicitly towards reducing risk. This falls in line with the overall aim of DSPD policy, which was to draw groups who were previously excluded from the mainstream back into 'circuits of security' or inclusion described by Rose (2000). The aim of the cost-effective and humane management of difficult prisoners is to become a more central concern under the OPD Pathway, discussed below.

Survival and Reconfiguration: the OPD Pathway

Paula Maurutto and Kelly Hannah-Moffat (2006) argue that, in a context of limited resources, prison treatment services that are 'not readily amenable to evaluation or for which improvements may take a considerable length of time, like those that target self-esteem or psychiatric symptoms, are devalued and cut' while services that have been proven to reduce recidivism are prioritised (Maurutto and Hannah-Moffat, 2006: 450). Given its unclear impact on reoffending rates, the persistence of the DSPD programme would seem to contradict this analysis (see further O'Loughlin, 2014). The experience in England and Wales demonstrates, however, that rehabilitative interventions are not only valued where they serve to protect potential future victims from harm (Robinson, 2008; Garland, 2001) but can also be co-opted in pursuit of the cost-effective management of offender populations. Furthermore, prisoners' mental health needs are most likely to be met where this serves the prison's priorities of reducing recidivism, maintaining external security, upholding order and control, and providing a safe and 'decent' environment for prisoners (Crewe, 2009: 26). Therapeutic environments also have the potential to clash with these aims, however, raising the question of how such tensions are likely to be resolved in case of conflict.

A study of the first DSPD cohort at HMP Whitemoor demonstrates that the unit not only targeted those thought to be dangerous but also housed prisoners who presented management problems for prisons. Many had spent time in segregation and tightly controlled close supervision centres (CSCs) due to violent or self-harming behaviour, substance abuse or inappropriate relationships with staff (Saradjian et al., 2013: 435). Furthermore, prisons and secure hospitals were more likely to refer individuals who were difficult to manage to the other pilot DSPD units (Kirkpatrick et al., 2010: 278). This not only included individuals who were likely to rate highly for psychopathy but also those whose behaviour was 'characterised by high levels of emotional instability or repeated incidents of self-harm indicative of [borderline personality disorder]' (Kirkpatrick et al., 2010: 278). The presence of patients and prisoners with borderline traits in the DSPD programme is also reflected in the experiences of frontline staff, who were surprised at the high levels of self-harm and the neediness and continual demands of the DSPD population (Trebilcock and Weaver, 2010b: 80).

A review of the effectiveness of the DSPD programme was undertaken by the Ministry of Justice and Department of Health in response to Lord Bradley's *Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. Noting that personality disorder affected around 63% of the prison population and the bulk of provision was concentrated in the high secure prison estate, Bradley called for an interdepartmental strategy to ensure the system was able to respond to the level of need. The result was proposals published in 2011 to replace the DSPD Programme with the Offender Personality Disorder (OPD) Pathway. Under the plans, the high secure prison DSPD units would be absorbed into the OPD Pathway while the hospital units would be decommissioned and taken over by NHS England. Resources recouped were funnelled into new treatment and progression units in lower security category prisons and in the community. Overall, the Pathway seeks to provide interventions for a greater number of offenders using the same resources as the DSPD programme (see Department of Health, 2011; Department of Health and NOMS, 2011).

The plans for the Pathway were developed at a time of economic austerity. Under planned spending cuts to combat the deficit in Britain's public finances, the Ministry of Justice stood to lose 23% of its budget (HM Treasury, 2010: 56). The Ministry of Justice noted that a large-scale evaluation of the high secure DSPD units for men had found weak, but statistically significant, reductions in Violence Risk Scale (VRS) scores amongst participants, suggesting that treatment may have been beneficial in the short-term (Ministry of Justice, 2011: 7). Due to the lack of a control group, however, it was not possible to say for certain whether these

reductions were a result of treatment or other factors (Ministry of Justice, 2011: 7). Nevertheless, it was clear that the DSPD programme achieved some success in managing violent and self-harming prisoners at a lower cost than in other parts of the prison estate. The Department of Health estimated that if DSPD programme were to close, the use of tightly controlled close supervision centres (CSCs) would significantly increase, costing £60,000 more per prisoner per year (Department of Health, 2011: 6). In addition, managing this group of prisoners without providing therapeutic interventions would increase violent disruption, putting additional pressure on prison segregation units (Department of Health, 2011: 6). It would also potentially lead to greater use of transfers to secure hospitals, where a bed cost around £290,000 per annum (Department of Health, 2011: 6).

