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## Rehabilitating antisocial personalities: treatment through self-governance strategies

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Offenders with antisocial personality disorder (ASPD) are widely assumed to reject psychotherapeutic intervention. Some commentators, therefore, argue that those with the disorder are better managed in the criminal justice system, where, following the introduction of indeterminate sentences, engagement with psychological treatment is coercively linked to the achievement of parole. By comparison, National Institute of Clinical Excellence guidelines on the management and treatment of ASPD recommend that those who are treatment *seeking* should be considered for admission to specialist psychiatric hospitals. The rationale is that prison-based interventions are underresourced, and the treatment of ASPD is underprioritised. The justification is that offenders with ASPD can be rehabilitated, *if* they are motivated. One problem, however, is that little is known about why offenders with ASPD seek treatment or what effect subsequent treatment has on their self-understanding. The aim of this paper is to address these unresolved issues. It draws on the findings of Economic and Social Research Council (ESRC) funded qualitative study examining the experiences of sentenced male offenders admitted to a specialist personality disorder ward within the medium secure estate and the medical practitioners who treat them. The data are analysed with reference to Michel Foucault's work on *governmentality* and *strategy* in power relations. Two arguments are advanced: first, offenders with ASPD are motivated by legal coercive pressures to implement a variety of Foucauldian-type strategies to give the false impression of treatment progress. Second, and related, treatment does not result in changes in self-understanding in the resistive client with ASPD. This presupposes that, in respect of this group at least, Foucault was mistaken in his claim that resistive behaviours merely mask the effectiveness of treatment norms over time. Nevertheless, the paper concludes that specialist treatment in the hospital setting *can* effect changes in the resistive offender's self-understanding, but not if the completion of treatment results, as is commonplace, in his prison readmission.

**Keywords:** antisocial personality disorder; treatment; Mental Health Act 1983; Indeterminate Sentence for Public Protection; parole; *governmentality*

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## **Introduction**

Thirty years after the American Psychiatric Association first introduced us to antisocial personality disorder (ASPD), the prognosis remains uncertain. Many medical practitioners assert that the diagnosis constitutes an unfounded basis for medical intervention. The usual justification is that antisocial personality *disorder* is a chimera: an aberrant personality is not an illness, and so, cannot offer itself to a cure in the ordinary way. Other commentators argue that in light of its positive correlation with imprisonment (Fazel & Danesh, 2000; Singleton, Meltzer, & Gatward, 1998), ASPD is better '*managed* in the criminal justice system' (reported in Duggan & Kane, 2010). Some even contend that the label of ASPD may encourage the adoption of an 'invalid role', which is incongruous with our wish to see offenders take responsibility for their behaviour (National Institute of Clinical Excellence [NICE], 2010). Whilst this latter application of labelling theory might be a step too far for most, it is impossible to deny that those with the disorder suffer from complex problems, including significant psychiatric comorbidity (Ministry of Justice, 2011; NICE, 2010).

Pursuant to this reality, treatment regimes for offenders with ASPD are located within and alongside the criminal justice system, and so, cater for both sentenced offenders and those transferred to hospital at trial or during imprisonment (sections 37 and 47 of the Mental Health Act (MHA) 1983, respectively). At the time of writing, the coalition government appears committed to increasing the capacity of prison-based treatment facilities for the most prolific and dangerous offenders with ASPD (Department of Health/Ministry of Justice, 2011). For the 'risky' majority, however, criminal justice policy is often ambiguous about the best way to reduce reoffending. On the one hand, following the introduction of the Indeterminate Sentence for Public Protection (IPP) under the Criminal Justice Act 2003, dangerous offenders with ASPD, sentenced after April 2005, are expected to have engaged in psychological treatment programmes aimed at reducing criminogenic risk factors prior to achieving parole. On the other hand, the ostensible aim of treatment–rehabilitation is hampered by insufficient resources resulting from overzealous use of the IPP (Ministry of Justice, 2010). Whilst a new extended determinate sentence is set to replace the IPP from April 2013 (Legal Aid, Sentencing and Punishment of Offenders 2012, section 124), it will not act retrospectively. Currently, 6020 offenders are subject to the IPP, of whom 59% have passed their earliest date of release (Ministry of Justice, 2012). For this group, the result is offender incapacitation; the effect is the exacerbation of learned helplessness and distress associated with imprisonment; the habitual treatment response is to administer high dose psychiatric medication (Sainsbury Centre for Mental Health, 2008). Not only is there no firm evidence in support of this practice (Khalifa et al., 2011), it cannot be overstated that if you deny offenders the chance to be responsible, 'you cannot blame them for behaving irresponsibly' (Pryor, 2001, p. 4).

The NICE guidelines on the management, treatment and prevention of ASPD attempt to counter these paradoxes. Recognising the importance of offender responsabilisation, and, in particular, the poorly met treatment needs of offenders in prison, it recommends:

Where antisocial personality disorder is suspected and the person is *seeking help*, consider offering a referral to an appropriate forensic mental health service ... [F] or problems directly relating to the personality disorder it may be to a specialist personality disorder or forensic service. (2010, p. 65, emphasis supplied)

Previous research highlights widespread refusal among forensic psychiatrists to admit offenders with ASPD who are not seeking treatment to forensic mental health services (Grounds et al., 2004). The operating assumption in these cases is that treatment-seeking behaviour is strong evidence of motivation to engage. Others counter that, even if the offender initially presents as motivated, his desire for power, status and influence means that treatment is rarely tolerated for long. However, in 2008, the Mental Health Act Commission (MHAC) (as it then was) surprisingly reported that 85% of sentenced offenders with personality disorder admitted to hospital were treatment compliant. A number of plausible explanations for this counterintuitive result were proposed:

Prison transferees may have a longer than average period of hospitalisation, and long-term detainees are likely to form a group of comparatively 'well' and insightful patients in the forensic system who may be more likely to be compliant with their continued treatment.

