THE REHABILITATION OF PERSONALITY DISORDERED OFFENDERS: A FOUCAULDIAN ANALYSIS

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ABSTRACT

This empirical thesis explores the way in which the lives of offenders with personality disorder are governed in society. It is a socio-legal examination of decision-making under section 47 of the Mental Health Act 1983, which sanctions the transfer of offenders with mental disorders from prison to secure psychiatric hospitals for the ostensible purpose of providing treatment. This study elucidates the relational and extra-personal factors underlying admission decisions to a specific medium secure psychiatric hospital, and evaluates the rehabilitative effects of subsequent treatment on those clients, in light of the widely held belief that the client group are largely unresponsive to treatment.

Previous research looking at admission decision-making to medium secure units has answered similar questions by considering the values, assumptions and contextual pressures shaping psychiatrists’ decision-frames. It is argued that this working method adumbrates our understanding of admission decision-making. Whilst it is undeniable that the psychiatrist occupies a privileged position in the care and control of the mentally disordered (offender), this study uses Michel Foucault’s analysis of power relations to explore the possibility that all individuals – including offenders – may direct the conduct of others through the implementation of strategy. This study, therefore, posits that the accounts of professionals other than psychiatrists, who also make up the multidisciplinary team, and clients themselves, are equally important to our understanding of admission decision-making under s.47 of the 1983 Act. It is
submitted that this will also provide for a richer account of the therapeutic
effects of treatment on the client group.

In terms of structure, Part I of the study discusses what is meant by the
governance of personality disordered offenders. It contextualises the research
agenda by reference to the legal and philosophical salients. Part II of the study
delivers, discusses and critiques empirical findings, before offering tentative
conclusions.
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This socio-legal, empirical study examines how and why decisions are taken to transfer personality disordered offenders from prison to a named psychiatric hospital for treatment under mental health legislation. Drawing on first hand accounts of those who have been transferred and the medical staff treating them to, this study explores whether the client group can be rehabilitated.

Personality disorder (PD) forms the focus of this study because it is both fascinating and contentious. As a medical diagnosis, it continues to divide opinion over whether it can be treated. Many professionals are unwilling to work with those with PD for this reason, and those who do often become disenfranchised with the complex and fractious behavioural tendencies presented by their patients. The result is that many with PD are supported by families or other carers in the community; primary care becomes a fringe effect of the disorder; and secondary care (in either general or psychiatric hospitals) is reserved for notable instances of actual or threatened self-harm. However, in rare cases, the lack of support, care and / or detention will result in either possible violence to others or related criminal conduct. Indeed, many offenders in prison have either been diagnosed, or would meet a diagnosis of, PD.

Since 1992 it has been Government policy to recommend that ‘mentally disordered offenders should, wherever possible receive care and treatment from
health and personal social services rather than in custodial care'. That is, they should be “diverted” out of the criminal justice system and into hospital for the purposes of treatment, and rehabilitation. Under the Mental Health Act 1983, diversion can take place at either the point of sentencing or during an offender’s custodial sentence. In reality, statistics show that it is much more likely to occur during a sentence of imprisonment. For this reason, this study concentrates on the mechanics and rehabilitative potential of diversion from this point on.

It will be seen that a series of factors have the potential to delimit ‘effective’ diversion. In 2009, the Bradley Report noted a number of procedural, contextual and relational factors complicating effective diversion and treatment. These include (but are not limited to): the availability of resources to ensure diversion takes place; the complexities of decision-making between various medical professionals and offenders; the willingness of professionals to engage with personality disordered offenders; the fallibility of accepted markers of treatment success; and the operation of statute, policy and rights-based discourse which intersect these various elements of ‘diversion law’.

From a methodological point of view, this study employs Michel Foucault’s analysis of governmentality. The relevance of Foucault to this study will be discussed further in subsequent chapters; however, it suffices here to note that Foucault provides an appropriate and useful framework according to which one might discuss the factors surrounding diversionary law provided by Lord Bradley’s analysis. More specifically, Foucault’s analysis of law encourages

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us to see (diversion) law not only as ‘a determinate and contained entity’ imposing limits and restraint on excesses of power that result, for example, in the practice of psychiatry (the rights-based agenda), but also as ‘responsive to what lies outside or beyond its position…’³

Lying ‘outside’ law in systems of ‘government’ is the total of social interactions (“power relations”) in time and space. Space, at least in the Foucauldian sense of the word, should be understood to mean wider society as well as the architectural units of, for instance, the psychiatric institution and prison. Within these institutions, discourse ‘produces’ subjects, including the madmen,⁴ sexual deviant,⁵ delinquent,⁶ and the personality disordered offender. The discourse common to the creation of these subjects is psychiatry. Within a system of government, the aim of psychiatric discourse is to normalise the marginalised; the aim of the marginalised, so the story goes, is to be normalised.

However, Foucault tells us that resistance, strategy and conflict (‘petty calculations, clashes of wills, meshing of minor interests’)⁷ are endemic to the social order. Competing claims by other discourses, such as psychology, to be better able to normalise, or rehabilitate, psychiatric patients make the truth-claims of psychiatrists open to criticism. In the modern era, this is made more likely by the fact that treatment in psychiatric hospitals is usually of a multidisciplinary character (i.e. it also involves input from psychologists and

nurses). Nevertheless, researchers who have previously explored the complex question of why decisions are reached to admit (personality disordered) offenders from prisons to hospitals have focused only on the accounts of psychiatrists. Following Foucault, it is argued that a wider survey of professional approaches to the decision-making forum is called for.

Moreover, the same researchers should be equally attentive to the potential for offenders to influence professional decisions, without more. Whilst the ‘madman’ is an outsider ‘par excellence’ with regards the discourse which gives him his namesake, the ever-present potential for the marginalised to resist the social order imposed by psy-professionals raises the possibility that personality disordered offenders may not be seeking transfer to hospital for the therapeutic reasons they portray to professionals.

Foucault usefully grounds this point in his discussion of the “confessional”, or the notion that the marginalised recognise their ‘otherness’ in society, and will confide in professions this fact in order to submit to normalisation techniques (self-government). This mechanism is especially relevant to personality disordered offenders, for the mainstay of treatment for them is, broadly, talking therapies. Talking therapies rely on honesty and the offender’s belief in their being other; this means that if the offender’s confession prior to admission is unsafe, talking therapies may be less successful in creating an alternative self-understanding.

Therefore, Foucault provides a framework by which the personality disordered offender can be seen as both potentially receptive (docile) and

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resistant to psychiatric treatment. Of course, how docile and resistant they are in reality will tell us a great deal about the potential to rehabilitate them.

Against this backdrop, this study is divided into two parts. As a prelude to the empirical heart of this study, Part I considers the theoretical and practical matters outlined in detail above. Chapter 1 sets the scene by introducing personality disorder in all its legal, social and medical guises. Chapter 2 is more theoretical and discusses Foucault’s ‘macro’-level analytics of power-as-government. It draws on important Foucauldian terms of reference: namely, power relations, resistance, government (bio-power), discipline, the confession and self-government – and consider limitations shored up by his account both in its own right and through its application to the personality disordered offender. Chapter 3 moves to a more ‘micro’-level analysis of power relations and resistance. It examines power dynamics within multidisciplinary psychiatric teams, and considers how they reach decisions to admit individuals to hospital (from prison) for treatment. The chapter then incorporates the patient within this ‘professional’ forum. It provides evidence of the strategic ways in which patients are able to manipulate professional decisions, and considers whether this has a detrimental, if not fatal, influence on the potential to rehabilitate them.

Part II of the study explores these themes by reference to original empirical data. Chapter 4 details the methods and methodologies employed to analyse the decision-making practices and the effects of a treatment regime on a named personality disorder unit (PDU) in Leicester, England. Pursuant to this, Chapter 5 describes the relational and practical factors underpinning how the multidisciplinary team reached its decisions to admit personality disordered
offenders for treatment during the study. Chapter 6 is more patient-centric. It examines what impact the personality disordered offender’s ‘approach’ to the decision-making forum has on the multidisciplinary team’s decision as to whether or not to admit him. Chapter 7 describes the psychiatric regime to which the client group are admitted. The focus here is to understand whether, and if so to what extent, treatment results in the adoption of more pro-social behaviours. At no point is it suggested that this is a simple question to answer; it is merely suggested that one must try.
PART I

GOVERNING PERSONALITY

DISORDERED OFFENDERS
Chapter 1

Personality Disordered Offenders: Conceptions and Orientations

The subject is either divided inside himself or divided from others. This process objectivises him. Examples are the mad and the sane, the sick and the healthy, the criminals and the “good boys.”

Michel Foucault (1982)\(^1\)

1.1 Introduction

In this brief, cloaked statement, Foucault reveals much about the main themes of this empirical study. At its root, he is asserting that society has become imbued with systems, such as the psychiatric hospital and prison, which single out subjects in order to normalise their aberrant behaviours. Within these systems, certain discourses are accepted as truth, and the ‘divided’ accept their domination, without a voice of their own. Only their “confession” is taken to be important by professional. Foucault notes:

> The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships and love relationships, in the most ordinary affairs of every day life, and in the most solemn rights; one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles.\(^2\)

In the case of madness, if decisions are to be reached about how best to care for and treat the subject-service user, the confession must be interpreted. This privilege is reserved for the agents of the human sciences – principally

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psychiatrists – with ‘a sort of pressure and something like a power of constraint on other discourses’.³

As presented, this short abstraction – the dichotomisation of madness and health in society and knowledge-mediated power – a Foucauldian analysis of power shores up a number of relevant and practical questions central to this study. Principal among them: how should patients’ position within this potentially dominating framework of treatment be seen? Are patients passive recipients of care who blindly assume their rehabilitation to be in their best interests? Is the patient really marooned in a sea of medical power? Does the power of psychiatry constrain other interested professionals in decisions pertaining to the service user’s care? Can professionals external to the dominant discourse tell us anything about how decisions are reached in the (forensic) mental health system?

These are some of the key questions to be addressed in this study. At its heart, it is a study about the real lives of patients, and those professionals who treat them, within two sometimes complimentary, but equally juxtaposing, systems of the prison and psychiatric ward, under the respective jurisdictions of the criminal justice and mental health systems. It is a socio-legal study which animates the apparently simple question of what one means to speak of rehabilitating mentally disordered offenders.

To be more specific, this study concentrates on a particular form of mental disordered offender: namely, antisocial personality disorder.⁴ This group of

⁴ A useful working definition of (antisocial) personality disorder is ‘Severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption. Personality disorder tends to appear in late childhood or adolescence and continues to be manifest into adulthood.’ World Health Organisation (1992) The ICD-10
offenders has been chosen because the diagnosis is inescapably contentious. Many medical professionals believe it should not constitute a medical diagnosis, and those who choose to work with the client group are sometimes obliged to concede that many, if not most, are unresponsive to treatment. As a result of pervading beliefs about their untreatability, many with antisocial personality disorder have, hitherto, been left at-risk in the community, sometimes committing devastating crimes. This has contributed to the high numbers of individuals with personality disorder in prisons, many of whom have little chance of being released.

A minority of personality disordered offenders are subsequently transferred, or diverted, from the prison estate to secure psychiatric facilities under the Mental Health Act 1983 for treatment. This legal disposal is the focus of the current study, which considers and contributes to the enduring debate of whether or not this group of offenders respond to treatment. To ground this debate, this chapter introduces the relevant medical, legal and practical problems associated with personality disorder and personality disordered offenders. There will then be discussion of the relationship between talking therapies, the preferred form of treatment for this group, and consent. It will be seen that rarely do members of this client group submit to treatment of their own volition. Yet, forcing the patient to “confess” during therapy is pointless. This raises an interesting paradox in situations where consent is forthcoming: namely, why have [they] confessed at all?

1.2 What is personality disorder?

Personality disorder (PD) is a relatively new diagnosis. Prior to 1980, the wider behavioural characteristics now associated with certain forms of PD were assimilated within the narrowly defined diagnosis of psychopathy. Psychopathy was first described by Philippe Pinel in 1801 as *la folie raisonnante* (‘insane without delirium), and was subsequently developed by Hervey Cleckley. Robert Hare embraced Cleckley’s construct of psychopathy, and, through a series of prison case studies, developed the psychopathy checklist (PCL-R) that remains a diagnostic tool in medicine today. The PCL-R will be discussed further below. The point to be made here is simply that few patients, or offenders, will meet the diagnostic threshold for psychopathy; it is much more likely that they will receive a diagnosis of antisocial PD.

The diagnostic preference for antisocial PD was introduced by the third edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorder*, which conceptualised a new PD, or a ‘clinically significant behavioral or psychological syndrome’. Psychiatrists now usually identify PD – including anti-social PD – according to two general psychiatric references: the fifth edition of the *Diagnostic and Statistical Manual of Mental

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Disorders (DSM-IV-TR)\(^9\) and the International Classification of Diseases of the World Health Organisation (ICD-10).\(^10\) Accordingly, there are now ten recognised types of PD which may differ markedly in their clinical presentations. The ICD-10 arranges forms of PD into three clusters:\(^11\)

- Cluster A: the ‘odd or eccentric’ types: paranoid, schizoid and schizotypal;
- Cluster B: the ‘dramatic, emotional or erratic’ types: histrionic, narcissistic, antisocial and borderline; and,
- Cluster C: the ‘anxious and fearful’ types: obsessive-compulsive, avoidant and dependent.

A degree of overlap between the clusters, and indeed types, of PD is commonplace. To accommodate this, the DSM-IV-TR specifies an eleventh category of PD, not otherwise specified, for those people whose symptoms straddle several forms.\(^12\) What this eleventh category shares with diagnostically-superior forms of PD is that dysfunction will have been identified in two (or more) areas of personality:\(^13\)

- Cognition (i.e. ways of perceiving and interpreting the world);
- Affectivity (i.e. the range, intensity, lability, and inappropriateness of emotional response);
- Interpersonal functioning difficulties; and,
- Impulse control.

The dysfunction will be enduring and deviate ‘markedly from the individual’s culture’.\(^14\) This is an important caveat to diagnosis, since the dividing line between personality dysfunction and accepted (or acceptable) behaviours such

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\(^10\) Supra n.4.

\(^11\) Ibid., p. 629. For useful case studies of behaviour falling within the individual clusters, see NIMH(E) (2003) Personality Disorder: No Longer a Diagnosis of Exclusion, pp. 10-11.

\(^12\) Op cit, p. 629.

\(^13\) Ibid., p. 633.

\(^14\) Ibid.
as eccentricity, shyness, melancholia, egoism and aggression might otherwise be difficult to draw.

In one prominent study exploring illness recognition for narcissistic, paranoid and obsessive-compulsive disorder among lay-people, narcissistic PD was least recognised as a psychological ‘illness’, indicating that professionals are more willing to diagnose more ‘conventional’ diagnoses such as schizophrenia and obsessive-compulsive disorder. Further evidence of professional unease with PD was similarly displayed in 2009, when the journal *Personality and Mental Health* ran a full issue dedicated to highlighting medical professionals’ views regarding the retention of borderline personality disorder (BPD) as a psychiatric diagnosis. Among the discussants, Peter Tyrer opined – controversially for some – that it should remain a mental disorder but be re-classified as a mood disorder. Nevertheless, he concluded:

…it is loyalty, and the fear of abandoning a loved friend, rather than science that is holding BPD within the family of other personality disorders.

There is some truth to the notion that psychiatry determined for itself what constitutes PD. That said, the process by which psychiatry came to be in a position to discern normality from dysfunction is far more complex than this.

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16 Defined as ‘a pervasive pattern of instability of interpersonal relationships, self-image and effects and marked impulsiveness that begins in early adulthood, is present in a variety of contexts, and is manifested in frantic efforts to avoid real or imagined abandonment, including self-mutilation or self-harm’. *Ibid.*
prosaic statement suggests. Andrew Ingleby sums up this complexity well. His position is that, in contrast to the class domination thesis inherent to Marxism and the labour of medical dynasty relied on by the anti-psychiatry movement, psychiatrists are not their own masters but ‘operate by virtue of a mandate’. The nature of this (latent) mandate focuses many legal and ethical problems at the heart of the complexities inherent in the social control functions of diagnosing a person with PD. However, this more esoteric claim should not be overstated at this point; there is no question that the low incidence of PD in society suggests that there is a distinction to make between ordinary and abnormal personality.

Based on the categories contained within DSM-IV-TR, the most common forms of PD in America are avoidant (5.2 per cent of the general population), borderline (1.6 per cent) and antisocial (1.0). In England, obsessive-compulsive PD is the most prevalent (2.6), followed by paranoid (1.2) and then the borderline and antisocial forms (1.0). It is undoubtedly the case that these figures are much lower than the commonly cited figures of 1 in 3 who will suffer from mental illness at some point in their life. What separates PD from other psychiatric disorders is arguably its greater negative impact on those around them, and therefore on society. This is particularly true of antisocial PD, which is highly prevalent in the penal system. Given that this work is concerned with the rehabilitation of personality disordered offenders, reference to antisocial PD is especially important. In this context, it is a reoccurring

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theme that the distinction between rational and disordered criminal conduct is often difficult to discern.

1.3 Antisocial personality disorder

1.3.1 The appearance of vice and disorder

Like other forms of PD, there are many definitions of antisocial PD (ASPD), simply because there are many potential expressions of antisocial behaviour. Current guidelines issued by the National Institute for Clinical Evidence (NICE), however, observe that those with ASPD ‘consistently exploit others and infringe society’s rules for personal gain as a consequence of their personality traits’. The ICD-10 states that those with a diagnosis of ASPD will have displayed a ‘gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations’ from late adolescence. Often, however, there will be a history of childhood misdemeanour (such as animal cruelty and aggressive tendencies); s/he may have a criminal record, and may seem incapable of responding to punishment. If psychiatric intervention has been deemed necessary, s/he may have also received a prior diagnosis of conduct disorder or oppositional defiant disorder during childhood. Once the child has reached at least 15 years of age, the DSM-IV sanctions the diagnosis of ASPD if three (or more) of the following enduring behaviours is present:

25 ICD-10, supra n.4, p. 204.
26 DSM-IV-TR, supra n.9, pp. 645-50.
Failure to conform to social norms;  
Deceitfulness;  
Impulsivity;  
Irritability or aggressiveness;  
Reckless disregard for safety of self or others;  
Consistent irresponsibility; and,  
Lack of remorse.

The clinical features of ASPD strongly resemble those warranting a diagnosis of psychopathy. Unlike ASPD, however, a diagnosis of psychopathy will only be made if the criteria of the Psychopathy Checklist (PCL-R) are made out. The PCL-R measures affective-interpersonal traits (Factor 1) and behavioural or antisocial lifestyle criteria (Factor 2) identified as core traits (see further Chapter 5). These core traits are construed according to four, again, widely construed categories: namely, interpersonal factors (superficial charm, grandiosity, pathological lying, manipulation); affective factors (callousness, lack or remorse, shallowness, failure to accept responsibility); impulsive lifestyle (impulsivity, attention seeking, irresponsibility); and antisocial conduct (general rule breaking).  

Interestingly, the legion symptoms associated with psychopathy (and, therefore, ASPD) appear thematically linked to Aristotean writings of unscrupulousness, which have more a tenor of strategic ‘immorality’ than disorder. Theophrastus, a student of Aristotle, writes:

The Unscrupulous Man will go and borrow more money from a creditor he has never paid... When marketing he reminds the butcher of some service he has rendered him and, standing near the scales, throws in some meat, if he can, and a soup-bone. If he succeeds, so much the better; if not, he will snatch a piece of tripe and go off laughing.

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This crafting of abnormality from normality has led one legal commentator to claim that the diagnoses of ASPD and psychopathy is confounding in the sense that ‘…mental disorder is inferred by from [his] anti-social behaviour while the anti-social behaviour is explained by mental disorder’.\textsuperscript{29} Difficulty with the tautologous nature of ASPD is also noted in the medical community. For instance, Henry Maudsley described psychopathy as ‘a form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical intervention’.\textsuperscript{30} By comparison, Talcott Parsons draws a distinction between crime and mental disorder on the basis that crime is ‘motivated’ and mental disorder ‘unmotivated’ deviance,\textsuperscript{31} insofar as mental disorder does not result from one’s own ‘sentiments’.\textsuperscript{32} However, by ignoring that mental disorder may lead to crime in rare cases, his account fails to consider the issue of moral responsibility that is written into the criminal law. In the vast majority of cases, the potential negation of culpability will not be at issue at trial; instead, the issue for the judge will be whether to take the offender’s mental disorder into account when passing sentencing. This will, broadly speaking, determine whether punishment (in prison) or treatment (in hospital under the Mental Health Act 1983) is the appropriate legal response to the personality disordered offender.

Statistics show that the majority of offenders with ASPD receive a custodial sentence. This contributes to the high rates of ASPD in the penal system (49

per cent male and 37 per cent of female). Nevertheless, ninety per cent of prisoners suffer from at least one form of mental disorder. For some commentators, this demonstrates that ASPD is not ‘synonymous’ with offending. Others, unmoved by the statistics, assert that it is right that those with ASPD be ‘managed in the criminal justice system’ rather than the mental health system.

This assertion is borne of two related factors that have created a feeling of nihilism in the profession: first, the increase in ASPD in the penal system is a bi-product of failed attempts to engage the individual in treatment in the community; and, second, professionals have found that treating this group of offenders in specialist treatment settings has not had the impact hoped for.

### 1.3.2 Risk and Dangerous and Severe Personality Disorder

Although there is a lack of robust evidence, it is a commonly held belief that the large-scale closure of psychiatric hospitals in the 1970s and 1980s and

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subsequent reliance on community care led to increased rates of mental disorder, and ASPD, in prison:\(^\text{36}\)

Many prison staff have a strong belief that…the criminal justice system has been used by society to deal with the presentation of mental health on the streets. Rather than address need through a mental health system these people are now housed in prison.

It has been evidenced elsewhere that material factors such as homelessness, unemployment and debt contribute to the commission of crime by those with mental disorder who are at-risk in the community.\(^\text{37}\) Poor community care has also led to a greater visibility of people with mental disorder who, in rare cases, pose a serious risk of future violence to the public. For those who subsequently committed a serious crime, ASPD (or, less often, psychopathy) was often implicated as a cause. One devastating example was provided in the case of Michael Stone.

Stone’s background was particularly fraught; he had a police record dating back to the age of 12, and a fairly prolific adult criminal career. He was gaolod in 1981 for robbery and grievous bodily harm; in 1983 for wounding and dishonesty; and in 1987 for armed robbery. On release in 1994, he was shortly thereafter ‘sectioned’ under the Mental Health Act 1983 (civil section) owing to fears that he presented a real risk of harm to the public. Nevertheless, he was discharged into the community when he failed to engage with treatment. It is well known by now that he went on to commit crimes of peculiar brutality. During the inquest that followed, Ruth Carnall, Chief Executive of the relevant


hospital, defended the decision to release Stone. She pointed out that Stone although had a severe PD and was considered dangerous, his condition was untreatable, which meant there was no authority to detain him under the 1983 Act (section 3). Carnall went on to describe Stone as a classic “psychopath”, incapable of feeling guilt or empathy.

The general result of crimes committed by Stone and other dangerous individuals who also had a mental disorder (such as Beverley Allett, Horrett Campbell and Christopher Clunis) was to increase the reach of professional accountability for decision-taking in the late 1990s. Commentators exploring this phenomenon cite the birth of a blame culture as occurring during the 1970s. The focus of culpability, and subsequently protectionist idealism, was on the effects of actions taken by governmental agencies and businesses on individuals, which had decisive risk-effects: 38

…we are almost ready to treat every death as chargeable to someone’s account, every accident as caused by someone’s criminal negligence, every sickness a threatened prosecution. Whose fault? is the first question… What restitution?

Displays of risk-thinking and risk-acting arose in several contexts: for example, empirical research has shown that police, as distinct from being crime solvers, are now expected to prevent the chances of antisocial behaviour and crime from materialising. 39 In respect of mentally disordered offenders, the protectionist agenda saw a shift from an emphasis on penal welfare programmes during the 1970s (allied to a faith in the possibility of rehabilitation) to protectionist mechanisms. David Garland cites this as further

evidence of a ‘culture of control’ endemic to Western societies.\textsuperscript{40} According to Garland, the overarching justification of increased control is ‘need for security, the containment of danger’, and the dominant result is penal policy orientated towards ‘the identification and management of risk of any kind’.\textsuperscript{41}

One tangible result of public protectionist agendas is that prisoner numbers continue to rise. In response to this overwhelming increase, the government has developed specialist treatment services outside of the criminal justice system for those offenders who have a mental, or more accurately personality, disorder.

The Dangerous and Severe Personality Disorder (DSPD) national pilot was launched as an alternative to penal treatment for offenders with severe PD in the high secure estate. However, in reality DSPD services have acted as a guise for prolonged detention, often being imposed under mental health legislation (see 1.4 below) once offenders reach their earliest date of release from prison. Bracketing the question of the ethical problems that a conflation of rehabilitation and incapacitation creates, the key point here is that DSPD services were only ever going to operate thus.\textsuperscript{42}

Prior to its national roll-out, the Ministry of Justice stated that DSPD services would be for those offenders presenting a ‘high risk’ of committing (further) offences who needed to be ‘managed and treated through the appropriate pathways of care’.\textsuperscript{43} In its \textit{Planning and Delivery Guide} that

\textsuperscript{40} Garland, D. (2001) \textit{The Culture of Control: Crime and Social Order in Contemporary Society}. Oxford University Press.
\textsuperscript{41} Ibid., p.12.
\textsuperscript{42} Prior to its partial decommissioning, the DSPD pilots website had as its motto: ‘Ensuring the public is protected from some of the most dangerous people in society’: \url{www.dspdprogramme.gov.uk}.
followed, it was stated that admission decision-making should be based on the following criteria:

- ‘Whether the individual has mental health needs that can be best met in a hospital environment; and,
- Whether an individual is near the end of their sentence and is likely to require continued detention under mental health legislation in order to complete treatment.’

In the aftermath, psychiatrists complained that DSPD would be no more than a legal expedient which threatened to change the role of psychiatrist from ‘treating the sick, to social control’. However, Moran is right to remind us that psychiatric nihilism itself facilitated this unwelcome shift in policy:

Politicians and civil servants invented dangerous and severe personality disorder (DSPD) in 1999. The announcement of a new service coincided with the conviction of a notorious offender, Michael Stone, but it is a mistake to attribute too much significance to this piece of political theatre. The true motivation was not a single case but longstanding frustration within government at the refusal of psychiatrists to address the problem of high-risk offenders with personality disorder. The profession was seen as cynically hiding behind the 'treatability' clause in the Mental Health Act 1983 in order to avoid responsibility for dangerous and difficult patients.

Antagonists of the DSPD pilot who warned that [its] ‘success’ would be down to the ‘connivance of psychiatrists’, presumably breathed a sigh of relief when the pilot scheme began to demonstrate a number of contextual and practical problems including prohibitive operational costs, and limited patient

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44 Ibid., p. 10.
45 The notion that such offenders would have received treatment in prison is, of course, open to question.
49 Whilst precise figures are scarce, in a study of one DSPD unit it was found that between 2002/03 the mean cost of providing care over a 6 month period was £65,545 per person:
capacity of 300 prisoners. Research also pointed out that only 15 per cent of the prison population who satisfied the DSPD admission criteria were admitted for treatment. But perhaps the greatest concern has been that reoffending rates following treatment in DSPD services have been disappointingly high, especially given the high operational costs associated with the service.

Sensitive to these practical (and ethical) shortcomings, in 2009 Lord Bradley called for ‘an evaluation of the DSPD programme to ensure it is able to address the level of need’. The Government responded by publishing the Personality Disorder Strategy. The Strategy, though specific in its target population, more generally encapsulated the Government’s general re-assertion of reformist principles that there is ‘a strong case for investing in rehabilitation’. Nevertheless, amid the rhetoric of ‘Rehabilitation Revolution’ that surrounded the Strategy, there was of course a much more difficult and elusive question that had to be considered:

How can we reshape services to provide more effective treatment for those offenders with severe forms of personality disorder?


Antisocial Personality Disorder, supra n.7, p. 29.


In one study, for instance, 41 per cent of the offender sample (n = 1,353) went on to reoffend within approximately two years after discharge: ibid., p. 4.


Ibid., p. 39.
1.3.3 Antisocial offenders in the contemporary penal system

1.3.3.1 The ‘Personality Disorder Strategy’

In recognition of the limitations of DSPD services, Ministers agreed that funding for NHS-based forensic treatment should be re-allocated to co-ordinate and consolidate a more comprehensive system aimed at treatment and the reduction of risk.\(^57\) The Personality Disorder Strategy argued for the creation of more comprehensive, and effective, services from ‘community-to-community’ across varying levels of security. Central themes would be: new and effective services; joined-up thinking; long-term management; and early identification.\(^58\) According to the Strategy, DSPD pilots will be removed between April 2011 and 2014. Instead, the bulk of high secure treatment services, ‘other than in exceptional circumstances’, will be provided within the criminal justice system (two secure services, ‘at least’ four therapeutic communities and ‘accredited behaviour offending programmes’).\(^59\)

A thorough critique of this Strategy is beyond the scope of the current study. Nevertheless, two positive general observations can be made about the proposal to locate more treatment within prisons. First, prisons are cheaper per inmate than hospitals,\(^60\) meaning that more resources could be made available to greater numbers if services were marshalled into prisons.\(^61\) Second, insofar as few offenders with PD currently benefit from specialist services outside the criminal justice system, ‘internal’ arrangements might enable more offenders to

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\(^{57}\) Ibid., p. 1. See also, The Personality Disorder Strategy, op cit, p. 1.

\(^{58}\) The Personality Disorder Strategy, ibid., p. 2-3.

\(^{59}\) Ibid., p. 5.

\(^{60}\) Blurring the Boundaries, supra n.36, p. 62.

\(^{61}\) The Ministry of Justice suggest that treatment capacity for those with severe forms of PD could be increased from 300 (the total capacity of current DSPD services) to 570, ‘mostly in prisons’: Breaking the Cycle Evidence Report, supra n.55, p. 37. No mention is made in this document about the potential merits of treatment outside of the criminal justice system (see below).
be accommodated within a rehabilitative model (though it is not clear to what effect). However, a distinctly problematic aspect of the proposal is that it seems to side step the preference for indeterminate sentencing that has resulted from the introduction of the Criminal Justice Act 2003 under the Labour government. The effect that the CJA 2003 has had on the lives of offenders with ASPD cannot be underestimated (see, in particular, Chapters 6 & 7). Briefly, the reasons will be outlined now.

1.3.3.2 The Criminal Justice Act 2003 – ‘dangerous’ provisions

The Criminal Justice Act 2003, like its 1991 predecessor, does not explicitly deal with mentally disordered offenders. Nevertheless, the Act’s sentencing provisions, particularly those in relation to dangerous offenders contained in sections 224-229, are pertinent here as they provide for swingeing penalties to which offenders with ASPD are prone. This is because the 2003 Act introduces specific sentences for offenders who have committed one of 153 ‘specified’ offences referred to in Sch 15, and who are assessed by the court to pose ‘significant risk to members of the public of serious harm occasioned by the commission of him of further such offences’. The specified offences range from serious sexual and violent offences to less serious crimes such as affray and actual bodily harm. For less serious crimes (that is, those which carry between two and 10 years’ imprisonment), an extended sentence was introduced (s. 227). For an offence which carries a maximum penalty of life imprisonment, the sentence of life imprisonment remained appropriate (s. 225(2)). Between the two extremes, for offences carrying a maximum penalty

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62 Section 229(1)(b)
of 10 years or more, an indeterminate sentence for public protection (IPP) was introduced for those over 21 years of age.63

Amongst these sentences, the IPP is notably coercive. The court will set a minimum term (“tariff”); thereafter release depends on the Parole Board assessing that it is safe to release the offender.64 However, to demonstrate suitability for parole, the (personality disordered) offender is expected to have engaged, and benefitted from, cognitive-behavioural programmes (a form of talking therapy) in prison. If the Parole Board is not satisfied that the offender should be released, incapacitative restraint will follow.

In reality, the overuse of IPP’s is creating an incapacitative sentence,65 as offenders struggle to obtain the courses they need for parole. And though the number of those sentenced to an IPP has decreased – partly down to the measures introduced by the Criminal Justice and Immigration Act 2008 –66 only 140 offenders had been paroled as of July 5, 2010.67 It is now the case that 46 per cent of prisoners serving IPP’s are beyond their original tariff.68 Those who have brought judicial proceedings, complaining that this breaches

63 Section 225(3). For those under 21 years of age, the sentence would be Detention for Public Protection: s.226.
64 In released, it will be on an IPP licence. The effect of this is that the offender can be recalled to prison if they are deemed to present a danger to the public. However, the offender may have the licence cancelled after 10 years in the community. See HM Prison Service (2009) Indeterminate Sentence Manual (formerly Lifer Manual). PSO 4700, para. 1.17
65 As of July 2010, 6,130 offenders had been made the subject of an IPP, and this figure continues to rise. Figures rounded to the nearest 10: Breaking the Cycle Evidence Report, supra n.55, p. 13.
66 Sections 13 to 18 of that Act remove the rebuttal presumption of dangerousness where the offender has committed a previous violent or sexual offence, and afford the judiciary greater sentencing powers; and the use of IPPs is restricted to cases where the minimum tariff is 2 ½ years. For a critique, see Prison Service Instruction Number 27/2008 (2008) Criminal Justice and Immigration Act 2008, Sentencing Policy Changes. PSO 4700 Lifer Manual & PSO 6650 Sentencing Calculation, p. 11.
68 Ibid., p. 27.
their human rights have been given short shrift.\textsuperscript{69} One result of incapacitative
detention with little opportunity for parole is its deleterious effect on the
already unstable mental health of prisoners.

Evidence of this was provided by the Sainsbury Centre for Mental Health at
around the time of the \textit{Walker / James} cases.\textsuperscript{70} Though the report was unable
to comment specifically on the levels of PD among the IPP population, their
findings make for uncomfortable reading. Based on previously unpublished
data of 2,204 IPP prisoners using the Offender Assessment System (OASys)
(the Government’s prisons and probation risk measurement tool), 66 per cent
were identified as requiring a clinical assessment for PD, compared with 34 per
cent of the general population.\textsuperscript{71} Within the total population of those serving
IPP’s, it was pointed out that most prisoners made a link between the
completing of courses and the achievement of parole.\textsuperscript{72} It is, therefore,
unsurprising that in a survey of offenders in two prisons between a third and a
quarter of prisoners were experiencing acute mental health problems associated
with the ‘stress of helplessness’.\textsuperscript{73}

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\textsuperscript{69} Principally, article 5(4) of the European Convention on Human Rights (the right to a speedy
trial), with the potential to engage art. 5(1)(a) (the right not to be deprived of one’s liberty). In
the seminal case of \textit{Secretary of State for Justice v James (formerly Walker and another); R
(Lee) v Secretary of State for Justice (Respondent) and one other action} [2009] UKHL 22, it
was ruled that delayed detention as a consequence of Parole Board delays would not engage
art. 5. Delivering the leading judgment, Lord Carswell stated: ‘Delays are apt to occur for all
sorts of reasons even in the best-resourced system. Continued detention will only become
unlawful when the Board decides that it is no longer necessary for the protection of the public
that the prisoner should be confined. Until that stage is reached each step that the Board takes
in the review process confirms the lawfulness of the detention.’ See para. 20.
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\textsuperscript{70} (2008) \textit{In the Dark: The Mental Health Implications of Imprisonment for Public Protection.}
London: Sainsbury Centre for Mental Health. \textit{[In the Dark].}
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\textsuperscript{71} \textit{Ibid.}, pp. 38-40.
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\textsuperscript{72} \textit{Ibid.}, p. 33.
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\textsuperscript{73} \textit{Ibid.}, p. 41.
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‘I’ve seen this sentence destroy people, people going off the edge because of what the sentence makes them do.’

Other concerns voiced by those subject to IPP’s was (over) medicating, which, as one offender put it, induced the feeling of ‘walking around the wing like a zombie’. Beyond the common sense arguments against chemical coshing, there is no firm evidence supporting the use of psychiatric medications for individuals with ASPD. By comparison, the provision of cognitive-behavioural interventions is supported by evidence-based treatment guidelines, which, it is argued, demonstrate a ‘small but positive effect’ on offenders with PD.

Noting the contentious effects of the indeterminate sentence, in March 2010 a joint inspection conducted by HMI Probation and HMI Prisons argued that ‘a major policy review should be conducted at the Ministerial level, analysing the costs and benefits of [these] sentences’. The resulting Green Paper, Breaking the Cycle, published in December 2010, does not explicitly engage with the possibility that the IPP intensifies mental health problems (including PD);

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74 In some cases, the intolerability of the prison conditions leads to actual or attempted suicide – and there is every reason to suggest that PD is implicated in the figures. In the absence of more recent figures, Dooley found that in 26 per cent of cases of suicide, PD was implicated: Dooley, E. (1990) ‘Prison Suicide in England and Wales, 1972-1987’. British Journal of Psychiatry, 156: 40-5. In respect of attempted suicides, 57 per cent of respective offenders had PD: Jenkins, R., Bhugra, D., Meltzer, H. et al. (2005) ‘Psychiatric and Social Aspects of Suicidal Behaviour in Prisons’. Psychological Medicine, 35: 257-69.
75 In the Dark, op cit, p. 44.
77 NICE guidelines advocate: ‘For people with antisocial personality disorder with a history of offending..., consider offering group-based cognitive and behavioural interventions... focused on reducing offending and other antisocial behaviour.’ Antisocial Personality Disorder, supra n.4, p. 191.
78 Ibid., p. 181.
80 In the section ‘Managing offenders with mental health problems’, it suggests that previous research ‘indicates’ that 12 per cent of offenders have a ‘mental illness or depression as a long-standing illness’, presumably as distinct from acute problems: Breaking the Cycle Evidence
however, in conceding that the IPP was ‘only intended and expected to be used in a limited number of cases’, it does propose sweeping reform:  

[This] Government intends to restrict the sentence to those who would otherwise have merited a determinate sentence of at least ten years (i.e. at least five years in prison and the remainder on licence). This change ensures that the sentence applies to serious rather than broad categories of crimes and will capture very serious sexual and violent offenders. Offenders who no longer receive an IPP would instead receive a determinate custodial sentence for the crime for which they have been convicted which in serious cases would of course be very substantial... We think that this combination of IPPs in restricted circumstances and often long determinate sentences will enable us to plan rehabilitation more effectively in order to protect the public better.