While the aims and methods of the Pathway and those of the DSPD programme are similar, the Pathway is much greater in scale. At 20,000, the number of men expected to be eligible for the Pathway is ten times higher than under the DSPD programme (Benefield et al., 2015: 4; Boateng and Sharland, 1999). The number of women eligible has increased from around 50 to between 1,000 and 1,500 (DSPD Programme et al., 2006: 8; D'Cruz, 2015: 48). This expansion in numbers is facilitated by significantly broader entry criteria:

Entry criteria for men's services:

> At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others; and
>
> 1. Likely to have a severe personality disorder; and
> 2. A clinically justifiable link between the personality disorder and the risk; and
> 3. The case is managed by [the National Probation Service] (Benefield et al., 2015: 6).

Entry criteria for women's services:

> 1. Current offence of violence against the person, criminal damage, sexual (not economically motivated) and/or against children; and
> 2. Assessed as presenting a high risk of committing an offence from the above categories OR managed by the NPS; and
> 3. Likely to have a severe form of personality disorder; and
> 4. A clinically justifiable link between the above (D'Cruz, 2015: 49).

Under the new criteria, the risk of serious harm threshold appears to be higher than under the DSPD programme as the likelihood of offence repetition is now required to be 'high'. However, as the Pathway includes male offenders who have been assessed as presenting a high or very high risk of harm to others 'at any point during their sentence' (Benefield et al., 2015: 6) it may be expected to draw in individuals who have already made some progress within the prison estate. The strategy here is to enable further progression into lower security settings. 'Repetition' in the criteria for men indicates that the Pathway will nevertheless continue to focus on those individuals who have previously committed serious sexual or violent offences. For women, on the other hand, the seriousness threshold is lower, widening the net significantly (see further Player, 2017).

Perhaps the most striking difference with the DSPD criteria is that individuals now need only be 'likely' to suffer from a severe personality disorder before they can be referred to the Pathway. Those assessed as suitable 'have complex needs consisting of emotional and interpersonal difficulties, and display challenging behaviour of a degree that causes concern in relation to their effective management' (Department of Health and NOMS, 2011: para. 17). The intention behind this 'is to avoid disappearing down the rabbit hole of diagnosis and free the service to identify those struggling to progress on their sentence by virtue of emotional and interpersonal problems' (Minoudis and Kane, 2017: 209). Under the Pathway approach, therefore, disruptive behaviour will increasingly be interpreted through the lens of personality disorder, with the aim of encouraging difficult prisoners to engage with rehabilitative interventions not only to reduce their risk of recidivism but also to improve their management within prisons.

Completion of treatment programmes on the OPDP could also become a condition of security categorisation decisions and affect a prisoner's chances of progressing towards parole. In *R (S) v. Secretary of State for Justice* (2009) the Deputy Director of Custody (High Security) decided not to downgrade a prisoner's security category to Category B on the grounds, *inter alia*, that he was 'not satisfied that he [could] make the judgment on risk which he is required to make without the whole six years of the Fens Unit [DSPD] programme being completed'. On judicial review, this decision was found by the High Court not to be unreasonable or irrational and was allowed to stand. Similarly, in *R. (Falconer) v. Secretary of State for Justice* (2009), the High Court held that it was 'in the prisoner's own interests that he undertakes the work required by the DSPD programme, onerous as it is, so as to establish the grounds for a finding that the risk he presents is substantially reduced'. In the absence of participation in the

programme he was unlikely to make further progress towards release. Thus, participation in a programme such as those now available on the OPDP can become a condition of progress for those subject to indeterminate sentences, such as the IPP. Failure to engage and make progress in treatment is likely to result in longer periods of detention as unmet treatment needs are easily elided with risk in the risk/need paradigm (Hannah-Moffat, 2015).

While the hospital DSPD units have been decommissioned, secure hospitals retain a place on the Pathway and mental health settings have been co-opted to serve criminal justice ends. Hospital personality disorder wards are expected to relieve prisons of their most challenging and complex cases and to play a role in the assimilation of the most distressed and disruptive prisoners into the mainstream. Hospitals are expected to provide a place for those who cannot be managed in prison due to 'repeated failure' and 'irretrievable breakdown of relationships in custody' and 'therapy-interfering behaviours' such as 'litigiousness, breaches of boundaries [and] pathological attachments' (NOMS and NHS England, 2015: 17). Further criteria include uncertain, changing or disputed diagnosis or risk levels, a need for interventions not readily available in prison, deliberate self-harm, co-morbid mental illnesses requiring stabilisation in hospital, and complexity compounded by borderline intellectual functioning or neurological impairment (NOMS and NHS England, 2015: 17).