Transferees subject to restriction orders (who are even more likely to be consenting than the group as a whole) may be returned to prison if hospital treatment is deemed to be no longer necessary, or effective, in their case. Such patients may comply with their treatment regimes to avoid such an outcome.

Patients with experience of serving prison sentences, especially if they have experience or knowledge of the parole system, may equate treatment compliance with the 'good behaviour' that leads to quicker release from custodial sentences or step-down from the higher security levels of the prison system, and (in most cases quite correctly) therefore view treatment compliance as likely to hasten their transfer to lower security hospitals and/or release into the community.

The first of these explanations implies that continued cooperation is the effect of long-term psychiatric treatment. The tacit assumption is that psychiatric treatment imposes normative constraints on the offender, which eventually provokes in him greater pro-social behaviour. Most importantly, the resistive behaviours common to offenders with ASPD are not seen to undermine this process.

The second and third explanations relate to behaviours undertaken by the offender in pursuit of ulterior gain. For example, the offender may have been sentenced to an IPP prior to his admission, and may (rightly) perceive that

cooperation with treatment will reduce the chances of his readmission to prison, where resources are scarce, and where, by necessity, the chances of his parole are reduced. In this example, we would assume that although it is *possible* treatment will rehabilitate him, he has no intrinsic desire to adopt an alternative form of self-understanding.

General anecdotal support for the latter explanations comes from Len Bowers' informative study of nurses' attitudes towards offenders with ASPD in their care (2002). He reveals widespread scepticism among nurses that treatment has the potential to rehabilitate offenders who are engaging with it for subversive reasons. For instance:

But what you've got to watch here with [personality disordered] patients, is they can be manipulative, and they can say that they're doing, they're getting better, and they can conform to all the treatments they're having and they're not, they're only doing it for their own benefit. To get out of this place. And when they've been discharged, they've *re-offended*. (p. 40)

In one alarming study, 41% of 1353 offenders with ASPD released from high secure settings went on to reoffend within two years (Coid et al., 2010). And, whilst this bland figure cannot tell us whether treatment engagement was the result of legal coercive pressures (the second and third explanations above), it does not indicate that offenders are motivated to become more pro-social *or* that treatment norms are capable of rehabilitating offenders by *overcoming* resistance (the first explanation). The NICE guidelines appropriately warn:

It is very unlikely that all antisocial patients can be *coerced* into pro-social thinking or behaviour. This raises important issues of balance between the rights of individuals to have liberty restrained or treatment imposed against the rights of a community to be protected from potential harm. (2010, p. 34)

The important question of the correct 'balance' to be struck between offenders' rights and public protection is clearly beyond the scope of this paper; however, a cogent (and ethical) response will derive from what is shown of the potential to rehabilitate those in question. The overarching aim of this paper is to contribute to this knowledge store by examining the findings of an Economic and Social Research Council-funded empirical study looking at the reasons for treatment-seeking behaviour in offenders with ASPD, and the effects of hospital treatment on them.

## **Methodology**

### ***Locative context and working method***

The study was conducted on a specialist personality disorder ward in a medium-secure psychiatric hospital. The aims of the study were twofold: first,

to examine why offenders with ASPD might cooperate with treatment, and, second, to identify the therapeutic benefits, if any, resulting from its provision. Data were primarily generated through one-to-one semi-structured interviews, each lasting 20–75 min. Typical questions included: how did you hear about the personality disorder service? What are your experiences of prison treatment? What do you hope to achieve from treatment? Were you concerned that you would not be admitted?

The respondents comprised two groups: patients transferred from prison to hospital for treatment under section 47 of the MHA 1983 ( $n=11$ ) and members of the multidisciplinary treatment team (senior and low-grade nurses, occupational therapists, psychiatrists and psychologists:  $n=12$ ). Interview data were verified (triangulated), and supplemented, following systematic and detailed analysis of patients' medical records (34 folders in all).

Consistent with the ward's admissions' policy, all patient respondents were male. The average age of patients was approximately 33 years (the youngest patient being 23 and the oldest 43 years old). All identified as being white British. Diagnostically, patients presented with significant comorbidity: many had multiple personality disorders in addition to ASPD (mainly avoidant and borderline types), history of substance misuse, depressive disorders and/or psychopathy. Interestingly, 10 of the 12 patients had been sentenced to an IPP prior to their admission; the remainder had received automatic life sentences for murder.

All respondents were fully informed of the purpose of the research. Consent was a prerequisite to participation and subsequent use of anonymised data. Participants were duly informed of their right to withdraw from the study at any time, without prejudice to their legal rights or treatment plan; however, it remains possible that patients might have felt obliged to participate in order to present to their carers the image of pro-social behaviour. Following review, the study's working method was approved by an NHS ethics committee and the researcher's academic institution. Subsequent consideration was given to increasing the formal sample size by way of 'substantial amendment' – that is, one likely to affect the 'scientific value of the study' to a 'significant degree' (National Research Ethics Service, 2012). But, with clear evidence of data saturation, this was deemed to be unnecessary and, therefore, unethical. A more substantial charge might be that the single-site character of the study limits the generalisability of its findings (Melzer, Tom, Brugha, & Fryers, 2004). For example, it is appreciated that patients may have been apprised of the interview questions prior to offering their consent to participate. However, this argument must fail because multisite research merely perpetuates this standard limitation of qualitative research. It must also fail because, on final analysis of a working method, data will 'speak for itself' (Liebling, 2001). Moderatum generalisations remain, more than anything else, the product of 'a broader set of recognizable [theoretical] features' (Williams, 2000, p. 215).