However well intentioned the proposed reforms, the numbers subject to IPP’s are likely to remain high. Notwithstanding the intention of the Ministry of Justice to reconsider the “test” applied by the Parole Board (that the risk of release is ‘minimal’), the tendency towards ‘robust licence arrangements’ and high recall rates to prison, that have hitherto helped to enlarge prison numbers, will likely continue to do so. As the strain on cognitive-behaviour treatment resources continue to be felt, this will, in turn, have negative health implications for the prison population. This raises a strong, prima facie, objection to the notion that ‘providing’ treatment for personality disordered...
offenders in prison is preferable to using services outside the criminal justice system specifically designed for that purpose.

1.4 Diversion out of the criminal justice system

1.4.1 The Mental Health Act 1983

1.4.1.1 Specialist (medium-) secure hospitals

In addition to the relational and resource-driven factors discussed above, one further argument in favour of diverting personality (if not all mentally) disordered offenders out of the criminal justice is conceptual:

The primary purpose of a prison is punishment and deterrence together with a secondary purpose of social control. Social control is also a secondary purpose for a secure hospital but its primary purpose is treatment and rehabilitation.

This also shores up a practical limitation of regimes favouring security (over rehabilitation):85

Prison staff are trained to be security staff first and to regard their charges as competent adults. They may well be assisted by therapeutic staff but major policy decisions are always taken in terms of security. Secure hospital staff are also trained in security but they are almost exclusively recruited from the therapeutic professions and have therapeutic skills which can be deployed even in highly dangerous situations. Staffing ratios are also different between prisons and hospital...

It has already been seen that (the soon to be removed) DSPD services pursue the containment of risk over the pursuit of rehabilitation through treatment. The more latent justification for the development of DSPD services was that it would offer an individualised approach to rehabilitation where ‘the individual

84 Ibid., p. 62.
85 Blurring the Boundaries, supra n.36, p. 63.
has mental health treatment needs that can be best met in a hospital environment’.\(^{86}\) In reality, after an *anticipated* stay of between 3 – 5 years, many offenders are simply transferred to medium or low-secure facilities rather than released into the community.\(^{87}\) This means a ‘definitive evaluation’ of the effects of treatment will have to wait until treatment has been received in a new regime.\(^{88}\)

Most offenders will never go to high-secure DSPD services, but will instead receive treatment in medium secure units (MSU’s) at the point of sentencing or during their sentence of imprisonment. The benefits of receiving treatment in MSU’s rather than the penal system are that they can be far more responsive to the needs of offenders. For instance, MSU’s employ multidisciplinary assessment prior to admission to ensure better targeted treatment; they achieve a more favourable ratio of Consultant Psychiatrists to patients (targeted at 1:14); and the provision of treatment is benefitted from multidisciplinary approach, including input from psychiatrists, nurses, psychologists, occupational therapists and social workers.\(^{89}\) Some MSU’s even focus exclusively on admitting clients with PD for treatment, absent to a greater extent the ‘political’ baggage and ulterior motives of the DSPD services.\(^{90}\)

MSU’s have become important spaces for implementing and working through evidence-based guidelines, such as those issued by NICE on the

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87 *Antisocial Personality Disorder*, supra n. 7, p. 29.
88 Ibid.
subject of management and treatment of ASPD. The themes of this research are diverse, but examples include: a review of all randomised controlled trials of psychological interventions, attempts to understand the reasons for treatment non-completion among service users with PD in light of the affective, volitional and cognitive factors they describe, the effects of therapeutic alliance between service users and therapists on treatment outcome, and reading treatment outcomes in light of psychometric pre-admission assessment retrospective data. What these themes share is the aim of constructing ‘models of engagement that are theoretically based and empirically evidenced that can underpin assessment and treatments’. Identifying the work that is done in such units, in contrast to current government policy favouring more ‘internal’ treatment arrangements within the CJS, the NICE guidance recommends.

91 See Antisocial Personality Disorder, supra n.7.
96 Ibid.
97 Particularly, for those offenders who do not pose a grave and immediate danger’ to the public, and who might need a more ‘active pathway of intervention’: The Personality Disorder Strategy, supra n.54, p. 6.
98 Antisocial Personality Disorder, supra n.7, p. 65. Emphasis added.
Where the antisocial personality disorder is suspected and the person is seeking help, consider offering a referral to an appropriate forensic mental health service depending upon the nature of the presenting complaint. For example, for depression and anxiety this may be to general mental health services; for problems directly relating to the personality disorder it may be to a specialist personality disorder or forensic service.

It is not clear from this succinct statement what ‘seeking help’ means – it seems to imply that offenders with PD are motivated to receive treatment in recognition that their aberrant symptoms require psychiatric intervention. Moreover, what seeking help means in the context of how decisions are actually reached to admit such clients is equally unclear. This research explicitly, and empirically, interrogates these complexities in an effort to lend an evaluative lens to evidence-based guidelines amid the suggestion that treatment in (medium-) secure psychiatric settings is favourable for personality disordered offenders.

As a precursor to the discussion of diversion decision-making from the point of view of interactions between medical staff and offenders discussed in Chapter 3 (and closely examined in Part II), it is first necessary to consider the legal mechanisms of diversion and its relationship to the receipt of treatment. Moreover, any contextual and / or ethico-political problems which may preclude the diversion of an offender with mental disorder such as PD must also be explored. One such problem is that of identifying suitable transferees, and it is to this issue which we now turn.
1.4.1.2 The importance of information gathering

In 2008 the government sponsored a review of the extent to which offenders with mental disorder and learning disabilities were diverted out of the criminal justice system for treatment, and the barriers that might preclude this from happening. The subsequent Bradley Report,\textsuperscript{99} found many such barriers, but began, rather ironically, by pointing out the fluidity of the term ‘diversion’ itself. The following working definition was applied:\textsuperscript{100}

‘Diversion’ is a process whereby people are assessed and their needs identified as early as possible in the offender pathway..., thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of the offence.

Elements of the ‘offender pathway’ thus include:\textsuperscript{101}

the structural interaction between criminal justice and health care systems, as determined by mental health legislation and sentencing policies; arrangements for health care within the prison system and the manner in which this impacts on pathways through it...

In substantive terms, the ‘structural interaction’ between the two systems is governed by the Mental Health Act 1983. The 1983 Act bestows a range of powers to the police, psychiatrists and the courts in respect of hospital admission and treatment. Section 136, for example, states that a policeman may convey a person deemed to be ‘in need of care or control’ to a psychiatric hospital for assessment, whether or not that person is implicated in a criminal

\textsuperscript{99} Bradley Report, supra n.53, p. 15.
\textsuperscript{100} Ibid., p. 16.
However, Lord Bradley identified the police stage as being ‘the least developed in the offender pathway in terms of engagement with health and social services’. He noted that barriers to effective assessment include the reliance on self-reporting; lack of standardised screening; lack of police awareness of mental disorder (for which there is little guidance or advice available); and the difficulties of identifying mental disorder when a significant proportion of detainees are under the influence of drink or drugs.

To improve access to health and social care services, it was recommended that police custody suites have access to liaison and diversion schemes run by NHS nurses to enhance screening and identification issues. Upon appropriate assessment, decisions can then be reached about how best to respond to the needs of the individual, and so the public. Typical responses are: release from police custody; bail; remand; or transfer to a psychiatric hospital.

In the event of a prosecution, if suitable information has been gathered from the earliest opportunity there is a greater chance that the courts will be properly informed of the accused’s needs. In cases where the offender has committed a dangerous crime (and, therefore, crosses the custody threshold), following conviction the court is at liberty to decide two general disposals: hospital treatment under mental health legislation or a sentence of imprisonment. For

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102 This is complimented by section 136 the granting a warrant of entry to a person’s home, if that person is believed to be at risk due to a mental disorder.
103 The Bradley Report, supra n.53, p. 34.
104 Ibid., p. 39.
106 A further disposition exists, which combines passing of a sentence with hospital treatment at the same time (the ‘hybrid order’: ss. 45A & B of the MHA 1983, as amended). If the prison sentence has not expired during detention in hospital, the result is that the offender may be released (in conjunction with a first tier tribunal – mental health) with the consent of the Secretary of State. If the prison sentence expires during the time spent in hospital, hospital treatment can only continue under a civil section (principally, section 3). However, the hybrid order will not be considered further for the reason that it has been imposed very infrequently.
those sentenced to imprisonment, there remains the possibility of hospital admission at a later date. In both cases of hospital admission, the rules of Part III of the 1983 Act are relevant.

1.4.1.3 The ‘hospital order’ (section 37)

Before a sentencing judge can impose a hospital order, the contents of a pre-sentence medical report should be considered. Regard will also be had to ‘all the circumstances including the nature of the offence and the character and antecedents of the offender, and to all other available methods of dealing with him’ (s.37(2)(b) of the MHA 1983). The hospital implicated in the hospital order must be able to provide ‘appropriate treatment’ test (s.37(2)(a)), within the meaning of s.145:

‘medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations’.

The ‘appropriate treatment’ standard introduced by the amending Mental Health Act 2007 and implemented in November 2008 replaced the inelegant, and in some respects obfuscatory, ‘treatability test’. The revised substantive standard reflected the government’s wish to be able to detain dangerous individuals – who were also often personality disordered – in hospital absent the support of doctors or patients. The Sainsbury Centre for Mental Health explains:

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108 *Blurring the Boundaries*, supra n.36, p. 65.
Replacing the treatability criteria with ‘available appropriate treatment’ paces the way for the long term incarceration of mentally disordered offenders whether they choose to engage in treatment or not.

The potential for ‘long term incarceration’ is consolidated if the hospital order is combined with a ‘restriction order’ (s.41), since one effect of this is that the consent of the Secretary of State is required before the patient can be discharged. However, for those with severe PD, the removal of the treatability test is largely semantic. Even in the absence of a restriction order, a responsible clinician (formerly, responsible medical officer) may be unwilling to complete a discharge report if s/he considers the patient to be dangerous. This has led to claims that the hospital order is, or can be, ‘effectively an indeterminate sentence’.  

For similar reasons of public safety, the judge may prefer to impose on the dangerous offender an indeterminate sentence in the first instance, irrespective of medical opinion. In *R v Jonathan Paul Simpson*, two medical reports agreed there were four cogent reasons why the judge should impose a hospital order with restrictions on an individual with delusional disorder charged with attempted murder. The full-length quote reveals much about both the factors influencing medical discretion and the potential benefits of specialist treatment:

First, he would receive the appropriate medication; the effects of his medication would be more closely monitored by health professionals than it would be in the prison setting, where prescription and monitoring were significantly more difficult. Secondly, he would receive psychological assessment and treatment by a multi disciplinary team.

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110 [2007] EWCA 2666.
111 Ibid., para. 27.
Within prison the nature of psychological therapy was a limited nature because of the circumstances. In particular, the appellant would have the opportunity to work with those with real expertise in his type of offending behaviour. This would assist not only in assessing the risks he presented but also in reducing those risks. Thirdly, the appellant could be observed more effectively in situations which arise within the community. Occupational therapists in secure hospital units may see patients in general activities and assess their progress in a number of ways which is not open to those subjected to a prison regime. Fourthly, there would be substantially more effective opportunity under a hospital order to plan his rehabilitation and eventually reintroduction into the community.\textsuperscript{112}

The trial judge declined to follow the advice of the medical report, believing that the discharge conditions of life licence imposed by the Parole Board would better protect the public than the discharge provisions of the MHA 1983 relating to a first-tier tribunal mental health (see Chapter 7).\textsuperscript{113} However, recognising the reality is that most dangerous offenders receiving a hospital order will have it combined with a ‘restriction order’ (s.41), Gibbs J pointed out that the trial judge had not given sufficient weight to the fact that the first-tier tribunal – mental health could not have ordered discharge without the consent of the Secretary of State.\textsuperscript{114}

Further reasons why a custodial sentence may be passed relate to the inadequacy of pre-trial screening alerting the court to the individual’s needs (1.3.1.1 above) (or perhaps the individual has ‘sub-threshold’ needs)\textsuperscript{115} and the

\textsuperscript{112} The problem of continuity of care between prison and the community has long been considered a cogent reason for preferring hospital treatment; see, for example, Carlile, A. (1997) \textit{House of Commons Hansard Text}, column 57-8.

\textsuperscript{113} \textit{Op cit}, paras. 17-19. Gibbs J stated that the trial judge had not given sufficient weight to the fact that the first-tier tribunal – mental health could not order discharge without the consent of the Secretary of State: see paras. 26-28.

\textsuperscript{114} Paras. 26-28. See sections 41(3)(c) and s.74 of the MHA 1983; and \textit{R v LA} [2006] 1 Cr App R(S) 521, para. 37.

unavailability of a hospital bed. In the round, the practical realities of service provision mean that ‘many, if not most, “disordered” offenders do not receive the therapeutic “hospital order” disposal, even though their culpability may be mitigated’. Again, however, it remains possible for the offender, who will be ‘serving a sentence of imprisonment’ (s.47(5)), to be transferred to hospital for treatment by warrant at a later date.

1.4.1.4 The ‘transfer direction’ (section 47)

Under s.47(1)(b), the Secretary of State may direct the transfer of an offender to hospital (not being a mental nursing home) at any point during his or her sentence (‘transfer direction’), if it is believed to be in the public interest and all the surrounding circumstances. The medical criteria to be satisfied before the making of a transfer direction reflect those for the making of a hospital order; however, in practice, the transfer direction is used much more frequently. The discrepancy results from inadequate psychiatric screening at the sentencing stage. For those offenders who are identified, delays in transfer mean the requirement to find a bed within 14 days (s.47(2)) is largely otiose.

Delays mainly arise due to administrative delays in prison; the attitudes of prison staff towards mental illness slowing down the process; disputes over

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116 Contra, Aerts v Belgium (2000) 29 EHRR 50, in which it was ruled unlawful to have held an individual with borderline PD on remand for seven months while a hospital bed was sought, in accordance with the direction of the court: para. 54.


level of security required; and communication breakdown between prison and hospital. The inevitable result is that some offenders remain untreated in prison for as long as several months. The well-intentioned Bradley Report recommended a ‘minimum target’ of 14 days for transfer for prisoners with ‘acute, severe mental illness’. Nevertheless, with no tangible signs of improvement, the recommendation is most likely to highlight the importance of guidance issued by the Code of Practice to the MHA 1983:

Any unacceptable delays in the transfer after identification of need should be actively monitored and investigated.

By comparison, the ethical undercurrents of the transfer direction are not always assuaged if admissions go ahead in timely fashion. Consider: one benefit of the implementation of s.47 under the 1983 Act was that it was supposed to prevent indeterminate hospital detention for severely personality disordered offenders for whom treatment was proving problematic under s.37. By warrant of the Secretary of State, the transfer direction can be combined with a ‘restriction direction’ (s.49). Unless terminated by the Secretary of State, the restriction direction lapses on the date when the patients would have been released from prison. In the case of fixed-term offenders, this is power is

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120 The Bradley Report, ibid.
122 Op cit. The Report also acknowledges further guidance by the Department of Home, but does not dwell on the fact that it introduces no new measures or requirements into current arrangements. See Department of Health (2007) Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the ‘Mental Health Act (1983)’. Version 4. London: DH.
straightforward; in the case indeterminate sentence prisoners, this is the date on which the Parole Board directs release.\textsuperscript{124}

The positive effect of these sections is that they reinforce ‘the clear distinction between the penal and therapeutic aspects of the detention’.\textsuperscript{125} The negative effect is that the power to transfer offenders is occasionally reserved for those offenders with ASPD serving fixed-term sentences nearing his or her earliest date of release (EDR).\textsuperscript{126} The incapacitative agenda is enhanced by the potential of the Secretary of State to write into a probation licence the threat that patient disengagement and / or hospital discharge will result in a breach and his or her subsequent return to prison.\textsuperscript{127}

The judiciary have expressed concern about the practice of evoking s.47/s.49 close to offender’s EDR. In \textit{R on the Application of TF and the Secretary of State for Justice}, Thomas, LJ stated:\textsuperscript{128}

‘Where section 47 is proposed to be used at the very end of the sentence, and hopefully that will only be in very exceptional circumstances, the onus must be on the Secretary of State to show that the mind of the decision maker has focused on each of the criteria which it is necessary to satisfy if there is to be power to issue a warrant directing transfer to hospital.’

\textsuperscript{124} Patients transferred from hospital under s.47 have the right to apply for a first-tier tribunal – mental health hearing in the first six months of detention, and thereafter at 12 month intervals. However, the tribunal may not direct the release from hospital of the lifer without the prior consent of the Secretary of State: see HM Prison Service (2009) \textit{Indeterminate Sentence Manual} (formerly Lifer Manual). PSO 4700, paras. 15.11-12.
\textsuperscript{127} More general, as a consequence of s.47 of the Crime (Sentences) Act 1997, the Secretary of State may specify that the patient is transferred to a hospital of high, rather than lesser, security, so as mitigate the risk of absconson and to bolster the authority to refuse an the individual’s subsequent transfer to a hospital of lesser security as part of graduated discharge.
\textsuperscript{128} [2008] EWCA Civ 1457, para. 31.
This comment followed an earlier stipulation that whilst ‘danger to the public’ understandably influences the use of s.47, the decision to transfer ‘can only be taken on the grounds that his medical condition and its treatability (to use a shorthand) justify the decision’. As it is, the absence of an explicit treatability requirement in the MHA 1983 paves the way for transfer directions to further the central aim of governmental of ‘maintaining the highest possible levels of public protection’.

In this respect, the fixed-term prisoner may be acted against in a manner concordant with the indeterminate sentence prisoner. The difference between the two groups is that the offender serving an indeterminate sentence may view treatment in a different light; that is, s/he may be more ‘accepting’ of the need to receive treatment, since this is pre-condition of release of the Parole Board. What this means in the context of the offender, to use a phrase, ‘seeking help’ and its relationship to rehabilitation requires further explication.

In Part II of this study, Chapters 6 and 7 will introduce a survey of personality disordered offenders receiving treatment in a medium secure hospital in order to try to distinguish the ‘therapeutic’ from the ‘coercive’. The focus, however, will not be on the hospital order but on the transfer direction (under s.47 of the MHA 1983). Although both equally highlight some of the contextual and practical problems of diversion, the hospital order is statistically less prevalent. Consequently, the empirical research at the heart of this study is confined to offenders sentenced to terms of imprisonment who are

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129 Ibid., para. 18.
130 Department of Health (1998) Modernising Mental Health Standards: Safe, Sound and Supportive. London: The Stationary Office, para. 4.2.4. It is notable that public protection is referred to nowhere in s.49; see R v Secretary of State for the Home Department, ex p T [2003] EWHC 538: ‘If Parliament had intended public protection to be a let alone the main consideration, it would have said so’: para. 35. Emphasis in the original.
131 Antisocial Personality Disorder, supra n.98.
subsequently transferred to MSU’s. In assessing the potential to rehabilitate personality disordered offenders by mandate of the transfer direction, complex issues of consent, treatment, coercion and autonomy loom large. This point may be put as a series of interconnected questions which bear on the central question (namely, whether it is possible to rehabilitate personality disordered offenders):

What is the nature of the relationship between autonomy and consent?
How should consent be understood in a coercive regime?
Does treatment bestow therapeutic benefit on the consenting client?

Before these knotty issues can be meaningfully tackled in the context of the transfer direction, some basic observations regarding consent to treatment, and therefore autonomy, must first be made.

1.4.2 Consent, autonomy and the transfer direction

In respect of personality disordered offenders, the necessity for patient consent before treatment can go ahead depends much on location. In prison, compulsory treatment (that is, in the absence of consent) flows from a finding of incapacity according to the provisions of the Mental Capacity Act 2005.\footnote{According to section 3, to refuse treatment s/he must (a) understand the information relevant the decision; (b) be able to retain that information; (c) use or weigh that information as part of the process of making the decision; and, (d) communicate his decision (whether by talking, using sign language or any other means). See also, \textit{Re C (Refusal of Medical Treatment)} [1994] 1 FLR 31.} The simplified position for a patient transferred to hospital under the MHA 1983 is that, irrespective of determinations of capacity, some treatments, such as medication, may be given in the absence of consent for up to three months.
The limited impact of consent in healthcare contexts has led Ian Kennedy to quip: 133

Is [consent] the great bulwark of ‘patient’s’ rights’? Is it a necessary nuisance granted as a concession to modish thinking? Is it simply a figment of some lawyer’s (or – awful word – medical ethicist’s) imagination which practitioners know is meaningless in practice? It is just part of the rhetoric of ‘patient power’, sent to try doctors’ patience and challenge their authority?

In the context of compulsory psychiatric treatment, the patient has little power: his or her autonomy is undermined by the legal dispensation for prior consent before treatment can proceed. However, the crucial point is that the absence of consent may act as a contra-indication to successfully rehabilitating a personality disordered offender. Baroness Hale explains: 134

‘A patient [with PD] may be offered various forms of psycho-therapy from, for example, a psychologist, but clearly these can only take place with his co-operation. Otherwise the treatment is counselling and guidance from the nursing staff, with a view to helping patients to observe appropriate boundaries in their behaviour and controlling their impulsivity.’

The necessity for patient ‘co-operation’ if talking therapies are to yield therapeutic effects delimits the benefit(s) of ‘treating’ in the absence of consent. Consider this description of the ‘psychopath’: 135

The psychopath is like a chow dog who may turn and bite the hand that pets it. The psychopath’s hard external shell, his disturbing aggression and his complete irresponsibility, make therapy a thankless task.

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134 R v Ashworth Hospital Authority, ex parte B [2005] UKHL 20, para. 10. (This case concerned a personality disordered offender who was challenging the right of doctors to compulsorily treat him for any mental disorder during his detention under the MHA 1983).
This animalistic conception of the mentally disordered human captures the medical distaste for patients who ignore what appears to be a unwritten expectation of self-responsibilisation, self-correction and self-government in the face of disorder. This point will be explored further in Chapter 2. For now, suffice it to note that this viewpoint assumes *inter alia* that the doctor-patient relationship is a relatively stable, harmonious and productive union.

Commentators who have made this point about the prison argue that the general orderly comport of prisoners is more profound than the occasional shifts between crisis and re-equilibrium (for example, riots between inmate and prison guard).\(^{136}\) The countervailing argument is that major crises are the ‘culmination of a series of minor crises, each of which sets in motion forces for the creation of a new and more serious crisis’.\(^{137}\) However, is apparent order really the bi-polar opposite of major crises in the exchanges of power between, for example, prisoners and prison guards? Might the balance of power in power relations be more subtle between custodians and the marginalised? The resistant and difficult personality disordered offender, for example, would seem to fit this definition well.

It is known, for instance, that cognitive-behavioural therapy (or talking therapy) is viewed by those with ASPD ‘as an affront to their attempt to seek and exert status and influence’.\(^{138}\) In medicine, this helps to fashion claims of the ‘challenging client’ and, subsequently, endorse professional

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disenfranchisement. How, then, should one understand those who are not challenging to authority and do comply with treatment expectations?

The Mental Health Act Commission (now Quality Care Commission) recently reviewed consent to treatment in prisons and secure psychiatric hospitals in their biennial report, *Risk, Rights, Recovery.* What they found makes for an interesting analysis of consent, autonomy and (potential) rehabilitation:

Patients transferred after sentence under a restriction order (i.e. under s.47 / 49) are the most likely to be consenting, and of such patients, 85% of those with personality disorder are consenting…

This compares with the finding that:

an important factor in the instigation (or perceived urgency) of transfers [to hospital] is prison staff concern over their perceived inability to give compulsory treatment, almost always in the form of antipsychotic medication, in the face of the prisoner’s resistance.

Why might personality disordered offenders consent to (cognitive-behavioural) treatment once received in hospital? The biennial report raises a number of suggestions:

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 complaint 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

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140 Ibid., pp. 132, 232.
141 Ibid., p. 232.
142 Ibid., pp. 232-33.
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 suggestion points to the compliant patient being a product of long-term treatment. This raises the possibility that the normative treatment framework of psychiatry has a direct impact on self-understanding and consent to treatment in cases which will largely concern the personality disordered offender.\textsuperscript{143}

The second and third suggestions relate to what the offender feels they will gain by consenting to talking therapies. It implies that resistance undermines by the normative forces of psychiatric treatment. This is the preferred view of the current author. It is one implicitly shared by other commentators. For instance, Margaret Brazier points out that:

[D]etained persons whether patients or prisoners may feel under pressure to consent to participate or may think that participation will afford them more favourable treatment or will make early release more likely.\textsuperscript{144}

Might it be that personality disordered offenders, who are also likely to be subject to IPP’s, are consenting to treatment in secure hospitals to avoid the

\textsuperscript{143} Contra, ‘morality’ has nothing to do with medicine: see, for example, Eastman, N. (1996) ‘Hybrid Orders: An Analysis of their Likely Effects on Sentencing Practice and on Forensic Psychiatric Practice and Services’. \textit{Journal of Forensic Psychiatry}, 7(3): 481-94. It is submitted that this view is innocent of the fact that psychiatry, by imposing a normative standard (namely, normal vs. abnormal behaviour), clearly defines acceptable (moral) and unacceptable (immoral) conduct.

pressure on treatment resources in prisons, depriving them of the possibility of achieving parole? This possibility will be explored further in Chapter 6, in conjunction with empirical data in respect of personality disordered offenders admitted to a named medium-secure personality disorder ward for treatment.

In the round, if it is borne out that the client group engage with treatment for subversive reasons, the model of treatment-as-rehabilitation is severely dented. On the other hand, the biennial report suggests that long-term prisoners appear the ‘most insightful’ of their own behaviour and are ‘comparatively ‘well’,”¹⁴⁵ and this implies that treatment may have the potential to rehabilitate (at least to some extent) anti-social behaviours.

In subsequent chapters, these complex issues surrounding the personality disordered offender will be discussed from a more nuanced perspective than has, hitherto, been considered in research. Chapter 2 begins by incorporating a suitable theoretical framework to facilitate discussion of treatment (and rehabilitation) in the context of the prisons and psychiatric hospitals for personality disordered offenders. The chosen locutor is Michel Foucault. It will be seen that his work on governmentality provides a useful framework for locating diversionary law within the plural strands of law, psychiatric power, resistance, power relations (including the doctor-patient relationship), the “confession”, and – the light of the central question addressed by this study – normalisation techniques aimed at rehabilitation.

With a view to answering the central question, a key corollary is, of course, to understand why transfer directions made in the first place. As was alluded to in the introduction to this chapter, the preferred methodology to date has

¹⁴⁵ Supra n.142.
been to explain decision-making by reference to the psychiatrist’s decision-frame.\textsuperscript{146} However, if one is to understand the true rehabilitative effects of the transfer direction, one must also survey personality disordered offenders themselves, in order to understand why compelled them to seek help (or to offer their ‘confession’) in the first place. The true rehabilitative effects of treatment can, therefore, be brought within broad causal network of admission-treatment-rehabilitation.

Chapter 3 examines this point by reference to empirical data elucidating how offenders (and patients) influence professional decisions concerning their future care and detention in practice. Moreover, it challenges the notion, without more, that admission decision-making is the prerogative of psychiatrists in an era of multidisciplinary treatment teams.

Chapter 2

Governmentality and the Psy-Subject

Although he’s been dead for more than two decades, Michel Foucault’s work has decisively lived on in academia. In humanities and social sciences scholarship, Foucault’s work has been and remains by far the most cited of the “big names” associated with theory.

Nealon, J. T. (2008)\(^1\)

This study considers the potential to rehabilitate personality disordered offenders. It has two interrelated parts: first, it elucidates the decision-making process under mental health legislation which enables the offender to be transferred to a psychiatric hospital for treatment from prison. Second, it considers what the therapeutic effect of treatment is on the offender once admitted. During the previous chapter, it was shown that many claims are made about the individual with personality disorder, most derogatory. These include his or her predisposition for resistance against ‘authority’ and, related to this, the likelihood that s/he will not benefit from treatment. In Part II of the study, such claims, amongst others, will be tested with reference to primary empirical data. To facilitate this process, Chapter 2 anchors the conception of the personality disordered offender within a Foucauldian framework of power and law. Whilst Nelson is undeniably right to name Foucault as a “big name” in social sciences scholarship, in law his reach is more limited.\(^2\) In the study of

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personality disorder, he is positively mute. And yet, Foucault is an invaluable locutor: his focus on cultural practices from the point of view of scientific discourse, notably psychiatry; his investigation of the normalising effects of scientific discourse on subjects in society and institutions, such as the psychiatric hospital and prison; his methodological presupposition that these superstructural phenomena are developed through fluid social interaction (power relations), within which resistance is a given; and his unwillingness – contrary to the view of some – to expel law from modernity, all help to make sense of the complicated patchwork of the law and governance of personality disordered offenders, and those who provide them with treatment. In the remainder of this chapter, the Foucauldian analytics of power will be described and, where necessary, critiqued. Key terms will be elucidated in respect of the central focus of this study; these include: power relations, governmentality (bio-power), discipline and resistance.

2.1 Foucault, Power Relations and Political Technologies

Towards the close of Chapter 1, the notion of ‘patient-power’ in a sea of medical authority was mooted. According to the ‘logic’ of the received view of socio-political literature, this notion presents a rhetorical device for pointing out that society is, in reality, made up of powerful elites and subjugated pawns. Rather than presume that patients possess ‘power’, the

4 Supra n.134 above.
more interesting question would be to understand ‘how’ powerful elites reach decisions.\(^7\) The current study asserts that this narrow focus of decision-making practices limits our understanding of decision-making in mental health law.

The principal methodological basis of this assertion derives from Michel Foucault’s conception of ‘power relations’, according to which power should not be considered a top-down phenomenon.\(^8\)

Power comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations, and serving as a general matrix – no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body.

Rather, power relations describe the totality of (re-)actions, (re-)formations and (re-)constitutions between social actors within respective social cleavages.\(^9\) Foucault posits that these social cleavages ‘form a general line of force that traverses the local oppositions and links them together’.\(^10\) The constant force presented by social actors within power relations is inherently productive; they result in the creation of recognisable discourses (such as psychiatry) and subjects, and, ultimately, the creation, modification and operation of modern societies.

Foucault’s work describes the interrelation between these three ‘effects’ of power relations. In particular, he is concerned with understanding how power relations result in the creation of subjects and how this affects their behaviour.

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\(^9\) Foucault takes a particular interest in his earlier work on power relations within the family, the psychiatric institution and the prison.

\(^10\) \textit{Op cit.}
Recognisable subjects pertinent to the Foucauldian project include the madman; the prisoner; the sexual deviant; the schoolchild; the teacher; the doctor; the psychiatrist; the psychoanalyst; and the prison guard.

The obvious paradox here is that power is supposed not to emanate from the ‘top down’, and yet his subjects are presented in the binary form of ‘rulers and ruled’ (for example, the madman and the psychiatrist). Indeed, Foucault posits that ‘power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations’. So, does this mean there are in fact major dominations within social cleavages, and that these limit the exercise of power by other subjects?

Not exactly. Take the example of psychiatric subjects: psy-subjects owe their diagnosis to psychiatrists operating within psy-discourse. In a very superficial sense, psy-discourse constitutes a major domination and psy-subjects are ‘ruled’. However, according to Foucault this is not the same thing as saying that psy-subjects are powerless. The marginalised subject remains at liberty to modify the precise “grip” of the ‘rulers’ in innumerable and often subtle ways through resistance.

What are much more elusive are the conditions which gave rise to the societal manifestation of the doctor-patient relationship. Another way of putting this is to say that the overall ‘political’ context of psychiatric discourse in society – within which the field of power relations are located – is less easy to modify or spot. Why so? As Dreyfus and

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11 Ibid. Emphasis added.
Rabinow explain, ‘the “rationality” is not captured by the political languages we still speak today’.

Citing Heidegger, they opine:

[O]ne is always already in a particular historical situation, which means that one’s account of the significance of one’s cultural practices can never be value-free, but always involve an interpretation.

It follows from this account that the psychiatrist and / or the psy-subject are only dimly aware of the wider ‘political’ implications of their actions with local power relations.

Power relations are both intentional and nonsubjective. If in fact they are intelligible, this is not because they are the effect of another instance that “explains” them, but rather because they are imbued, through and through with calculation: there is no power that is exercised without a series of aims and objectives. But this does not mean that it results from the choice or decision of an individual subject; …the rationality of power is characterised by tactics that are often quite explicit at the restricted level where they are inscribed…, tactics which, becoming connected to one another, attracting and propagating one another, but finding their base of support and their condition elsewhere, end in forming comprehensible systems: the logic is perfectly clear, the aims decipherable, and yet it is often the case that no one is there to have invented them…

A limitation of Foucault’s account of power relations is that he suggests that people in society can employ ‘aims’ and ‘tactics’ within power relations but, it is argued, by ignoring what their ‘secret motivations’ might be he is not forced

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14 Ibid., p. 166.

15 Foucault himself acknowledges the influence of Heidegger in this work, despite his lack of reference to him: ‘I think it is important to have a small number of authors with whom one thinks, with whom one works, but about whom one does not write’: (1988) ‘The Return to Morality’. In: L. Kritzman, L. (eds.). Politics, Philosophy, Culture: Interviews and other Writings 1977-1984. A. Sheridan (trans.). New York: Routledge, p. 250. [‘The Return to Morality’].

16 The History of Sexuality, supra n.8, pp. 94-5.
to prove they are ‘hypocrites or pawns of power’.\textsuperscript{17} His concern, or ‘the only problem’, is to provide oneself with ‘a grid of analysis which makes possible an analytic of relations of power’ according to such terms.\textsuperscript{18} This ‘grid of analysis’; this overarching political technology in society that escapes the precise will of the author is known as governmentality.

\section*{2.2 Governmentality (Bio-power)}

\subsection*{2.2.1 A bio-politics of the population}

It has been seen that Foucault invites us to ground power relations in a grid of intelligibility of the social order that is nominalistic. That is, social order is a product of a complex strategic relationship which is reshaped through power relations but has no inherent logic. The societal objective, which fashioned binary divisions and created subjects with the help of individual ‘aims’ and ‘tactics’, was historically emergent; it is only intelligible, if at all, in a retrospective sense. Foucault was, therefore, inherently interested in representing a genealogy of ‘modern’ society, within which discourses and particular subjects are accepted as valuable units of society. He describes the logic of this point in his thesis on ‘governmentality’:\textsuperscript{19}

\begin{quote}
[This] word must be allowed the very broad meaning it had in the sixteenth century. ‘Government’ did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or groups might be directed: the government of children, of souls, of communities, of the sick… To govern, in this sense, is to control the possible field of action of others.
\end{quote}

\textsuperscript{17} Beyond Structuralism and Hermeneutics, \textit{op cit.}, p. 187.


In his posthumously entitled lecture ‘Governmentality’, he explains the notion of conduct governing conduct by reference to more precise variables:

[T]he ensemble formed by the institutions, procedures, analyses, reflections, calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population.

‘Population’, in this sense, has a very specific meaning; as well as referring to people, it denotes subjects and objectives (‘techniques and functionings’) related to state ‘security’. Prior to the seventeenth century, security was imbued with the power effects of the sovereign: increasingly, states became endowed with military institutions, which enabled the sovereign the potential to control its citizens. A general feature of the ‘apparatuses of security’ (or dispositifs) was the ability to exercise control over the ‘bodies’ of citizens, in respect of space, territory and state boundaries. One early example is the control of the leper colony in Europe through force and quarantine.

Owing to the threat of death, whether real or imaginary, sufferers were separated, stigmatised and exiled. The effect was the creation of a ‘massive, binary division between one set of people and another’. This ‘historico-political discourse’, as Foucault puts it, came to denote a binary rift in society: ‘a splitting of a single race into a superrace and subrace’, the latter at liberty to

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24 Security, Territory, Population, op cit., p. 11. This conception is clearly shaped by Machiavelli’s The Prince; however, Foucault complains that ‘the prince’s relation to his state is only one particular mode’: Security, Territory, Population, ibid., p. 205.
define what constituted the ‘norm’ in society. In this sense, the development of the norm implies population-security-government, or the ‘biological-racist discourses of degeneracy’ and the ‘totality of the social body’.

Governmentality-as-art really took hold during the eighteenth century. Through the development of statistics in relation to peculiarities within society, the government of souls transcended sovereign control. In relation to birth and death rates, standards of living, diseases, housing, public ‘hygiene’ and economic effects, citizens became the target for the proliferation of numerous and diverse techniques for achieving the ‘subjugation of bodies and the control of the populations’. Government, thus, could be described as relating to bio-power: the social realm imbued with medical rationality, ‘arranged so as to lead to a suitable end’.