Hospitals also continue to provide a means for detaining those who continue to present threats to public safety. While the aim of the OPD Pathway is to identify eligible prisoners early in their sentences, but it continues to be possible for those whose prison sentences have expired to be transferred to hospital by the Secretary of State under section 47 of the MHA 1983 (NOMS and NHS England, 2015: 17). Policy from the Ministry of Justice suggests that lessons have been learned from the experience of the hospital DSPD units, which had to deal with a disgruntled group of patients transferred from prison with the purpose of delaying their release (Burns et al., 2011; Trebilcock and Weaver, 2010b). Recent guidance instructs that the Secretary of State must be satisfied that admission is necessary on clinical grounds before authorising a transfer late in sentence (National MAPPA Team et al., 2012: 123-124). However, the MHA 1983 does not present a barrier to late transfer decisions motivated by public protection so long as the requirements of the Act are 'scrupulously satisfied' (*R (SP) v. Secretary of State for Justice*, 2010).

Under the plans for the most expensive high secure intervention units on the OPD Pathway, resources follow those who pose the highest risks, those who are most resistant to intervention and those with a more antisocial profile (Department of Health and NOMS, 2011:

para. 49). Consequently, those individuals who present primarily with borderline personality disorder (BPD), who may be more treatment-seeking and possibly more amenable to treatment given the stronger evidence base (NCCMH et al., 2009), may be left out of high secure services. This indicates a move away from the welfarist ambitions of early policymakers towards a greater focus on drawing treatment-resistant high risk individuals into normalising interventions. Individuals primarily characterised by antisocial traits often do not perceive themselves as needing help and are therefore more difficult to engage in treatment (NCCMH et al., 2010). Furthermore, success in treating this population is often calculated in terms of reduced risks to others rather than benefit to patients (NCCMH et al., 2010).

Despite the overarching concern with public protection, just over half of the prisoners on a DSPD unit reported deriving benefits from the assessment programme (Tyrer et al., 2007). These included greater insight into their personalities and offending behaviours and new ways of thinking they believed would help them to move forward. None of the prisoners had previously been offered such an opportunity (Tyrer et al., 2007), reflecting the paucity of interventions available to high risk individuals with psychopathic traits in the past. In a more recent study of the London Pathways Progression Unit on the OPD Pathway, prisoners reported improved coping and communication skills, better relationships with staff, a greater ability to control their emotions and behaviours and greater self-understanding (McMurran and Delight, 2017).

The plans for the OPD Pathway indicate, however, that the extent to which the initiative pursues its stated aims of enhancing wellbeing is contingent on the risks individual prisoners pose to the public and, perhaps to a lesser extent, to order, control, safety and 'decency' within prisons. Subjective benefits to wellbeing such are therefore likely to be a side-effect of programmes largely aimed at high risk and serious offenders, casting doubt on the extent to which the programme can be expected to tackle health inequalities in the spirit of the Bradley Review (2009).

It should also be borne in mind that participation in therapeutic interventions in coercive prison environments poses risks to vulnerable prisoners. Notwithstanding the focus on high risk offenders, the characteristics of prisoners screened as eligible for the Pathway indicate both a disruptive and vulnerable group. Of those meeting the criteria for the OPD Pathway, 42% of men and of 59% of women had a history of self-harm or suicide attempts, 38% of men and 58% of women had a history of mental ill-health, 56% of men and 47% of women had a history

of childhood difficulty; and 35% of men and 27% of women were displaying challenging behaviour (Skett et al., 2017: 217).

As the Bradley Review noted, imprisonment can 'exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide' in already vulnerable individuals (Bradley, 2009: 7). These risks can be exacerbated by therapeutic interventions that force prisoners to face traumatic past experiences and come face-to-face with their problems or inadequacies in a context in which they are separated from support networks and have little choice but to participate (Moore and Hannah-Moffat, 2005; see also Genders and Player, 2014). Elaine Player has raised particular concerns in relation to the OPD Pathway for women, which involves 'psychologically intrusive programmes' 'in a legal and ethical framework of uncertainty about the duty of care owed to the women prisoners who participate' (Player, 2017). These concerns also apply to the male population in a context of criminal justice policy that 'supports rehabilitative opportunities that address the risks offenders pose to the public, yet remains inattentive to the risk of harm that rehabilitative programmes can pose to offenders' (Genders and Player, 2014: 434).