### **Theoretical orientations and study questions**

The study adopted a constructionist ontological and an interpretivist epistemological approach to data collection. Data were analysed by reference to work of Michel Foucault on *governmentality*, which continues to be very influential among those examining the link between increasingly pessimistic modes of crime control (such as punitive sentencing) and loss of faith in the capacity of psychiatric experts to reform offenders (Garland, 1995, 2001; Giddens, 1990). His main contribution to this field is his examination of the relationship between the growth of psychiatry in the nineteenth century and the deploying of treatment linked to the desire for improved social welfare. He argues that, since the early 1800s, antisocial members of society – the madman (1965), the sexually depraved (1981) and the delinquent (1979) – have all been offered up to increasingly sophisticated forms of psychiatric treatment in penal and psychiatric (*disciplinary*) institutions. The ultimate goal of the psychiatric practitioners who administer treatment is to reintegrate antisocial individuals into society with a pro-social outlook. Rehabilitation occurs, he posits, because the normative content of psychiatric treatment is capable of effecting changes in self-understanding over time. To increase the chances of rehabilitation, psychiatric practitioners implement *disciplinary* techniques aimed at enhancing the normative effectiveness of treatment within the institution. Such measures include systems of reward and punishment, the ranking of subjects in order of their responsiveness to treatment norms and constant surveillance.

In his early work, Foucault stops short of claiming that psychiatric treatment is always effective at eliminating antisocial tendencies or criminal behaviour, for antisocial individuals seldom believe they ought to change. The adaptive state response is to make offender-responsibilisation programmes an essential component of risk-centred policy (Garland, 2001; O'Malley, 1992, 2000; Rose, 2000). The IPP, for instance, is a prime example of what Reichman has termed 'an insurance concept of crime control' (1986, p. 153), for it both facilitates 'responsible' offenders who are treatment seeking (resources permitting) and excludes from society, through incapacitative restraint, 'irresponsible' offenders who do not insure society against the risks they pose.

However, Foucault later questions whether rehabilitative and anti-rehabilitative sentiments held by antisocial individuals dictate whether the achievement of new self-understanding is possible through punishment correction. Rather, he contends that responsabilisation techniques are capable of inducing behavioural change because antisocial individuals may be *unaware* that norms are taking hold (Foucault, 1981). What this means is that psychiatric treatments are informed by risk concepts that 'construct particular norms of behaviour which are used to encourage individuals to engage *voluntarily* in self-regulation in response to these norms' (Lupton, 1999, p. 25, emphasis supplied).

The problem for the researcher is to evaluate the meaning of 'voluntariness' in circumstances where offenders are being coerced into



receiving treatment. For responsabilisation is predicated on individuals being able to exercise agency *and* form concrete strategies about how they and *others* should act (Nealon, 2008). Whilst strategies between individuals can be mutually beneficial (e.g. the professional's giving of treatment; the offender's efforts to become more pro-social), they can equally be calculated to gain 'advantage over' others (Foucault, 1982). Consider:

Might the offender with ASPD in receipt of hospital treatment claim to be pro-social in order to gain 'advantage over' their custodians?

The background information in this example of strategy would, presumably, be that the antisocial offender has sought access to hospital treatment for reasons unrelated to the pursuit of pro-social outlook. Foucault would ground this possibility in discussion of the 'confessional': a shorthand for the process of pre-admission assessment, during which one is obliged to confess 'one's crimes, one's sins, one's thoughts and desires' before normalising techniques (such as psychiatric treatment) are made available by the professional (1981, p. 59). Upon gaining admission, the treatment-seeking offender must then seek to counter his 'systemic deprivation' by purchasing freedom through cooperation and engagement (Foucault, 2006, p. 156). An example of the potential psychodrama this can lead to is captured by Peay (1989), in her qualitative study of the circumstances of patient discharge from Special Hospitals where they detained under the MHA 1983. Among her many findings, she showed that patients who did not desire, or believe they needed, psychiatric medications, nevertheless took them. One patient explained: 'medication is my ticket out of here' (p. 52).

Whilst the administration of medication in coercive circumstances is unlikely to completely undermine therapeutic efficacy, the usefulness of psychological therapies will be in large part determined by the patient's reasons for offering his cooperation. If, as above, the patient engages for strategic reasons, an important question is raised about the extent to which treatment reliant on self-responsibilisation techniques can *ever* be effective in coercive circumstances. In Foucauldian speak: can the resistive and docile qualities of the antisocial individual be harnessed in any meaningful through psychiatric treatment? The following 'partial' hypothesis is proposed:

Patients with ASPD do not self-govern in accordance with psychiatric norms; rather, they present the image of pro-social behaviour in order to achieve expedited parole.

One inevitable challenge of employing a Foucauldian lens to test this hypothesis is the need to show that patient cooperation, if present at all, is due to his pursuit of ulterior motives rather than exposure to treatment norms inducing pro-social behaviour (Luke, 2005; Nealon, 2008). To address this methodological



requirement, assertions made in respect of the data were submitted to a working burden of proof (balance of probabilities). So, for instance, if on the balance of probabilities, the evidence suggested that the presentation of pro-social behaviours was mediated by legal coercive pressures, a case could, or should, be made for the normative ineffectiveness of treatment on offenders with ASPD. Only by adopting this rigorous burden of proof could the data remain sensitive to the more general, underlying question: 'To what principles does the individual refer in order to moderate, limit, regulate [his] activity?' (Foucault, 1984, p. 53). The remainder of this paper addresses this murky question.

### **Rehabilitation amid resistance?**

The regime from which the data are taken is a typical example of a disciplinary institution. From the moment the patient arrives on the ward, and for the duration of his two years' stay, he experiences a 'meticulous assumption of responsibility' for his time and body (1979b, p. 130). This process begins each morning at 7.50 am, when he is expected to 'negotiate' with a member of the multidisciplinary team, the activities he will pursue that day (oversleeping is recorded as a 'refusal'). Negotiated activities range from group therapy sessions to 'privileged' activities, such as escorted leave, exercise in the gym and playing on the ward computer console, to commonplace activities, like eating in the canteen, getting a haircut, taking prescribed medication and setting a time for homework.