An example of a ‘suitable end’ recognised in modern society is the normalisation of psychiatric ill-health, by reference to the art of psychiatric discourse. Bio-political control is read into the power effects of psy-discourse acting on the medium of the doctor-patient relationship, according to psychiatric norms. Foucault contends that the model for the doctor-patient relationship as an art of government has Christian roots. Using the metaphor of the ‘shepherd and the flock’, Foucault points out that the expert shepherd

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26 Society Must be Defended, op cit., p. 61.
27 Ibid.
29 Until this point, Foucault opines, government was ‘imprisoned’ within monarchic force: Security, Territory, Population, supra n.22, p. 101.
31 Ibid., p. 104.
32 The History of Sexuality, supra n.8, p. 140.
exercises a constant and individualising (pastoral) power over the flock. By the eighteenth century, Foucault points out that modern society demonstrates a number of similar relationships; therefore, he opines, ‘many citizens could quite legitimately claim the title ‘shepherd of men’’. Just as pastoral power cannot function without expert knowledge, medicine (psychiatry) – an ‘heir’ to pastoral power – cannot function as a form of bio-power ‘unless knowledge, or rather knowledge apparatuses, are formed, organized and put into circulation’.

What is interesting in bio-political terms is the implication that the putting into ‘circulation’ of knowledge denotes societal acceptance of ‘absolutely new tactics and techniques’. On this account, first, psychiatry (like other major dominations) achieves its position by relying on ‘tactics’ within local power relations in likely retaliation to competing claims to preferable ‘techniques’ of normalisation. Second, the acceptance of psychiatry is predicated upon its social utility, which leads, if in an ill-coordinated sense, to its position as ‘ruler’. Accordingly, ‘the subject of needs and aspirations, but also the object of government manipulation, vis-à-vis government, [population] is both aware of what it wants and unaware of what is being done to it’.

The same dichotomisation of behaviour (awareness / unawareness) may equally be constructed in relation to the psy-subject. On the one hand, by reference to power relations, the marginalised subject is free to act according to ‘aims’ and ‘tactics’. On the other, one is told that they are unaware of the

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34 ‘Politics and Reason’. In: Politics, Philosophy, Culture, supra n.12, p.62
35 Ibid., p. 66
36 Ibid., at 199
38 Security, Territory, Population, supra n.22, p. 106.
39 Ibid., p. 105.
wider political implications of their position as psy-subject. Indeed, as Foucault continued to develop the idea of the ‘art of government’, it became synonymous with self-government or control of the ‘self’ by the ‘self’ in response the “hidden” normative force(s) of discourse.\textsuperscript{40} In Chapter 3, and in particular Chapter 7, an attempt is made to discover whether the personality disordered offender’s ‘awareness’ of his or her actions can mask the normalising effects of psychiatric discourse on their behaviour (‘unawareness’) within the institution.

A useful conceptual tool in this respect is Foucault’s “confession”: an ideal-type formulation of the way in which marginalised communities are brought within the normalising bio-power. The doctor-patient coupling as it is understood today was a product of the patient’s confession during the eighteenth and, even more so, nineteenth century. It was at this point that psy-discourse and the psy-subject were incorporated within the bio-political institutions of the psychiatric hospital and the prison, the two institutions with which this study is concerned. Within these institutions, bio-power was framed in the language of antisocial personality.

\section*{2.2.2 The madman and the “confession”}

What is immediately striking about the English, eighteenth century psy-subject is its similar construction to antisocial personality disorder (ASPD).\textsuperscript{41} In particular, his or her consistent irresponsibility and failure to conform to societal norms is redolent of the embryonic psy-subject, or the pauper-‘insane’ during the Victorian industrial revolution. The construction of abnormality at

\footnotesize{\textsuperscript{40} See The History of Sexuality, supra n.8.} 
\footnotesize{\textsuperscript{41} Chapter 1, 1.3.}
this point was inspired by the growth of capitalism. In brief, few families actually benefitted from the financial rewards of presumed market growth in the eighteenth century. The poor vastly outnumbered the rich, which left the family in a state of difficulty caring for the pauper-insane family member. More specifically, whereas incarceration in asylums (an antecedent of the modern psychiatric hospital) had previously been reserved for those who were violent, Peter Bartlett notes that the early eighteenth century saw a radical increase in asylum admission requests by family.

From the point of view of ‘biological-racist discourses of degeneracy’, the pauper-insane became a site for state intervention for s/he was taken to be able, but unwilling, to work. In strategic response, born of the metanarratives of psychiatry, the great invention of eighteenth-nineteenth asylum was the birth of the psy-subject. Within the asylum space, the bodies of a substantial number of pauper-subjects fell within the psychiatric ‘gaze’. The overarching aim was simple: to effect cures by cultivating a ‘familiar geometry’ of the subject-object in a now familiar language:

This was a domain where the constant and reciprocal relation between theory and practice was supplemented by an immediate confrontation between doctors and patients… [T]his would require a common language, a communication at the very least imagined between doctor and patient.

The psy-‘communication’, in reality, was more akin to a confession. In illustrative terms, by drawing on the deployment of sexuality throughout

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45 Society Must be Defended, supra n.23.
society in the nineteenth century, Foucault demonstrates that the confession was inherent within the control of the body and species through a ‘problematization of health’ aimed at maximising life.\(^48\) One example is the development of social welfare programmes to eliminate perversions, such as incest. At the behest of the bourgeois, forbidden desires become a target of intervention by psychoanalysis, meaning the confession became synonymous with ‘the command to talk about that which power forbade one to do’\(^49\).

Morality and confession was equally applied to the embryonic psy-subject within asylums\(^50\). Foucault points out that, prior to this, all forms of ‘mental alienation’ were homogenous: the poor; mad; violent; ‘girlish old women’; epileptics; ‘malformed, damaged simpletons’; those who spoke profanations in relation to established religious doctrine; free-thinkers; and the ‘incorrigible’ (i.e. experiences touching upon sexuality in the bourgeois family) all fell within the same ‘abstract dishonour’\(^51\). Madness, being a form of sin,\(^52\) was treated corporeally.\(^53\) The growth of (curative) psychiatry as a bona fide discourse required an understanding of why the pauper-madman was before the

\(^{48}\) *The History of Sexuality*, supra n.8, p. 123.

\(^{49}\) *Beyond Structuralism and Hermeneutics*, supra n.13, p. 141.

\(^{50}\) Foucault opines: ‘The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships and love relationships, in the most ordinary affairs of every day life, and in the most solemn rights; one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles... Western man has become a confessing animal:’ *The History of Sexuality*, supra n.8, p. 59.

\(^{51}\) *The Correctional World*, supra n.42, pp. 81-2


\(^{53}\) Even in the nineteenth century, psychiatric treatment included lengthy cold baths; wrapping them in cold; insulin to induce artificial comas; removing sections of the patient’s brain; and passing an electrical current through the brain of the patient. Of course, the last two remain treatments performed today: Fennell, P. (1996) *Treatment without Consent*. London: Routledge, pp. 129-50.
psychiatrist; only in this way could reasons be transformed into symptoms.\textsuperscript{54} The confession was instrumental in the psy-case being cast in a non-superficial light, according to a fusion of symptoms and, subsequently, psychiatric nosology. Morality became synonymous with the sense that the psy-subject had an internal core of self that, if disordered, could be brought back within the realms of acceptable behaviour within the asylum, or psychiatric hospital.

Today, the DSM-IV-TR reference book of the American Psychiatric Association, for instance, contains 300 different disorders,\textsuperscript{55} all of which derive from the patient’s own self-understanding and his or her interaction with a treating psychiatrist.\textsuperscript{56} However, the scope of Foucault’s convincing “confessional” is limited by the fact that the making of a diagnosis and the provision of treatment does not apply in the same way to all mental disorders. So, schizophrenia is characterised by ‘fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect’.\textsuperscript{57} Diagnosis is, therefore, the \textit{absence} of confession linked to self-understanding:\textsuperscript{58}

The most intimate thoughts, feelings, and acts are often felt to be known to or shared by others, and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the afflicted individual’s behaviour or thoughts.

\textsuperscript{56} They are also constantly evolving in response to society’s attitude to mental disorder: \textit{Winterwerp v the Netherlands} [1979] 2 EHRR 387, para. 37. In reality, society probably has more of an ‘iterative’ exchange with psychiatric convention.
\textsuperscript{58} \textit{Ibid.}, p. 87.
A consequence of this is that curative treatment relies on anti-psychotic medication. Of course, this contrasts with antisocial personality disorder, which relies heavily on talking therapies. Following Foucault’s confessional, it can be said that the utility of talking therapies for this group is predicated upon the notion of self-understanding linked to feelings of guilt and remorse regarding previous conduct. In this particular account, the offender was being treated in a medium-secure psychiatric hospital.

‘People are at us all the time about how I feel, “How do you feel about this?”’, “How do you feel about that?”’. You know, have a conversation, “What do you feel?” – bombarded by “how you feel” questions, you know it’s just… I know why they are doing it, because the [sic] logic is not enough to stop us from getting in trouble again to have an emotional connection to what I have done in the past with my crimes and to have an emotional connection between what’s wrong and right makes a difference in [sic] whether or not I will reoffend again.

The same confession-treatment complexities linked to psychiatry operate within the prison. For example, s/he may have first received an indeterminate sentence (under the Criminal Justice Act 2003) before being transferred to hospital for treatment under the MHA 1983. Before passing the sentence, the court will have had access to the contents of a psychiatric report on the offender’s mental state to ensure the correct disposal. In ‘The Dangerous Individual’, Foucault demonstrates that the incorporation of the offender within the bio-political grid arose due to the homicidal maniac between 1800


61 In: Politics, Philosophy, Culture, supra n. 12.
and 1835. This offender was perplexing to the court, for in his confession he could not provide a satisfactory account of his criminal acts, and he did not appear mad. This challenged all efforts to determine precisely which punishment morally fitted the crime.\textsuperscript{62} The psychiatrist was called upon to furnish an account of the differences within and between mad and bad people in order to enable this distinction to be retained.\textsuperscript{63}

In modern medico-legal criminology, the offender with antisocial personality disorder softens the distinction between mad and bad by virtue of his incorporation within both the penal and psychiatric systems. And morality and punishment can be reconciled in both the prison and psychiatric ward by the incorporation of confession-mediated treatments, such as talking therapies, into the (indeterminate) sentence or stay in hospital, as part of the rehabilitative process. In this sense, psy-discourse facilitates the construction of ‘a network of causality in terms of an entire biography [of the offender] and...a verdict of punishment-correction’.\textsuperscript{64} Through treatment, it directs ‘the effects of power to the most minute and distant elements’ of the offender’s mind.\textsuperscript{65}

The underlying assumption in this account is that the offender is ‘docile’, that the effects of treatment result in the inculcation of more acceptable pro-social behaviours over time. By locating the offender within the institution, his or her conduct can be closely monitored, scrutinised and acted upon to ensure governance (domination) according to the whims of bio-power. Dreyfus and

\textsuperscript{62} He says: ‘When a man comes before his judges with nothing but his crimes...when he has nothing to say about himself, when he does not do the tribunal the favor of confiding to them something like the secret of his own being, then the judicial machine ceases to function’: \textit{ibid.}, p. 151. This corresponds to the aim of the modern penitentiary to ‘not punish less but punish better’: \textit{Discipline and Punish, supra n.21}, p. 82.

\textsuperscript{63} In the process, psychiatrists were able to establish a ‘new domain for themselves’: \textit{ibid.}, p. 133.

\textsuperscript{64} \textit{Ibid.}, p. 252.

\textsuperscript{65} \textit{Discipline and Punish, supra n.21}, p. 216.
Rabinow, therefore, rightly point out that it is only when accepted discourse is located within specific institutions, ‘when [they] “invest” these institutions, that bio-power really begins to take-off’. Foucault advances the same notion in his account of the ‘disciplinary institution’: an architectural space which circumscribes the related threads of bio-power (discourse, the subject, racist divisions of acceptable and unacceptable conduct, the confession and techniques) in order to direct conduct and harness the mind of society. ‘Discipline,’ he opines, ‘was never more important or more valued than when the attempt was made to manage the population.’

2.3 Disciplinary institutions and accepted discourse

2.3.1 The ‘docile’ body and the panoptic regime

As Dreyfus and Rabinow allude to, disciplinary institutions are widely dispersed within society. They include (psychiatric) hospitals, prisons, army barracks, monasteries, schools, and many more. The common thread of these institutions is that they employ specific measures (‘training’) to manipulate conduct. Training is highly specific to the institution; it might include the inclusion of specific drills in the parade yard, the holding of the pen or, as is at issue in this study, the provision of cognitive-behavioural therapies (talking therapies) in prisons and psychiatric hospitals. The precise nature of training is determined by ‘experts’ of the accepted discourse, whose remit it is to bring

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66 *Beyond Structuralism and Hermeneutics, supra* n.13, p. 185. Even where compulsory psychiatric treatment is provided in the community, it is likely to involve out-patient treatment. Moreover, a failure to comply with the terms of compulsory treatment will result in (re-) admission to a psychiatric hospital.

about systems of efficient and economic control by reference to broad dichotomies of behaviour. These include ‘the mad and the sane, the sick and the healthy, the criminals and the “good boys”’. To facilitate this process, micro-penalties (for example, solitary confinement in the prison or prolonged detention in the psychiatric hospital) usually invigilate the process of change. Ultimately, however, Foucault tells us that it is the constant observation of the offender that ensures the normalisation of unacceptable behaviours. He demonstrates this by reference to Jeremy Bentham’s plan for the perfected use of the Panopticon (1791). Though it was originally applied to the prison, the Panopticon is a generalisable model of functioning; a way of defining power relations in terms of the everyday life of men… It is the diagram of a mechanism of power reduced to its ideal form… It is in fact a figure of political technology that may and must be detached from any specific use… It is polyvalent in its application.

The Panopticon consists of a central tower and a courtyard, hemmed in by an annular building around the periphery. The buildings are architecturally precise; they are divided into cells which each contain two windows, which, together, are like ‘small theatres in which each actor is alone, perfectly individualized and constantly visible’. However, the subject is unaware of when s/he is being watched, and ‘this invisibility is the guarantee of order’, an assurance of ‘the automatic functioning of power’, for over time the subject becomes his or her own guardian.

In reality, the ever-present, watchful eye is a metaphor for the interiorisation of training-effects deployed by discourse, buttressed by observation, confession

68 Foucault refers to this as “dividing practices”: ‘The Subject and Power’, supra n.19, p. 208.
69 Discipline and Punish, supra n.21, p. 205.
70 Ibid., p. 200.
71 Ibid., p. 223.
72 Ibid., p. 203.
and self-understanding. Some examples will assist. In these cases, offenders were receiving treatment in a medium-secure unit: 73

‘Learning to control my anger, which I think I am doing very well. Um, not creating any riots – I manage that… I get angry a little bit, but not as much as I used to…now, I think before I act, whereas before, I didn’t think, I just acted straight out, or said it, whatever, but I actually think before I approach someone which…this place has taught me you know.’

‘Well I’ve learned a lot about my diagnosis and how it affects me, you know what, how it’s likely to affect me in the future and how I can work around that. You know, I’ve learned a lot about like, where my violent behaviour in the past came from, what led into [sic] it and how I can sort of head it off before it becomes a problem again.’

What is interesting about this idealisation of normalisation techniques is to discover whether observation-correction results in actual behavioural change, or whether the existence of penalties may inspire the appearance of normalisation through the threat of penalties. Clearly, it would not be appropriate to suggest this is the case in the examples above; but, presumably, for any offender who is compulsorily detained (either in the prison or psychiatric hospital), the grand threat of inexpedient release may weigh large on their minds and decision-frames. This notion is underscored by the potential for resistance within institutions.

### 2.3.2 Resistance and strategy

Ervin Goffman was the first to demonstrate the potential for resistance within psychiatric hospitals – or, as he called them, the ‘total institution’. 74 The total institution is characterised by locked doors, barbed wire fences and high walls,

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73 Supra n.60.

which form ‘barriers to social intercourse’. Activities are tightly scheduled and brought together into ‘a single rational plan purportedly designed to fulfil the official aims of the institution’. To facilitate this process, as in the disciplinary institution, surveillance is employed: ‘a seeing to it that everyone does what he has been clearly told is required of him’. As patients adapt to the social regime, however, they also become ‘defiant’. Against the rules of the institution, a patient will be witnessed, for example, “working someone for ‘a nickel or dime to spend in the canteen’.

Foucault similarly opines that the coercive potential of disciplinary institutions is undermined by resistance within local power relations: ‘Where there is power, there is resistance.’ Unlike Goffman, what Foucault does not do is provide examples of what resistance might look like in practice. Amy Allen complains:

The only social actors in [these] works are the dominating agents, there is no discussion of the strategies employed by madmen, delinquents, schoolchildren, perverts, or ‘hysterical’ women to modify or contest the…power exercised over them.

One oft-cited rejoinder to such complaints is that Foucault did not wish to prescribe a theory of power; instead, his wished his work to be read as a

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75 It is arguable that the modern-day psychiatric hospital is permeable. Service users are increasingly in contact with the outside world during their time on the ward, due to factors such as relatively short stays, the presence of recreational drugs, the use of mobile phones and plain dress: see Quirk, A., Lelliott, P. & Seale, C. (2006) ‘The Permeable Institution: An Ethnographic Study of Three Acute Psychiatric Wards in London’. Social Science and Medicine, 63: 2107-111.
76 Discipline and Punish, op cit, pp. 15-18.
77 Ibid., p. 21.
78 The History of Sexuality, supra n.8, p. 95.
80 He was unequivocal on this: ‘I am in no way developing a theory of power’: Politics, Philosophy, Culture: supra n.12, p. 38.

I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area... I don't write for an audience, I write for users, not readers.

Whilst, therefore, Foucault does not discuss the particular strategies employed by the marginalised, he does provide the analytical tools to enable us to try to determine ‘how’ power is being exercised. In ‘The Subject of Power’, he describes “strategy” in three ways:\footnote{The Subject and Power', supra n.19, p. 224-25.}

First, to designate the means employed to attain a certain end; it is a question of rationality functioning to arrive at an object[...]

Second, to designate 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; it is the way in which one seeks to have the advantage over others[...]

Third, to designate the procedures used in a situation of confrontation to deprive the opponent of his means of combat and to reduce him to giving up the struggle; it is a question therefore of the means destined to obtain victory.

By reference to these forms of strategy, Foucault tells us that at any moment, ‘the relationship of power may become a confrontation between two adversaries’.\footnote{Ibid., p. 226.} Equally, there may be no confrontation; strategies also have the potential to ‘sometimes cancel one another out, sometimes reinforce one another’\footnote{Ibid., p. 224.} One might refer to this as ‘co-strategy’.

For the purposes of this study, Foucault’s elucidation of the manner in which resistance occurs within power relations is invaluable. In Part II of this


\footnote{The Subject and Power', supra n.19, p. 224-25.}

\footnote{Ibid., p. 226.}

\footnote{Ibid., p. 224.}
study, an attempt is made to identify and, if necessary, demarcate the strategies employed between the respective actors (professional and patient) caught within a specific decision-making forum. It asks: how (and why) is the decision taken to transfer personality disordered offenders to a named secure psychiatric hospital from prison for treatment? Chapter 3 will introduce the complex dynamics at hand by reference to the available empirical data on the institutional life of the mentally disordered and those who treat them. Unfortunately, very little data is available on the approach of patients to decisions concerning their future care and detention; the approach of ‘experts’ in the field of medicine is given far greater weight. And yet, the fact that resistance is endemic to the disciplinary institution indicates that the marginalised have a great deal to tell us about the workings of disciplinary institutions.

Thomas Ugelvik, for instance, provides interesting examples of resistance in his research on mealtime resistance on two different wings in an Oslo prison. He notes that the ‘official’ prison food is ‘extremely unpopular’, and goes on to discuss various forms of alternative food making employed by prisoners. Whilst all of these practices are prohibited, some are tolerated (for example, heating chicken using a cell lamp). Others, such as making a fire to prepare food, would result in punishment if detected:

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To assist my research, as he puts it, [the prisoner] offers to show me his homemade ‘oven’ in use... I look nervously towards it, afraid that one of the officers might check on me to see that everything’s all right... My host sits back in his chair stoically, amused by my nervousness. [He] tells me he’s confident they won’t search his cell right now, and if they did, they wouldn’t suspect anything out of the ordinary.’

Ugelvik contends that official food represents a limit on prisoner autonomy; and that they often resist by flouting prison rules to compensate:

[T]he food works as a metaphor for the control over the prisoner’s body, as a sort of link between the experience of being a prisoner and the experience of having an imprisoned body.

James Scott further discusses the idea of being passive and active in his theory of the ‘hidden transcript’. His interest is in everyday forms of resistance at play in asymmetric power relations (these include peasant and feudal lords, slaves and their owners and prisoners and prison officers). Concentrating on peasants and feudal lords, he demonstrates that the former are highly resistant in words and actions behind the scenes, but in public respect the hierarchy of the dominant (‘public transcript’). For subordinates, hidden resistance is evidence of their inability to create ‘a counterfactual social order’, and thus evidence of domination.

Foucault does not readily entertain the idea of relations of domination, but opines that strategies employed by the ‘ruled’ are generated by the introspective question: ‘Who are we?’ Strategy represents, in bio-political

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88 *Ibid.*, p. 81. Examples cited include: ‘Taking advantage of small linguistic nuances their captors would not notice, [they] often managed to insert in a publically read apology or confession before other prisoners an indication that their performance was forced and insincere.’ *Ibid.*, p. 84.
terms, a determined refusal of ‘a scientific or administrative inquisition which determines who one is’.

Thus construed, resistance may be, as is Scott choice, both ‘public’ and ‘private’. Strategy may be private, or subversive, if that is called for by the nature of the power relationship. But it may equally be public – as is the case, for instance, in prison riots; those who seek alternative explanations of aspects of their behaviour not accounted for by the medical model; and those who invoke the law to complain of abuses suffered by the ‘disciplines’.

Indeed, this latter, juridical, realm of power relations is a particularly good example of why domination in the ‘public’ domain is more complex than Scott suggests. To illustrate this, a psychiatric patient who refuses treatment can be lawfully given it if s/he is compulsorily detained in a psychiatric hospital (under section 63 of the MHA 1983). If clinician’s ‘strategic’ recourse to law results in the patient’s future acquiescence, one may speak of a relationship of domination. That is to say:

A relationship of confrontation reaches its term, its final term (and the victory of one of the two adversaries) when stable mechanisms replace the free play of antagonistic reactions. Through such mechanisms one can direct, in a fairly constant manner and with reasonable certainty, the conduct of others.

However, the ‘term’ is in fact an unstable stasis, for the potential for strategic innovation obviates terminal domination. So, to continue the example, if unreasonable force is used to provide the said treatment, or if compulsory treatment has been given for behaviour not relating to the mental disorder, the

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89 The Subject and Power, supra n.19, p. 212.
90 Ibid., p. 225.
patient may seek the relief of the courts.\footnote{With the potential finding that the psychiatrist has committed, or authorised, a battery. Alternatively, the patient may seek injunctive relief to prevent treatment being given in the first place.} Two related points must be raised in connection with this: first, it is self-evident that rehabilitation of mental disorder is fraught with complexities relating to patient autonomy and resistance. Second, the ability to resist ‘who one is’ in the public domain, according to psy-discourse, may require the law’s observation of patients rights. Put another way: the extent of the marginalised psy-subject’s domination may be determined, in a very real and practical sense, by the quality of assurances provided by law. As Foucault asserts:\footnote{(1980) ‘Two Lectures’. In: \textit{Power / Knowledge, supra} n.18, pp. 107-08.}

\begin{quote}
When today one wants to object in some way to the disciplines and the effects of power and knowledge that are linked to them, what is it that one does, concretely, in real life, if not precisely appeal to [this] cannon of rights.
\end{quote}

This may seem like a perfectly common sense application of strategy which both limits the potential for overt domination \textit{and} shows, as regulation scholar Colin Scott puts it, that ‘the use of the law is one amongst “a range of multiform tactics” for governing’.\footnote{(2004) ‘Regulation in the Age of Governance: The Rise of the Post-Regulatory State’. In: J. Jordana & D. Levi-Faur (eds.). \textit{The Politics of Regulation}. Cheltenham: Edward Elgar Publishing, p.156.} In [this] system of government, the law has modified the field in which the free play of antagonistic relationships place at the behest of patient strategy, and at the expense of a relationship of domination instrumented by the psychiatrist. Of course, this does not mean that abuses of ‘power’ do not take place; rather, when they do the law is called upon to adjudicate between competing interests in a system of bio-political control.
Thus construed, the law is in a precarious position; it appears to form ‘a wider scheme of regulation which has monitoring and behaviour modifying mechanisms’,\(^96\) within which it is a determinate entity that tells us very little about why people act the way that they do. The fact that, for example, personality disordered offenders do not, by their very description, adhere to the normative presupposition of the law suggests that discipline is far more inventive than law could ever be.\(^97\) However, this innocuous point shores up an important debate within Foucauldian scholarship about the true relationship between law and the ability to normalise conduct. Some would argue that Foucault’s law is marginalised within *bio-power*, and that perhaps this view suggests that the rehabilitation of personality disordered offenders is not a legal question at all. That would be an erroneous conclusion.

### 2.3.3 Law and medicine

As previously alluded to, the innocuous statement by Foucault on the inherent relationship between the disciplines and law (in the form of rights belies academic contention on the subject. Some, if not most, scholars would argue that Foucault’s law is a mere accessory to disciplinary power,\(^98\) or that his ‘critical’ project narrates the demise of law.\(^99\) There is nothing inherently wrong with this view; Foucault, in fact, is clear that law is a construction of the Middle Ages, linked to the ‘monarchic system’s mode of manifestation and the

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97 In law, ‘what is determined is what one must do, and consequently everything else, being undetermined, is prohibited’. *Security, Territory, Population*, supra n.22, p. 46.


form of its acceptability’. Power at this point, he posits, was expressed as the ‘poverty and monotony of interdictions’. Nevertheless, this does not mean that law is expelled from governmentality; instead, the law may be one way in which it is easier for dictatorial power to mask its effects on the population:

The history of the monarchy went hand in hand with the covering up of the fact and procedures of power by juridico-political discourse.

It transpires that law, which functions as a coercive, unitary authority in the event of recalcitrance, should be seen in its capillary form, ‘where power surmounts the rules of right which organize and delimit it and extends itself beyond them’. During a series of lectures delivered at the College of France, prior to the publication of *Discipline and Punish*, he notes:

There was the elaboration of what could be called a new economy of the mechanisms of power: a set of procedures and analyses that enabled the effects of power to be increased, the costs of its exercise reduced and its exercise integrated in mechanisms of production. By increasing the effects of power I mean that there was the discovery in the eighteenth century of a number of means by which, or at least, the principle in accordance with which power could exercised in a continuous manner, rather than in a tual, ceremonial, discontinuous way it is was exercised under feudalism and continued to be exercised in the absolute monarchies. That is to say, it is no longer exercised through ritual, but through permanent mechanisms of surveillance and control.

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100 *The History of Sexuality*, supra n.8, p. 87.
103 *Power / Knowledge*, supra n.18, p 96. He urges: ‘We must construct an analytics of power that no longer takes law as a model and a code’: *The History of Sexuality*, supra n.8, p. 90.
Thus construed, law is attenuated. Foucault does not mean to say that ‘the law fades into the background or that the institutions of justice tend to disappear’;\(^{105}\) rather, as Ivison puts it, ‘the clamour for Right only ever muffles the sound of war continuing on around us’.\(^{106}\) The question, then, is how to read law into disciplinary controls?

It is submitted that the better view is that bio-power is a triumvirate of broadly symbiotic forms of control: namely, law, discipline and government, ‘which has population as its main target and apparatuses of security as its essential mechanism’.\(^{107}\) Indeed, Golder and Fitzpatrick argue that law should be seen to facilitate ‘a wider dispersal of governmental sites and functions throughout the social body’; and, by implication, that laws and policies ‘governing health’ in society are predicated upon “the knowledges of man’ generated by the emergent human sciences’.\(^{108}\) Law, therefore, facilitatesthe deployment of disciplines within the institutional space. This has already been considered in the context of what Foucault calls the ‘floating population’\(^{109}\) of the eighteenth century, when law ‘consecrated psychiatry as a medical discipline’ and ‘sanction[ed] the role of psychiatry as a particular scientific and specialized technique of public hygiene’ within the Victorian asylum.\(^{110}\) Some two hundred years later, Foucault tells us that a consequence is:

> the techniques of discipline and discourses born of discipline are invading right, and that normalizing procedures are increasingly colonizing the procedures of law.\(^{111}\)

\(^{105}\) The History of Sexuality, supra n.8, p. 144.


\(^{107}\) Security, Territory, Population, supra n.22, pp. 107-08.


\(^{109}\) Security, Territory, Population, supra n.22, p. 46.

\(^{110}\) Abnormal, supra n.104, pp. 140-41.

What this means in practice is that, whilst one might appeal to one’s ‘cannon of rights’, the reality is that law may simply act to reinforce the forceful hold of the disciplines on that individual. Law, thus, has been argued to be ‘no more than a rubber stamp that sanctions the functioning of [the] disciplinary system’.  

Whilst this claim is fatalistic – and nihilistic – it is undoubtedly true that the common law provides ample examples of judicial preference for the accounts of psychiatrists rather than patients. To reconsider the example of mealtime resistance, it is well known that Ian Brady was a compulsory detained patient in Broodmoor under the MHA 1983, and whilst there he sought judicial review of the doctor’s decision to force feed him (under s.63 of the MHA). His argument was that he had competently embarked on a hunger strike as a protest over the conditions of his detention, and that his behaviour was unrelated to his personality disorder. The judge, however, agreed with the doctor’s view that his underlying personality disorder explained his behaviour, and that nasogastric tube feeding could be justified on the basis that the doctors would be treating a symptom of his disorder. This was in spite of the fact that an independent expert contended that it could not be known that Brady’s refusal of food was a consequence of his mental disorder, since a rational individual could also have chosen this method to challenge his or her conditions of

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112 Supra n. 94.
114 For instance, see R (on the application of PS) v G (RM0) and W (SOAD) [2003] EWHC 2335 (CA) (the court should ‘pay a very particular regard to the view held by those specifically charged with a patient’s care’, per Silber J, para. 39); R (JB) v Haddock and others [2006] EWCA Civ 961 (Convention safeguards ‘should not be employed so as to cut across the grain of good medical practice’, per Auld LJ, paras. 32-3).
detention. Nell Munro points out that this case identifies the problem of the rational-disordered continuum which mental health law struggles to resolve in a way which safeguards patient rights. It also reinforces, prima facie, that the law fails to promote the involvement of patients in decision-making about their care. This study challenges that notion from the point of view of diversion decision-making under the MHA 1983, but equally does not dismiss out-of-hand the notion of patient discreditation as an inherent bi-product of government.

One useful, supplementary account of Foucault suggestive of why this might happen is provided by systems theory. Broadly, systems theory posits that communications, rather than (strategic) actions, generate social order. Discourses, or systems, generate meaning through self-referential processes; psychiatry, for instance, generates normative expectations that render its position tenable in the social world, and this becomes written into the social order governing interaction. Therefore, if the normative system of psychiatry is to be altered, it must be through self-reference; it cannot come from outside interference [of the marginalised]. What this means in a system of ‘right’ is that the psy-system typically retains the normative expectation that it holds the most advanced knowledge available based on its code, whilst the judiciary is bound to ‘accord with the expectations one

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116 In contrast, where treatment is not proposed to take place in the psychiatric hospital, the court has upheld the rights of those with personality disorder to refuse food where doctors agree they have capacity to do so (for to do otherwise would constitute a tort of battery): Secretary of State for the Home Department v Robb [1995] 1 All ER 677 (HC); and in the case of an individual in the community, see David, A. et al. (2010) ‘Mentally Disordered or Lacking Capacity? Lessons for Managing Serious Deliberate Self-Harm?’ BMJ, 341. (The case of Kerri Wooltorton).


believes must be assumed for social relations to continue’.\textsuperscript{120} Systems theory, thus, provides an account of the separation of law and morality in (medical) decision-making.\textsuperscript{121}

Whilst an interesting and valuable account, the alternative morality-encompassing view is that because the medicalisation of madness serves an important bio-political function, it does not have to be overly troubled by reflexive accounts of its actions. The law will broadly support society’s bio-political function in ‘recognition’ of the moral and practical consequences of not doing so:\textsuperscript{122}

\begin{quote}
[T]he law sets itself up in putative opposition to disciplinary power and, in so doing, works symbiotically with it in order both to shore up its own position as law, and to perform this constituting task for disciplinary power. That is, by purporting to exercise its supervisory jurisdiction over the more egregious aberrations, abuses and excesses of disciplinary power, law confirms the basic claim at the heart of disciplinary power to adjudicate on questions of normality and social cohesion.
\end{quote}

So, for example, it has been held that doctors are both ‘entitled and obliged’ to exercise their professional judgment.\textsuperscript{123} They are ‘entitled’ on the basis of having achieved hegemonic dominance, and ‘obliged’ in the sense of having a professional mandate relating to a ‘complex strategical situation in a given society’ (bio-power).\textsuperscript{124}

However, what the two ‘moral’ perspectives share, at least to some extent, is the view that, first, the legal and social order is predicated upon the “belief” that psychiatric discourse fulfils, or will fulfil, its normative aims (the

\begin{itemize}
\item \textsuperscript{120} Social Systems, op. cit., p. 235.
\item \textsuperscript{122} Foucault’s Law, supra n.108, p. 64.
\item \textsuperscript{123} Ibid., at para. 29.
\item \textsuperscript{124} The History of Sexuality, supra n.8, p. 93.
\end{itemize}
normative function). Second, as a consequence of this investment in truth, psychiatric “experts” are afforded a privileged status to describe the ways things are, or should be, in society (the decision-making function). And third, if less obviously, law defers to psychiatrists on the subject of what patients ought to be doing to safeguard their own health in bio-political terms (the self-governance function). In practice, all of these functions should be responsive to one another within the domain of medical decision-making and treatment.

2.4 Commentary: medical decision-making and treatment

2.4.1 The normative function

The first of these points encompasses the scope of Foucault’s (earlier) works on discipline, government and – if mainly a purview to the former – law. This chapter has demonstrated that disciplinary technologies receive purpose and normative expression in relation to wider societal aims, described as bio-power; but, equally, the ‘minor processes’ of the disciplines also ‘gradually produce the blueprint for a more general method’ in society, denoting a circular relationship with government.¹²⁵ What is apparent, moreover, is that the disciplines would risk losing legitimacy, and status, if its ‘minor processes’ could not resolve the problematisation of health (government). However, in practice, the promise of normative fulfilment is sufficient to maintain hegemonic dominance. Foucault says as much in relation to the prison regime:¹²⁶

For a century and a half the prison had always been offered as its own remedy: the reactivation of the penitentiary techniques as the only means of overcoming their perpetual

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¹²⁵ *Discipline and Punish, supra* n.21, pp. 138-39.
failure; the realization of the corrective project as the only method of overcoming the impossibility of implementing it.

This study is interested to know whether, if at all, psychiatric discourse can normalise personality disordered offenders receiving treatment within the disciplinary hospital. It is clear that patients, and prisoners, resist; it is not clear how much. This study will examine how decisions are reached to admit members of the client group to hospital from prison for therapeutic reasons.

2.4.2 The decision-making function

Decision-taking in the given forum is often presumed to be the prerogative of psychiatrists. This is reflective of the fact that psychiatrists have achieved a major domination in the treatment of mental disorder since the eighteenth century birth of bio-power and the instrumentalisation of the institution. This dominancy has been furthered by legislation. For instance, medical officers under the Poor Law 1834 were given the role of visiting every quarter those pauper lunatics not residing in an asylum, along with stewardship in the preparation of admission documents. In modern psychiatric practice, law continues to recognise the authority of psychiatrists to prepare admissions documents. In Chapter 3, legislative developments which permit other professionals within the multidisciplinary treatment team (for example, nurses, psychologists and social workers) to complete admission paperwork will be discussed. That said, though the law has a clear function in defining inter-

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professional boundaries, ‘how’ decisions are reached between those professionals and patients may require an entirely different framework.

Foucault believes in the inexorability of resistance between social actors within power relations; he provides the ‘user’, or the researcher, with examples of what abstract strategy might look like in this context. This is invaluable, because there are often a variety of actors who are interested in decision-making in hospitals. It follows that it might not necessarily be the case that a dominant professional figure should be considered to be the author of medical-related decisions. To reiterate the Foucauldian logic, though ‘major dominations are the hegemonic effects that are sustained by all [these] confrontations’; they do not necessarily replace the possibility that another actor might direct the conduct of the other (the psychiatrist) through (subversive) strategy:

[T]here is no binary and all-encompassing opposition between rulers and ruled at the root of power relations…

Instead:

The term “power” designates relationships between partners (and by that I am not thinking of a zero-sum game but simply, and for the moment staying in the most general terms, of an ensemble of actions which induce others and follow from one another).

The same functional significance of strategy in local power relations raises the related question of outstanding interest: namely, might personality disordered offenders themselves factor significantly in the admission decision taken by

\footnote{128 The History of Sexuality, supra n.8, p. 94.}
\footnote{129 Ibid.}
\footnote{130 ‘The Subject and Power’, supra n.19, p. 217.}
professionals – and, if so, why and how? Chapter 3 advances empirical evidence which suggests that they may.