As well as the potential for re-traumatisation, highly structured and coercive penal environments may undermine therapeutic efforts with personality disorder as successful treatment is predicated on motivation for change and active engagement on behalf of participants (Howells and Day, 2007; NCCMH et al., 2010). Conversely, the challenges of therapy and the need to test out progress by gradually easing security constraints increases the potential for risks to staff and inmates and to the public in the case of escape. This struggle between security and therapy is reflected in the experience of staff and inmates on the DSPD programme and OPD Pathway.

Male patients and prisoners commented that security procedures in prison and hospital DSPD units interfered with therapeutic and structured activities and staff spoke of conflicts with host institutions on the issue of security (Burns et al., 2011: 215-217; Trebilcock and Weaver 2010b: 27-30). Similarly, staff at the London Pathways Progression Unit reported that restrictions on prisoners' visiting rights hindered the development of supportive relationships with friends and family needed for successful reintegration into the community (McMurran and Delight, 2017). From the perspective of prison officers at the DSPD unit at HMP Whitemoor, on the other hand, the therapeutic model threatened the smooth management of the prisoners and generated risks to the safety and security of staff (Fox, 2010). These tensions at HMP Whitemoor were eventually resolved as officers came to see that, by challenging the

prisoners, the programme was working towards reductions in risks to the public in the long-term. Subsequently, officers became more tolerant of the short-term risks to safety and good order provoked by treatment (Fox, 2010).

Other criminological studies illustrate the vulnerable position of specialist therapeutic units within the prison setting and the tendency for conflict to be resolved in a direction that favours the overarching aims of the prison. Elaine Genders and Elaine Player (1995, 2010) observed in their study of the Therapeutic Community (TC) at HMP Grendon that where a conflict arose between the interests of the mainstream prison and the TC, penal power tended to prevail. Similarly, Richard Sparks' (2002) work also yields evidence of conflict between the agenda of the wider prison and that of the 'experimental' Barlinnie Special Unit, which contributed to its eventual closure. Thus, the work of treatment units such as those on the OPD Pathway may be best understood as a process of on-going negotiation between the sometimes conflicting and sometimes complementary aims of rehabilitating prisoners and maintaining internal security and order. Given the priority placed on internal control in times of crisis, however, if funding priorities change, if the public mood shifts away from rehabilitation or if this is seen to generate unacceptable risks to prison governance, the aims of maintaining order and security within prisons will take priority.

Conclusion

It has been argued that the construction of personality disorder and dangerousness as potentially mutable qualities was a means for policymakers to legitimate the detention and treatment of the DSPD group primarily to reassure the public that they would be protected from individuals who provoke fear. In addition, however, the 1999 DSPD proposals were intended to respond to a myriad of other risks: to offenders themselves, to staff and other inmates and ultimately to the institutions that housed difficult, disruptive and distressed offenders who could not easily be governed through mainstream regimes. Rather than being excluded from rehabilitation and re-integration due to their perceived dangerousness, serious offenders with personality disorders were therefore to be drawn into 'circuits of security' (Rose, 2000) through participation in interventions tailored to their needs. For those individuals who could or would not be governed at a distance, however, more coercive measures of preventive detention would be available.

In light of the history of the DSPD programme, it has been argued that ‘intervenable’ treatment ‘needs’ (Hannah-Moffat, 2005) in prison rehabilitation programmes are not only those linked to a risk of recidivism. Rather, prisoners’ mental health needs may also be met where this is a necessary first step towards engaging them in risk-focused interventions. Furthermore, the experience of England and Wales yields evidence that therapeutic programmes can easily be co-opted to facilitate the prison’s goals of order, control and a safe environment for prisoners and staff. Conversely, where a conflict arises, evidence from the DSPD programme and the OPD Pathway indicates that the overarching priorities of security and control will prevail over therapeutic intervention. Thus, the seeming consensus on rehabilitation as an aim of the criminal justice system relies on therapy serving the interests of the prison, which must be conceived more widely than an interest in reducing recidivism. Given the balance of power within prisons, therefore, therapeutic units, and those within them, ultimately occupy a vulnerable position.

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