If he carries out his routine activities in the annular communal area, security staff, health support workers and nurses keep watch from their 'panoptic' office. If he enters one of the dimly lit corridors, where they cannot see, static cameras record and report his behaviour. If he is seen transgressing the rules, an 'incident' is logged in one of the many medical files. During the subsequent progress review meeting, he will be expected to explain his difficulties following rules; and, if the transgression was significant, decisions may be reached about the status of any privileges previously enjoyed. For more serious or persistent rule breaking, he risks being readmitted to prison, for a 'period of reflection' (with the opportunity of readmission if he is remorseful). Usually, however, this disruptive measure is reserved for rare instances of treatment refusal unresolved by moderate forms of surveillance-coercion. The most effective, and impressive, of these is peer pressure:

In order to get the best out of that course, they have to participate. We can talk to them first: we can ask them what the problem is, what's going on ... And better than that, their peers wouldn't let them get away with [that]. They would actually be the first to challenge them ... (Nurse)

For instance, Mr H began refusing food in protest over his loss of privileges 12 months into treatment, only to be heard crunching sweets during a group meeting. His peers responded with an ultimatum:

Challenged by patients when he informed them he was ok and yet his expressions said otherwise. It was suggested to him by his peers that if he didn't want to be at the meeting maybe he should leave. (Ward Round Notes)

Mr H chose not to leave the meeting, because he feared 'he would lose his negotiations' (Ward Round Notes). In so doing, he demonstrated the self-referential behaviours expected of those with ASPD. What is, therefore, fascinating about this exchange is not so much the effectiveness of peer pressure in securing Mr H's compliance as the phenomenon of patient solidarity itself. In a world where the lowest common denominator is patient resistance, how do we explain the *collective* reaction to Mr H? Two potential explanations are proposed.

First, the collective condemnation of Mr H's resistive treatment behaviour was a coextensive strategy used by patients to evidence their commitment to pro-social norms. Patients may (rightly) equate good behaviour with the long-term goal of achievement of expedited parole. Short-term derivative goals might also be lost without solidarity. For example:

[O]n this ward, if someone is upset, and is distressed, is angry, hostile, aggressive, and refuses to go through to the dining room ... if someone refuses to do that, then no-one goes ... That would be happening quite a lot if we didn't have an effective way of dealing with that, and the most effective way is peer pressure. (Nurse)

The second explanation, which runs counter to the author's working hypothesis, is that the phenomenon of peer pressure is evidence of the efficacy of the highly structured 'disciplinary' regime at inculcating antisocial personalities with treatment and professional norms over time.

The first explanation is attentive to the possibility that legal coercive pressures (external motivation) may encourage patients' health-seeking behaviour; it requires us to compare the 'quality' of the patient's engagement with treatment in prison (if treatment was received) with the hospital ward. What we should expect to find is evidence of external motivation at the point of admission to hospital and, because of the underlying resistance to the idea of rehabilitation, no great difference in the quality of engagement in the respective institutions. Crucially, what we actually find is evidence of external motivation to seek treatment and differences in the *quality* of engagement between prison and the ward:

When they brought in this IPP system, in theory it's fantastic. I don't knock the prison system at all, I don't knock the sentences. At the end of the day, I did wrong and they were doing their job. But with the IPP, they're giving them out willy-nilly. (Mr H)

[In hospital], you get on courses, boom, straight away. But in prison, there's a big waiting list, you can wait years and years to get on courses ... To be honest, I thought I'll just give it a shot, and see what's what. (Mr B)

[Y]ou go to the treatment group [in prison] and all you're doing is ticking the box ... You do work but you throw it away. You don't put anything into practice or remember it. (Mr K)

I don't think I would learn anything [in prison] because nobody wants to learn, everyone wants to tick the boxes for their parole hearing. At least here I'm doing something useful. Everyone here wants to learn. They're not ticking the boxes. We feel as a patient group that if someone comes along just ticking boxes then they get challenged not by the staff but by the patient group. The patient group literally have a meeting at 9am. Those meetings are there, say, you were a patient and you were messing about in groups and you weren't bringing anything to it and you were being a distraction on the ward, you would be challenged and they'd want to know the reason why. (Mr H)

If we accept Mr H's account of treatment response in hospital, it follows that his prior resistance (refusal to eat; sweet crunching) has been overcome by *internal* motivation to address his offending behaviour at some point. It also follows that the prison regime must lack the essential ingredients to effect pro-social changes in the self-governance of inmates (including Mr H). One possible reason is negative interpersonal relations. Sykes, for example, states that one manifestation of the 'cohesive inmate society' is that 'inmates' will habitually deny the 'custodians' 'power to strip [him] of his ability to control himself' (1958, p. 107). Those who do more than superficially engage in prison treatment, risk doing violence to the code of inmate solidarity – if not their own personal safety ('I couldn't ask the prison officer for help. You couldn't be seen as weak. In that environment, it's them and us' (Mr L)). For this reason, the prison regime cannot, as Foucault would say, 'bend behaviour towards a terminal state' through 'repetitive' and 'graduated' treatment (1979b, p. 161).

Another, less obvious, limitation is the relative absence of psychiatrists to deploy, or oversee the deployment of, cognitive-behavioural treatment in prison. Yet, this is relevant because psychiatry is an eclectic discourse whose treatment rationality derives as much from the original biochemical model of mental disorder as the psychosocial model provided by psychology. A consequence is that cognitive-behavioural therapies, though not necessarily delivered by psychiatrists in prison (or elsewhere), may require for their legitimacy, and so, their normalising potential, the presence of the behavioural science which has the right to define the medico-legal problem (Foucault, 1972).