2.4.3 The self-governance function

Chapter 3 concludes by considering the possibility of self-governance as a power-effect of psychiatry once offenders are received into hospital from prison. Undeniably, the notion of self-governance could have been discussed in concert with the mechanisms of power employed within the disciplinary institutions (discourse, micro-penalties, constant surveillance and the interiorisation of training over time). However, it was not until his last works that Foucault began to pay attention to the possible relationship between truth, power, individual conduct and self-responsibilisation in greater depth:¹３¹

In my earlier works, I tried to locate three major types of problems: the problem of truth, the problem of power, and the problem of individual conduct. These three domains of experience can only be understood in relation to each other, not independently.

He complains that his earlier works only focus on the first two experiences; indeed, in works such as Discipline and Punishment, the reader is told what disciplinary power looks like but not why discourse-mediated power might work. The third experience, he posits, ‘seemed to provide a kind of guiding thread which…did not have to resort to some rhetorical methods of avoiding one of the three fundamental domains of experience’.¹３² Foucault was not concerned with healthcare generally, though his discussions on self-government during the early 1980s are of wide application.

¹３² Ibid.
In *The History of Sexuality*, he offers a re-reading of public hygiene and *bio-power* by drawing on the discourse of sexuality. He posits that sex was a nineteenth century bourgeois ‘fiction’, which orchestrated a racist dichotomy in society in terms of acceptable and forbidden sexual practices, which were aimed at controlling the sexual acts or perversions of the ‘lower’ classes.

Foucault describes these techniques as:

> [P]rocedures…suggested or prescribed to individuals in order to determine their identity, maintain it, or transform it in terms of a certain number of ends, through relations of self-mastery or self-knowledge.

Foucault posits that the deployment of sexuality in society generated ‘self-mastery’ in terms of a ‘certain number of ends’ (principally, the labours of productivity: birth, longevity, health and wealth). Sexuality-as-discourse was effective for even those who tried to resist its normative standards were caught by its grip. The bourgeois fiction increasingly spoke about tabooed desires, believing themselves to be resisting repression; and those who were actively resisting – for instance, through engaging in degenerate sexual practices – were not liberated, but were equally ensnared within its normative effect, since sex (compared to a broader conception of ‘bodies and pleasure’) is an invention of sexuality.

Dreyfus and Rabinow describe this power as constraining and coercive, distorted by the formation of knowledge which fears truth, and having the effect of suppressing desires, ‘fostering false consciousnesses’ and ‘promoting

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133 *Supra* n.8.
134 *Supra* n.51.
136 *The History of Sexuality*, *supra* n.8, p. 157.
ignorance’. Foucault does not himself talk of ideology and false consciousness; rather, as Golder and Fitzpatrick point out, he describes the rise of the bourgeoisie in terms of ‘an explicit, coded and formally egalitarian juridical framework’ and refers to forces emanating within ‘systems of micropolitical power that are essentially non-egalitarian and asymmetrical that we call the disciplines’. However, in Foucault’s account, an individual may still become duped as to the origins of their autonomous action. He asks of the ‘devious and supple’ system of discipline: would [they] accept it if [they] did not see it as a mere limit placed on their desire, leaving a measure of freedom – however slight – intact?

The point behind this rhetorical question is that he wishes to posit that a refusal to accommodate the truth-claims of accepted discourse do not preclude it exerting normalising effects. It is on this basis that Nickolas Rose coins the phrase ‘healthism’ to provide a theory which couples the ‘public objectives for the good health and good order of the social body with the desire of individuals for health and well-being’. And, presumably, as a function of health-based
discourse, Roy Porter observes that ‘Doctors and “consumers” are becoming locked within a fantasy that everyone has something wrong with them, everyone and everything can be cured’. However, this takes Foucault one step further back, since it implies, without more, that individuals actually seek health. As such, no room is left for the possibility that health-related discourses shape preferences in spite of the potential for resistance.

Reading this point into the wider three functions of law and government (normative, decision-making and self-governance) discussed in this commentary, the questions to be examined in subsequent chapters are as follows: how are decisions reached to admit those with mental disorder to (medium) secure hospitals for treatment? Is decision-making the domain of psychiatrists? Do personality disordered offenders influence, through strategy, their admissions to psychiatric hospitals from prison? If patients direct professional decisions regarding their future care and detention, how and why do they do it? And, once admitted, does successful strategy become a petty achievement masked by the self-governmental strategies subsequently employed by the individual directed towards more pro-social, ‘healthy’ ways?

Chapter 3

Understanding Admission Decision-Making: Is Psy-Discourse Dominating?

In my studies of madness or the prison, it seemed to me that the question at the centre of everything was: what is power? And, to be more specific: how is it exercised, what exactly happens when someone exercises power over another?

Foucault, M. (1965)¹

The last chapter introduced Michel Foucault’s theoretical work on power relations, governmentality and discipline. Using this framework, it was demonstrated that psychiatry, psychiatric hospitals and prisons are expressions of the ill-coordinated attempt of ‘modern’ society to normalise (rehabilitate) individuals suffering with madness. During this epoch, psychiatry has, since the nineteenth century, been the dominant discourse in the treatment of madness. This fact is reflected in the preference of researchers to survey psychiatrists when seeking to understand admission decision-making under the Mental Health Act 1983.

However, in contrast to the nineteenth century treatment of madness, modern ‘psychiatric’ practice is notably multidisciplinary; combined interventions by nurses, psychologists and psychiatrists are now commonplace, especially where the client in question has a personality disorder. Moreover, it is now possible that other professionals external to psychiatry can assume overall responsibility for the patient’s care. This suggests that a wider sample of

professionals from within the multidisciplinary team ought to be considered. In this respect, Foucault’s elucidation of the ways in which individuals can employ strategies to direct the conduct of others is invaluable. What Foucault is less clear about, however, is the effect leadership and collaboration might have on group decision-making. This limitation will be considered in light of the work of Talcott Parsons.

The second part of this chapter argues that the prioritisation of professionals’ decision-frames is unhelpful, without more. After Foucault, might it be that patients (also) harness strategies to direct professional decisions concerning their future care and detention? This chapter considers the available empirical evidence. Against this backdrop, it then investigates the issue of whether ‘resistant’ patients who are not motivated by the possibility of rehabilitation can, nevertheless, benefit from treatment.

### 3.1 Antisocial Personality Disorder and Hospital Admissions

#### 3.1.1 Setting the scene: implied research methodologies

The Mental Health Act 1983 is largely concerned with setting out the circumstances in which a person with a mental disorder may be admitted, either compulsorily or informally, to hospital. The majority of compulsory admissions are for treatment under sections 3 (civil detentions), 37 or 47 (criminal detentions). Before an individual is admitted to a secure psychiatric hospital for treatment, there will usually be a multidisciplinary assessment by psychiatrists, nurses and psychologists. This standard is explicitly advocated by
evidence-based guidelines on the treatment and management of patients with antisocial personality disorder (ASPD):²

People with antisocial personality disorder often have complex needs, which in turn require complex assessment often from a multi-disciplinary agency and multi-professional perspective.

One perspective of admission decision-making might, therefore, be that the decision is reached by all members of the multidisciplinary staff who provide patient care. By comparison, before admission can go ahead, a doctor approved by the Secretary of State as having experience in the diagnosis and treatment of mental disorder must recommend that the provisions of the relevant provisions are made out (section 12(2)).³ Since only a psychiatrist can diagnose a mental disorder for the purposes of admission, psychiatric recommendations remain the ‘cornerstone of the admission procedure’.⁴

This bland fact is reflected in the preference for surveying psychiatrists in hospital multidisciplinary decision-making. In one notable study covering ninety-eight per cent of the total medium secure bed estate, Grounds et al. employed semi-structured interviews to understand the ‘values, assumptions and contextual pressures’ shaping decisions to admit or refuse individuals diagnosed with a mental disorder for treatment.⁵ Eight-one per cent of respondents were psychiatrists and ‘most of the remainder were nurses’. No


³ Before admission can take place under s.37, the court will give regard to the contents of a medical report in deciding whether a custodial sentence would be more appropriate (s.157 of the Criminal Justice Act 2003).


further members of the multidisciplinary team were invited to participate. The authors offer the following critique of their working method:⁶

The study was limited to a modest sample of lead clinicians, predominantly forensic psychiatrists. Further research that has a larger and more varied sample base, particularly including other medium secure unit staff, would be merited.

Whether, in the authors’ views, a ‘more varied sample base’ is one that should also include the patient or offender is unclear. The specific reference to ‘other medium secure unit staff’ would suggest not. This is unfortunate: the authors had concluded that such factors as being detained in prison and the views of patients (or, perhaps more accurately, offenders) towards treatment were highly relevant to the decision to admit. It is not evident why the decisions of professionals should be read as taking place in a vacuum.

3.1.2 The chosen methodological approach

The methodological approach adopted by this study is that a binary conception of power – that is, one which presumes decisions rest with a single privileged actor – fails to tell us why (personality disordered) offenders are admitted to hospital for treatment. Foucault tells us that actors within power relations can employ ‘a whole field of responses, reactions, results, and possible inventions’ to influence others.⁷ This also means that power may be ‘pervasive, complex and often disguised’,⁸ meaning that all those who have a vested interest in the admission decision, including the offender him- or herself, should be considered as relevant to our understanding of how that decision is reached.

Equally, it is not in doubt that it is the psychiatrist, rather than his or her multidisciplinary team, who must authorise admission. What is simply claimed is that s/he will not necessarily be the author of the decision, for ‘[p]ower only exists when it is put into action’. This assertion will now be tested against accounts of psychiatric power and decision-making within multidisciplinary teams.

3.2 The Decisional Fora: Strategy and Collaboration

3.2.1 The preponderance of psychiatry

In the history of mental health care and treatment, psychiatric power, or domination, has been more manifest than latent. The psychiatric responsibility for admission decision-making in respect of patients compulsorily detained was first introduced in the Mental Health Act 1959, within the role of Responsible Medical Officer (RMO). The RMO was responsible for authorising admissions, (compulsory) treatment, discharges, and for observing any statutory safeguards within the Act. However, the ease with which the psychiatrist seemed to assume this role in fact belies a struggle of 200 years.

By the late eighteenth century, psychiatry was attempting to position itself as the dominant discourse in cases of madness in the asylum. However, the authority of psychiatrists to become ‘moral’ advisors to patients in Victorian England was not guaranteed; rather, they had to deny major competition from an early form of psychology called moral therapy. Moral treatment also used a moral code; practised at the York Retreat from 1796, it offered treatment

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independent of medicine, with a degree of retained sensibility.\textsuperscript{10} It was thus described at the time as ‘a rather damning attack’ on the capacity of psychiatry to deal with madness.\textsuperscript{11} The strategic response of psychiatry was to question the ‘expertise’, credentials and lack of positive ideologies employed by practitioners of moral therapy.\textsuperscript{12} Psychiatry, on the other hand, was soon to develop the use of stimulants and hypnotics, which compared favourably to the general approach of medicine in the treatment of malady.

That said, in 1877 the Lancet Inquiry found that life in the asylum could actually lead to further deterioration in health,\textsuperscript{13} if not death from the over use of chemical restraint.\textsuperscript{14} One notable consequence of this was s.2 of the Lunacy Acts (Amendment) Act 1889, which specified that judicial authority was required before admissions were sanctioned. It appears that it took psychiatry forty years to overcome the aftermath of this; when the Medical Treatment Act 1930 reversed the need for judicial authority, it was, Unsworth points out, the result of the profession’s ‘carefully plotted process of consulting interested parties, pacifying opponents and preparing public opinion’.\textsuperscript{15} It is in this way

\textsuperscript{10} Treatment employed methods of trust, empathy, education and social activities aimed at distracting patients from obsessive and intrusive thoughts; see, for example: Jones, K. (1960) \textit{Mental Health and Social Policy, 1845–1959}. Routledge, p. 9; Digby, A. (1985) \textit{Madness, Morality and Medicine}. Cambridge University Press, p. 34.
\textsuperscript{12} David Ingleby points out that ‘each discipline puts considerable energy into denigrating the efforts of its rivals’: (1983) ‘Mental Health and Social Order’. In: S. Cohen and A. Scull (eds.). \textit{Social Control and the State, Historical and Comparative Essays}. Oxford: Robertson, p. 168 [‘Mental Health and Social Order’].
\textsuperscript{13} Glanville, J. (1977) \textit{The Care and the Cure of the Insane: Being the Reports of the Lancet Commission on Lunatic Asylums, 1875-6-7, for Middlesex, the City of London, and Surrey, Vol 2}. Hardwicke and Bogue, p. 150.
\textsuperscript{14} Even prominent members of the medical profession expressed their concerns; see, for instance, Savage, G. H. (1879) ‘Use and Abuses of Choral Hydrate’. \textit{Journal of Mental Science}, 25: 4–8.
\textsuperscript{15} Unsworth, C. R. (1987) \textit{The Politics of Mental Health Legislation}. Oxford University Press, p. 172. However, to be clear, the 1930 Act afforded hegemony to psychiatry only in relation to voluntary or ‘temporary’ patients.
that Foucault is bound to speak of the ruling discourse as ensuring ‘a sort of pressure and something like a power of constraint on other discourses’.

However, it is simply not the case that psychology had no further role in the care of those with madness. Through negotiation and opportunism, it developed its practice in areas of the socialisation of children, in the munitions factories during World War I, where there was the issue of shell shock, and later in relation to battle fatigue during World War II. Nickolas Rose, furthermore, cites the emergence of laboratories, degree programmes, and the establishment of journals and learned societies between 1875 and 1925 as further evidence of paradigmatic growth:

In this way, [it] would gradually (and incompletely) distinguish itself from philosophy and ethics on the one hand and medicine and biology on the other, to form itself into a single … discipline.

It is now some years on and competition between various professions continues to mark the treatment of mental disorder. Foucault describes this enduring phenomenon as ‘counter-conduct’, in which professionals outside the ruling discourse envision:

a different form of conduct … by other leaders (conducteurs) and shepherds, towards other objectives and forms of salvation and through other procedures and methods.

Evidence of ‘counter-conduct’ is well-demonstrated in the context of reforms to the MHA 1983, which began to take effect in 2008. Among the changes introduced, the Mental Health Act 2007 abolished the RMO role and replaced it with the role of Responsible Clinician (RC). The actual duties accompanying

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18 Ibid., pp. 194–95.
the RC role remained the same; however, unlike the RMO role, any clinical supervisor, or approved clinician (AC), who has overall responsibility for a patient’s case, is eligible to apply for the RC role.

Schedule 1 of the Mental Health (Approved Clinician) Directions 2008 stipulates that the relevant professions are nurses, psychologists, psychiatrists, occupational therapists and social workers who possess ‘the necessary competencies’. The relevant competencies include: knowledge of the MHA 1983 (as amended); the ability to identify mental disorder and determine whether it is of a severity warranting compulsory confinement; sensitivity to the patient’s needs; suitable skill in clinical risk assessment; and responsiveness to the treatment needs of the patient. In addition, s.6 of the 2008 Directions stipulates that the AC must be able to demonstrate ‘the ability to assimilate the views and opinions of other professionals, patients and carers, whilst maintaining an independent view’, ‘effectively lead’, and seek help if their skills are limited in a particular area. Since psychiatrists retain the power to authorise admissions, in practice the extension of the RC role marks the ambition to create multidisciplinary teams comprised of professionals with different skills working in concert with one another, as well as ‘the establishment of corporate consensual goals in delivering a service’. It is, in essence, the antithesis of self-interest that is being promoted in medical decision-making.

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19 The RC retains the power to authorise leave of absence, order discharge from hospital, renew compulsory detention, recall patients being treated in the community to hospital, and provide authority for treatment.
20 Direction 4 of the Mental Health Act 1983 (Approved Clinician) Directions 2008.
21 Schedule 2 of the 2008 Directions. To date, it is not clear how one demonstrates suitability for the role of RC, or what training might be necessary for that purpose.
3.2.2 Multidisciplinarity: a place for self-interest?

In practice, Nicola Glover-Thomas demonstrates that the basic tenet of multidisciplinarity is rarely achieved in mental health care decision-making: defensiveness, unclear professional boundaries and responsibilities, and competitive professional tendencies in seeking to achieve professional dominance will undermine productivity. Indeed, such evidence of this point abounds in the historical power play between psychiatry and psychology during the nineteenth century.

Today, the Explanatory Notes accompanying the 2008 Directions state that ‘psychiatrists and psychologists of consultant status’ are expected to be among the first to be approved. That this dual-preferencing of patient government should be read as being indicative of the continuing hegemonic tension between the two professions was clear during the Bill stage of the MHA 2007. Heavily debated was the issue of perceived competency of professionals external to psychiatry in providing efficacious treatment to various client groups. Psychologists were particular critical of psychiatric hegemony.

In 2002, for instance, May and Kinderman spoke of their wish to see the 1983 Act amendments undermine ‘paternalistic psychiatry’, and noted the reticence of some psychiatrists toward other professionals undertaking the RMO role was an intentional hindrance to the paternalism being railed

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Moreover, on the subject of caring for individuals with personality disorders, Kinderman asserts:

In many cases, I am the consultant with the greatest expertise, apart from when it comes to developing that into the professional roles under the [unamended 1983] Act. For many of my colleagues, such as psychologists who work with clients with personality disorders in the forensic field, there is no medical treatment for the personality disorders of their patients. They are offered care, rehabilitation and psychological therapies, and the medical treatment is a relatively small part of their care plan. However, _those people defer at the moment to responsible medical officers…_ It is just simply not the case that in all cases the person with the greatest expertise is necessarily, by default, a medic.

Two issues are borne out in this quote: the tension between professional self-interest and deference to psychiatry (the RC) in multidisciplinary teams. According to Kinderman, the professional designated as RC will be the author of the multidisciplinary team decisions. The perceived expertise, or self-interest, of other professionals within the care team does not appear to displace this (accepted) authority. Thus, power presents as domination or, as Max Weber put it, ‘the probability that a command with a given specific content will be obeyed by a given group of persons’, due to professional customs giving rise to agreement or an imposition.

Foucault similarly defines domination as ‘a strategic situation more or less taken for granted and consolidated by means of a long-term confrontation between adversaries’. It is ‘more or less’ long-term for it remains open to

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challenge and modification through resistance, as May and Kinderman demonstrate above.\textsuperscript{29} Whether resistance is absolute, however, is less clear. Foucault posits that the effects of discourse on the soul are not by nature ‘the manifestation of a consensus’.\textsuperscript{30} This means that it may well be that the inscription of localised episodes of resistance by the professional external to psychiatry are merely inscribed into ‘the effects that it includes on the entire network in which it is caught up’.\textsuperscript{31} The practical effect of this is that the ‘free’ and/or resistant subject invests in discourse and is, in turn, invested by (or subjected to) it:\textsuperscript{32}

\begin{quote}
\textit{[P]ower is not totally entrusted to someone who would exercise it alone, over others, in an absolute fashion; rather this [disciplinary] machine is one in which everyone is caught, those who exercise this power as well as those who are subjected to it.}
\end{quote}

The point is that actors with the multidisciplinary team, such as Kinderman, may be orientated toward the normalising functions of the psy-discourse. Acting in concert is, in essence, a co-strategy which complements the normative expectations of the hegemonic discourse (plainly: treat, cure and rehabilitate). However, this extrapolation of Foucault’s position raises the contention that he is not thinking enough about why group leadership is essential for this function to be performed adequately. He merely points out

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\textsuperscript{29} Foucault asks: ‘Are there no great radical ruptures, massive binary divisions, then? Occasionally, yes. But more often one is dealing with mobile and transitory points of resistance, producing cleavages in society that shift about, fracturing units and effecting regroupings, furrowing across the individuals themselves, cutting them up and remoulding them, marking off irreducible regions in them, in their minds and bodies’: Foucault, M. (1981) \textit{The History of Sexuality, Vol. 1: The Will to Knowledge}. R. Hurley (trans.). Penguin Books, pp. 95–6 [\textit{The History of Sexuality}].
\textsuperscript{30} ‘The Subject and Power’, supra n.7, p. 220.
\end{flushright}
that ‘certain positions preponderate and permit an effect of supremacy to be produced’.\textsuperscript{33} Elsewhere, he says there are ‘forms of institutionalization’ which mix traditional pre-dispositions, legal structures, phenomena relating to custom or to fashion … [its] own regulations, [its] \textit{hierarchical structures} which are carefully defined.\textsuperscript{34}

If this is an invitation to expect (disciplinary) institutions to be imbued with leadership as an effect of discourse, does Foucault also believe that leadership is necessary to ensure professional self-interest remains subservient to the collective interest of the group?

The fact that he does not say so severely limits discussion of the relative balance of self-interest, collaboration and leadership within multidisciplinary groups. In light of this limitation, a more thorough exposition of this triumvirate is proposed. The chosen commentator is Talcott Parsons, whose explication of the role of leadership in solidary groups is both interesting and, it is argued, a useful companion to Foucault.

\textbf{3.2.3 Recapitulating Foucault: Talcott Parsons and leadership}

Talcott Parsons’ general thesis is that the building blocks of social order are co-ordinated actions within solidary groups.\textsuperscript{35} Consequently, he is sceptical of favouring the pursuit of self-interest over collective or wider societal interests. His starting point is to critique the Hobbesian ‘state of nature’. Hobbes posits that man’s basic position is as a servant of his own passions, which are

\textsuperscript{33} \textit{Ibid.} Emphasis added.

\textsuperscript{34} ‘The Subject and Power’, \textit{supra} n.7, p. 223.

\textsuperscript{35} This contrasts with Luhmann’s systems theory, in which social order is a manifestation of the coding and transmission of \textit{communication} within self-referential social systems (including medicine and law): Luhmann, N. (1995) \textit{Social Systems}. Stanford: Stanford University Press, pp. 38–9.
gratified if necessary through force and fraud.\textsuperscript{36} In Parsons’ view, a society preferring self-interest over collective interest is untenable, for it foreshadows a life which is ‘solitary, poor, nasty, brutish and short’.\textsuperscript{37} Whereas Hobbes focuses on the power of the sovereign to re-order social forces by way of a social contract with its members, for Parsons societal norms and values shape individual conduct (whether or not within institutions) by first specifying certain role expectations.\textsuperscript{38} Role orientations are vital, not because they increase productivity \textit{per se},\textsuperscript{39} but because they ensure social solidarity, stability and homeostasis:\textsuperscript{40}

the society should be oriented to mastery over that environment in the name of ideals and goals which are transcendental with reference to it.

For this purpose, he identifies the doctor–patient relationship as an important ‘collectivity’, and assumes as its focus the health of the ill, or ‘deviant’, subordinate. Another, related, collectivity would be the multidisciplinary decision-making team, which also has health as its function. The goal of the team is achieved through solidarity:\textsuperscript{41}

an articulation or integration of the actions of a plurality of actors in a specific type of situation in which the various actors accept jointly a set of harmonious rules regarding goals and procedures.


\textsuperscript{37} \textit{Leviathan}, op. cit., p. 65.


\textsuperscript{39} Indeed, much of his work stemmed from his dissatisfaction with the principal theories of capitalism, most notably Marxism, which he argued ‘tended to characterize the whole of modern society in terms of this conception.’ See (1965) ‘Some Theoretical Considerations Bearing on the Field of Medical Sociology’. In: Parsons, T. \textit{Social Structure and Personality}. 2\textsuperscript{nd} ed. London: The Free Press, Collier-Macmillan Ltd, p. 327 \textit{[Social Structure and Personality]}.  

\textsuperscript{40} ‘Definitions of Health and Illness in the Light of American Values and Social Structure’. \textit{Ibid.}, p. 277.  

\textsuperscript{41} \textit{On Institutions and Social Evolution}, supra n.38, p. 118.
Contrary to Foucault, Parsons’ basic premise is that the pursuit of solidary goals is not automatic but is harmonised by leadership. An example of a leader would be the psychiatrist. Parsons says that it is the psychiatrist who has historically been a residual locus of care for the patient when their somatic or mental difficulties extend beyond the capabilities of the family. This results in power or, more accurately, ‘authority’ disciplined by ‘legitimacy’. A useful working example of this is provided in the Grounds et al. study on multidisciplinary team decision-making:

‘I think you could direct [it] one way or another … I could … in quite an influential way, because of the position that I have, not because of who I am but of what I am.’

Parsons takes this position further, arguing that a legitimate authority figure will direct the conduct of others by virtue of his or her office. He explains that, provided there is the ‘manifestation of performance’ within the decision-making collectivity, ‘trust’ will maintain the psychiatrist’s personal security within the power system. A lack of trust in a psychiatrist, however, could result in his or her replacement, since this would benefit rather than destabilise the group. He proceeds:

One of the ways in which this is done in some social systems is by the definition of the criteria of eligibility for incumbency of the role by membership in solidary groups, thus regulating the flow of persons into such roles. In all social systems access to roles is regulated by the possession of qualifications which might be, but are not always necessarily, memberships or qualities.

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42 ‘Mental Illness and “Spiritual Malaise”: The Role of the Psychiatrist and of the Minister of Religion’. In: Social Structure and Personality, supra n.39, p. 315.
43 ‘A Qualitative Study of Admission Decision-Making’, supra n.5.
44 Ibid., p. 121.
45 On Institutions and Social Evolution, op cit., p. 118.
46 As a corollary to this, one would have to assume a degree of self-interest is acting on members of solidary groups to seek out the role. Parsons has no problem with conceding that groups form and function due to ‘needs-disposition’, ‘rewards’, ‘the allocation of power’ and
An example is the professional external to psychiatry seeking out the RC role. However, despite documented evidence of ‘global’ resistance towards psychiatry, in practice it is not obvious that this will happen. One reason is the degree of responsibility that is attached to the RC role. Another reason, specific to the domain of (antisocial) personality disorder, is that the uncertainty facing multidisciplinary teams in the provision of effective treatment (talking therapies) means loss of trust is less important if things go wrong. Conversely, effective treatment, even if provided by psychologists (as is likely), will engineer trust in the RC. The reason for this that the truth boundaries between the ruling and ‘minor’ discourses may be fluid. So, for example, it is sometimes the case that psychiatrists will undertake psychotherapeutic (talking therapies) training as part of developing their art, seemingly untroubled by psychology’s alternative explanation of the causes of mental aberrances. Psychology, therefore, provides the ruling paradigm with a further manifestation. The result is that trust in the RC is implicit, and conflict would presumably operate at a low level.

Foucault tells us that conflict within power relations resolves in favour of

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47 Supra n.24, n.25.
48 A psychiatrist in the Grounds et al. study explains: ‘So you’ve got the public protection hat. You’ve got your regional hat or sub-regional role, so you are there in an advisory capacity, in a way. Having assessed the individual, you may decide that they – for a variety of reasons – are not suitable and not appropriate or do not need your particular facility but may have just the job up your sleeve, or so you think … So then you have a role in engineering that and being Mr Fix-it. You have a hat of managing the expectations of others even if you can’t meet them – the expectations of the prison, or the referrer, or the Home Office, or the courts, or the solicitor or the patient’s relatives, or whoever it happens to be. And you also have to have your sort of future gazing hat as well, because at the point of admission you should be thinking of where is this person going, what is the game plan? What do I need to be doing now that will improve the likelihood of them being re-settled elsewhere if and when it is ultimately safe to do so?’: ‘A Qualitative Study of Admission Decision-Making’, supra n.5.
50 ‘Mental Health and Social Order’, supra n.12, p. 168.
whoever prevails in strategic terms. By comparison, Parsons posits that conflict always resolves in favour of the group leader. Within goal-orientated groups (or a *Gemeinschaft*-relation), there are four means by which the leader (‘ego’) may try to control or guide his or her team (‘alter’):  

(a) *Persuasion* (intentional channel, positive sanction): why it would be a ‘good thing’ to agree with ego. This is distinct from situational advantages;  

(b) *Activation of commitments* (intentional channel, negative sanction): ‘offering reasons’ why it would be ‘wrong’ to refuse;  

(c) *Inducement* (situational channel, positive sanction): ‘situation advantages contingent on ego’s compliance with his suggestions’ – for example, money; and  

(d) *Deterrence* (situational channel, negative sanction), which might include the use of force, but usually involves the imposition of disadvantages.

This interesting account of ego and alter relations in solidary groups is not without problems. For James Coleman, a blind spot in Parsons’ account is the notion that ego’s influence over alter derives from trust that decisions taken will benefit the group; yet, he points out, this is incongruent with the need of ego to employ strategy to ‘get results’ in an interaction. Why cede to the view of ego? Why must it be assumed that alter *always* invests in ego?  

The alternative account provided by commentators is that the pursuit of co-operative goals (impliedly, alter’s agreement with ego) co-exists with the pursuit of competitive goals (deriving from recalcitrance towards ego), and that conflict need not resolve in favour of ego. In reality, the evidence that both ego *and* alter might direct group decision-making is mixed.

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An account broadly supportive of Parsons’ is provided by Nugus et al.\textsuperscript{53} in their qualitative study of healthcare decision-making. On clinical divisions and collaborative goals, one professional commented:

All have input: we ask and consult with each other and consulting is across professions … It is a multidisciplinary team.

Nevertheless, leadership was perceived to be fundamental to the working of the multidisciplinary team:

‘Working together – like on [multidisciplinary student week] – is really important because we get to know where each other is at … That’s really important because as a doctor I need to know what the allied health guys can provide my patient and have confidence in them.’

(Medical student, Aged Care and Rehabilitation Services, observation)

The authors conclude:

[This] suggests socialized role expectations that doctors evaluate and determine the extent to which they will accept the input into patient care delivered by those with different professional backgrounds.\textsuperscript{54}

Furthermore, whilst no strategy was explicitly endorsed in this study, conflict within the team was said to be resolved through deference to the doctor:

‘If a doctor says [they can’t go] they won’t be discharged… If I say they can’t go [it makes no difference].’

(An ‘allied health clinician’)

By comparison, in Len Bowers’ study of nurses working with personality disordered offenders, there is clear evidence of strategy being employed by the


\textsuperscript{54} A similar point is made by a psychiatrist in the Grounds \textit{et al.} study: ‘Do I keep the patient waiting for admission in order to get the nurses to come and see him, because they like to feel enfranchised, empowered, and they’ve got a role in the decision-making?’: ‘A Qualitative Study of Admission Decision-Making’.
psychiatrist (ego) to resolve conflict:  

‘You sit in Care Team Meetings (CTMs) and the docs, the medical staff here, I think, are appalling. I’ve actually sat through a CTM and had a doctor tell me more or less that my opinion is irrelevant.’

Demonstrating less ego-centric decision-making, Napier and Gershenfeld demonstrate both ‘competitive’ and ‘co-operative’ goal-seeking within solidary groups. They remark that power is a source available to all group members, irrespective of status. A more nuanced account is provided by Riley and Manias, who demonstrate common ‘gatekeeping’ practices by nurses within operating theatres. One example is ‘granting or denying access to time and space for surgeons to undertake procedures’. This acts, they conclude, as a strategic means of negotiating their social position in the medical hierarchy, ‘both in relation to one another and with their medical colleagues’. The result is a very un-Parsonian account of the solidary group, and a more prototypical Foucauldian account. More precisely, the strategies evidenced by Riley and Manias reify Foucault’s third general mode:

[T]he procedures used in a situation of confrontation to deprive the opponent of his means of combat and to reduce him to giving up the struggle; it is a question therefore of the means destined to obtain victory.

Nevertheless, this lone account of alter-derived power cannot of itself deprive Parsons of his explanatory potential when it comes to the nature of solidary

56 In Parsonian terms, the humiliation which the nurse was subjected to by the psychiatrist (ego) corresponds with strategy in the form of ‘deterrence’ (the situational channel, negative sanction): supra n.51.
group decision-making. The better view is that multidisciplinary teams incorporate both ego- and alter-mediated strategy – or, offering a less laboured interpretation of Parsons, that

A power relation requires that “the other” (the one over whom power is exercised) be thoroughly recognised and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results, and possible inventions may open up.60

Put into the context of admission decisions reached in respect of personality disordered offenders, this raises a number of possibilities. In the broadest terms: first, the employment of strategies, or ‘inventions’, by professionals external to psychiatry will guide or manipulate the decision of the RC, either in concert or as individuals (Foucault). Second, the RC may disagree with the prevailing view of his or her team, or a member within it, and use strategy to resolve the conflict (Parsons). Third, there may be explicit agreement within the multidisciplinary team (although this might mask strategy by either the leader or his or her team) (Foucault/Parsons). In all cases, the approaches of all members of the multidisciplinary team are valuable to our interpretation of the author of the decision. Without this wider survey, it is more likely, as Steven Lukes warns, that ‘people may agree about the facts, but disagree about where power exists’.61

Beyond this interpretation of the relative strengths and weaknesses of Foucault and Parsons in the group decision-making context, an exhaustive dialectic between the two commentators is not intended. For one, they come from very different schools of thought (Parsons, the Anglo-American sociology

60 Ibid., p. 220.
unmoved by positivism; Foucault, continental philosophy post-Marx) and so one should expect divergent accounts of power. It is sufficient to note that Parsons offers much of interest in terms of his analysis of collaborative group dynamics, particularly in his elucidation of potential strategies employed by the group leader in the face of conflict. Equally, Foucault’s important account of power relations would have benefitted from more explicit reference to leadership and solidarity within groups. The absence of this wider analysis is best explained by his particular interest in examining how the marginalised in society become subjects, how – if at all – they resist this and, ultimately, how they might be normalised by the presuppositions of accepted discourse in society. Parsons takes a more limited view of the patient within the collectivity of the doctor–patient relationship. The patient is represented as wholly passive in respect of decisions concerning them. Researchers who have examined decision-making in professional teams endorse this limited view.

3.2.4 The underlying body-politic of the patient (in research)

Whereas Foucault affords the patient the probability of resistance within the local power relationship, Parsons disregards (as in solidarity groups) the potential for effective patient resistance against his or her doctor. Rather romantically, he asserts:62

The classic “doctor–patient relationship” should then be considered to be the minimal relevant collectivity. It is the solidarity of this collectivity which constitutes the basis of mutual “trust” between physician and patient. It seemed to follow that the primary function of medical practice what we ordinarily call therapy, should be regarded as the goal not simply of the physician but of the collectivity constituted by physician and patient taken together.

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62 Social Structure and Personality, supra n.39, p. 338.
When researchers take up the challenge of understanding the social system of medicine, and the decisions made within it, it is as though this ‘function’ of solidarity and normalisation preludes patient subjectivity and resistance. The ‘active’ patient is lost in the haze of deference to professional accounts. The reason researchers seem less inclined to try to understand the approach of patients appears to be a wider consequence of social patterning. Foucault points out that:

the man of madness communicates with society … by the intermediary of an … abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirement of conformity.

The underlying assumption here is that psychiatric discourse gives rise to flawed ‘selves’ and an everyday discourse where, in the absence of mental disorder, people are encountered as ‘having a voice of their own’. However, this simple dichotomy, predicated upon the notion of ideal-type conformity, is problematic in practice.

To take the individual with ASPD, s/he usually externalises life problems. It is for this reason that the disorder is so prevalent in prisons, and it is why few offenders in practice seek treatment in healthcare settings. For those who do, Foucault tells us that the path to rehabilitation must begin with the ‘confession’. An offender, at the very least, must both ‘confess’ to his or her mental disorder and to being motivated to receive help. In one of only three entries on the influence of patients on professional decisions to admit them to

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63 *Madness and Civilisation, supra n.1, p. x.*


65 *Antisocial Personality Disorder, supra n.2, p. 24.*

66 Chapter 2, *supra 2.2.2.*
medium secure units, Grounds et al. reflect:67

[F]or patients with personality disorder who were being considered for psychological treatment, the patient’s attitude towards co-operation with treatment was crucial. Resources were too scarce to admit those whose stays would be unproductive.

Whilst this study provides an interesting insight into psychiatrists’ decision-frame, what this account cannot tell us is why the patient was co-operative. Should it be assumed that the actions of patients are underpinned by the pursuit of health esteemed by professionals? How can this question hope to be answered without giving patients ‘a voice of their own’? Bartlett and Sandland ask:68

Are we content that [these] languages of mental health and illness remain exclusive of the voices of their client groups, and if not, how are these voices to be included in an understand of law and policy in the mental health area?

The approach of this study is to understand why ‘resistant’ personality disordered offenders embark upon a course of treatment in hospital. Rather than relying on the decision-frames of professionals in isolation, the approach of the current author is to understand the decision-frame of patients, and rupture the implication that psychiatric domination accounts for the actions of the mad.

3.3 Integrating the Patient into the Professional Fora

3.3.1 Being ‘Nutted Off’

It is beyond doubt that ‘confession’ can be strategically employed by patients to direct professional decisions. The ‘strategic patient’ has been popularised in literature, from One Flew Over the Cuckoo’s Nest to Girl, Interrupted, and in respect of decision-making issues adjacent to Goffman’s work, the ease with which Rosenhan, along with six of his research students, were admitted to hospital by presenting symptoms of schizophrenia is well documented.

Early empirical evidence of individuals presenting to professionals in a tactical manner is provided by Peter Bartlett in his account of the prominence of the Poor Law officers overseeing asylum admissions under the Poor Law 1834. He points out that the ‘insane’ poor were not as ‘helpless’ and ‘acted upon’ as one might think, but could instead ‘manipulate’ admission decisions for personal gain. Discussing why this might have been the case, he points out the attractive aspects of the asylum, such as brass bands, periodic excursions, occasional theatrical entertainment, weekly dances, and so on; even the provision of regular food contrasted favourably with life in the community.