Since forensic psychiatric hospitals do not face these limitations, the suggested improvements in *internal* motivation following a period of treatment causes the first explanation (patients are really *externally* motivated) to converge with the *second* (motivation is a result of the internalisation of treatment norms over time, allowing for occasional petty resistance). This account was preferred by several members of the multidisciplinary team:

[F]or some people you get more of a sense they don't really want to change, but are pursuing an avenue as a means to an end ... albeit, part way through that

process, they might have some enlightenment and decide it's worth changing. (Psychologist)

[P]eople who aren't particularly motivated at the beginning have a sense, you know, I get what this is about and I want to do it properly. (Psychiatrist)

I suppose, ultimately, gaining parole is one of the main motivating factors for a lot of the guys on the ward. And you can often find once you get somebody into more of a therapeutic environment, their gaining parole is the end point, but they actually perhaps see there's a process in between, which they can benefit from. (Occupational Therapist)

But, are these statements innocent of the potential of patients to 'fake' rehabilitation? Does psychiatric treatment (talking therapies) result in patients with ASPD adopting pro-social behaviours due to internal motivation? Mr C argues not:

As soon as you get into groups and start talking with the nurses, it's like everyone puts a front on. You know, I have seen that when the [psychiatrists] come into certain meetings, as soon as, if [Psychiatrist] comes in, certain patients will start talking differently. I think to myself: if I can see this, surely they can. I do think they get sucked in. I can predict what they're gonna say. They'll say they've put this skill into practice, when I know they haven't.

Other patients who were asked – towards the end of the interview process – if it was possible to 'fake rehabilitation' were unequivocally dismissive. Mr K, for instance, argues: 'You can't just go in [to treatment sessions] and tick a box. You've got to show motivation and a certain degree of work. It gets looked at'. Mr E implicitly agrees, pointing out that: 'Everything's analysed inside out'. Later, he states: 'When I first came here I was quite cold and callous. I wasn't really very pleasant to be around. But, you know, I've changed a lot'.

During the study, patient medical records proved a valuable tool for cross-referencing patient self-assessments with a variety of clinical data and anecdotal accounts of patient responsiveness to treatment. In the case of Mr E, there is indeed evidence of positive change:

... despite provocation [Mr E] chose not to become involved in [the altercation with another patient]. This should be seen in a positive light as an indication of his expressed motivation.

However, elsewhere in his medical records, a ward round note describes an incident in which he was one of the two patients who took an 'active dislike' to one another, each retaliating by 'saying the other was not committed to treatment; was putting a front on'. As well as demonstrating the continued importance of parole-seeking behaviour in explaining patient engagement, it also shows us that patient solidarity towards this mutually desired goal is subject to rupture, because of the '*multiple forms*' of individual disparity, of

objectives' that actors within power relations may have from time to time (1982, p. 224). In Mr C's case, the objective in dismissing the truth of his peers' pro-social behaviour during therapy was to assert that he was being unfairly held up to a higher standard of behaviour by his peers than they were themselves achieving: '[They'll] find a way of trying to say [my behaviour is manipulative], and when I try and explain it's not, they say, you're just trying to justify it's not ... More probably with the patients'. Necessarily, taking himself outside the scope of patient solidarity, he can only protest: 'I can't work this place out'. By comparison, in the case of Mr E and his protagonist, the strategic aim was, in Foucault's words, to 'deprive the opponent of his means of combat and to reduce him to giving up the struggle' (1982, p. 225). And, although it is counterintuitive that Messrs C and E would engage in petty struggles that could undermine their respective chances of achieving parole, it is likely to be a consequence of their comorbid diagnoses of psychopathy – a diagnosis associated with cognitive dissonance. Cleckley writes:

Despite his excellent rational powers, the psychopath continues to show the most execrable judgment about attaining what one might presume to be his ends. He throws away excellent opportunities to ... be dismissed from hospital, or to gain other ends that he has sometimes spent considerable effort towards gaining ... This exercise of execrable judgment is not particularly modified by experience, however chastening his experiences may be. (1976, p. 345)

A further form of strategy offering an analytical lens through which to argue for the absence of internal motivation among patients on the ward is described by Foucault as 'the manner in which a partner in a certain game acts with regard to what he thinks should be the actions of the others and what he considers the others think to be his own' (1984, p. 225). What he means by this is that one actor in the power relation will endeavour to direct the 'other' by preempting their expectations and acting accordingly. For example, the patient may anticipate (not unreasonably) that the interviewer has negative preconceptions about the manipulative disposition of those with ASPD (and the diagnostically less popular psychopathy), but rely on this to his advantage. Mr D states:

I find that, because of the stigma attached to [personality disorders], things are probably analysed too much, and it can sometimes end up confusing you. And, actually, it's face value ... Straight away, there's an angle ... I have to take responsibility for that. People are going to question my motives, but I'm at the point now where I don't feel I do do that. I find it quite insulting. But at the end of the day, I'm in hospital and I have to put up with that.

His response:

[A] lot of us here still have the mentality that you're here for your parole; you're not here to change your life; you're here to fulfil the criteria [they] set for you,

and that's the big divide. And a lot of patients here are not in that mentality, they're here, not because they want to change themselves; they want to change other people. The people who are going out there and being successful, which has [*sic*] not been many, have changed because they've had enough in their life and they wanna change. You can't come here with the mentality with, I'm gonna change because I really want parole, I'm gonna tick all the boxes, which is the kind of mentality that's in prison. In here, you have to show that you're using your skills; you have to do it for your own benefit, not for everybody else.

By impliedly allying himself with those purporting to be internally motivated, Mr D may provide a further illustration of the scope of coextensive strategy between patients linked to the desire for parole. In support, a nurse subsequently selects Mr D to demonstrate her scepticism of the general truth of patient self-reports on the issue of rehabilitation:

[Mr D], for example, he's been here for quite some time, excellent paper work, problem solving, done [*sic*] all the groups, getting along quite well in the meetings and stuff like that ... [H]e couldn't assimilate it. He ended up going back to prison [for a 'period of reflection'], and we had him back. You know, and you just think to yourself: Is he taking it all on board this time? He appears to be. But does he just behave in the way that, you know, he thinks we want him to behave? Does he say the things that we want him to say?

The empirical data in this paper suggests this possibility. Patients with ASPD (and psychopathy) would appear to engage with treatment as part of coextensive strategy, which, although prone to occasional recaptulation, is attentive to the potential for earlier release (external motivation). Consequently, practitioners are justified in expressing reserve over the apparent effects of treatment. The NICE guidelines rightly state:

A key issue in the treatment of [ASPD] and psychopathy is the test of therapeutic outcome: how will the practitioners know if the treatment has been successful?

The remainder of this paper responds to this question. It then goes on to discuss how treatment success might be promoted in the forensic psychiatric system.

### **'Key performance indicators' as treatment success**

Treatment success in forensic psychiatric practice is usually evaluated by reference to rates of patient reoffending. Available empirical evidence indicates these to be high (McCarthy & Duggan, 2010). Whilst this should undermine public support in psychiatric discourse, the logic of *government* dictates that the mere promise to isolate and normalise mentally disordered subjects ensures its viability (Foucault, 1979a, p. 272). Ultimately, however, in the absence of verifiable treatment success, this effect of power runs counter to the best interests of professionals:

[Y]ou kind of get a bit despondent and wonder: why am I doing this? But then people say, you know, it's little changes. Maybe it's their self-esteem that's improved ... If you measure every little bit of change that's important to them, it makes it easier not to feel quite so disappointed. (Nurse)

Foucault argues that the task facing us all is to imagine the 'political "double bind"' individualising us within 'the totalization of modern power structures', and subvert it (1982, p. 216). For patients, this means resisting the imposition of pro-social treatment norms (an act which it has been shown they embrace). For professionals, resistance means recognising that '[p]rotection of the public should be the welcome *by-product* of improved clinical care, not the goal of such management' (Mullen, 2002, p. 229, emphasis supplied). This entails that improved clinical care should service both the reasons for patient engagement with treatment (achieving parole, more generally, to improve the quality of their lives) and alleviate the professional pressures exerted by modern power structures (*governmentality*). One possible means of achieving this – which was alluded to by the nurse above – is to focus on what McCarthy and Duggan call 'key performance indicators', or:

Changes in psycho-social functioning (e.g. educational attainment, employment, independent living), and outcomes which focus on the perceptions and experiences of service users (e.g. perceived levels of distress/safety, quality of life) may help clinicians to assess the efficacy of treatment programmes beyond the presence of offending behaviour and is an issue the authors will address in future work with this forensic population. (2010, p. 125)

Key performance indicators achieved by patients during the study included less severe and frequent episodes of self-harm; lower levels of learned helplessness linked to incapacitation in prison; completion of educational qualifications; and independent living. Mr K, a particularly 'successful' patient, had completed numerous college courses (which he described as 'enjoyable'), and was at the time of his interview living in a hostel three days per week. He reflects on his progression thus:

I couldn't sit and talk to you now and look you in the face. I couldn't communicate. I just didn't do very well ... [T]his place has offered me a lot. The harder I work, the harder they put the effort into trying to achieve what we want to achieve, which is for me to get released ...

The probability that patients will, like Mr K, seek to achieve key performance indicators to improve their chances of parole is a potential concern. Mr C, for instance, states: 'I'd like to go straight out and live with at my dad's or my mum's or something, but I'll go wherever gets me parole'. McCarthy and Duggan (2010) seek to mitigate the consequences of hollow engagement by urging us to evaluate the practical significance of key performance indicators by reference to a wider evaluation of 'the *quality* of patient engagement during specific



components of treatment'. Their (implied) rationale is that enhanced emotional stability resulting from external motivation (legal coercion), rather than internal motivation (an honest desire for alternative self-understanding), might merely create 'a more successful criminal' (Psychiatrist) – that is one who is more able to commit crimes without detection.

The problem with this analysis is that it presupposes three contingent propositions, each of which undermines the very notion of patient treatability. First, we are told that the difference between the successful and unsuccessful criminal is his underlying emotional stability. Second, it follows that it is immaterial whether enhanced emotional stability is mediated by internal or external treatment motivation: the will-to- recidivate will remain. And, third, key performance indicators actually increase the chances of antisocial conduct, because they may improve the patient's chances of parole, but have no material impact on the quality of treatment engagement.

The better view is that key performance indicators can, in conjunction with treatment, improve recidivism, *irrespective* of the quality of his engagement. The reason is that the achievement of key performance indicators is in patients' best interests. In the short term, their achievement directly improves the patients' conditions of detention. In the medium term, their achievement provides better evidence of suitability for parole than is available in prison. In the long term, upon gaining parole, and having achieved key performance indicators (such as feasible independent living), the patient may believe it to be in his best interests to continue to implement cognitive behavioural skills in public in order to ensure retention of current (psychosocial) benefits. The practical result is that the patient is encouraged, as Foucault would say, to 'regulate the cycle of repetition' of pro-social behaviour on himself (1979b, p. 149). Consider the analogous, idealised example of the schoolchild in the 'disciplinary' school:

A schoolchild who is forbidden from using her pen in her left hand (as was once often the case) may cooperate with her teacher's instruction to change hands for fear of reprisal. When 'training' ceases, she might continue to exercise the skill of using the right hand to pen or may dismiss it at the earliest convenience. Equally, the semi-ambidextrous child may call upon the new skill accidentally, whimsically or, better, *sel-servingly* over a period of time. Each time the skill is repeated, convergence between 'training' and performance is reinforced.

Of course, in this example, only the acquisition of a fine motor skill is in the balance; where changes in personality are hoped for, creating the conditions for the repetition of desirable behaviour is undoubtedly more precarious. It is submitted that a crucial element is that patients achieve parole from hospital.