Take, for instance, one Robert Capenhurst, who is recorded as having confessed to a suicide attempt in order to be transferred from the workhouse to the asylum.

Peter Bartlett also points out that the feigning of lunacy was well known in

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72 It is not inconceivable that similar factors might operate today. Note that, in response to budgetary constraints, prisons have seen cutbacks in the provision of fresh meat and vegetables: Temko, N. ‘Warning over Jail Unrest as Prisoners Face Menu Cuts’. The Observer, July 6, 2008.
73 Adm. 23 March 1868. Casebook LRO DE 3533 / 191.
the context of the insanity defence in criminal law. During the building of Broadmoor asylum for the ‘criminal lunatic’, he describes how one physician, Charles Hood, resident at Bethlem, acknowledged offenders’ ability to deceive ‘authorities’. What is also interesting is that, on some occasions, he shows that the patient was discharged if this concern was substantiated in practice, thus demonstrating the potential to employ strategy and counter-strategy in diffuse power relations.

More recently, it has been shown that nurses are equally attentive to the potential for patients to pretend they have a personality disorder in order to increase their chances of getting out of prison:⁷⁴

‘Many patients have talked to me about behaviours they have displayed say in prison, and the term that they use is ‘I was facing a long stretch so I decided to get nuttered off so that life will be easier’.’

Despite this reasonably rich vein of history, there is currently little research on the strategic ways in which offenders interact with professionals charged with deciding their suitability for admission to psychiatric hospitals from prison (under section 47 of the Mental Health Act 1983).⁷⁵ This study will address this limitation. In the process, it will also address the complex issue of whether it is possible to rehabilitate personality disordered offenders who may be seeking admission for non-healthist reasons.

This concern is presumably now more acute given that the Criminal Justice Act 2003 has introduced an indeterminate sentence for public protection for dangerous crimes committed after April 2005. The result is that an offender

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must be seen to engage positively with psychological treatment before they can hope to be released. Some offenders will receive their quota of treatment in psychiatric hospitals by virtue of having been found to have a mental disorder. Whether engagement will result in normalisation of unacceptable behaviours is unclear. Evidence-based treatment guidelines are cautiously optimistic:

It is very unlikely that all antisocial patients can be coerced into pro-social thinking or behaviour.\(^76\)

The better view is that the caveat of coercion precluding rehabilitation is a red herring. Since coercion is endemic both to the criminal justice and mental health systems, the normative ‘persuasiveness’ of psy-discourse is what remains at issue. A more general sphere of analysis serves this point well:\(^77\)

\[\text{T}he \text{q}uestion \text{of} \text{how} \text{prisoners} \text{engage} \ldots \text{and} \text{the} \text{ways} \text{in} \text{which} \text{[these]} \text{practices} \text{do} \text{or} \text{do} \text{not} \text{actually} \text{shape} \text{prisoners’ subjectivity} \text{and} \text{behaviour} \text{is} \text{a} \text{separate} \text{issue} \text{of} \text{great importance.}\]

### 3.3.2 Does the receipt of treatment lead to normalisation?

In theoretical terms, Foucault’s thesis is that resistance, or coercion, can hide the real workings of normalising psychiatric power in society. Parsons, on the other hand, takes therapeutic benefit to be a natural consequence of the doctor–patient solidarity:\(^78\)

It is highly probable that, whether or not the physician knows it … in practicing medicine skilfully he is always in fact exerting a psychotherapeutic effect on his patients.

\(^{76}\) Antisocial Personality Disorder, supra n.2, p. 34. Emphasis added.


\(^{78}\) On Institutions and Social Evolution, supra n.38, p. 178.
Drawing on Parsons, Giddens refutes the matter-of-fact claim that actors conform to social norms, whatever their social situation. Taking a more pragmatic approach, Nealon points out that Foucault’s work is severely limited by the necessity to prove where resistance ends and adherence to norms begins. He states the problem as being:

how to measure, predict, incite, or guarantee subjective resistance in the face of interpolating social norms.

Treatment guidelines on ASPD make this point in the context of defining and measuring treatment success:

A key issue in the treatment of antisocial personality disorder and psychopathy is the test of therapeutic outcome: how will the practitioner know if treatment has been successful?

One measure has been to rely on recidivism statistics. However, defining a causal relationship between treatment and reoffending is problematic. Is aftercare being offered, or is the offender at risk in the community? Was treatment of sufficient quality? How much treatment is enough to exert a

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79 He contends: ‘It is quite common for sociologists naively to assert or to assume that conformity to any specific course of social action is founded either on ‘internalization’ of appropriate moral values or upon some form of coercion’: (1968) “Power” in the Recent Writings of Talcott Parsons’. Sociology, 2: 257–72.


81 Antisocial Personality Disorder, supra n.2, p. 33.

82 Ibid., pp. 144–69.

83 ‘[P]eople with antisocial personality disorder may find themselves excluded from a range of services that might otherwise support them in the community (including during transition from the care of the criminal justice system to the community), such as housing, welfare and employment services’: Antisocial Personality Disorder, supra n.2, p. 173. It is argued that a failure to reintegrate the offender is directly related to recidivism: Kubrin, C. E. & Stewart, E. A. (2006) ‘Predicting who Reoffends: The Neglected Role of Neighborhood Context in Recidivism Studies’. Criminology, 44(1): 165–97.

rehabilitative effect? What was the offender’s motivation for engaging in treatment the first place? With myriad factors all intensifying the difficulty of evidencing the normalising potential of psychiatric treatment, it is probable that one can do no more than appeal to the evidence. Much of the evidence suggests that resistant patients do not internalise psychiatric norms.

Evidence of this point is provided by Jill Peay. In her seminal study on special (high-security) hospital discharges ordered by the Mental Health Review Tribunal (MHRT; now First-tier tribunal – mental health, Peay demonstrates that patients are adept at influencing professional decisions. In an era in which behavioural therapies were less favoured, she shows that, despite patients generally being of the view that (anti-psychotic) medication was not helpful, most were acquiescing. As one patient stated, ‘medication is my ticket out of here’.

Since Peay’s study, other researchers have confirmed that coercion resulting in adherence to the taking of medication may be more realistic than the notion that detained patients comply with treatment demands out of perceived therapeutic benefit or, by the same token, due to underlying acceptance for their mental disorder:

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87 Ibid., pp. 51–52.
'I will take it to keep them happy at the end of the day. To keep them off my back. I’ve never been satisfied with [it]. I never will.'

(Community treatment patient realising the threat of compulsory detention under the MHA 1983)

Similarly, in the prison context adherence has been found to be related either to the use of ‘incentives’ or the threat of a more restrictive regime.\(^9^1\)

‘Some of the staff bribe me … [saying for example] ‘I’ll give you proper cigarettes if you take your medication’.’

‘They told me if I didn’t take it, I’d go to healthcare which is like punishment … [you are] banged up [for ages] down there. They were like ‘we can make you take it’. And I was just like ‘oh stuff that then, I’ll take it over here’.’

Others comply because the regime itself is intolerable. Peay notes that some patients may ‘equate treatment compliance with the ‘good behaviour’ that leads to quicker release from custodial sentences’.\(^9^2\) The same point has been made by nurses working with patients with ASPD:\(^9^3\)

‘But what you’ve got to watch here with PD 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 reoffended.’

Professionals may employ various counter-strategies to subvert the possibility that patients are ‘strategically’ engaging with treatment.\(^9^4\) Elizabeth Perkins presents an example of this in a more recent study of MHRT decision-

\(^9^1\) Ibid.

\(^9^2\) Tribunals on Trial, supra n.86, p. 152.

\(^9^3\) Dangerous and Severe Personality Disorder, supra n.74, p. 40.

\(^9^4\) Foucault would define this 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’: ‘The Subject and Power’, supra n.7, p.224
The patient in question had always complied with the treatment prescribed by psychiatrists, and was adamant that he would continue to do so in the event of discharge. The RC was sceptical, and stated to the tribunal:

‘He sees his time here as a sentence and compliance as a way of reducing that sentence, therefore I am not sure how much he would comply when he was out.’

Peay also evidences some ingenious, if unethical, counter-strategies employed by psychiatrists to encourage continued patient detention. These include: the augmentation of medication prior to a hearing to increase its soporific effect; the reduction of anti-Parkinsonian medication used to counter side effects of taking anti-psychotic medication, and, finally, the common practice of reclassifying a patient to informal status to remove the right of the tribunal to discharge.

There are several reasons why the psychiatrist might wish to prevent discharge. One is that the perceived imprudence of recommending discharge in a culture of accountability and blame can been avoided:

‘Forensic psychiatry and people working in the specialty are dealing in a high profile area. There’s a lot more criticism now if things go wrong, therefore, people are much more careful, at times over-defensive.’

Of course, underlying all the concerns and counter-strategies is the appreciation that psy-discourse does not, or cannot, always produce normalised

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96 Ibid., p. 65.
97 Tribunals on Trial, supra n.86, pp. 51–2.
98 Ibid., p. 191.
100 Mark Freestone et al. explain this phenomenon in more sober terms: ‘it is not in the best interests of any clinician to posit a reduction of risk in any patient, if their primary concern is the retention of their job’: Freestone, M., Manning, N. & Evans, C. (2007) A Comparative Ethnographic Investigation into the Culture, Organisation, Management Techniques and Environmental Features of High-Secure Mental Health Units. Full Research Report, p. 25.
subjects. When a patient states, ‘you’re impotent without your [RC],’ it is not necessarily because that patient sees their relationship with the treating psychiatrist as crucial to their self-understanding. Rather, it may be a signification of the patient’s acceptance that only through speaking the ‘language’ of his or her captors will they extricate themselves from the power relationship. Foucault reminds us that:

In a society such as ours – or in any society, come to that – multiple relations of power traverse, characterize, and constitute the social body; they are indissociable from a discourse of truth, and they can neither be established nor function unless a true discourse is produced, accumulated, put into circulation, and set to work. Power cannot be exercised unless a certain economy of discourses of truth functions in, on the basis of, and thanks to, that power…

Once the language of ‘truth’ is understood, and the lines are well conceived, the patient can create the impression that conformity is domination:

The theatrical imperatives that normally prevail in situations of domination produce a public transcript in close conformity with how the dominant group would wish to have things appear.

Domination is, perhaps, to overstate the point. How successful the grand narrative of psy-discourse is at modifying the self-understanding of psy-patients is of perennial concern. Foucault wishes us to believe that it is the impression of freedom that masks normalisation in society. Consequent upon

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101 Tribunals on Trial, supra n.86, p. 40.
the impression of freedom, individuals resist their dominators in a variety of imaginative ways:105

[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.

And though the respective actors may one day act and speak the language of normalisation for real, under the glare of spotlights it is probable that some ‘beggars’ or ‘poor folk’ are simply more motivated by the prospect of spare change. To put this another way: on the stage of power, might it be a stark reality that personality disordered offenders continually improvise their parts, whilst gazing down to observe the lines they were given?

Concluding Remarks – Part I

This literature review began by contextualising the question of how decisions are reached to transfer personality disordered offenders from prison to psychiatric hospitals for treatment under the Mental Health Act 1983. It was shown that prominent researchers are committed to the notion that psychiatrists dominate this decision-making forum. This is reflected in their preference for surveying psychiatrists but not other professionals within the multidisciplinary team. The same researchers have also yet to survey patients. In the process, it is implied that patients have little to do with professional decisions concerning their future care and detention. In response, and by building on the work of Foucault on power relations, it is argued that all actors caught within this decisional context have the potential to influence the psychiatrist’s decision by employing precise strategy.

In respect of the doctor-patient relationship, this position on power was reified, for instance, in Jill Peay’s informative study of mental health review decision-making. She demonstrated that patients try to manipulate psychiatrists by agreeing to the prescribed treatment plan to win favour when expedite release hangs in the balance. However, without a suitable theoretical framework to anchor this finding, Peay concludes that eighty-six per cent of tribunal decisions agreed with the patient’s psychiatrist, not ‘irrevocably from the facts of patient’s circumstances’ but ‘constructed according to both [the psychiatrist’s] views of the case and their professional experience’.¹ That said, if the respective psychiatrist feels that the patient is engaging with treatment for this superficial reason, it was

shown that s/he may employ a counter-strategy to try to prevent that patient’s release.

Among professionals, the fear that patients might be manipulating the treatment process for subversive reasons is felt particularly acutely in respect of those with antisocial personality disorder. It is undeniable that personality disordered offenders continue to problematise the simplistic view that psychiatric patients engage with treatment to enable better self-understanding – or that, following Foucault, their engagement with treatment promotes the development of meaningful pro-social behaviours in those who are resisting the rehabilitative aims of ‘system’. This appears to be a major limitation of Foucault.

A further limitation of Foucault is his lack of discussion of the ways in which solidary groups reach decisions. In Chapter 3, this was addressed by reference to the work of Talcott Parsons. He posits that collaboration and consensus is central to group dynamics, and that this is furthered by the actions of an accepted leader. It is the leader who will employ strategies if low level conflict threatens to undermine the achievement of the group’s aims. In the field of personality disorder, Bateman and Tyrer explain:²

The team has to be willing to assign the responsibility of leadership to one of its members and that member must be willing to undertake the leadership role. Underlying rivalries within a team will inevitably bring with them inconsistency as individuals attempt to develop greater influence.

The predominant leader in multidisciplinary treatment teams has been shown to be the psychiatrist. On the evidence available, psychiatrists do heavily influence multidisciplinary team decision-making. Nevertheless, ‘underlying rivalries’ also

exists within multidisciplinary teams, and this supports the thesis that professionals other than psychiatrists can also direct the team’s decision.

Peter Morriss is critical of this sort of approach to power. He argues that writers tend to pack far more into their discussion than is justifiable: ‘claims which ought to be considered as empirical are crammed into the concept itself,’ he opines ‘whereby, of course, they tend to become true by definition’. The better view is that the enunciation of one’s politics helps inform readers of any underlying presuppositions guiding data analysis. It is highly unlikely that data can perform this function on its own. Furthermore, by offering Foucault as the author’s main locutor, critical reflection and further interpretations of the data are explicitly invited.

In Part II of this study, the Foucauldian account is advanced in an effort to further our understanding of how hospital admission decisions are reached in respect of personality disordered offenders. It is also advanced as an analytical tool for understanding the effects of treatment on those patients once admitted. However, it does not purport to be the final word on the matter, or on the pertinence of Foucauldian analysis. Some thirty years after his death, there is still the sense that his work may have succumbed to ‘unexpected twists and turns’. This cannot be wholly ignored. Indeed, one wonders what Foucault would have made of the findings of this study had he been alive to read them.

4 Talcott Parsons notes: ‘We never investigate “all the facts” which could be known about the phenomena in question, but only those which we think are “important”’: (1938) ‘The Role of Theory in Social Research’. American Sociological Review 3: 13-20.
PART II

A STUDY OF DECISION-MAKING UNDER

THE MENTAL HEALTH ACT 1983
Chapter 4

The Research Project

Part I of the study introduced and critiqued Michel Foucault’s analysis of power in relation to understanding decision-making under section 47 of the Mental Health Act 1983. This section of the Act permits the transfer of offenders with mental disorder from prison to forensic hospitals during their sentence for treatment. On demonstrating the ‘strategic’ nature of human behaviour, and its potential to direct the conduct of others, it was shown that an explication of decision-making necessitates a survey of all those interested in the final result. The aim of this study is to further this methodological standpoint by introducing survey methods which incorporate, in Hawkins’ words, ‘the structure of values and meanings which the decision maker as a human being brings to any choice’,¹ into the question of why hospital directions under the 1983 Act are made.

This chapter is dedicated to describing the methods and methodological locus informing data collection in the study. In scope, it is conscious of ‘the poverty of research in method and conception’ which befalls studies on legal decision-making.²

4.1 Methodological context

It often seems the law governing the treatment of mentally disordered offenders develops faster, and with more fervour, than does an appreciation of the decisions it informs. From a traditional legal view, this would only be acceptable if the law provided precepts which did not involve the personality of the decision-maker. However, as Peay asserted as far back as 1989, this is a view which has ‘gradually been replaced’, in theory if not in practice.

In 2004, Grounds et al. took up the challenge of explicating the ‘decision-frame’ of clinicians (principally psychiatrists) involved in pre-admission assessment and deliberations for mentally disordered offenders at both the sentencing stage and during their imprisonment. This meritorious research, therefore, served in part a concern of a subsequent Innovation in Prison Healthcare conference, in which it was stated that

A better understanding is needed about the criteria and decision-making processes which determine whether and when a prisoner should be transferred to a secure psychiatric hospital, especially when clinicians disagree when making such decisions...

However, Grounds et al. made little reference to competing approaches to the decision-making fora. For instance, decisions were usually attributed to psychiatrists with little reference to other members of the multidisciplinary team; yet, one would assume, all members would be equally motivated to ensure that the appropriate service user, in their respective opinions, is

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admitted. Moreover, reflecting the common sense approach of authors in other decisional contexts, subsequent commentators invite the researcher to survey service users, since it is said that they can ‘provide a valuable perspective which has been shaped by experiencing health issues and receiving services’.

Concurring with this common sense presupposition, elsewhere the then Sainsbury’s Centre for Mental Health [now Centre for Mental Health] opined that service user involvement in research ‘…provides services and government with insights into real lives in order to help develop policies. Most policies,’ it continues, ‘are made up without speaking to people with life experience…’

In respect of understanding decision-making under s.47, this may be a condition of access in empirical research, since it relies on valid consent by service users but implied consent by staff to allow access to ‘their’ patients, who may believe access to be irrelevant to understanding professional decision-making. Becker, indeed, coins the term ‘hierarchy of credibility’ to describe the bias typically lobbied at the underdog, or ‘subordinate’ by reference to ‘established order’:

We can use the notion of a hierarchy of credibility to understand this phenomenon. In any system of ranked groups, participants take it as given that members of the highest group have the right to define the way things really are…


Robert Dingwall, instead, warns that to understand the way in which society operates, one must comprehend the perspectives of ‘top dogs, bottom dogs and, indeed, lap dogs’. In support of these perspectives, the reader will by now be aware that this study seeks to incorporate a wide variety of perspectives by adopting the reasoning of Michel Foucault’s analysis of power relations. It was seen in Chapters 2 and 3 that this was chosen to guide the research because he argues that power does not ‘subordinate’ individuals, or a class, but is diffuse and non-dispositional. Pursuant to this conception, power may be assigned to actors on account of any strategic approaches or tactical denouements they might employ with a view to directing the conduct of others. Accordingly, it is submitted that to understand all aims which have the potential to affect decision-making, one is obliged to consider the approach of all actors involved in the admission process on the referral of the service user from prison. This is both an imperative and an overarching aim of this study.

Thankfully, this imperative was one supported by the institution in which the research was conducted. It is, therefore, with optimism that those who continue to cede to a ‘binary’ view of power – according to which decision-making is a top-down phenomenon – will not necessarily win favour within the research community and, moreover, with professionals themselves.

4.2 Working methodology

4.2.1 Locative context

The study took place at Arnold Lodge medium-secure unit in Leicester in 2009. The psychiatric hospital is located under the auspices of

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Nottinghamshire Healthcare NHS Trust and is the base for the East Midlands Centre for Forensic Mental Health. Identified as a ‘notable practice site’ by the Government document *No Longer a Diagnosis of Exclusion* in 2003,\(^{11}\) it remains one of the most experienced providers of adult medium secure care in England. The unit comprises seven wards, two of which, named Cannock and Ridgeway, are the only specifically designed personality disorder wards within the total medium secure bed estate.

However, the two wards differ in their client base. Cannock ward is almost exclusively made up of service users transferred during their period of imprisonment under s.47 of the MHA 1983. Ridgeway ward is a much newer ward, having opened in 2007. Only a small minority of service users on Ridgeway are admitted from prison under s.47,\(^{12}\) and then only if the service user is deemed to pose added security issues or has committed a different type of offence, such as a sex crime, which makes them uncomplimentary to the current mix of service users on Cannock ward. In general, therefore, Ridgeway ward represents a step-down facility for service users previously detained in high-security. Residence on the ward will often be for around three to four years as part of the path to low security services or even release – thus, as a rehabilitative practice, soundly reflecting the assertion of Kaye & Franey, that ‘most patients needing high security also need long term care (not necessarily in high security)’.\(^{13}\)

Recognising the differing client focus of the two wards, Cannock ward was chosen as the place of survey. Like Ridgeway, however, its aim of

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\(^{11}\) NIMH(E), p. 17.

\(^{12}\) During the period of data collection, only one service user was admitted to Ridgeway ward under s.47.

rehabilitating offenders is furthered by a multidisciplinary approach to treatment; and utilises the skills of psychiatrists, psychologists, nurses, occupational therapists, social workers and health support workers. Treatment is focused on psychological treatments with medication providing adjunctive therapy. The modes and foci of treatment are discussed more fully in Chapter 7. Suffice it to say for now that the principles guiding treatment are redolent of those outlined by the Reed Report in 1992,\(^\text{14}\) in which it was recommended that ‘proper attention must be paid to the needs of individuals; under conditions of no greater security than is justified by the degree of danger patients present to themselves and others; in such a way as to maximize rehabilitation and chances of sustaining an independent life…’ Whilst the aim of the research was not to pontificate on the degree to which the personality disorder unit allies itself to these aims, it was comforting to witness a dedicated multi-disciplinary team who were keen to offer a complex and often difficult client group the best chance of ‘successful’ rehabilitation where nihilistic attitudes continue to present challenges.

### 4.2.2 Respondents’ characteristics

At the time of the study, eleven beds were occupied on Cannock ward. Ten service users were recruited to take part in the study. A further service user declined to take part. They had all previously been transferred to the ward under s.47 of the MHA 1983, and had given their consent to receive treatment there. Deriving from the ward’s admissions policy, all respondents were male. The average age of the men was found to be around 27, with the youngest

respondent being 23 and the oldest 41. All identified as being white British.

Regarding sample selection, Crewe previously employed random sampling to document experiences of power and adaptations to control in a medium security men’s training prison, and succinctly argues that this avoids ‘over-representing’ more extroverted subjects.\(^\text{15}\) The current study was not concerned with the possibility of recruiting extroverted subjects, since there is no reason to suspect that this characteristic tells us anything about the potential for the respective service user to influence professional decisions concerning their admission and the effects of treatment. Moreover, since the ward caters for no more than twelve service users, and given the finite amount of time available for data collection, convenience (or purposive) sampling was preferred.\(^\text{16}\)

In addition to surveying service users, nine members of the treating team were formally surveyed using convenience sampling. This encompassed psychologists, nurses, psychiatrists and occupational therapists who were directly involved in the pre-admission assessment of the respective service users. Also, ‘observations’ and opinions generated by informal discussions with a further four members of staff during time in the ward’s office were included as data. Three of these were staff nurses and one other was a health support worker. Two further potential respondents initially expressed interest in taking part in the study but did not subsequently take part. This meant that nineteen respondents took part formally and four informally. This was not


\(^{16}\) In sum, convenience sampling means that participants are selected on the basis of availability by virtue of accessibility; random (or probability) sampling means that all potential participants have a known chance of being selected: see Bryman, A. (2004) Social Research Methods, 2\(^{nd}\) ed. Oxford University Press, pp. 87, 100. [Social Research Methods].
thought to be a compromise between time constraints and richness of findings, however: the decision to conduct no further interviews was determined by clear evidence of data saturation across both groups of respondents.  

4.2.3 Ethical considerations

Clearly, one ethical dimension pertinent to the research design of this study recognises the claim that ‘conducting research that makes statements about, or may inform policies or change systems of care, should always consult those that may be affected by the potential outcome’. Another, however, is that the wish for data should not compromise ethical standards in seeking to recruit potential respondents. Making this point most forcefully is the Research Governance Framework for England and Wales, which states: the ‘dignity, rights, safety and well-being of respondents must be the primary consideration in any research study’. Whilst it is not always clear when or how these pillars will be offended in social sciences research, it was nevertheless decided that an operative diagnosis of dementia or mental retardation would have been grounds for exclusion from the research. Moreover, it was decided that capacity to

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17 Opinions vary as to when one should accept data saturation as having been reached. The researcher, however, agrees with Guest et al., who pose the rhetorical question: ‘How many interviews or data points are enough to achieve one’s research objectives given a set research team? Without a doubt, anyone can find, literally, an infinite number of ways to parse up and interpret even the smallest of qualitative data sets. At the other extreme, an analyst could gloss over a large data set and find nothing of interest. In this respect, saturation is reliant on research qualities and has no boundaries.’ See Guest, G., Bunce, A. & Johnson, L. (2006) ‘How Many Interviews are Enough?: An experiment with Data Saturation and Variability’. Field Methods, 18(1): 59-82.


19 Department of Health (2005) Research Governance Framework for Health and Social Care. 2nd ed. London: DH, para. 2.2.1. The remit of the RGF is to consider research conducted under the auspices of the Department of Health.

consent did not need to be an independent variable; and it was on this basis that the research was approved by Leicestershire, Northamptonshire and Rutland Research Ethics Committee on January 14, 2009. Within the meaning of paragraph 4.35 of the Code of Practice to the Mental Capacity Act 2005, it was accepted that ‘any practitioner’ could assess the status of the potential respondent’s capacity. At no point did the respective responsible clinician indicate that the service user did not have capacity to consent. Moreover, there was no reason to doubt that participants had capacity to consent to taking part in the research.

The process of achieving consent was multi-faceted. It began by making contact with the service user on the ward, and offering them an information sheet on the research. A similar sheet was provided for professional staff. These contained information including an accessible statement of the purpose of the research and procedures to be employed; an explicit account of what would be required of the potential respondent if they consented (and did not subsequently withdraw their consent, with their data destroyed); a reasonable time estimate of how long their involvement would last; information on who they could approach for further information on the research or support – or in the event that they wished to lodge a complaint; and details of how to seek compensation in the event of injury resulting from participation. Prior to survey, the potential participant was asked to sign a consent form.

Despite the taking of consent, one adverse event was noted. In this case, Mr. H, after having given his consent, some weeks later demanded that all

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21 Issues of capacity are dealt with by s.3(1) of the Mental Capacity Act 2005.
22 See Appendix 1.
23 Appendix 2.
24 Appendix 3.
information on him be destroyed. It appeared that a terse encounter with a member of staff had unsettled him. He subsequently called his solicitor, who was informed that Mr. H had given valid consent to take part in the research, and that his name and all information that had been gained through his participation would remain anonymous. This reassured Mr. H, who expressed no further wish to revoke his consent.

4.2.4 Modes of survey employed

4.2.4.1 Semi-structured interviews

Interviews were chosen as the principal mode of survey. All interviews took place in a variety of private rooms at Cannock ward, and lasted between 20 and 75 minutes. By way of design, the methodological bias of artificial reduction of complex phenomenon to restrictive responses has been noted elsewhere, and for this reason, upon the receipt of consent, semi-structured interviews were chosen, with a preference for open ended questions. With the respondent’s permission, all interviews were tape recorded and later transcribed. Where discussions were of an informal nature, notes were taken by hand. In some cases, this was after the event, raising potential concerns of imperfect recall and a lack of prior consent to record and use that information. This put an obvious premium on researcher integrity and respondents observing their perceived best interests. However, at no point was anything said with an ‘off the record’ proviso; and, in any event, every effort was made to record information in the

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27 What is more, open-questions may increase internal validity, through providing a forum for respondents to organise their answers within their own frameworks: Aberbach, J. D. & Rockman, B. A. (2002) ‘Conducting and Coding Elite Interviews’. PS: Political Science and Politics, 35: 673-76.
participant’s company and with their knowledge. Finally, and fortuitously, the researcher observed one pre-admission meeting convened by the multidisciplinary team on Cannock ward.

4.2.4.2 Medical records
Following interview, service users’ medical records were read and analysed in two offices. The records were rich in data, providing detailed accounts of service user’s offending behaviour; admission and treatment on Cannock ward; in some cases, conveyance back to prison, and, indeed, subsequent re-admission to the ward. From a methodological point of view, the addition of multiple methods of data collection has, as Gutek points out, the benefit of affording greater internal validity to the study. From a practical point of view, the medical records also provided a background, and valuable insight, into the service users’ experiences of the penal environment prior to admission, which included details of their engagement with prison in-reach treatment services and any adjudications received. In total, 34 medical files were read.

4.2.4.3 Interpretivist methods of data collection
Rather than advance a view that data can ‘speak for itself’, King, Keobane & Verba contend that all research methodologies, whether explicit or not, have limitations – ‘The advantage of explicitness,’ they opine, ‘is that those limitations can be understood and, if possible, addressed.’ Following this

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sound advice, this section does not purport to be the last word on ‘interpretation’ in social sciences but offers a critical base for the researcher’s preconceptions, which are two-fold. Put simply, the approach taken to the survey of clients in this study derives, first, from an ontological standpoint of Constructionism: the belief that social phenomena are both produced and revised through peoples’ interactions; and, secondly, the epistemological position of Interpretivism – associated with the hermeneutic movement – which sees as legitimate the viewpoint that subjects actively construct their social world.\(^{31}\)

The theoretical framework adopted in this study is Michel Foucault’s analysis of power relations. What is not precisely clear is whether his methods support an interpretivist approach to data collection. It could be argued that he is animated by Heidegger’s preconceptions of interpretation. Specifically, as was alluded to in Chapter 3, Heidegger posits that one is unable to interpret data free from the context of one’s own peculiar history. In *Being and Time*, he explains the science of being of entities by way of an interpretation of ‘Dasein’: a special ‘ontologico-ontically’ distinctive entity signifying the ‘primordial signification’ of the word hermeneutic.\(^{32}\) It follows that, when seeking to ‘interpret’, one does not throw a ‘signification over some naked thing present-at-hand’, for one already has some involvement disclosed in our understanding of the world, the interpretation of which is grounded in a ‘fore having’, ‘fore sight’ and ‘fore conception’. When something is understood but still veiled, ‘it becomes unveiled by an act of appropriation’, under the

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guidance of a point of view. Consequently, an interpretation, expressed in discourse, is never a ‘presuppositionless apprehending of something presented to us: any attempt to interpret, coming from that which is already understood, creates a circle which hides the positive possibility of ‘the most primordial kind of knowing’. Thus, one must be on guard against the presentation of our ‘fancies and popular conceptions’ and work out ‘fore-structures in terms of the things themselves’.

Foucault seems to express similar optimism on one occasion when asked why he was interested in the problem of madness. He responds by citing a series of relevant precursors, which include the study of philosophy, then psychopathology and the training and rehabilitation carried out within the psychiatric hospital, where he was neither a patient nor a doctor. He then concludes that this enabled an interpretation of events in ‘a fairly open-minded, fairly neutral way, outside the usual codes’. What one is to notice, however, is his reliance on the prefix of ‘fairly’ in relation to the interpreter’s own, un-historicised, account of truth. This appears at a time when Foucault’s work was undergoing a theoretical shift which uses his earlier conceptions of the truth conditions of accepted discourse with their effects on the self-making of subjects in society. Thus construed, Foucault himself was on the verge of locating himself within the strictures of societal government qua discourse, the

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33 Ibid., pp. 190-2.
34 Ibid., p. 203.
effects of which he may only have had a dim awareness of. The result would be that he, as interpreter, and the respondent, as Gadamer would say, are ‘placed on the same level’. However, this is not to preclude an effort to interpret human behaviour. In ‘The Subject and Power’, for instance, he advocates a move towards a ‘new economy of power relations’, which is more empirical. He explains:

It consists of taking the forms of resistance against different forms of power as a starting point... Rather than analyzing power relations from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies. For example, to find out what our society means by sanity, perhaps we should investigate what is happening in the field of insanity.39

But he then says that the study of the putting into action of power between individuals must be integrated into ‘a disparate field of possibilities brought to bear upon permanent structures’,40 which of course have their point of anchorage in forms of government and domination. A premium is clearly put on the subjugating properties of accepted discourse where the intended subject, the service user, of psychiatric discourse is concerned. In respect of the interpreter, one is forced to accept that the respondent-service user may be unaware of the significance of their actions as they unwittingly serve the whims of government. This aspect of Foucault’s work, then, is in a sense Interpretivism serving an essential historicism of accepted discourse. He remains, therefore, both a useful heuristic tool and an interesting source of critique in light of the empirical findings to be discussed.

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39 Beyond Structuralism and Hermeneutics, op. cit., p. 211. Emphasis added.
40 Ibid., p. 219.
4.3 Themes guiding data collection

It is hoped that data collection was conducted as an iterative process; notwithstanding, the following should be seen as initial sources of exploration in the study, if not ‘partial’ hypotheses:

1. Understanding decision-making under s.47 of the Mental Health Act 1983 from a variety of professional staff and service users’ perspectives will highlight the adumbration of seeking only the clinician’s (principally psychiatrist’s) viewpoint in previous research.

However, previous research continues to be both informative and useful. In the study of Grounds et al., for instance, it was found that admissions are determined by personal factors (such as the ‘patients’ views) as well as extra-service user factors. These include the use of exclusion criteria; the availability of resources, including beds; relationship with colleagues, both within the institution and with prisons; and the effect of policy – principally risk-based discourse.

2. Extra-personal factors, such as policy considerations, may emasculate the potency of offenders’ strategies aimed at gaining admission to Cannock ward.

Finally, and more nuanced by the study’s theoretical perspective on power, and deferent to previous empirical findings on the subject of service user care, it is claimed that

3. Patients do not blindly ‘self-make’ according to psychiatric norms, but act according to rational self-interest.

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41 Supra n.4.
42 These are discussed in full in subsequent chapters.
It is hoped that these metaphysical expedients will assist, rather than cloud, the interpretation of empirical findings. Finally, whilst the researcher sought to minimise limitations in its design, potential limitations still exist. These will now be discussed.

### 4.4 Potential limitations of the study

Foucault has been criticised, particularly in feminist literature, for his androcentrism.\(^{43}\) It will come as no comfort, therefore, that the current study employs Foucauldian method in its assessment of the effects of power on male service users (though it surveys male and female staff). On the side of justification, Melzer et al. point out that 86.8 per cent of male versus 13.2 per cent of female services users were assessed as needing medium secure care in their study of admission practices,\(^{44}\) indicating that female service users might be better cared for in environments other than medium security. Grounds et al. note the problem of caring for female service users with PD in a medium secure environment, as expressed by one clinician:\(^{45}\)

> ‘Patients we take have multiple problems...substance abuse and alcohol abuse; more of the predatory males who you wouldn’t want to mix with your vulnerable females. So that is what the patient groups have become in many ways – more difficult to manage.’\(^{46}\)

It is noteworthy that Arnold Lodge also offers treatment to female service users with PD on another specialist ward. Clearly, future researchers may address the

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\(^{45}\) Supra n.4.

\(^{46}\) Though beyond the scope of this study, one could conceivably take issue with this dichotomisation of ‘predatory’ males versus ‘vulnerable’ females.
question of admissions’ practices to specific units such as these – preferably including the perspectives of service users’ themselves. Whether such research should occur in individual units or on a more national scale is a point of contention, one which the current study can hardly avoid.

Consider, it has been claimed that ‘the characteristics of a unit have powerful effects on admission, and thus generalizing from local studies can be hazardous’.\textsuperscript{47} Some academic commentators have, indeed, questioned the extent to which case studies are ever representative and generalisable; their value perhaps instead referable to intensive case analysis. Williams instead argues that moderatum generalisations are possible, in that instances of the enquiry can be seen to be ‘instances of a broader set of recognizable features’.\textsuperscript{48} Indeed, in the current study, an important generalisable feature might be, for instance, the reification that service users are active in the decision-making forum.\textsuperscript{49} The explicitness of these claims, together with the underlying theoretical presuppositions – so often lacking in research of even larger sample sizes – has the benefit, Bryman confirms, of improving external validity by facilitating the future researcher’s adoption of a similar role to the original researcher.\textsuperscript{50}

One final, at least, ostensible limitation of the study is that those who were unsuccessful in their transfer application were not surveyed. Initially, it had been hoped that ethical approval would be given for multisite research to take place in a series of referring prisons, in addition to Arnold Lodge. However, a

\textsuperscript{47} Supra n.4.
\textsuperscript{49} In this respect, the cogency of the researcher’s theoretical reasoning will be important to generalisability. See Mitchell, J. C. (1983) ‘Case and Situation Analysis’. Sociological Review, 31: 186-211.
\textsuperscript{50} Social Research Methods, supra n.16, p. 285.
refused proposal and, related to this, unexpected time constraints, made this an unviable alternative to the current project. On reflection, it was felt that the rich data gained through interviews and reading of medical / prison records of those who were admitted made it quite clear why others were not.

The elucidation of those results now becomes the focus. Chapter 5 begins by an examination of group decision-making practices on Cannock ward, which chapter 6 will then animate by reference to service user approaches to the decision-making forum.
Chapter 5

Professional Admission Decisions: Formalities, Competition, Collaboration

Power only exists when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures.

Michel Foucault (1982)

Chapter 5 introduces the formal requirements governing the admission of offenders with personality disorder to Cannock ward (Arnold Lodge), under section 47 of the Mental Health Act 1983. By presenting the results of empirical research on the admission process, it is asked how decisions are reached by reference to those overt admissions policies, and, from a theoretical point of view, power. Continuing the thread of chapters 2 and 3, Michel Foucault’s analysis of power relations will be adopted – which posits that all social actors can influence the conduct of others by implementation of ‘strategy’, irrespective of factors such as professional status. However, by acknowledging the privileged position of psychiatry in the care of the mentally disordered, in law and practice, the notion that members of the multidisciplinary team (MDT) may exert mutual influence is open to question. The presence of contextual factors, such as the availability of resources on the ward, may also have an impact on the free play of antagonism between members of the MDT. It will be seen that this is to identify the limitation that

Foucault’s analysis of power is innocent of the nuances of particular ‘systems’.