### **Parole from hospital: a coextensive strategy**

The usual route into the community for the IPP patient who has completed treatment, but whose tariff has not yet expired, is to return to prison. Upon its

expiry, the patient becomes eligible for a parole hearing; if he is successful, he is released on life licence. If, on the other hand, his earliest date of release arrives during his stay in hospital, he is entitled to apply to the First-tier Tribunal (Mental Health). Since the patient will, in all probability, require the consent of the Secretary of State before he is discharged ('restriction direction': section 49 of the MHA 1983), the Tribunal may not order discharge. Rather, the Tribunal may recommend that the patient would be entitled to absolute or conditional discharge were he not subject to the 'restriction direction'. If this is the recommendation of the Tribunal, the patient will remain in hospital. A parole board hearing will then take place in prison in the ordinary way.

Between these two possibilities, prison and hospital, patients unanimously felt that it was in their best interests to achieve parole from hospital. One reason is that parole hearings for prisoners are scarce, and this inevitably results in protracted detention. Another reason was the legal requirement that a patient discharged from hospital receive an aftercare plan under section 117 of the MHA 1983; the result of which, taking into account the considerable discretion of the relevant Primary Care Trust or Health Authority, should include the provision of community psychiatric nurses, social security benefits, support with employment and housing. This was said to compare favourably to prison, where '[they] give you a little bit of wad, and they just expect you to go on your own and stay out of trouble' (Mr H).

The multidisciplinary team also favoured patients being paroled from hospital. In working alongside community services, it was argued there would be more scope to 'help [patients] manage crises more effectively ...' (Psychiatrist). Furthermore, parole from hospital would ensure better continuity of employment and educational arrangements, which, like the provision of housing and social security benefits, are in the nature of key performance indicators linked to independent living and repetition of pro-social skills. All members of the multidisciplinary team were, therefore, disappointed that no patient serving an indeterminate sentence had achieved parole through the mental health route.

At the time of the study, Mr K had received a favourable response from a First-tier Tribunal (Mental health), but a parole hearing was proving elusive. Such delays led one Psychiatrist to note that facilitating patients in their attempts to achieve parole from hospital would require 'unconscionable amounts of money'. Indeed, one patient was subsequently transferred to another hospital, against his wishes, to avoid bed-blocking. Other patients, disenfranchised by the limits of the care pathway, had historically returned to prison of their own volition before treatment was complete. Mr C notes:

[They] lose motivation some people, because they get towards the end [of treatment] and they don't see that parole's gonna happen, so they think I'm just gonna go back to where I started from ... If [Mr K] gets turned down, we're gonna think: well, so where's gonna go back, may as well go back now instead of wasting energy here ...

One related limitation of the pathway was that behavioural courses on the ward were not recognised by the Ministry of Justice. Patients who submitted to the demanding regime did so in blind faith that the Parole Board would deem treatment in hospital and prison to be therapeutically equable:

[B]ecause [treatment is] not recognised, some people do see it as a waste of time. But it's not really; you wouldn't be getting on the courses anyway ... There's a chance. You have to start somewhere and work your way through. (Mr E)

It has been suggested that a patient who is either sent back to prison, or 'chooses' to return, is most unlikely to self-regulate in pro-social ways (Rickford & Edgar, 2009). This is because his return to prison will cause a breakdown in several self-governmental factors, namely: 'loss of faith in the possibility of change'; 'sense of personal failure'; 'sense of betrayal and exclusion'; and 'undermining self-efficacy in previously existing coping strategies' (Jones, 2002).

To put these factors into context: 'loss of faith' relates to the patient's disbelief that the mental health system has the procedural tools in place to offer parole. Sense of 'betrayal and exclusion' is a response to the failure of the system to deliver parole following engagement. The sense of 'personal failure' is indicative of the patient's failed attempt to improve the conditions of his life. And, finally, the disjunct between the patient's responsible behaviour and the custodians' response to him may undermine 'self-efficacy'. Mr L illustrates this point well:

My first week here, I don't know, it was overpowering in many ways. I started helping someone painting the wall, and I started to become conscious, there's so much security in prison, coming here, right, [Mr L], here's your tools. I'm thinking, what's this fucking place about. But it's good. I was realising the responsibility I had.

Consider that highly volatile patients like Mr L, who are removed from the treatment regime against their wishes, have fewer chances to receive the plaudits (or rewards) that result from being perceived as productive, responsible and self-efficacious (the patient as 'painter and decorator'; the 'educated' patient, and so forth). Consequent upon the disavowal of key performance indicators and the inability of the patient to determine his future, he is likely to feel 'confused, lacking in confidence, or worthless' (McMurran & Theodosi, 2007). The behavioural consequence is that he is primed for what Foucault refers to as an 'after the event reaction' (1982, p. 225).

For example, prior to his admission to the personality disorder ward, Mr L was transferred from a category B prison to a therapeutic community for treatment. Four months into the programme, he was discharged back to HMP Nottingham, because his high PCL-R suggested to staff that he would benefit from treatment if it was administered in a highly structured regime. Powerless to

influence the decision of his custodians, his ‘after the event’ reaction was to threaten suicide and instigate a large-scale prison riot. The fact that he subsequently denied having taken part in that riot is further evidence of his shift to violent, anti-authoritarian forms of self-efficacy, consequent upon a breakdown in positive self-governance factors. Exposed to the perpetual threat of fellow prisoners (I was always living in fear. You didn’t know what was coming and when), antisocial behaviour was destined to become the principal of his personal safety.

By comparison, upon his admission to the personality disorder ward, he was re-exposed to a zero tolerance policy on aggression, and patient adherence to it. What is interesting is that the multidisciplinary team often assumes that the responsiveness of patients to this rule is part evidence of the potential of treatment to rehabilitate antisocial personalities outside prison. But, for antisocial personalities like Mr L, compliance with the rule is a strategy aimed at avoiding adverse outcomes related to their decision frame to engage:

[H]ere, if you got into an incident with someone, you get aggressive, that other person thinks in their head, I can’t react to this [because I’ll be sent back to prison], so they don’t, so that isn’t gonna fuel me anymore. (Mr C)

This reminds us that in a system aiming to rehabilitate, ‘resistance comes first’ (Deleuze, 2006, p. 74). It also serves to warn us that the primary success of the reformist agenda, whether evidenced in the psychiatric hospital or the prison, lies in its ability to assimilate ‘the transgression of the laws in a general tactic of subjection’ (Foucault, 1979b, p. 272). But, does this mean that antisocial personalities are beyond rehabilitation?