5.1 The Selection of Suitable Patients

5.1.1 Pre-admission assessment: a collaborative team approach

Once a referral has been identified during a business meeting, it is normal for a full multidisciplinary assessment to take place with the offender in prison, thus reflecting the contribution of numerous professions in the care of clients on Cannock ward. All members of the team will apply formal criteria to ascertain the suitability of the respective offender for admission. Following assessment, individual conclusions will be communicated to the rest of the team by way of written report. These may then form the basis of discussion.

In content, the reports will divulge the results of a mix of quantitative and qualitative assessments, depending on who conducts the interview. Psychologists, psychiatrists and nurses conduct both streams of assessment; qualitative assessments are carried out by nursing staff and Occupational Therapist (OTs) – sometimes jointly. In recognition of the important role they play in the care and welfare of patients, social- and health-support workers may also make a prison visit, but this occurs less frequently. Indeed, in practice, it seems the responsible clinician (RC – psychiatrist) – or the professional in charge of the patient’s overall care – plays a pivotal role in organising the mechanics of assessment; and a reasonable case can be made that nursing and psychology staff also play a particularly important role. One psychiatrist confirms:

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2 What determines referrals to the ward is considered in chapter 6.
‘...the RC does the first assessment. If I thought that someone wasn’t suitable, I wouldn’t ask the rest of the team to see them... So, if I thought there is no way I’d sign the section form, I wouldn’t ask the rest of the team to do the rest of the assessment. And there’s usually very good reasons when someone is excluded right at the beginning... I wouldn’t waste the time of the rest of the team. And, likewise, if a member of nursing staff or psychology did the first assessment and there were absolutely clear reasons not to go on with that, it wouldn’t progress further than that, but that’s rare. Most get the full assessment.’

Two points deserve clarification: first, the perceived importance of professions tangential to psychiatry performing the assessment exercise; and, secondly, those factors which might act to exclude the offender (exclusion criteria). On the first point, it may come as no surprise to learn that the psychiatrist will usually conduct the initial assessment. If, by reference to the diagnostic criteria within the International Personality Disorder Examination Manual (IPDE), the service user is deemed not to have a personality disorder (PD), there is little reason to involve other staff on the specialist treatment ward. On this basis, the situations in which nursing staff or psychologists would carry out the initial assessments are less compelling. However, in reverse, should these assessments go ahead, and the patient is found to engage one or more exclusionary criteria, this might obviate the need for further assessment by the RC to clarify whether the service user has a PD. Discussion now turns to the nature of these ideal-type exclusionary criteria.

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3 World Health Organisation (1995). WHO: Geneva. The service user will be assessed by means of semi-structured interview; responses will be assessed in light of the ICD-10 and DSM-IV classification systems.
5.1.2 Criteria excluding admission

5.1.2.1 Introduction

It could be argued that to exclude any offender who may benefit from a period of treatment in a medium-secure unit is an unfortunate limitation of the diagnostic criteria that marginalises, and potentially stigmatises, them. Where PD is concerned, the willingness of Cannock ward to admit a client group for whom there remains a nihilist fervour is a welcome rejoinder to the received ‘nothing works’ point of view. The trade-off, however, is that the admission of some client groups would likely disrupt the therapeutic ethos of the ward. Drawing on evidence-based practice, the remainder of clients are excluded in the belief that treatment is impracticable, or may actually be detrimental to their health.

5.1.2.2 Learning disabilities

Whether a service user has a learning disability is decided by a psychologist using the Wechsler Adult Intelligence Scale (WAIS), which records an intelligence quotient (IQ). The WAIS, together with Hare’s Psychopathy checklist (PCL-R) (to be discussed shortly), is standard to entry; it will only be dispensed with at the pre-admission stage if scores have previously been recorded during a prison assessment, perhaps as part of a pre-sentence psychiatric report.

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The WAIS defines intelligence or IQ as ‘The global capacity of a person to act purposefully, to think rationally, and to deal effectively with his / her environment.’ An IQ score of below 75 would not satisfactorily reflect these qualities for the purposes of admission and treatment. Though this undoubtedly excludes a potentially vulnerable group from accessing behavioural courses, the reasons can be cogently put:

‘... [they’re] quite vulnerable, and it’s frustrating for other patients... They often take more training, but they get it in the end... They can frustrate the patient group... I think in an ideal world, there needs to be a facility for people who are borderline with similar programmes, but with slower, more individual practicing’.

(Consultant psychiatrist).

5.1.2.3 Co-morbid diagnosis of schizophrenia or psychosis

Those found during pre-admission assessment to have a severe mental illness will also not be offered a place on Cannock ward. This is usually in relation to psychosis or schizophrenia, even if it is in remission, since experience tells staff that ‘the stress of the treatment is actually quite damaging...’ (Consultant psychiatrist). Surprisingly, in light of the need for ‘appropriate treatment’ to be available before diversion under s.47 of the MHA 1983 is permissible, this basis of exclusion appears at odds with the observed trend in the Grounds et al. study in 2004 – which revealed that many national units had effectively become a psychosis only service. The likely explanation for the discrepancy is that units catering for different mental disorders employ contrasting

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6 To indicate the scale of those potentially affected by the exclusion criteria, 7 per cent in prison are said to have an IQ below 70: see Loucks, N. & Talbot, J. (2007) *No One Knows: Identifying and Supporting Prisoners with Learning Difficulties: The Views of Prison Staff in Scotland*. Prison Reform Trust, p 11.

7 ‘A Qualitative Study of Admission Decision-Making’, *op. cit.*
treatment emphases: treating psychotic symptoms with neuroleptics, or anti-psychotic medication, is common, whereas the behavioural difficulties of PD are ideally addressed through cognitive-behavioural treatment, with anti-psychotic medication being an adjunctive therapy for ‘unmanageable’ symptoms, such as aggression.

When it is believed that the mental disorder in question will not compromise the ability of the service user to engage, it will not act as a bar to admission. Consider that almost all those admitted to Cannock ward were diagnosed as having co-morbid mental disorders, most often major depressive disorder (recurrent) or panic disorder, as well as the complications of alcohol dependence and polysubstance misuse. The message of the exclusionary potential of mental disorder on admission is that it is one of degree and manageability, and equally service user welfare.

5.1.2.4 Self-harm

Almost all of the patients surveyed were habitual self-harmers in prison. Whether this is grounds for exclusion is inconclusive. An offender presenting a real and current risk of suicide would almost certainly not be admitted; realistically, if suicidal ideation were acted upon, the therapeutic regime of the ward would be severely disrupted, and undermined. Take Mr. L., for instance, who described being provisionally accepted into a prison therapeutic community prior to coming to Cannock ward, only to be subsequently refused admission after one of its clients committed suicide. ‘It had an effect on everyone,’ he confided.

In the case of Mr. K., short entries of ‘overdose’ and ‘high risk suicide’ in
his documented prison medical file might have directed the minds of the assessors as to his unsuitability for admission. However, the fact that these entries were dated 1999, several years prior to his referral, were relevant to his subsequent admission. In any event, no staff member was innocent of the stressful, even deleterious, conditions of imprisonment. One nurse asserts:

‘...we’ve found over the years that [it] reduces massively when they come here’. If self-harming does not subside to a manageable level, the ability to convey the service user back to prison is a useful, if unfortunate, ‘safety-net’, as many staff put it.

5.1.2.5 Perceived danger to others

It is more common that acts of aggression or violence towards others will result in a return to prison than self-harm. This is to guard against actual battery or assault as well as to, again, preserve the ward’s therapeutic ethos. As one nurse confirms: ‘How can you have a therapeutic environment if there’s an element of fear...?’ 8 Indeed, the emphasis placed on mitigating against such disruption is reflected in the screening of certain risk factors through the conducting of a mix of qualitative and / or quantitative assessments by nurses, psychiatrists and psychologists.

In general, however, it is apparent that across the medium-secure estate assaultive or aggressive behaviour may well be more tolerated when the client group in question does not suffer from a PD. In respect of mental illness, one psychiatrist in the Grounds et al. study comments: ‘If the patient’s attitude is hostile and assaultive, then…that’s one of the reasons why you would consider

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8 The primary sex offender (though some who are admitted have committed sex crimes) or those experiencing sadistic sexual fantasies are excluded on the same basis; but also because the client-group requires a different treatment emphasis.
admitting them. This variation in admissions policies can be accounted for by the different treatment approaches emphasised across different client-groups. For patients with PD, talking therapies are employed, which require full co-operation to be effective. Where mental illness is concerned, co-operation has a different function: namely, consent to treatment may merely guard against civil or criminal liability if the disapplication of section 63 of the Mental Health Act 1983 is disregarded in the criminal context.

Therefore, it is perhaps unsurprising that it was found that inadequate motivation to engage in treatment is far more likely to lead to exclusion than those exclusionary criteria which are strictly binary in function (a diagnosis of PD, severe mental illness or specific learning disabilities). In fact, it will transpire during the remainder of this chapter that a service user’s motivation to engage in treatment adulterates the applicability of other exclusion criteria to him.

5.1.3 Motivation to engage with treatment

5.1.3.1 An essential pre-requisite to admission

It was unanimous amongst the MDT that an offender should be highly motivated to receive treatment before he should be admitted to Cannock ward. Thus, one reason why the previously quoted psychiatrist might not ‘waste the time of the rest of the team’ following his or her initial assessment is if the service user says ‘… there’s nothing about them which needs to change…’ Related to this is whether treatment will be of any benefit. A nurse clarifies this point:

‘I think one of the things that we try to tease out in the interviews is they’ve got problems; they believe that by engaging in some sort of treatment, they can manage things in a different way. So, there has to be some sort of insight and motivation, and a sort of ownership of problems.’

As with the offender displaying aggression, violent or sadistic tendencies, those who subsequently disengage with treatment once admitted will be returned to prison; though, in practice, this might turn out to be a ‘period of reflection’ followed by re-admission. This hardline approach to motivation confirms the ward’s central philosophy, that people are ‘treatment seeking’ (Psychologist). Presumably, in recognition that one may merely claim to have the requisite motivation to engage with treatment effectively, staff may cross-reference the patient’s presentations (strategy versus counter-strategy) with evidence of their behaviour in prison:

‘I know there are limitations in prison, but have they gone out of their way to go to education...or have they hung around their cell? That would drive some of the decision-making as to whether they should come in.’

(Nurse).

This approach alludes to the problematic nature of assessment in the main: professional views may not in fact alert us as to why the offender really wishes to be admitted. Again, it is for this reason that a survey of patients has incorporated into this study (see Chapter 6). The justification being that all social actors may be able to determine the conduct of others. For present purposes, it is as well to elucidate how professionals understand or perceive the

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10 This corroborates the findings of Grounds et al., who studied admission decisions to medium secure units. That study did not interview service users, but through interviewing psychiatrists found that the service user’s ‘attitude towards cooperation with treatment...’ was crucial. Supra n.4.

11 A period of reflection is typically a few months. If the service user disengages on re-admission, there will be no possibility of return.
ability of service users’ to determine professional decisions through their conduct during pre-admission assessment. In so doing, it appears that the belief amongst staff that service users can influence decisions concerning their future care and detention is an historical imperative. Consider the experiences of staff on the former Cairngorn ward: Cannock’s predecessor.

5.1.3.2 The experience of Cairngorn ward

Cairngorn ward opened in 1987. It was to witness first hand the inherent tension in achieving a working balance between care and custody for those with PD. Running along therapeutic community lines, Cairngorn was a mixed sex ward which accepted a large number of offenders on remand to assess their suitability for treatment after sentencing. One psychiatrist notes:

‘Generally, they behaved themselves when they were on remand, were given a hospital disposal [under s.37 of the MHA 1983], and then once that was achieved acted out in a very disagreeable way. And then the hospital was saddled with a whole number of people who didn’t want to be in the hospital and the hospital didn’t want to have them, but there wasn’t much that they could do about it.’

The ward was subsequently closed in the wake of drug and alcohol use, poor staff morale and inadequate security, which culminated in a protracted riot. When Cannock ward subsequently opened in 1997, one noticeable change to admissions policies was that only those who had already been sentenced were admitted, in the hope that this would enable a better assessment of the offender’s motivation.12 Consider Mr. E., who during his pre-sentence report (conducted by a former psychiatrist on the ward), having declared that he

12 Again, as the aforementioned quote attests, our understanding of the determinants of admission is not exhausted by a study of professionals’ decision-frames alone (contra, by implication, see ‘A Qualitative Study of Admission Decision-Making, supra n.4).
wanted to change ‘for his son’s benefit’, asked for an application form so that in the likely event he received a prison sentence, in respect of his potential admission, he could start ‘the ball rolling’. The psychiatrist’s reply read unequivocally: ‘It is our policy to take sentenced prisoners rather than those on remand as usually this gives a clearer indication of motivation.’ However, even if adopting this measure, it is possible that the offender’s expressed motivation for seeking admitted may later be perceived by staff as a well cloaked strategy for leaving prison:

‘They'll say they’re motivated, but when you check if they’ve got a job in prison, or...what they do all day, they say, I stay in bed.’

(Nurse).

By expressions of motivation, then, one is really describing the interface between real commitment to engage in treatment for the purposes of achieving behavioural change or strategy aimed at achieving some ulterior motive. The quality of strategic innovation – that is, how effective it is at directing the conduct of staff at the pre-admission stage – will, in part, be determined by the apparent integrity of the service user’s commitment to treatment in light of the conditions of the prevailing discourse, which in general include, as one OT puts its, observed compliance with ‘boundaries, rules, systems’. For example, prior to admission, an offender will be expected to give up smoking (Arnold Lodge operates within the NHS and has a no smoking policy); abstain from painkillers, to which the offender user may have developed a dependency; and reduce high levels of psychotropic medication he may well be taking in prison, so that, in the words of a health support worker, ‘... you get to see who they really are’ with a view to assessing the effect of treatment on current
behaviour. However, that the service user might adhere to these conditions tells us nothing about his ambitions for seeking admission and treatment. Only once this is known would it be reasonable to assert that one knows the nature and origins of their actions. Since these might not be discoverable (as the experience of Cairngorn attests), it is unsurprising that staff on Cannock ward fear that the counter-motives of offenders might not be intercepted or known prior to admission.\textsuperscript{13} This was expressed most forcefully in respect of one client-group: the psychopathic client.

\textbf{5.1.3.3 The psychopathic client}

Psychopathy is a clinical diagnosis strongly correlated to antisocial PD (ASPD). Reid and Gacono describe its relationship with ASPD thus:

\textit{The majority of ASP individuals are not truly psychopathic, and overlap of ASP and psychopathy may not be complete. ASP is merely behavioural. Psychopathy… is described by a combination of trait and behavioural criteria.}\textsuperscript{14}

Trait-behaviours, as described by Hare’s Psychopathy Checklist (PCL-R), generally exhibited by the psychopath include manipulation, grandiosity, a lack of empathy, shallow effect, impulsivity, irresponsibility and callousness. Much, however, is owed to Hervey Cleckley’s account of the clinical psychopath in \textit{The Mask of Sanity}, in which he describes the psychopath as unreliable, untruthful and insincere.\textsuperscript{15} Accordingly, he says: ‘the conception of living up to [his] word seems, in fact, to be regarded as little more than a

\textsuperscript{13} What this might mean in terms of defining treatment success is discussed in Chapter 7.
\textsuperscript{15} (1988) \textit{The Mask of Sanity ~ An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality}. 5\textsuperscript{th} ed. Emily S. Cleckley, p. 337.
phrase sometimes useful to avoid unpleasantness or to gain other ends.\textsuperscript{16}

Given the clinical similarities of ASPD/ASP and psychopathy, as one would expect, service users on Cannock display varying degrees of psychopathy. One psychiatrist attests:

‘...there’s been a comparison between people from maximum security and Cannock, in particular, and those people in Cannock have got more disturbance than those in maximum security: higher PCL-R scores, earlier age of offending, more violence. That doesn’t surprise me, because I think we fish people out who are probably quite criminogenic...’

As many as a third of those in prison are said to have high levels of psychopathy.\textsuperscript{17} As to why Cannock ward might ‘fish out’ this client group may be a consequence of offenders seeking, as Cleckley suggests, ‘to gain other ends’. Indeed, in ‘ordinary’ circumstances, commentators have noted, particularly in the case of those with psychopathy, that ‘antisocial symptoms are not painful or egodystonic in themselves making it even less logical for the antisocial person to seek or tolerate treatment’.\textsuperscript{18} One nurse comments thus on the client group:

‘...these particular individuals know what they’re doing; they know what they’re saying and...some are more manipulative than others, and...when they get in it’s a different ball game. And you always have that risk...’

As has already been said, the identified ‘risk’ is sought to be mitigated by the use of the PCL-R assessment: a standard tool for measuring the subject’s level

\textsuperscript{16} Ibid., p. 342. Emphasis added
\textsuperscript{18} ‘Treatment of Antisocial Personality’, op. cit.
of psychopathy as against a prototypical psychopath. It is thought to be a useful tool guiding admissions because, as Hart explains, psychopathy ‘…is empirically related to future violence, is theoretically important in the explanation of violence, and is pragmatically relevant in making decisions about risk management…’ ^19 Whilst it remains the case that violence is only perpetrated by the minority of those with a mental disorder, it is irrefutable that for those who do commit violent crime, psychopathy is highly correlated. For these reasons, many within the MDT were reluctant to admit offenders diagnosed as having psychopathy:

‘I think it’s deviousness, the dishonesty, that side of it... Psychopaths set other people up as well; they’re behind the scenes... And they’re quite charismatic, you see... And they cause a lot of difficulties within the staff team because they’ll target people, and they’ll befriend people, and people will feel quite positive about them, and others feel quite negative. And they actually create that scenario. And it often results in violence...’

(Nurse).

As with any quantifiable, diagnostic criteria, cut-off scores vary. For diagnostic and research purposes, a threshold score of 30 is usually applied in North America; and, indeed, for Cannock ward this would be grounds for refusing admission. A diagnosis of psychopathy is, thus, the final exclusion criteria. Along with other exclusionary criteria, it should ensure that the task of selecting the appropriate service user for treatment is an easier one. In reality, if one could only extricate decision-making processes under s.47 of the MHA 1983 from the web of power relations that mark and divide service users and professional staff alike, this might be true.

5.2 The admissions process

5.2.1 The pre-admission meeting

Following pre-admission assessment, those members of the MDT who have visited the offender in prison will complete a report on his perceived suitability for admission to Cannock ward. The views of the MDT will then be aired, and disagreements resolved, pursuant to reaching a collaborative decision. But what does one really mean by group decision-making, especially if one wishes to utter with confidence words such as collaboration? After Foucault, is it appropriate to explain group decision-making by reference not to collaboration but the richer descriptors of influence and strategy? Perhaps, instead, one suspects that decisions are authored by the RC, whether or not there is disagreement between his or her team, which borders on a stable relationship of power – that is, decisions are not the result of collaboration at all? And how do contextual factors animate this debate? These guiding questions will now be addressed.

5.2.2 The case for collaborative decision-making

The ways in which the multidisciplinary team reached decisions on Cannock ward was inherently complex. Often, there appeared a strong disposition for RC-led decision-making, just as Talcott Parsons envisioned.\textsuperscript{20}

\textsuperscript{20} See, for example, (1965) Mental Illness and “Spiritual Malaise”: The Role of the Psychiatrist and of the Minister of Religion’. In: \textit{Social Structure and Personality}. 2\textsuperscript{nd} ed. London: The Free Press, Collier-Macmillan Ltd, p. 315.
‘I think as far as the various disciplines are concerned, everyone has an opinion. But, ultimately, it will be guided by what the RC will say. We do our best by saying, we think this person should be brought in, or this person shouldn’t be brought in, but if you do bring him in, then these are the things you need to watch out for. I think that’s the best we can do in that situation.’

(Psychologist).

‘The psychiatrists just make that decision, I think. But you can put your recommendations in your report, and that’s all you can do, really.’

(Nurse).

Equally, the group was presented as egalitarian. One psychiatrist comments:

‘...there’s not always an agreement... More often that not, it’s been my experience, we’re all probably in agreement, and if we’re not, we try to do it that it goes to a vote, so it goes with the majority. If the medic says yes, it doesn’t automatically mean yes. And we try and always do that, and I think that can sometimes be hard, because you could very strongly disagree with your team, but I think, on balance, that’s the best way to do it – you make a fair decision that’s based on a whole range of views.’

The view of solidarity and collaboration was shared by others members of the MDT. Consider, for instance, the account of decision-making provided by an OT:

‘I mean, certainly over the years, I’ve been in one where [Consultant Psychiatrist] has completely disagreed and everybody else has agreed to admission, and he’s said he’ll go along with admission. And, interestingly, certainly [Consultant Psychiatrist], I’ve heard [the doctor] on more than one occasion say that, you know, you’re the people who’ll be managing this man on a day to day basis; if you don’t think you can manage him safely, then, urm. But I suppose being the RC, if he was adamant. But I’m not sure he would, though.’

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21 This corroborates the findings of nurses in a former study on the provision of care in secure settings. See Bowers, L. (2002) Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team. London: Routledge, p. 104.
The implication, therefore, is that the psychiatrist could make binding prescriptions on his or her team, and that this would be accepted as legitimate by the rest of the team. The reality depicted is that RC assimilates the majority opinion of the multidisciplinary and acts in concert with it. Particularly as the RC’s position formed the minority view, this deference could be explained by the wish to sustain the working ethos of the team. In the Grounds et al. study, one psychiatrist notes:

‘The key…is staff-staff working relationship. To have a full multidisciplinary team working together well will overcome the majority of limitations. If someone were to say “you can have your ideal purpose built unit or you can have your ideal staff team”, I’d stick with the staff team rather than the geography and the environment.’

By comparison, what was particularly noteworthy was the import of nurses’ views within the decision-making forum. The relative importance of their opinions seemed predicated upon their role in matters of supervision and day-to-day observation – which one recalls is vital to the effective functioning of the (Foucauldian) disciplinary regime. One RC comments:

‘I think if there’s very substantial disagreement between the various professions involved, then nursing generally trumps the others. And I think it ought to trump the others, because the nurses have to manage the patient on a day-by-day basis… It hasn’t happened very often; it’s happened, in fact, very infrequently when there’s a stand-up fight about the issue, but when that has occurred in the past, I certainly have given way to the nursing views.’

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23 Chapter 2, 2.3.1.
Nursing staff were almost unanimously in agreement with this claim, confirming in the process previous claims that centrality in clinical practice is predictive of nurses’ ‘power’: ²⁴

‘...at the end of the day, if the nurses have got to manage these people 24 hours a day, you know, they’re there at 9 o’clock at night, not a psychiatrist, when someone is shouting down a corridor and, you know, threatening people. So, that usually did win the war, basically’.

In Parsonian terms, this suggests that nurses (alter), rather than the psychiatrist-leader (ego), have the ‘rights to the action of others and the obligations to perform the actions expected by others’, ²⁵ pursuant to their central role on the management of patients on the ward. In practice, if their centrality does not result in the RC favouring their collective viewpoint, nurses may resort to other means of ‘winning the war’:

‘I think one goes against the nursing view at one’s peril... I think with PD it’s an interaction, and, if people have a particular view at the beginning that someone is unsuitable, then they will need a considerable amount of persuading that that view is wrong unfortunately. [Mr. F.] didn’t provide that. So, I think that’s an additional reason, actually, why one ought to be careful about going against the nursing profession, in my view.’

(Consultant Psychiatrist).

It is not proposed, without more, that this is an instance of competitive strategy trumping co-operation in the face of responsibilities to patient; there is every reason to suspect the nurses in question had justifiable motives for resisting the admission of the respective offender. The returning of a patient to prison is not viewed as contentious by the team:


‘...I think when people are unsure, we need to have a clear reason as to what we’re unsure of, and how we’re going to manage that’.

(Occupational Therapist).

Nonetheless, from another perspective, the account provided of ego and alter relations seems indistinguishable from a ‘stable relationship of power’, within which successful strategy, as Foucault would put it, directs ‘in a fairly constant manner and with reasonable certainly, the conduct of others’.26 In such a relationship, the result of winning strategy is that one must be content with reacting to a relationship of confrontation ‘after the event’ (here, the psychiatrist conveying what appears to be displeasure over the state of affairs).27 This would indicate alter’s success over ego. Furthermore, though in this instance the RC did not, it appears, offer a counter-strategy to the situation surrounding Mr. F., one would be justified in suggesting that at some point in the future, in relation to another offender over whom there are disagreements, s/he may. The point is that one must at least be open to the possibility of a free play of antagonistic strategies between ego and alter, even if the account provided by Parsons is, prima facie, a compelling one.

Whilst not couched in terms of strategy, one psychologist implies the inherent potential for all members of the MDT to influence or direct the final outcome of the admission decision, in situations, presumably, where diverse approaches have not led to reasonable stable relations of power between the RC and nursing staff (as implied above):

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27 Ibid.
‘It might depend on the people involved and the day, and just how the decision-making process goes. But, you know, if there’s a disagreement, there’ll always be a compromise. I’m sure other times [Consultant psychiatrist] will compromise and the thing will work the other way around. I’m not sure it’s because of the RC role. You might have had a role in that decision on that day, but I don’t think it always goes like that...I guess there’s an acceptance, there’s a compromise; if there’s a difference of opinion, then the thing that somebody thinks shouldn’t happen will happen, and sometimes it’s your day for that to happen.’

To take this point further: to what extent does the current decisional forum shore up evidence of ego-alter relations of a more Foucauldian kind, where the pursuit of goals is referable, and least to some extent, to the pursuit of self-interest through strategy open to all?

5.2.3 Group relations, competitive strategies

It has been suggested that even within ostensibly co-operative groups there is the potential for strategy to be employed by members of the solidary group. One general example of this was the use of ‘gatekeeping’ practices by nurses:28

‘You would get other doctors that would come onboard...for a period of time, and they’ve come from a medical model, so they thought they could just walk onto the ward and see a patient when they want. But that was down to me to say...you need to be booking an appointment to see that patient... They didn’t like it.’

Moreover, consider this striking use of strategy to govern the outcome of the MDT pre-admission meeting by one particular nurse, which seems to draw on their recognised centrality in many aspects of forensic practice:

‘...we’d say, right, this is what they’ve got to achieve in the next 3 months or 6 months, or whatever, and we’ll keep in contact... And..., when you do do something like that, very often, the patient can’t comply with it, and that’s why they don’t get admitted, because they perhaps don’t choose to come off their Valium, which they’re addicted to over a three month period, and they’re not prepared to sign up and reduce it...’

Here, the nurse’s strategy has clearly thwarted the psychiatrist’s will because of the perceived difficulties admitting the particular service user would entail. Having as part of its frame of reference the likely conduct of the service user, properly speaking it is also a strategy or counter-strategy directed at him in relation to his presentations during pre-admission assessment. The importance of offenders’ approaches to governing the final decision are discussed in Chapter 7; but, for present purposes, it confirms both the ability of alter to influence ego by subversive means (the most concrete and least predictable of all strategies) and of the indispensible nature of strategy within groups.

However, it must also be pointed out that there was much less evidence of strategy in practice than expected. In the case of psychologists, there was absolutely no evidence of strategy. It may be that Parsons is generally correct: groups seeking to maximise productivity are far more inclined to follow the lead of ego. Alternatively, it might be that strategy is deemed – even if subconsciously – to be synonymic with lying or, worse, pathological manipulation (a symptom of PD / psychopathy), meaning that few were inclined to articulate reliance upon ‘deviant’ behaviour. Another possibility is that strategy would have been better documented had there been a larger

29 Parsons has described this ‘jurisdiction’ as ‘obligations which are imposed on categories of persons by some process of decision-making where the ultimately relevant agency is held to have “legitimate authority” under a system of normative order’: On Institutions and Social Evolution, supra n.25, p. 179
sample size. Perhaps, this is too convenient an argument. Instead, rather than unduly privilege a co-operative view of power – which is tantamount to a re-assertion of a Parsonian, ego-centric view of power – it was decided following primary analysis of the data to consider the degree to which contextual factors were limiting the possible implementation of strategies.

5.3 Re-focusing strategy: the informal context to admissions

5.3.1 Formal changes to pre-admission assessment

There were two accounts of pre-admission assessment and the decision-making process: the former, discussed above, reflected on the skills that each profession brings to the question of whether the respective offender is suitable for admission. This is represented by formality of decision-making process:

‘The nursing assessment is a lot more formal than it was before... When [nurse] was there, [they] did the family history, index offences, whether they'd been any adjudications, whether they were on medication, whether they've got issues of smoking, anything that affects us, risks, you know, any risks they might present on the ward. So, it was really something they did on the top of their heads, whereas this one is more risk orientated; it’s got a lot more specific questions..., and it is more in depth.’

(Nurse).

Juxtapose this with a more recent account of the nursing assessment:

‘I’ve been on the HCR-20 assessment training and people have said: What d’you mean you’re only asking these questions – what about the HCR-20? What about the in depth questions? You should be sticking to a more formal assessment...’

The effect creeping ‘informality’ has on the depth and breadth of pre-admission deliberations is predictable. In the words of an Occupational Therapist:
‘The pre-admission meeting would be much longer... We used to have something that wasn’t tagged on to the end of a ward. We’d have an hour, two-hour slot, where we’d discuss things in much more depth. I don’t think people can dedicate that amount of time, unfortunately, anymore.’

A young nurse, unfamiliar with the changing face of admission procedures, undermined the pre-admission process in its entirety:

‘The pre-admission assessment isn’t that important. You have to see them here to know. It’s just to get an idea of what they’re like.’

In some senses, this is a realistic account: it is undeniable that the ability to send a service user back to prison in the event that they prove to be unsuitable after 3 months (if not before in particularly difficult cases) is, again, an important ‘safety-net’. However, strictly speaking, the ability to return patients back to prison is not supposed to act as a panacea to inadequate admission procedures. From a clinical point of view, there is evidence that treatment non-completers are at high risk of reoffending compared with completers, and it may even make some offenders more likely to re-offend. This may be a consequence of the way in which they are responded to when they return to prison:

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30 In reverse, for the service user, the safety net means ‘[They] don’t feel trapped in something that may not work’ (Occupational Therapist). In the legal sense, it also reflects the fact that service users have the right not to be treated compulsorily under s.47 of the MHA 1983 if he decides he wishes to dis-engage.

'...once someone’s brought out of the prison system into the NHS, and to a PDU [personality disorder unit], there’s potential for stigma as part of that. And, if they fail in that treatment, and are returned to the prison system, which would happen if we brought them at the wrong time, they’re sort of doubly stigmatised, because a specialist treatment system couldn’t help them...’

(Psychologist).

Evoking the jurisdiction of s.47 of the MHA 1983 to transfer offenders to Cannock ward is also a costly (the expense of treatment and accommodation) and onerous affair:

‘I know there’s [sic] problems getting [them] back. I don’t know whether it’s a problem with beds in prison, in the cell or whatever, or whether it’s the process of having them here and we’ve got to, because I’ve heard [Consultant Psychiatrist] say: “We’ve got to show we’ve attempted everything before we send them back.” So, I’m not sure if it’s the prison’s issue or ours now... It’s certainly more difficult to get people out of here... And that’s when the RMOs get back on the phone over a short period of time and try to speak to the governor. But you can’t just speak to healthcare and say [they’re] coming back.’

(Nurse).

In sum, these corollaries reinforce, rather than diminish, the importance of rigorous admissions procedures so as to achieve, as far as practicable, a patient’s realignment, in ‘disciplinary’ terms, from ‘sick’ to ‘healthy’ and criminal to reformed.32 Why, then, if it is not necessarily in the best interests of ward practice does the degree of formality and time spent on any individual case seem to vary?

32 ‘The Subject and Power’, supra n.26, p.208
5.3.2 The ‘bed situation’

In previous research covering ninety-eight per cent of the total bed estate in 2004, Grounds et al. comment thus on the changing face of admissions’ policies amid resource pressures:33

‘The study revealed a system that was seized up in its ability to respond rapidly to those needing admission.’

This entrenched position in forensic mental health services, which they later describe as the ‘bed situation’, is described from the perspective of two psychiatrists: ‘I could fill them twice over’; and,

‘Not only here, but anywhere, we can’t even find beds nationally most of the time. So that’s the thing that really does worry me most, you know, will this person hang themselves in [prison] while we’re waiting.’

Compare this position with one of many similar accounts in the current study:

‘...ideally, we should have a full ward. And we have had in the past a dozen people, and half of them have been assessed and are just waiting for a space and half of them we could assess in the future. But now it seems we’re always down to ten beds, and there’s [sic] three or four people who need to be assessed.’

Elsewhere in the previous study, however, a psychiatrist gives a more useful account of the effect of resources on admissions to individual units:

‘Decision-making is...contingent on what is available on the day, what you can do at the time. That changes constantly from week to week, sometimes day to day, and also varies on what can be provided in the patient’s own district. It depends on how well we get on with the local services, how well the services know each other and how well the clinician’s know each other.’

The discrepancy in the two previous opinions in the study is indicative of the danger in trying to create nationwide generalisable data. Whilst it is agreed that ‘the characteristics of units can have a powerful effect on admissions’, meaning ‘generalizing from local studies can be hazardous’, it is evident that only by appreciating the contextual pressures having an effect within individual units can spurious generalisations be avoided. Suffice it to say that only in the case of the latter quote does one find support in the current study.

For instance, it was noted that the relationship with a particular prison is an important predictor of the ‘bed situation’:

‘You think: what is going wrong here, you know? We were inundated six months ago... and now we haven’t got any referrals... I used to go out and make contact with [the prison staff], and they used to say, I didn’t know you existed, because someone new had come along.’

(Nurse).

Some members of the MDT opined that there was a great deal of pressure to fill beds, and that this directly explains changes to pre-admission assessment:

‘[It] was very formal. We were in a position where things were different anyway, and we could cherry pick. Bed situation and, obviously, commissioners are questioning if you’re sitting there with empty beds and pressure’s on, and then people start to question the viability of that service: do we need that service if we can’t fill beds?’

(Nurse).

In relation to the previous discussion on power in the decisional-forum, the issue of resources may explain why there is little evidence of strategy between staff:


'I think one of the unfortunate things is we are governed by our bed situation..., and I think it has influenced some of our decision-making, that perhaps when we may have said no..., we have said yes.’

(Occupational Therapist).

Even more starkly:

‘There is disagreement..., but I get the sense... sometimes that there’s an underlying understanding from people who are expressing concern and disagreement that we’ve got to fill the bed, you know, we can’t create too much disagreement because, you know, that bed has got to be filled. It’s difficult.’

(Nurse).

Pursuing this line of inquiry further, Shaw, a social psychologist, explains the importance of context in decision-making groups as follows:

When individuals interact, pressures towards uniformity are generated and the individual members tend to behave in a manner which conforms to that of the modal group member.36

This does not mean all members of a solidary group believed that resource ‘pressures’ dictated admission decisions. One psychologist states: ‘I think the clinical decisions are made anyhow, and then there’s the context in which they’re made.’ However, it is difficult to see how this statement does not in fact agree with the tenor of other statements if context underscores, as it must, all decisions. One interesting example of this is provided in the case of Mr. F., which was touched on above.

Following pre-assessment in prison, two members of the MDT were adamant that he should not be admitted to Cannock ward for treatment. The RC’s response was pragmatic: ‘But we need to fill beds.’ Assuming a

Parsonian stance for a moment, one might explain this by reference to his schema,\textsuperscript{37} according to which one way ego is able to direct the conduct of alter is by an ‘Activation of commitments’, such that s/he offer reasons why it would be “wrong” for alter to refuse to comply (Intentional channel, negative sanction).\textsuperscript{38} Following the pre-admission meeting, Mr. F. was admitted:

‘Both my nursing and Occupational Therapy colleagues were less than enthusiastic about admitting him… I, on the other hand, took a different view… After discussion today, it was agreed that he ought to be admitted for a further assessment. In the event, however, of him refusing to engage on any terms other than his own; then we would wish to return him to prison.’\textsuperscript{39}

It could also be argued that this letter (‘I, on the other hand, took a different view’) presents evidence of ‘persuasion’ (Intentional channel, positive sanction): reminding the staff of the safety-net of return to prison. But this is a tenuous deduction, because the statement merely reflects the default position of the unit: when any patient is deemed, following a period on the ward, to be unsuitable for treatment, he may be sent back to prison. Therefore, the intentional channel, negative sanction seems more likely to have been in play (linked to the need to fill beds).

To put the Intentional channel, negative sanction into a discursive context, the pressure to fill beds seemed to be borne out in respect of client-groups who would, hitherto, have not been admitted (on the basis of exclusionary criteria). One example concerns the expectation that service users will have at least two years of their sentence remaining before being considered for admission. One nurse complains that the contrary is true in practice:

\textsuperscript{37} See Chapter 3, p. 102.
\textsuperscript{38} Reasons might include the need to be filled near to capacity to ensure the viability of the service; professional jobs; accolade; the affirmation of roles in situ; and so forth.
\textsuperscript{39} Taken from a letter written to the healthcare team of the detaining prison.
'You know, we’ve had someone who’s only got nine month left on their sentence. What can we do for this person in nine months? Again, there’s a sense that we’re setting people up... So, these people are all going back to prison and they’re not coming back.’