The aim of this paper has been to respond optimistically to this vexed question. Drawing on empirical evidence, it was broadly proposed that legal coercion (external motivation) and the achievement of key performance indicators can improve treatment outcomes, *provided* patients are given the opportunity of parole from hospital. If this ‘mental health pathway’ approach were adopted, it would offer an ideal type solution to reducing high reoffending rates, without needing to refer to the postmodern Foucauldian fiction that psychiatric treatment *imposes* rehabilitation effects. Instead, custodians could speak without cynicism about the ways in which resistive patients actively seek to impress upon them this *possibility*. As Foucault himself once observed:

[B]eggars, poor folks, or simply the mediocre ... appear in a strange theatre where they assume poses, declamations, grandiloquences, where they dress up in bits of drapery which are necessary if they want to be paid attention to on the stage of power. (1979a, p. 88)

On this stage of power, it is plausible that the actors may *one day* act and speak without equivocation. However, under the spotlight’s glare, the

well-versed ‘beggars’ and ‘poor folk’ are likely to be motivated only by the prospect of spare change. And so, whilst we do not deny those who treat antisocial personalities the possibility of rehabilitation, we remind them that there are those who are particularly adept at learning their lines, in order to improvise their parts.

### **Conclusion**

The antisocial personality is solely motivated by self-interest. To achieve his desired ends, he ‘actively intrudes upon and violates the rights of others, as well as transgresses established social codes through deceitful or illegal behaviours’ (Millon & Davis, 1996, p. 444). Whilst the result is often harmful to others, the absence of ‘painful or egodystonic’ symptoms means that it is illogical for him to engage in treatment to address his interpersonal exploitativeness (Reid & Gacono, 2000). When he is convicted of a violent crime, we are, therefore, faced with a difficult choice: treatment or incapacitation? After April 2005, the antisocial personality who commits a dangerous crime is faced with the same ‘choice’. One effect of the IPP, under the Criminal Justice Act 2003, is he is unlikely to be paroled unless he engages with treatment in prison. If he is subsequently diagnosed with ASPD *and* is ‘treatment seeking’ (NICE, 2010), he may be offered hospital treatment. The available statistics reveal that those with ASPD are the most likely group to consent to treatment in hospital (MHAC, 2008).

The aim of this study was to explore this counterintuitive phenomenon, and to examine if hospital treatment results in changes in the patient’s self-understanding. It was argued that treatment-seeking behaviour in hospital would be predicted by scarce prison resources, linked to prolific use of the indeterminate sentence. It was hypothesised that patients would present the image of pro-social behaviour in order to improve their chances of securing parole (external motivation). What was found (on the balance of probabilities) was that patients’ strategic poise also extends to pre-emptive tactics used to dispossess others of this negative preconception. For example:

My motivation ... it starts off by ‘oh, I want to get parole, and I want to get out’, and all the rest of it, then, you come here and you get into the programme and it changes to the motivation of changing your life. It’s a personal journey, you know. You come to understand that the person you are can’t survive outside ... (Mr K)

Rather than cite this as evidence of untreatability, it was shown that external motivation (legal coercion) is an important prerequisite to exposing the patient to what might be an effective ‘treatment dose’ over time. It was then concluded that readmitting the patient to prison, either on treatment completion or at his behest (because he has become disillusioned that treatment will lead to parole), undermines this process for two reasons. First, if the patient is returned

to prison, there is the potential for (violent) reaction deviance. Second, after-care from hospital favours the consolidation of what is known as 'key performance indicators': independent living, employment, educational achievements and so forth (Hollin, 1995). These may incentivise the patient to act in pro-social ways in the community to safeguard the benefits accrued during hospital treatment. Upon reaching a notional 'treatment dose', pro-social behaviour may become self-regulating, thereby reducing the likelihood of reoffending.

However, this raises the important issue of temporal contingency: just how long is long enough? That we do not, or cannot, know the answer to this question belies the claim that there is *now* 'a strong case for investing in rehabilitation' (Ministry of Justice, 2010, p. 4). For, although the rehabilitative intent of the indeterminate sentence may seem modern, it is in fact no more than a renewal of early 1990s government policy directed at improving the 'quality of life' of inmates through delivery of structured programmes (HM Chief Inspectorate of Prison, 1993). Then, as now, the promise by behavioural sciences that rehabilitation is possible justifies the tacit assumption in government policy that 'on the soft fibres of the [offender's] brain is founded the unshakable base of the soundest of Empires' (Foucault, 1979b, p. 103). The problem is that the *goal* of individualisation and totalisation only makes sense because of the consistent refusal of the antisocial personality to accept the logic of bio-political controls. Yet, this coextensivity is rarely discussed. For example:

Many prisoners were crying out for 'rehabilitation' and for 'courses'. Some were very positive about such courses and others were scathing, demanding a more individualized approach to their offending behaviour. Most, however, seemed to want to stop offending, and wanted 'the prison' to help them achieve this. This appeared to us to represent both a genuine wish by many prisoners to change their lives and find new ways of thinking, as well as successful domination by 'responsibilization' and self-governance penal strategies (which include enforced participation in 'tackling offending behaviour' programmes). (Liebling, 2004, p. 316)

By comparison, those who believe, like the current author, that the political 'double bind' is poor in form and sparing in methods will reason that legal coercion better explains offenders' will-to-engage in treatment. Actually, *producing* behavioural change first requires honest recognition of this.

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