In response, a contrary argument is that the 2 year timeframe is an arbitrary reflection of the length of stay that was envisaged when medium secure units came into operation, rather than a reflection of what is medically appropriate in individual circumstances, as these converging accounts seem to suggest:

‘The doctors here do what they can, and they have their best intentions, but two years ain’t enough. They can do their best for us in two years, but the majority of us go back. And I don’t wanna go back and revert to old behaviours, because then the two years have been for nothing, and I don’t want that.’

(Mr. H.)

‘I’m thinking when I get to the end of my two years here... where do I get the help for them issues? My feedback today from my ward round is they are going to extend my stay here. So, I haven’t got two years here, I’ve got longer.’

(Mr. C.)

‘I mean, I think, six months is sometimes enough. I think sometimes people come, there’s a particular skill, they get skilled up in it, and that to me is success. I know it’s not a very clear definition... Some people would perhaps need longer here... Some people it’s bang on. Some people it’s too long. Some people it’s not long enough. I guess sort of shifting the way people think and function is success, however long that may be.’

(Occupational Therapist).

This latter remark raises the prima facie contention that the ‘bed situation’ has not compromised the achievement of therapeutic effect on the unit; that there is every reason to agree with the generalisation of Grounds et al., who assert that ‘Clinicians resist pressures they perceive to be in conflict with a primary
therapeutic purpose for their services.  

Consider, one RC in the current study, who is commenting on the position of offenders on fixed-term sentences:

‘But I think we point out to them that, once they do pass their EDR [earliest date of release], if they then choose not to stay, certainly my practice is that I would discharge them, irrespective of whatever risk they posed. And, in fact, there is someone on the waiting list who is in exactly that position at the moment who has about 9 months to serve. He certainly needs about two years, and we’ve offered him the option of coming in and staying in beyond his 9 months – but it’s not absolutely required that he does so – but if at the time of his 9 months he then decides to leave, I would discharge him.’

The reality is that offenders admitted with less than two years to run on their sentences are few and far between; and, in accordance with this, few members commented specifically on this aspect of admission decision-making. Much more divisive was the issue of admitting client groups with IQ or PCL-R scores either (well) below or (well) above the cut-off for admissions. In defence, it should be said at the outset that there has always been a tendency to alter the cut-off score for admission, irrespective of the number of referrals received. For instance, originally, admission was refused if a service user presented with an IQ score below 83; but this was reduced several years ago to 75. At the time, this was justified on the basis that the client group harbours a ‘real need’ and that ‘they do respond well to the type of structure the PDU offers’. It follows that every effort is made to allow those falling within the client group the opportunity to make full use of the programme – ‘…in some cases,’ stated one nurse, ‘what we started to do, if the programme was a little bit too difficult

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40 Supra n.4.
41 There remains the possibility that the Parole Board could coerce the patient into staying. The psychiatrist points out: ‘What can be done is to make a condition of their licence that they stay in hospital and receive treatment. I’m very much against that being imposed actually; I think it’s another way of detaining people.’
to understand intellectually, we would tailor it for that person…’

It transpires that a similar justification is offered for admitting those with high PCL-R scores for treatment:

‘…there’s no good evidence that treating people with high PCL-R scores is good or bad – we simply don’t know’.

(Consultant psychiatrist).

If one accepts this rationale – which derives from evidence-based practice – one also ought to agree with one psychologist, who says that psychopathy ‘... shouldn’t be, like PD, an exclusion thing, more something that informs treatment’. In fact, it may be that a more inclusive approach to treatment is becoming customary of mental health services in general:

‘Well, originally, we sent out a spec, which we didn’t keep to, of not taking people with a score of 25. We often departed from that in practice, it wasn’t an absolute. What we’ve observed over the last, I suppose, over the last 5 or 6 years is the mean score of the PCL-R has gone up…about 25, I suspect... So, that’s a feature of mental services in general, where they are now taking more and more severely affected people ... So, I think one has to wait and see how that’s going to play out.’

(Consultant psychiatrist).

But, more fundamentally, if mental health services are changing in terms of client-groups, and diagnostic criteria have the potential to stigmatise, is there an argument against, for instance, the PCL-R as an instrument informing admissions policies?

From a nosological point of view, the very development of the PCL-R is underpinned by three claims that can be critiqued: (a) that it provided a reliable and valid means of identifying those who are unsuitable for current interventions intended to reduce criminal re-offending; (b) that it provided an
appropriate basis for the development of new interventions for psychopathy; and, (c) that it provided the best means of assessing future risk of violent recidivism. Yet, as David Crighton points out, none of these claims have been supported by emerging evidence. The problem of course is that a sympathetic researcher may assess the tool’s fitness for purpose favourably.

Rather than critique nosology, instead, perhaps diagnostic criteria should be seen as no more than one of many considerations taken into account. In relation to IQ scores, Mr. B. is a case in point. He was assessed by a psychologist as having an IQ below 70, but his ‘level of processing’ and ‘other peoples’ experience of him’ (Psychologist), and the fact he had completed a demanding behavioural course while in prison, meant that the MDT felt able to offer him a place. One may make an even stronger case against absolutism in respect of the PCL-R in that, procedurally, obtaining a meaningful score seemed plagued with difficulties. Consider: the checklist is expected to be complimented by collateral prison information to provide a comprehensive picture of the offender’s suitability for admission. However, this may take a day to conclude, and in practice is often compromised by a lack of joined-up thinking within the prison regime – which might, for instance, account for restricting access to the offender; poor links between healthcare and the rest of the prison; the attitude of staff; and how well resourced the prison is.

Essentially,

‘...you’d want access to healthcare records; prison records; their custody files; their psychology file; their probation file. So, what you’re actually saying is...we’re coming in; we need a prisoner for a whole day; we need you to help us move around; we need access to every file you have. And of course it doesn’t happen’.

(Psychologist).

One downside of this changing face of forensic services is that some staff may perceive admission to be an injustice to offenders themselves. One nurse, for instance, comments that Mr. B. is ‘hanging by his fingernails’. On the subject of psychopathic clients, it was similarly complained that ‘...we’ve never been very successful with people with high PCL-R scores. I don’t know of one high PCL-R patient who’s survived the whole programme’. Furthermore, ‘Before Christmas,’ another nurse laments, ‘we had about three people on here with high PCL-R scores, and it was quite chaotic on here. There was [sic] a number of staff who burned out.’

One must acknowledge these claims, of course, but do so with equal compassion for the complex needs of offenders in prison. Accepting that those with PD have always posed additional pressures on services, a degree of inclusivity, whether or not catalysed by pressure to fill beds, is not necessarily a negative aspect of admissions. For a society which accepts an inclusive approach to diagnosing mental disorders, such as PD, on the basis of nosological claims, is one which ought not to sanction medical nihilism and the subsequent disempowerment of service users on the same basis. It might be said that the greatest achievement of specialist units, such as Cannock ward, is its willingness overtime to marry developing nosology with treatment inclusivity. Consider the alternative:

44 This assertion was unable to be verified.
‘I’d rather come here because in prison you’re not gonna get the help you need. And some of the courses you get in prison, because of your PCL-R score, they wouldn’t really put you on courses. Because if you were going into a therapeutic community, the cut-off is usually 25, they won’t have you... Here’s good because they do, d’you know what I mean, it brings you here and it sort of can reduce your risk, and it gives you a chance to at least show you can engage with a treatment programme and still do well, whether your PCL-R score is high or low.’

(Mr. E.)

However, there is another side to widening access: for every development the ward undergoes, the staff must adapt. Adaptation is likely only to be married with effective outcomes if the unit’s policies are – contrary, it would seem, to those such as Parsons who take homeostasis as a given – broadly respected. And, apart from two of those surveyed who believed that contextual pressures were not leading to greater inclusivity in admissions, the vast majority of the MDT were of the opinion, first, that they were, and, secondly, that it was not a positive step for either staff morale or – however one wishes to define them – treatment outcomes. The starkest example of this general consensus was provided by a nurse, who argued that criteria had been ‘dropped’, almost to the point of ‘setting people up to fail’.

Once again, one might question the aptitude of formal instruments at predicting the likelihood of treatment success. One might also reinvigorate the discussion of ego versus alter in respect of admission decisions in respect of the fact that they appeared to be largely unanimously, if sometimes grudgingly, agreed to. This seems to indicate relatively stable relations of power between ego and alter, in favour of ego. One must, therefore, ask: had admission decision-making become the prerogative of the RC because of the ‘bed situation’?
5.3.3 Ego-led re-orientation of the collectivity’s focus

It will be remembered that Parsons, in offering us tools for the structural analysis of society, is clear that the desire to act according to one’s own dictates and desires always resolves in favour of some collectivity-orientation guided towards prescriptive goals. He says, however, that ‘No social system can be completely integrated; there will, for many reasons, always be discrepancies between role-expectations and performances of roles.’ Nevertheless, society and its subunits will never disintegrate, since the fact that ‘human beings who live in a social system are socialized to some extent gives them many need-dispositions which can be gratified only by conformity with the expectations of others and which make them responsive to the expectations of others’. 45 Yet, this presents a paradox: alter – as a consequence of power vesting in ego – continues to have his or her need-dispositions met despite occasional value-discrepancies between ego and alter; but conflict, in respect of these discrepancies, always resolves in favour of ego, which should cause alter to perceive role conflict.46 Of course, value- and role-conflict is generally minor: the mandate to treat those with PD according to one’s own art seems not to be unduly compromised by widening access (the ability to return a service user to prison in the event of disengagement may be important here, once again). But Parsons probes further, implying that ego may re-orientate the group’s focus in subtle ways via ‘institutionalization of trust’:

45 On Institutions and Social Evolution, supra n.25, p. 127.
46 A case in point is the nurse’s comment above (p. 174), that ego’s insistence to admit certain service users was ‘setting people up’. It is assumed by alter that the decision is at odds with the service user’s best interests, if not also staff who will treat him, and yet alter still agrees.
There will be value conflicts and role conflicts. The consequence of such imperfect integration is in the nature of the case a certain instability, and hence a susceptibility to change if the balance of these forces, which is often extremely delicate, is shifted at some strategic point.\textsuperscript{47}

There remains a sense that trust is undermined when ego may need to direct his or her team by the means described by Parson’s schema in order to ‘get results’.\textsuperscript{48} Except that here alter is bound to invest in ego’s declaration of the need to fill beds because it is only through the admission of patients on the ward that individual mandates or arts, if you will, can be fulfilled. Thus, one is not dealing, properly speaking, with an ego-alter power relationship in isolation, but within the context of, and conditions ‘imposed’ by, Commissioners, who are dealing with quite different pressures. Moreover, the espousal of these commitments by ego does not change the fact that alter is already aware of the pressures they face, and may subsequently act on them as part of the decision in respect of the particular offender. Thus understood, the previous nurse’s complaint (‘we’re setting people up to fail’) is one lobbied at the situation facing both alter and ego, meaning that it is not a complaint of ego having the potential to diminish trust in him or her for reinforcing the team’s binding commitments. Alter may be right, of course, but the point at issue is that psychiatry must assume the position of ego and have responsibility to shift admissions policies over time in light of existing pressures because it is psychiatry that both defines the nature and parameters of the medical problem to be addressed. To his credit, Parsons, again, seems to take such a notion as given; and he goes on to situate his functionalist approach within the claim that

\textsuperscript{47} On Institutions and Social Evolution, supra n.25, p. 128.

\textsuperscript{48} Chapter 3, supra n.52.
the law has the ability to collectivise the forces (power relations) of society and order them for the purposes of their (potential) output. He posits:

In a highly differentiated society, the primary focus of the integrative function is found in its system of legal norms... such norms facilitate internal adjustments compatible with the stability of the value system or its orderly change, as well as with adaptation to the shifting demands of the external situation. 49

Certainly, this is not contentious, in as much as the diversionary provisions of the MHA 1983 underpin the forums of power that collect around the mandate to treat. A perusal of s.47 of the MHA 1983 also tells us that only ‘appropriate treatment’ need be available before diversion is sanctioned, meaning that alter would be hard-pressed to conceive of a strong moral, rather than intuitive, reason for arguing that ego is being deviant by advocating and encouraging inclusivity of admissions. Whether this is facilitated by the ‘bed situation’ or not is of no consequence once one understands this.

Furthermore, deferent to the requirement to shift demands according to the ‘external situation’, it stands to reason that one is less likely to see strategic innovation by alter to counter ego’s legitimate authority to make binding prescriptions in respect of admission decision-making. Nevertheless, the notion of strategy has been reified in this chapter, and for this reason one must point out that neither Parsons nor Foucault are completely correct about the goal-orientated behaviours of groups. In respect of Parsons, part of the reason is simply because he tries too hard to create a stable system of mutual exchange. This is not to say that such a conception is without utility, only that it deserves a recapitulation. In the words of a RC:

49 Ibid., p.163.
‘I think, like most systems, it’s almost like there’s an equilibrium... I mean it’s not acceptable to have a hugely costly hospital and not fill the beds, but then if we go and do more and more assessments some of the people on the waiting list could potentially never get in, so then that becomes a complete waste of resources, assessing and assessing. And then, if we cut right back, and we’ve got empty beds, then, you know, that’s not helpful – we’ll be criticised and funds will be taken away. I think that then we can concentrate too much on individual work or taking really complex people, because medium security, although well resourced, we don’t have that much psychology time, we don’t have that much Occupational Therapy time, in order to provide something that can carry on, where you can deliver what you say – which we’re not at the moment, there are lots of things we mean to delivery that we can’t. I think you have to get the balance right, what happens, and perhaps it’s healthy, is that we go too far in one direction and we pull back a bit. And I think any sort of service, as long I suppose look at yourself critically and respond, hopefully you’ll survive.’

5.4 Widening the scope of inquiry

At the heart of this quote, and this chapter, is the sentiment that rehabilitating personality disordered offenders is a complex and, often, iterative process of (re-) reflection. In an ideal world, the ‘really complex’ offender might not be admitted; then again, defining who constitutes a ‘complex’ case requires portentous insight into the mind’s of offenders, which is impossible to achieve in practice. In Chapter 7, the theme is to retrospectively account for offender’s approaches to the professional decision-making forum when admission to hospital from prison hangs in the balance. In respect of the constant search for equilibrium that services like Cannock ward face, accounting for this key variable is opportune, if not essential.
Chapter 6

From Gaol to Medium-Secure Unit:
The Political Lives of Patients

Generally, it can be said there are three types of struggles: either against forms of domination (ethical, social, and religious); against forms of exploitation which separates individuals from what they produce; or against that which ties the individual to himself and submits him to others in this way (struggles against subjection, against forms of subjectivity and submission)... I think that in history, you can find a lot of examples of these kinds of social struggles, either isolated from each other, or mixed together.

Michel Foucault (1982)\(^1\)

It has been said that relations of power describe the ability of social actors in co-extensive situations to achieve certain goals within systems of government. In Chapter 5, this ‘Foucauldian’ elucidation of power was analysed in the context of the professional decision-making forum in which the suitability of respective offenders for admission under s.47 of the MHA 1983 was being adjudged. Chapter 6 asks whether offenders themselves direct, through the use of strategy, the conduct of professional staff carrying out pre-admission assessments in prison. The findings drawn upon emanate from the survey of personality disordered offenders who had previously been voluntarily transferred from prison to a named medium-secure unit for the purposes of treatment under the 1983 Act. Understanding the reasons why offenders seek out, or at least consent, to treatment in the psychiatric hospital will go some

\(^1\) ‘The Subject and Power’. In: Dreyfus, H. L. & Rabinow, P., *Michel Foucault. Beyond Structuralism and Hermeneutics*. Harvester Wheatsheaf, p. 212. [‘The Subject and Power’].

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way to explaining how the client group approaches the potential to address their deviant behaviour.

To better contextualise the therapeutic effects, if any, of treatment once the offender is transferred to the psychiatric hospital (see Chapter 7), however, discussion will begin with an evaluation of his engagement with the prison-reformist agenda. Taken together, since both the prison and hospital are examples of institutions within the disciplinary grid, the analysis that follows provides apt occasion to discuss the normalising potential of discourse on the subjects they create.

6.1 On the prison wing: The fiction of pedagogical domination

As a preface to the overarching question of this study, first a polemic: it is submitted, *ex hypothesi*, that if the prison – perhaps like the psychiatric hospital, the army barracks, the school, and so forth – really aspired to be a place where individuals where ‘demoralised’; where ‘souls’ submitted to the great dichotomy of right and wrong; were surveilled from a privileged position; and, finally, emerged from a carefully orchestrated social space having internalised the sage practices of a ‘learned’ few, it has all but failed. In defence, Foucault’s disciplinary grid is arguably no more than an ideal-type formulation which probably relies too much on the persuasiveness of the human sciences to normalise those on the wrong side of racist divisions. But rather than critique discourse directly (indeed, that sort of ‘critique’ of disciplinary techniques has always been of little use), as a starting point his

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notion of discipline remains an important constituent of the debate on power relations. For one, it provides us with ideas about how society seeks ‘hygiene’ as an ultimate goal, through attempting to inculcate marginalised groups, such as the offender and the mentally disordered, with desired norms or behaviours within institutions. Secondly, and arguably more importantly, it contends that resistance by marginalised groups is an inexorable frontier for the dominating effects of discourse. In contrast to the position adopted by the current researcher, it is this latter point that is held to be most contentious by many commentators.

Consider James Scott, who argues that ‘subordinates conform’ as a result of ‘a basic antagonism of goals between dominant and subordinates that is held in check by relations of discipline and punishment’. This holds, he says, in ‘certain institutional settings between wardens and prisoners, staff and mental patients, teachers and students, bosses and workers’. However, one more obvious example of the partial effectiveness of subordination through imprisonment – by which one might also say the ability to induce rehabilitative effects free from resistance – is the use of (violent) riots by inmates. That said, one problem in citing violence as a means of undermining totalising power structures is that violence is not usually thought to be synonymic with power. Take Hannah Arendt, who asserts that power and violence never co-exist: ‘Power and violence are opposites,’ she opines; ‘where the one rules absolutely, the other is absent. Violence appears where power is in jeopardy, but left to its own course it ends in power’s disappearance.’

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engaged in games of ceremonial order, often of a violent kind.\textsuperscript{5} Mr. L., for instance, alluded to the constant vying for ascendency in prison between inmates:

\textit{‘My mind set in prison was: if I went for a shower, I had to take a tin of tuna with me in a sock... I was always living in fear. You didn’t know what was coming and when...’}

Perhaps, then, the preferable view is that one must allow strategy to apply violent means, as long as one does not, as Arendt warns, equate the two. Foucault would seem to agree when he says:

The exercise of power can produce as much acceptance as may be wished for: it can pile up the dead and shelter itself behind whatever threats it can imagine.

However, he continues:

\textit{In itself the exercise of power is not violence...} It is the total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action.\textsuperscript{6}

Nevertheless, the linking of violence with power (at least as a response against power) is inevitable if one cites violence as evidence, not of the inherent subjective freedom of individuals who engage in strategic games with others, but of the marginalised being inherently subordinate to the dominating effects of discourse and the agents of that discourse. A crucial point to make here is that there is no reason to equate the existence of a hegemonic discourse with dominating effects – even in the strictest of regimes.


\textsuperscript{6} ‘The Subject and Power’, supra n.1, p. 220. Emphasis added.
For Scott, his context for the discussion of power relations is the feudal society, where violence or ‘frontal assaults’, as he puts it, act not as strategy but as ‘the only way of reducing levels of frustration bound up with the relationship of domination’ that is essentially stable and patterned into society. Any act of violence aimed at overthrowing ‘power’ must, therefore, originate from behind the scenes (the ‘hidden transcript’), so as to conceal the workings of resistance.\(^7\) In contrast, on the prison landing, as on the psychiatric ward,\(^8\) it is clear that violent assaults do occur between service users and staff, as between service users themselves; but it is not so clear that this is necessarily referable to cathartic release amid the strictures of the repressive disciplinary grid. To argue otherwise, at least in the opinions of Useem and Kimball, ignores that

Some treat prison riots as merely ‘expressive’ acts, purposeless emotional outpourings. Those who are more prepared to view the masses as rational look for evidence of plan and strategy, interpreting riots as ‘instrumental,’ not merely expressive, and designed to relieve their suffering.\(^9\)

A good example of instrumental violence is provided by the transcript of Mr. L., who, prior to being admitted to Cannock ward, had been admitted to Gartree therapeutic community, only to be returned to his original prison after it was felt that he required greater structure. When, subsequently, threatening suicide failed to get him transferred out of the detaining prison, he instigated a riot in which several members of the prison staff were injured. Rather than

\(^7\) Domination and the Arts of Resistance, op. cit., pp. 186-92.

\(^8\) Len Bowers identified during his research that sixty-seven per cent of nurses had been ‘attacked or seriously threatened’ by a service user with PD during their careers. See (2002) Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team. Routledge, p. 57.

identify this as a means of cathartic release or power in the balance, he says of his relationship with the administration:

‘It becomes like a power struggle. It’s not a battle. I’m just trying to help myself.’

In this instance, the riot was unsuccessful, and when members of Cannock ward’s multidisciplinary team came to assess his suitability for admission to the specialist unit (more specifically, Cannock ward), there was evidence that he attempted to absolve himself of responsibility by blaming fellow inmates. The Pre-Admission Assessment Report notes his use of strategy thus: ‘[This] demonstrates his ability to influence others and to manage situations to work to his advantage.’

Violence to oneself, that is self-harming behaviours, may also only be a *prima facie* indication of the demoralising nature of imprisonment. For example, it was said of Mr. C. that ‘When ‘trying to release anger’ he would destroy his cell first, and if that was not enough he would self-harm, which would then lead to him feeling depressed that he had ‘done it again’.”

This could, and in some cases probably should, be taken as evidence of institutionalisation and learned-helplessness rather than strategic innovation. For instance, of one service user on Cannock ward, it was said:

Mr. G. was ‘tearful and said that he’s had enough he’s done 20 years already and cannot see a way forward there is nothing in the future for him except more jail time’.

Nevertheless, what is claimed is that the total, ‘demoralising’ institution that commentators such as Goffman envisaged is never more than partial.

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Therefore, whilst Mr. C. at first laments during interview: ‘I didn’t know anyone in the prison system... So, I was alone.’ And later: ‘I’ve done three sentences, and each one I’ve deteriorated even more’. Subsequently, he comments on his use of violence and self-harm in prison as though it could be used as a means of strategic advantage:

‘My anger was instrumental a lot... I knew what I was doing.’

In the context of the Foucauldian notion of discipline, this example features the obvious problem which he himself was aware of in relation to the possibility that resistance may compromise the internalisation of the reformative qualities of imprisonment qua discourse-mediated norms.

However, to digress briefly, it is envisaged that the argument could be made – a manifestly spurious argument given that a lack of service user capacity should not be presumed by the presence of mental disorder without more –¹² that what is on display in these examples of (instrumental) self-harm is not the weak hold of prison-reformist discourses on the ‘soul’ but an effect of mental disorder which compromises the internalisation of norms. Consider, for instance, in one notable study, Yang et al. surveyed 67 male service users who had been in one of six French security institutions (Maisons Centrales) for 10 years or more, asking them how imprisonment had affected their psychological state.¹³ In those with a recognised mental illness, it was found that the study group ‘expressed greater hostility and persecutory ideation, attributing their suffering to external factors…’, rather than as an effect of ill-conscience which

¹² Section 3(1) of the Mental Capacity Act 2005 noted.
punishment would hope to induce. Drawing particularly on the experiences of those with psychotic disorders, it is opined by the authors:

… [they] may have limited ability to understand the purposes of punishment and to assimilate the intended objectives of penal sanctions. Our findings suggest that in this subgroup, punishment may be less likely to achieve its stated goals, and may promote instead more withdrawal and misconstrual of other’s intentions.

Given that the authors had introduced, albeit cursorily, the themes of acceptance and ‘rebellion’ in their earlier appraisal of the prison system,\(^{14}\) it is unfortunate that they conflate mental disorder with the failings of reform as part of their acceptance that ‘penitence’ may impress the norms of punishment upon the ‘soul’. In practice, it may be more accurate to describe penitence, or an acceptance of punishment, as concealing rebellion. Indeed, without exploring ‘rebellion’ as a facet of the Foucauldian analytics of power, one is forced to read acceptance of guilt in the given study as evidence of the internalisation of censure, which in turn provides quasi-evidence of the success of reform through imprisonment:

‘I tried to escape several times when I couldn’t take it anymore… Now I know that I am guilty, and I know why I am here… The huge difference in relation to the beginning: I know who I am and why I am here.’\(^{15}\)

Rather than dwell on the limitations of the study’s methodology (indeed, they, like the current author, encourage the exploration of alternative theories to guide research), one may simply agree that patients have the capacity to learn what is expected of them within certain discourse-mediated regimes.


\(^{15}\) Op. cit.
However, to accept that the behaviour that emanates from this expectation is testimony to the reformatory qualities of imprisonment, subsequent upon the internalisation of ‘healthist’ norms, may be paltry in light of the potential for offenders to interact with the ‘system’ on their own terms. Even an ostensibly reformed offender may have in mind the potential to achieve subversive goals when speaking of past profligacy. For instance, on the subject of unsuccessful escape attempts, Mr. L. states (not dissimilarly to the offender cited directly above):

‘I haven’t been an angel, far from it… The first thing that struck chord with me was twenty years ago I scolded a prison officer, I stabbed another, did this and that, I was forever in segregation units. The other major impact for me, I’ve got four escapes on my record.’

Here, ‘impact’ seems to imply that at some level Mr. L. felt he should seek out rehabilitation; but, in fact, he was speaking in the context of his negative experiences in prison and whether his previous acts of resistance against the regime were going to act as a bar to transfer to hospital, absent any discussion of his desire to receive treatment. This fact, along with the perpetual recidivism documented in his medical records and the threat of suicide which he used as leverage to incite prison staff to transfer him to another prison, questions the reformative character of imprisonment that he wishes to impress upon us.

In all of this, then, one sees that in those surveyed subjectivity and displayed behaviour are potentially at odds. On the one hand, his subjectivity could be assumed to be have been affected by discourse by evidence of the (seemingly) penitent behaviour itself; on the other hand, his displayed behaviour, which may merely mask strategy aimed at some (as yet) unarticulated goal, need only
take into account what his subjectivity should be, as defined by the goals of that disciplinary institution. In respect of this dichotomy, the proper basis for analysis is, therefore, the context in which the reformist agenda arises. When this is known, the task of differentiating displayed behaviour from subjectivity is made easier. To be more precise: why at this point of analysis has the ‘training’ of the client group surveyed been, it seems, partially effective? And, as important, in what penal context is the notion of disciplinary training being raised to address rehabilitative concerns? To answer these questions, some background is necessary.

6.2 Indeterminate sentencing and rehabilitation

6.2.1 An example of the normalising grid in action?

The Criminal Justice Act 2003 applies to sentences after April 2005. Key sentences are the indeterminate sentence for public protection (IPP) and the life sentence.\(^\text{16}\) Both incorporate a treatment element which the offender must satisfy if s/he is to achieve parole from prison. The aim of treatment is, as Foucault would put it, to ‘reclaim them individually’,\(^\text{17}\) and inspire the development of more pro-social behaviours that will reduce reoffending. In practice, few resources are available, which precludes the pursuit of serious rehabilitative aims. It was, therefore, noteworthy that all those patients surveyed were subject either to an IPP or, to a lesser extent, a life sentence. Mr. H., an IPP’er, comments:

\[^{16}\text{For discussion, see Chapter 1, 1.3.3.2}\]
\[^{17}\text{Discipline and Punish, supra n.14, p.130.}\]
‘[It] doesn’t rehabilitate... And because there are so many getting IPPs and lifers, people are getting lost in the system. Unless you shout at the top of your voice, you get lost.’

This sentiment was reiterated by other patients interviewed. As Garland alludes to, what this reveals is the reliance of the disciplinary grid on proper administration, since there is no such thing as a ‘docile’ body absent the resources to invest in their productivity. Put another way: how can a subject be imbued (dominated) by the power effects of discipline absent contact with the human sciences? As a rejoinder, Foucault would presumably adopt a degree of pragmatism that is not wholly convincing. He states:

One would be forced to suppose that the prison, and no doubt punishment in general, is not intended to eliminate offences, but rather to distinguish them, to distribute them, to use them: that it is not so much that they render docile those who are liable to transgress the law but that they tend to assimilate the transgression of the laws in a general tactic of subjection.

It follows from this account that it is not necessarily incongruent to sympathise with Mr. H., that the prison faces problems rehabilitating its clients, but nevertheless agree with him – if, for the moment, only in principal – when he says:

‘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.’

What Foucault later sought to do was to meld the perceived acceptance of the penal regime, as with other forms of government, with a less apologetic stance on the dominating effects of power. Accordingly, whilst there was still the

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18 If one is to appreciate the moral force of Government, a tangential question of great importance is whether one should construe “shout” as indicative of activism or subversive strategy aimed at seeking parole. This will be considered anon.

potential for resistance (for example, prison riots) at the immediate level of relational interaction, in *The History of Sexuality* Foucault claims that active resistance to discourse merely confirms the subject’s subordination to it, and therefore the effect it will have on his subjectivity. He was to posit that, through Hegelian-type inheritance of discourse in society, the subject is bound to self-make according to the whims of *bio-power*. Furthermore, since self-government (subjectivation) and discipline (objectivation) both rely on discourse for their normalisation effects, they are not alternative explanations of power in society. For discipline, however, this is problematic: unknowing subjectivation to discourse should bolster the effectiveness of training in the disciplinary institution; and yet, if the penal regime is no more than partial in its elimination of recalcitrance, it is not clear why the grander claim of subjectivation to discourse in society should be accepted. Part of the answer to resolving the latent tensions between facets of Foucauldian method, perhaps in favour of one over the other (either discipline or government), is to know more about how those surveyed responded to their sentence and the need, if not wish, to incorporate the prison-reformist agenda into their schema of intent. It will transpire that this is to incorporate the question: what determines the making of hospital directions under s.47 of the MHA 1983 in respect of the client group surveyed?

6.2.2 The limitations of prison ‘training’

The first point to make is that upon being sentenced, if not before, it is likely that the offender is well aware that participation in prison behavioural courses and demonstration of the skills learned is a pre-requisite of parole. In fact,
there is evidence to suggest that this is made explicit to the offender during court proceedings. In the case of Mr. E.:

‘The Course that I have been told about, that you are to embark upon, is, of course, a significant step and if you are to achieve a happy outcome in the course no doubt it will inform the Parole Board’s decision in due course… I acknowledge that whilst this sentence is entirely necessary, you are a young man who has had significant difficulties in your life and who is doing something to address those difficulties. No doubt if you succeed it will inform the process that may lead to your release.’\textsuperscript{20}

The expectation of self-reformation is also explicit in the Parole Board literature; this makes it particularly clear that demonstrating reform (if this is not a perverse notion given that subjectivation supposedly happens in spite of free will) is vital to achieving parole:

Although successful attendance on courses aimed at reducing offending behaviour is helpful in providing evidence that the level of risk that a prisoner presents has been reduced, this is by no means a guarantee that the prisoner will be recommended for release. Attendance on courses...might not have been effective in reducing the level of risk. The Parole Board panel will need to take into account all the evidence available to them, including professional risk assessments, when making their decision.\textsuperscript{21}

Flowing from Foucault’s account of discipline, one is aware that normalisation can only achieve so much because of the potential to resist overt forms of discourse-mediated power. On account of resistance, or more specifically strategy, Foucault would presumably have little problem with the notion that, as well as outright refusal to submit to the goals of the institution, compliance can mask the pursuit of ulterior gains. Mr. K. says this of the effect of the

\textsuperscript{20} Emphasis added.
indeterminate sentence on treatment compliance:

‘...you go to the treatment group and all you’re doing is ticking the box... You don’t do work but you throw it away. You don’t put anything into practice or remember it’.

He later contradicts himself, however, when he says, ‘Now [they’ve] really cottoned onto it. You can’t go in and tick a box... It gets looked at.’ Of course, in practice this may simply mean that the service user is aware of what needs to be done to create a favourable impression of himself in the eyes of the Parole Board; it does not suggest that the investment of the human sciences has reached the ‘most minute and distant elements’ of his body: the potential for preventative detention post-tariff is a considerable motivator for tactical guise.

However, this reasoning may be slightly expedient, if not fatalistic, about the relationship between discourse and domination. Consider: it is possible that what may preclude the interiorisation of normative practices may be less to do with the means to which resistance may be put and more a consequence of administrative failings within the disciplinary regime, of which Foucault was largely silent.

Several factors may be posited which, to a greater or lesser degree, have the potential to undermine the potential for interiorisation of norms, and in turn suspend our critique of governmental technologies.

I. Scarce resources

When social anomalies, such as delinquency, are cast in the language of the human sciences, a failure to normalise these anomalies merely provides

\[22\] *Discipline and Punish*, supra n.14, p.216.
evidence of the need to ‘increase and spread the power of experts’.\(^{23}\) But what if there is an absence of expertise to normalise the problem in the first place?\(^{24}\)

Arguably, one would have to conclude that the possibility of rehabilitation is not given a chance. Thus, without sufficient investment by the human sciences in the system of indeterminate sentences, there can be no implementation and administration of behaviour courses, and so, \textit{ex hypothesi}, no rehabilitation.

Undoubtedly, the overzealous use of IPPs goes to the heart of scarce treatment provision in the prison system for the client group surveyed. It has resulted in the shipping around of offenders between various prisons and long waiting lists, causing those on the shortest tariffs to be prioritised for treatment. One lifer surveyed comments:

‘... [they’re] taking up the space in groups to try and get rushed through... I was in 16 months before they put me on a course. You can wait years and years to get on courses...’

(Mr. B.).

On the one hand, it is not clear why the administration expects to inculcate desired behaviours in offenders if they are ‘rushed’ through. On the other hand, conducting treatment in an expedient fashion ensures that the punitive portion of the sentence for those who are deemed to pose a lesser risk to the public is not out-lived by incapacitative restraint. However, for those, like Mr. B., who remain incarcerated and seeking treatment, continued detention is inevitable.\(^{25}\)

This does not undermine the disciplinary grid \textit{per se}, since all that is


\(^{25}\) No patient who was surveyed had appealed to the courts to challenge his detention under article 5(1) of the European Convention on Human Rights. See Chapter 1, \textit{supra} n.69 for context.
required for the assumption of subjection and investment is ‘A meticulous assumption of responsibility for the body and the time of the convict, a regulation of his movement and behavior by a system of authority and knowledge…’26 Yet, in the mind, if not the ‘soul’, of the offender, a system which facilitates the passage of only some who are subject to an indeterminate sentence may vitiate the moral appeal of the specific disciplinary regime, particularly if some treatment has been received. Foucault says:

>a penalty that had no end would be contradictory: all the constraints that it imposes on the convict and of which, having become virtuous once more, he would never be able to take advantage, would be little better than torture…  

II. Relational aspects

The usual tenor of prison relationships, as described in literature, is resistance towards prison staff and solidarity among inmates. These characteristics may be reinforcing. For instance, according to Sykes, the menace of the prison environment for inmates is reinforced by the binary distinction of ‘toughs’ and ‘hipsters’: those who either perpetrate violence or threaten it. However, this dichotomy helps foster a ‘cohesive inmate society’, which in turn helps ‘to solve the problems of personal security’ inherent in imprisonment.28 Therefore, by implication, the man who engages in behavioural treatment, rather than ‘ticks the box’, is incongruous with the morality of the ‘real man’. This was confirmed by many of those service users spoken to. For instance:

27 Ibid., p. 107.
‘In prison, you don’t walk away from things or you get bullied even more… [Here], you walk away, you’re gonna be praised by the staff, by the patients… You can open up in meetings… You can’t do that in jail.’

(Mr. C.).

‘…in prison there is stuff you can’t actually talk about for fear of what might happen to you’.

(Mr. B.).

A further facet of the ‘unity of inmates’ is the impossibility of ‘denying the cohesion of prisoners as a domination value when confronting the world of officialdom’. Mr. L. confirms:

‘I couldn’t ask the prison officer for help. You couldn’t be seen as weak. In that environment, it’s them and us. You don’t play chess, you don’t play pool, you don’t play fucking scrabble with the prison officers. The moment you do, you’re labelled a wrong’un, a grass, and then you’re open to target, everyone wants you.’

Nevertheless, claims that prison guards may be seen as therapists are not uncommon in literature. Ben-David and Silfen, for example, identify five prototypic staff-prisoner relationships in the prison psychiatric ward, which they believe may be extrapolated to the general prison: namely, punitive, custodial, patronage, therapist and personal types. The therapist type considers prisoners to be service users; relationships are structured so as to encourage maximum therapeutic advance, which is fostered by the service user’s co-operation. It was shown that a lack of co-operation – and so the improbability of the indeterminate sentence to bring about normalised individuals (as expressed by the offenders themselves) – may merely be milieu, for the ‘real man regains his autonomy, in a sense, by denying the custodians’

power to strip him of his ability to control himself...⁴⁰ This sense of autonomy, then, will not assist training, since its efficacy requires that one imposes on the body tasks that are both repetitive and different, but always graduated. By bending behaviour towards a terminal state, exercise makes possible a perpetual characterization of the individual either in relation to this term, in relation to other individuals, or in relation to a type of itinerary. It thus assures in the form of continuity and constraint, a growth, an observation, a qualification.³¹

But, strictly speaking, in as much as this account supports those who argue – Foucault and Parsons included – that the subjugating effects of discourse would be effective, it also supports ignorance of the fact that the efficacy of the human sciences (within the disciplinary grid) – that is, the service users cooperation with the aims of government – should nonetheless be guaranteed by the service user’s blind subjectivation to discourse. Presumably, however, this assertion relies on evidence of the particular discourse having its effect, and, thus far, the account has not provided such a discourse. This leaves oneself open to challenge that one is being either fatalistic about the lack of ‘power’ of discourse or nominalistic about the import of service user actions, qua strategy, in the pursuit of goals quite removed from the effects of discourse. In sum, is it enough to speak of ‘healthism’ as the operative discourse within prison training? Indeed, whilst healthist discourses, widely construed, provide the researcher with a sense of how governmentality could be deployed in general terms, perhaps one is always ill-advised to rely on its generality when in fact what is meant is the infiltration of (potentially) a plethora of ‘healthist’ discourses within a multitude of institutions within the governed world. These

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³⁰ The Society of Captives, op. cit.
discourses, the argument could conceivably continue, refer for their legitimacy – more or less successfully – to very different theoretical, and even moral, constructs.\textsuperscript{32} So, what in fact does one mean by discourse in the current context?

III. The specificity of discourse in the deployment of treatment

One who does not engage in prison training in the manner expected is certainly resisting, but it is not clear beyond general notions of healthism what exactly is being resisted, and what the effect of resistance is. This is problematic if one wishes with some degree of conviction to renounce claims that false consciousness may be acting on offender’s ‘real’ interests. One is not saying here that healthism, or the desire to be healthy and well, does not have a strong normative claim on service users; in fact, its potential to govern actions is seen the moment it is pitted against a competing discourse, such as comporting oneself with dignity and self-restraint in the face of adversity in prison. Consider that Sykes posits that the offender with the greatest ‘admiration’ is one who maintains ‘dignity and composure under stress’, since, collectively, this creates solidarity between inmates, thus ensuring more tolerable conditions of detention.\textsuperscript{33} But the inherent recalcitrance of active individuals means the pre-condition of solidarity is not always followed; healthism, instead, may win favour with the service user. For example, it has already been seen that Mr. C. did not cope well with the prison regime.\textsuperscript{34} The stress this resulted in did not inspire stoicism; it resulted in self-harming behaviours for which he sought treatment. So, what does this tell us?

\textsuperscript{32} The stigma associated with having a mental illness over physical illness comes to mind.
\textsuperscript{33} The Society of Captives, supra n.28, p. 102.
\textsuperscript{34} See p. 185 above.
Mr. C’s actions clearly alert us to the potential for health seeking-behaviours in the disciplinary institution. What his case does not confirm, however, is that the effects of healthism are at work. For one, he may have been acting strategically in seeking treatment – that is, discipline has not been buttressed by subjectivation (*The History of Sexuality*); it has been attenuated by resistance (*Discipline and Punish*). It also points out – and this is crucial to those who still argue that social action is founded upon the internalisation of norms – that psy-discourse and not healthism should be considered to be the operative discourse in deciding whether his actions have been governed. For his self-harming behaviours, read in conjunction with his prior diagnosis of mental disorder, means that it is psy-discourse here which is potentially promising the effects of subjectivation (domination) to healthism. When one assesses the resistance of service users caught by the indeterminate sentence (for example, approaching cognitive-behavioural therapies in prison as a tick-box exercise) in terms of psy-discourse, it is not clear whether one is justified in asserting that discourse does not have the potential to normalise.

More specifically, the framework of treatment on Cannock ward and in prison is very similar. This suggests that both should be effective at creating subjects who internalise norms. The eclecticism of psychiatry at incorporating aspects of other discourses into its own – such as integrating psychological theories of mental illness alongside biochemical ones – means that the treatment there has ‘historical’ legitimisation, whoever provides it. However,

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35 Consider that Mr. C. had previously used self-harming behaviours as a means of discharge from another disciplinary regime. One entry into his Care Programme Agreement Review reads: ‘He told [psychiatrist] that he took an overdose to get himself discharged from the army’.
Foucault points out: 36

Medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them.

In sum, medical statements require for both their legitimacy as truth, and thus their ‘therapeutic powers’, attendance by the discourse which defines the nature of the medical / society problem. For those offenders who are “divided” both by their criminality and mental disorder in prison, this makes the presence of psychiatry as an operative discourse crucial for any rehabilitation within the prison-reformist agenda. As it stands, treatments offered (if not always available) as part of the indeterminate sentence under the CJA 2003 recognise the import of psy-discourse (the fact they are cognitive-behavioural); but, crucially, for want of psychiatrists within the prison system, the courses may lack therapeutic legitimacy. The result is objectification in line with discipline, but without, it seems, the apparent possibility of subjectivation.

The fact that this assumes practices of resistance within the prison also shores up another important limitation of the prison-reformist regime: namely, recourse to inappropriate methods of behavioural ‘containment’. Take the extreme example of Mr. D., who was in fact diagnosed as having a personality disorder (PD) in prison, but was sent back to prison after his initial transfer to Cannock ward, for reasons that will become apparent. He had this to say about prison:

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‘... [they] sort of threw me on the wing and that was it, I didn’t see anybody. And everybody I did try and chase up, the members of the in reach mental health team would say, we don’t need to see you; you’re not a mentally ill person, you’re a mental disorder, whatever.’

Even more alarmingly, Mr. C. says of his ‘treatment’ in prison:

‘[They] can’t do anything for me. All [they] did was drug me up. I was on quite a lot of Chlorpromazine, Olanzapine, Valium and Concerta.’

Similarly, the consequence of Mr. K’s diagnosis of PD in prison was polypharmacy (twelve medications in all; six at the time of his referral to Cannock ward). Strictly speaking, whether there would be less reliance on medications in the respective prisons if more disorder-appropriate measures were available is not clear; presumably, in the absence of professionals such as psychiatrists sympathetic of the potential amenability of PD to cognitive-behavioural treatment, chemical coshing would remain a mainstay of treatment.

Of course, one ought not to forget that Mr. C. and Mr. K., like others serving the sentence of IPP, are at liberty to refuse to comply with the ‘treatment’ regime in prison (including medication). Thus, one reads their compliance as evidence of the subjugating effects of the prison-reformist regime (perhaps healthism at its most crude) – which has been shown to be unlikely – or, preferably, as a pragmatic reaction to the potential for post-tariff

37 This is not to suggest that this is always the case; consider the view of one member of prison in-reach in a different study: ‘I have had a difficult experience with the mental health team in another prison. I had a dispute over a prisoner they called a psychopath, not mentally ill, so nothing could be done to help with his management; I saw this as unsatisfactory.’ See HM Chief Inspector of Prisons (2008) The Indeterminate Sentence for Public Protection: A Thematic Review. London: HM Inspectorate of Prisons; HM Inspectorate of Probation, para. 5.44

38 Two anti-psychotics (neuroleptics), a benzodiazepine and an anti-depressant.
incapacitative restraint if they refuse to submit to treatment. It is, again, strategy in context; strategy which is not thwarted, it seems, by the appeal of psy-discourse on the self-making potential of those surveyed.

6.2.3 Commentary

Having addressed, on the available evidence, the issue of subjectivation in the context of prison reformist efforts, the central question of whether offenders are actively attempting to circumvent the potential for incapacitative restraint in prison by gaining admission to the better resourced Cannock ward can be discussed with greater clarity. This is to expound upon decision-making under s.47 of the Mental Health Act 1983 by moving beyond the decision-frame of professionals alone. It will be seen that this is to ask the associated question: how, if at all, do offenders come to be referred to Cannock ward, and receive a pre-admission assessment? At the outset, it is not claimed that referral is referable to service user strategy; instead, the less grandiose claim is made, that his active role in gaining admission is incorporated within, what appears to be, a rich, and often unpredictable, set of determinants.

6.3 Prison Referrals: the import of strategy

A consideration of how and why referrals occur is important in its own right. In respect of understanding admission decision-making practices, it is relevant because, as was shown in Chapter 1, the number of offenders in prison and the high percentage of those who will be suffering from one or more mental

39 *Contra*, it has been shown that some prisoners on IPP’s refuse medication because they believe it will prevent them from completing their sentence plan, and this might mean they are never released. See Sainsbury Centre for Mental Health (2010) *Blurring the Boundaries: The Convergence of Mental Health and Criminal Justice Policy, Legislation, Systems and Practice*. Report, p. 30.
disorders suggests that many who could benefit from a hospital disposal do not.

One explanation might be that, within prison – particularly those less familiar with diversionary mechanisms – in-reach teams will not be aware of the clinical needs of offenders. This may be a consequence of poor screening for mental disorder upon sentencing. Consider that, in 2007, a thematic review on mental health found whilst 17 per cent of the surveyed prison population had received some form of mental healthcare in the community, only in 3 per cent of cases was the ‘further information required box’ ticked during screening. And in only in forty-five per cent of cases was there evidence of a secondary health screen in the medical records. Where screening does take place, extensive research within European prisons confirms that standards vary, in accordance with factors such as (in)adequately trained staff and scarce financial resources.

But, of course, the identification of a complex disorder such as PD does not guarantee a perceived need for treatment, as was seen in the case of Mr. D. above, much less referral to specialist services. The situation may be different, however, if the offender displays symptoms of PD in a prison more experienced in providing the client group with treatment. For example, Mr. B. was referred to Cannock ward after receiving treatment for self-harm whilst at HMP Gartree. He was subsequently assessed by a consultant psychiatrist from Cannock ward, who diagnosed him as having a PD for which ‘appropriate
‘treatment’ was said to be available. Initially reluctant to give his consent to be admitted (in his case, he seems to have equated admission to a psychiatric hospital as a form of section, and so may not have been clear of his legal rights), he paraphrases nurses’ encouragement thus:

‘you’re self-harming and stuff and you need to go and get the help you need...’

This seems to suggest that, whilst the psychiatric diagnosis of PD may not have sufficient normative force to induce service users to submit to psychiatric treatment of itself, with professional ‘healthist’ advice that treatment is in the service user’s best interests, he concurred. Moreover, Mr. B. cites literature left by the visiting psychiatrist as relevant to his decision to be admitted to Cannock ward:

‘It just said ‘are you a self-harmer and impulsive?’ and all that lot; and I started thinking, I am those things and I do need help...’

However, one is forced to reconsider the force of normative pressures to seek treatment in light of the more apparent pressure to receive treatment amid the indeterminate sentence. He says:

‘Here you get on courses, boom, straight away. But in prison, there’s a bit of a waiting list. You can wait years and years to get on courses.’

Later, when asked if he had considered a forensic hospital to deal with his self-harming during his previous sentences, he replied:

‘To be honest with you, back then I had a release date and I didn’t really think I had any problems, so I would have probably thought no.’
This tells us that he equates treatment with increased chances of parole; but, equally, that parole is contingent upon manifest behavioural change. He later confirms as much when he says:

‘...if I really wanted to I could just stay the way I am and end up committing more offences in prison. But I though, nah, I don’t want that – especially meeting those people who are doing 28-30 year tariffs. I don’t really want to be like that. What kind of life is it being locked behind a door?’

It would, therefore, be inappropriate to contend that psychiatric norms do not play a part in one’s decision to seek treatment. The question of why is not so easy to answer: presumably, any notion that service users are subjectivated by discourse must contend with the normative pressures of the indeterminate sentence. In this respect, the ‘quality’ of service users’ engagement once they are received into hospital is shored up as a particular important area to explore (see Chapter 7).

Another reason why this partial case study is interesting is that it highlights the importance of relations between the respective prison and Arnold Lodge. It is known, for instance, that HMP Gartree (again, the feeder prison from which Mr. B. was transferred) is relatively unique in its support of therapeutic dispositions. Having been a main lifer centre since 1997, medical staff are likely to be well-appraised of the negative collateral impact of indeterminate sentences on service user mental health. Moreover, some former members of the multidisciplinary team (MDT) on Cannock ward were at the time of this study working in its healthcare wing, suggesting that in-reach are more likely to be experienced, and sympathetic, to the complex needs of those with PD. A ‘referral culture’ might equally arise through relations between individual staff at a prison and Cannock ward:
‘Sometimes we have referrals from prisons where, you know, there’s very little staff, there’s no treatment, but there’s a mental health worker who does a really good job, and knows their client and knows we’re here and does the referral...’

(Psychologist).

These ‘referral cultures’, it seems, produce a disproportionate number of referrals. Those who have finished their course of treatment on Cannock ward, and who are subsequently been returned to prison to await parole, may also contribute to the decision of the offender as to whether to consent to the hospital transfer. Mr. B. seems to have benefitted from positive testimonials of the service. He says:

‘a couple of prisoners who were listening to the nurses said you need to give it a shot, because you can’t continue living like you’re living’.

Mr. B. does not say whether this encouragement was particularly relevant to his consenting to the hospital direction; and, furthermore, it would be dangerous to presume that the advice of others to accept treatment is the result of subjectivation without knowing more about the social situation of the respective service users.

Moreover, opinions among members of the MDT varied on the impact of word-of-mouth on referrals and admissions. Whilst some were convinced that self-referrals had been a direct consequence of contact in prison with those who had had positive experiences on Cannock ward, the majority thought it could go either way. This makes intuitive sense in that, first, a patient could self-govern as a result of treatment but also not believe its receipt was a positive experience (less likely). Second, a patient might revoke his consent to treatment before the disciplinary effects of hospital training have taken hold on
the soft fibres of his brain. In this situation, there would be no reason to suspect anything but ‘negative press’ back in prison. Indeed, another patient who was diverted from HMP Gartree states:

‘Everyone else who I’ve known from Gartree didn’t like it and have gone back.’

At best, therefore, one can say that, absent specific encouragement from those returning to prison from Arnold Lodge, word-of-mouth acts merely as a signpost to what is therapeutically available outside the penal regime. It can only provide the offender with greater information with which to decide whether they wish to enter the formal process of pre-admission, and ultimately accept the offer of admission, should it arise.

If any of these ‘relational’ precursors to referral are not engaged, it either falls to the staff on Cannock ward to increase referrals, usually by promoting their service, as a response to the lack of joined-up thinking between the criminal and psychiatric regimes. One nurse says:

‘I even went out and did awareness training with staff... A lot of the prisons we went to, we got there and they hadn’t even bothered to plan to get the staff on duty. But then we went to Dovegate and it was fantastic the attendance. They had prison officers, nurses, psychologists... So, you could see a difference there. And Nottingham prison, we were lucky to get three or four people.’

There is also a recognition that this alone may not result in referrals, meaning that it is often necessary, in the words of one psychologist, to ‘nudge [them] from time to time’. But, as with any strategy, it may not prove to be effective. According to a former nurse:
‘I’d go and see somebody and whether they were suitable or not. I used to say, have you got anybody else? They used to reel off perhaps 6 people, and I used to say, can you do a referral? But they never bothered to do them. I’d be phoning up – remember you told me about these 9 people you’ve got, I’ve not had any referrals yet. Can you do them? It’s hard work.’

In this situation, the service user is taken to be unaware of the potential for referral and is, therefore, unable to influence the process. A conclusion could be reached that he seems unsuitable or it might be that certain ‘thresholds’ cannot be agreed, resulting in similar ignorance on the part of the service user. What is not claimed is that offenders must, in all cases, rely on prison staff to organise their referrals: the reality is that those who wish to ensure they are referred are no less creative in their approach than professionals.

Consider Mr. E, who suggested to his solicitor that he have a pre-sentence report completed. He later used this to encourage staff from Cannock ward to conduct a pre-admission assessment on him. But since this puts a premium on what is said in the pre-admission report, one must concur with one psychologist, who points out that ‘...there are many where [those] recommendations are not made and you could easily say should be.’

Similarly, Mr. C. adopted an alternative course of action when a prison psychiatrist refused to refer him to Cannock ward, following a previous, unsuccessful admission:

‘He was telling me I wasn’t suitable for here, and this place didn’t want me back... Then, one day, I thought fuck it... I got in touch with my solicitor and they commissioned for reports to be done, and he put the reports forward, and that was good enough. They came to see me, assess me... I wish I had done it sooner, but I just took their word that they didn’t want me..., so it was quite a struggle.’

In the round, the ability of offender’s to implement strategies to set in motion referral invites discussion on whether they may equally seek to influence their potential admission to the service, and if so how. This will be considered in the next section. For now, one might conclude that the conduct of Messrs E. and C. proves that service users are well-placed to influence their own referral in circumstances which show that referrals are large idiosyncratic. Relevant factors, again, include the attitude of prison staff; rates of screening for mental disorder; and the efforts of staff on Cannock ward to advertise their services. Tangential to this, of course, is the potential for admission to follow at the behest of the Secretary of State close to the offender’s earliest release date (in the case of fixed-term sentences), in which case the meaning of referral takes on a more limited, public protectionist meaning. This remains an extremely contentious mechanism for ensuring prolonged detention absent, for the most part, the wish to secure appropriate treatment considerations for the offender. Thankfully, this practice had not fallen ill-upon those surveyed (in the past), meaning the question of how service users approach decisions concerning their future conditions of treatment and detention remains as potent as ever.

44 For discussion, see Chapter 1, pp. 40-41.
6.4 A Wider Understanding of Admission Decision-Making

6.4.1 Strategic innovation and admission to Cannock ward

In juxtaposition to the theoretical approach of power relations and strategy adopted in this study, one is minded of the view of one psychiatrist during the planning stage of this project, who claimed:

‘But a patient can only express motivation to be admitted before the decision passes to the clinician.’

Another member of the administration claimed that the distinction between ‘active’ and ‘passive’ patients made no sense, in light of the fact that one would visit a doctor and, upon communicating symptoms, expect to receive the appropriate form of treatment, and that this was surely indistinct from decision-making under s.47 of the MHA 1983. To recapitulate this point, it presupposes that offenders are health-seeking and professionals make decisions on this basis, without more. But the service user in the current context might merely recognise the need to act subversively (and this is not here used in a perjorative sense) in decision-making circumstances which the civilian might not face, and for reasons quite removed from the wish to alleviate symptoms of his mental disorder.

Mr. D. was described in his pre-sentence report as ‘likely having a personality disorder’. Mr. D. subsequenrly tried, but to no avail, to gain admission to a therapeutic community (HMP Grendon) from a prison in which he had found treatment resources to be lacking. He lated applied to Arnold Logde, but was found to be outside the catchment area for admission. At a later date, following numerous prison transfers, one of which did fall within the
catchment area for admission, he secured a pre-assessment. He reveals:

‘...I was kind of excited, but I weren’t [sic] really as honest, well, I think I was perhaps too honest in the assessment... I probably exaggerated some of my answers... Once I discovered I had a PD, actually, I’m the kind of person, if you say something to me, I wanna know about it, I’ll go out and research it and look at it. So, I did investigate PD, in particular my diagnosis, so I knew what kind of stuff they were looking for.’

In this instance, his frank, and potentially exaggerated, disclosure of the symptoms of his mental disorder ensured he fell within the criteria for admission. He also communicated during interview that most professionals do not expect those with anti-social PD to show remorse or sympathy for their victims, and disclosed that he felt being ‘sorry’ for his crimes during his assessment would work in his favour.

Mr. C., it will be recalled, attempted, unsuccessfully, to gain re-admission to Cannock ward following discharge back to prison. He identified that the reason for his being sent back was ‘violent outbursts’. On securing a further assessment, he expressed to the MDT that ‘he had matured in wanting to sort out his anger and was motivated ‘more than ever’’. Seemingly well-versed on the requirements for admission to Cannock ward, he omitted, however, to tell the MDT that on the day of his transfer he was travelling to the ward from a prison segregation block, which he knew would have effectively blocked his admission. This would have been intolerable for Mr. C, who is noted in his medical records as having said that his IPP was “physical, emotional and mental torture”, and “my behaviour controls my release date”. At the time of

46 Mental state examination taken from a letter sent from his prison doctor to a consultant psychiatrist at Arnold Lodge.
survey, Mr. C. had been receiving treatment on Cannock ward for 13 months. The question of his response to treatment is of interest.

What is also interesting from the point of view of motivation to engage is that there were fewer examples than expected of offender strategy to effect admissions amongst this client group; and, yet, it is already known that resistance against the prison regime was rife. It might have been that respondents were unwilling to articulate strategies that they had relied on to direct the conduct of members of the MDT for the simple reason that it would reinforce the manipulation and ‘pathological’ lying that is said to be a behavioural manifestation of antisocial PD and psychopathy.47 At a critical point in their path through the criminal justice system, it is unlikely an ‘active’ patient would express to a stranger any ulterior motives in seeking treatment, which will in the future inform parole decisions.

For instance, Mr. H. was clearly preoccupied that I might not be an independent researcher at all, but an affiliate of Rampton high-secure hospital, there to assess his suitability for admission (and potentially protracted detention in a Dangerous and Severe Personality Disorder unit).48 Inevitably, he was reassured that this was not the case; that, again, he did not have to answer any questions; that all data would be handled sensitively; and that nothing he said would impact on the care he received on Cannock ward or his legal rights. Despite reassurance, he referred on several occasions to me ‘you lot’. In light of these concerns, it was unrealistic to assume that he would divulge material which he might believe to be sensitive.

47 One of many examples of this came from a young nurse, who stated: ‘Everything about their behaviour is controlled.’
48 Chapter 1, 1.3.2.
There is also the potential that service users were employing strategy during the interviews themselves. Consider, in theoretical terms, Dixon-Woods and Tarrant warning that ‘co-operation’ with researchers has inherent risks, which include those that derive from the fact that ‘the interests of researchers may not always be identical to those of the research participants’. Thus, whether or not Mr. H. could have told us more about his experience of pre-admission assessment is not clear; however, he seemed to acknowledge the basic conditions for the use of strategy when he says of Cannock ward:

‘I thought basically that it was an ace card, getting me out of prison, and that this was going to be somewhat easier.’

Subsequently, he was noticeably keen to impress upon me the ‘fantastic’ nature of the ward, on which staff had the ‘best interests’ of the client at heart, unlike prison. Furthermore, having on multiple occasions implied that the length of stay at Cannock ward was inadequate, he concludes the interview as follows:

‘If you speak to other members of staff, or the head man, I think you’re gonna have to explain to them that two years ain’t enough... The doctors here do what they can..., but the majority of us go back to prison. And I don’t wanna go back and revert to old behaviours, because then the two years have been for nothing, and I don’t want that.’

In another example, Mr. L. used the interview to continually express grievances about his perceived ill-treatment in prison. Following the interview, he subsequently demanded quid pro quo for having taken part by asking that a psychologist with a research interest in gambling and addiction from the University of Nottingham be contacted so that he might share his own experiences.

Finally, Mr. D., who encouraged his admission by modelling his answers to the diagnostic criteria for PD, and also by demonstrating his desire to reform, seemed to use his interview as a medium for orchestrating pro-social behaviour. On at least two occasions, he proffered literature in his possession which he thought might facilitate my research. When this was relayed to members of the nursing team, some explained that this was in the hope of being ‘liked’, owing to his lack of confidence and self-esteem.\(^{50}\)

His conduct might, therefore, suggest that the researcher is in a position of power, insofar as authors suggest that the vulnerability of patients is instrumental in ensuring participation in research (‘outcome exploitation’).\(^ {51}\) Accordingly, it would seem disingenuous to assert that a desire to be ‘liked’ led to strategic innovation. But, equally, Mr. D. had, just prior to interview, lost his unescorted leave for anti-social behaviour. This leaves open the possibility that it is equally disingenuous, if not wrong, to claim that patients are in a position to be exploited (if this is, in fact, the appropriate term) but not to exploit. Here, one is reminded of the view of another member of the MDT, who asserted that service users on the ward were ‘always up to something’. This is an unfortunate, if predictable, limitation of being thought of as inherently anti-social, in which symptoms of manipulation and cunning are self-fulfilling. This is particularly true of the psychopathic client, about whom the supporting literature presents a particularly damning picture of immorality, which in some respects is unfounded.

\(^{50}\) This seems to suggest that self-serving reasons are more important than altruistic ones. The preferable view is borne out of Healy’s work, who cites suspicion of kidney donors as evidence of the cultural implausibility of altruism. See Healy, K. (2006) Last Best Gifts: Altruism and the Market for Human Blood and Organs. The University of Chicago Press, p. 13.

\(^{51}\) More often, this is expressed in the context of clinical research, where there are inherent physical dangers to participants: see, for example, Shapiro, H. T. & Meslin, E. M. (2001) Ethical Issues in the Design and Conduct of Clinical Trials in Developing Countries’. New Eng J Med, 354 (2): 139-42.
6.4.2 The “cunning” psychopath – a preferable perspective

Many of those who figure highly in the account of admission decision-making in this study – Mr. H., Mr. C., Mr. L. and Mr. D. – possess many psychopathic traits, such as evidence of manipulating others, and as such have high PCL-R scores. In the case of Mr. D., for instance, his willingness to ‘exaggerate’ his appropriateness for admission would be linked to his diagnosis. In his seminal, largely alarmist account of the psychopath, Robert Hare claims:

> It is well known that psychopaths often convincingly malinger – fake mental illness – when it is to their advantage to do so. For example, an inmate…was able to con his way into a psychiatric unit – and back out again – by slanting his responses to the questions on a widely used psychological test.\(^{52}\)

Moreover, he says, it is said that the psychopath often rationalises or denies their responsibility for criminal acts by blaming ‘Memory loss, amnesia, blackouts, multiple personality, and temporary insanity…”\(^{53}\) Assuming for the moment that, in isolation, the psychopathic framework is causally related to determining the conduct of others, the experiences of Mr. E. make for interesting reading.

He originally instigated a pre-psychiatric report to be completed prior to his IPP sentence. When he was asked why he thought this might be necessary, he responded:

> ‘I think it was because of my initial offence and the way I was thinking at the time. I could remember certain bits but not everything. I blacked out. I think it was just for that.’

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He was then asked what difference this state of affairs might make to his disposal.

‘I thought it would have made a difference, so [he] made a suggestion in his report that if I get more than two years..., it would be beneficial to come to Arnold Lodge... I’d rather come here, because in prison you’re not gonna get the help you need. And some of the courses you get in prison, because of your PCL-R score, they wouldn’t really put you on courses... So, therefore, you’re not getting your courses, you’re not reducing your risk; you’re just staying in the system.’

His pre-sentence report in fact reads:

‘[Dr. K.] has stated that without a clear idea of [Mr. E’s] motivation, he is unsuitable for a Hospital Order, but he would be suitable for treatment at Arnold Lodge secure unit if he can demonstrate a desire to get help with his interpersonal functioning’.

It was earlier pointed out that Mr. E. referred himself to Cannock ward whilst on remand, but was told of the ward’s policy to accept only ‘sentenced prisoners’, as ‘usually this gives a clear indication of motivation’. Mr. E kept in contact with Arnold Lodge in subsequent months, at one point writing, quite extraordinarily in light of what is known about prison relations between inmates and prison staff:

‘I have made great progress since being on remand. In a strange way, I thank you for my incarceration due to being able to get some of the help I need, and for it opening my outlook into Committing crime and Coming to prison in it’s self. I don’t seem to fit in with the other prisoner’s..., and I am remorseful… So I often find myself Conversing with the prison staff..., because it seems only they are the ones that know normality.’

54 Emphasis added.
55 See pp. 194-96 above.
This is in stark contrast to his behaviour during a previous determinate sentence, about which his prison file reads: Mr. E. ‘speaks as an immature young offender who seems to believe he can manipulate and beat the system through bad behaviour.’

A further claim is that those with psychopathic traits ‘don’t feel they have psychological or emotional problems, and they see no reason to change their behavior to conform to societal standards with which they do not agree’.56 This is unless it is to their advantage, such as

‘...to help shape a positive image of themselves for the benefit of the parole board. They take classes and degree courses, enrol in programs for drug and alcohol abuse, join religious and quasi-religious groups, and adopt whatever self-improvement fad is in favor – not to “rehabilitate” themselves but to look as if they are doing so’.57

One might note in this regard the sudden conversion of Mr. B to Catholicism prior to his pre-admission assessment. This is against a backdrop of refused parole,58 and perceived lack of motivation to address his problems by the MDT on Cannock ward during pre-admission assessment. But, once more, it is possible that his actions do not constitute strategy but act as a means of improving his quality of life in the round. For instance, his CPA Review Meeting report reads: ‘He reads the bible regularly, looks at scripture and identifies prayer and meditation as further positive coping mechanisms.’

It is clear that the client group surveyed have led difficult lives. Their histories confirm that common antecedents to crime and anti-social behaviour

56 Without Conscience, op. cit., p. 195.
57 Ibid., p. 50.
58 His Parole Assessment Report reads: ‘I feel that whilst [Mr. B.] has commenced work to address his substance misuse and emotional well-being, I feel unable to reduce his level of risk at this time unless he completes the necessary offending behaviour work identified on his sentence plan...or entry into a Therapeutic Community.’
are protracted periods of abuse and neglect in childhood and adolescence. This may well mean that the client group (who may display psychopathic tendencies as a result) are more inclined to try to direct the conduct of others. What this does not mean is that other suitably motivated individuals are precluded from drawing on similar strategies. It is simply erroneous to equate strategy with pathology and dysfunction. Indeed, speaking of the potential for the client group to act subversively to secure earlier parole, a psychologist rightly points out:

‘…you don’t need a high PCL-R score to have that different motivation. You could understand it’.

Thus construed, strategic interplay is, as Foucault points out, merely a cost of being active individuals who, faced with a number of potentially competing goals – or at least the belief that such goals are incompatible in respect of another actor – will resort to tactical guise to encourage the achievement of those goals. But one might ask: what does this tell us about the perceived effect of treatment among staff on Cannock ward?

6.4.3 Admission and therapeutic benefit

The preceding quote suggests that staff on Cannock ward do not believe that treatment integrity is undermined if offenders gain admission by acting on

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59 A nurse’s account of Mr. C’s mind-set derived from pre-admission assessment makes this point well: ‘Possible early beliefs might have been ‘I set the rules, control others or be controlled’.’ On account of previous research, there seems little doubt that research indicates that psychopathic clients are more adept at directing conduct. For instance, a Canadian study of 310 service users found that psychopaths (both sexual and non-sexual offenders) are 2.5 times more likely to achieve conditional release than non-psychopathic offenders. See Porter, S., ten Brinke, L. & Wilson, K. (2009) ‘Crime Programmes and Conditional Release Performance of Psychopathic and Non-Psychopathic Sex Offenders’. Legal and Criminological Psychology, 14: 109-18. As evidence of deception, the study reports that psychopathic offenders spent fewer days on conditional release before revocation. The study does not comment on the nature of treatment received by those in the target group.
ulterior motives in the pre-admission forum. This is confirmed by one psychiatrist, who states:

‘I don’t care if they’re manipulative, as long as they engage.’

This initial surprising reaction is seen to be more pragmatic, however, when read alongside the experiences of providing treatment on the ward:

‘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).

This potential will to change also assumed to be operating on the mind of the ‘manipulative’ psychopathy, contrary to the received view that those with high PCL-R scores are unsuitable for therapeutic programmes. One nurses states:

‘…I always think that at its most basic level, if you’re teaching people basic social skills, life skills, interactions skills, things like that, there’s benefit, whether you’ve got a PCL-R of 40 or whatever, I think people will get some benefit out of that.’

These quotes indicate the latent belief that patients who come into contact with psychiatric norms within the disciplinary institution cannot help but self-make and implement more socially acceptable behaviours. Or, perhaps, this may be overstating the point:
'...for 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. And in that case, it’s of no benefit to them, to us, to other people who could’ve had that place, or to the therapeutic community as a whole to have them in, albeit, part way through that process, they might have some enlightenment and decide it’s worth changing. And that would be the same with any assessment for a treatment programme. Even if you’re in prison and you could identify that, are they really ready to change or not? But that’s kind of the more extreme end of it. You take motivation as a thing where people won’t be entirely sure about change and that’s okay. That’s good enough, isn’t it? But that’s different to if inside they don’t really want to change at all, but they think this will be a short circuit, that’s a different thing.’

(Psychologist).

And, furthermore:

‘I think well actually perhaps there should be a glimmer of anxiety about coming, or if somebody’s just saying they’re just coming to get their parole.’

(Occupational Therapist).

This suggests that Cannock ward may also be viewed by staff as a more disciplinary-type institution, in which a patient’s amenability to behavioural change is determined, not by the subjectivation effects of discourse, but by both engagement and (subsequent) motivation. How this motivation materialises makes for an interesting, if complex, question. Cullen captures the point well:

The well worn truism is that people are sent to prison as punishment, not for punishment, but it is equally true that they are not sent for treatment. They have not consented to either (few consent to punishment!) and, once in prison, it is a moot point whether they can truly consent to any activity which might affect their chances of an earlier or later release, as volition implies free will. Alternatively, they consent based on contingencies which lead us to suspect that their reasons are different from those which we wish them to have, i.e. ‘free will’ operating within imposed contingencies.60

‘Free will’, thus contextualised, does not necessarily preclude the internalisation of norms. For the patient, it may happen as a cost of the normative pressures of the disciplinary regime; indeed, as Foucault tells us, having free will is essential to ensuring our subjectivation to, or self-making according to, accepted discourse. In effect, then, the question to be addressed in Chapter 7 is one shored up by, first, the manifest potential for individuals to employ subversive strategies in the pre-admission forum, based on ‘contingencies’ out of their control; and, secondly, the divergent accounts of staff as to how therapeutic effects, if any, arise from treatment. One must, therefore, ask: what are the effects of treatment on the personality disordered offender? Or, as Foucault once put it:

To what principles does the individual refer in order to moderate, limit, regulate his activity? What sort of validity might these principles have that would enable a man to justify his having to obey them? Or, in other words, what is the mode of subjection that is implied in this moral problematization of [criminal] conduct?^{61}

Chapter 7

Images of the Treatable Patient: Subjectivation amid Resistance?

When I was studying asylums, prisons, and so on, I insisted, I think, too much on techniques of domination. What we can call domination is something really important in these kinds of institutions, but it is only one aspect of the art of governing people in our society.

Michel Foucault (2005)\(^1\)

It is not evident that offenders seek admission to medium-secure hospitals from prison under section 47 of the Mental Health Act 1983 for therapeutic reasons. The increase in the use of indeterminate sentencing (under the Criminal Justice Act 2003) in the client group surveyed appears to play a crucial role in their motivation to seek treatment, with offenders sometimes employing strategies to ensure referral and admission. It was seen in Chapter 6 that staff generally appreciate the potential for offenders to ‘manipulate’ professional decisions to admit them; but it was claimed that, in spite of this, once admitted, the client group could still benefit from treatment.

This chapter examines the effects of treatment on this client group. One would expect to find either that the desire for early parole continues to motivate those admitted to engage in treatment, potentially in a rather superficial way, or that treatment produces unexpected consequences in their behaviour. In this latter sense, one would assert, perhaps naively, that patients amid the normative expectations of psychiatric treatment in hospital begin to

self-make according to those norms, irrespective of their original motivation for admission. Notwithstanding, evidence that those with personality disorder and / or psychopathy may internalise treatment norms, irrespective of the resistance they display within the disciplinary institution, would provide for an interesting rejoinder to those who claim that little therapeutic benefit can be achieved with the client group.

7.1 Understanding Cannock ward: a ‘disciplinary’ regime

Cannock ward forms one of two wards dedicated to the treatment of personality disorder (PD) at Arnold Lodge in Leicester. Unlike its sister ward, Ridgeway, it primarily serves to receive service users from prison who present as motivated to undergo treatment. The focus of treatment is on rehabilitation and re-socialisation, as one service user describes:

‘On Cannock ward, everything is about learning about yourself and your difficulties. Your treatment revolves around group-based therapy over a 2-year programme. We have twelve single bedrooms, communal kitchen, living room, dinning [sic] hall, games room and bath / shower rooms as well as laundry facilities. A majority of your time will be spend [sic] in the communal areas, mixing with other patients and staff.’

Treatment focuses on the advancement of cognitive-behavioural skills with adjunctive therapy in the form of medication. Courses are numerous and varied, and delivery is shared between nurses, psychologists, psychiatrists and occupational therapists. Participation in many courses is mandatory for all service users – these include CALM (Controlling anger and learning to

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2 I am grateful to the service user who offered me a copy of the informative booklet from which the quote is taken. Hereinafter, it is referred to as ‘The referral booklet’. It was designed and written by patients receiving treatment at the time of the study to encourage, inspire and assist those who want to follow their successful journeys through Cannock Ward’: p. 10.
manage), Moral Reasoning, PICTS (Psychological inventory of criminal thinking styles) and Problem Solve. Others, such as Substance Misuse, COVAID-S (Control of violence and aggression in impulsive drinkers) and Trust and Self-Awareness, are assigned in accordance with the service users treatment needs. Courses are complimented by compulsory homework and the learning of practical strategies, such as ongoing relapse prevention plans, which are designed to aid assimilation and incorporation of the skills that have been learnt. In addition, patients are expected to be up in time to take morning medication; if they oversleep, this is recorded as a refusal. Failure to attend the relevant groups is seen as disengagement rather than refusal, and if prolonged may be discussed by the multidisciplinary team (MDT) with a view to possible discharge back to prison. Other potential reasons for discharge include physically or mentally abusing staff or other patients, and taking illicit drugs.

Treatment is structured according to the precise ward routine. There are times for waking, sleeping, studying, pursuing leisure activities, ward visits and exercising. Those latter activities, not being conventional treatments, must be ‘negotiated’ at 7:50am each morning, when patients discuss with an allocated member of the nursing staff what they wish to do that day. This might also include going out on escorted leave, if this has been granted, to something as trivial as getting one’s hair cut or playing on the ward computer console. Rules are seen as complementary to more conventional forms of treatment:

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4 ‘Legal’ calls may be made at any time of the day without having to be negotiated.
‘The routine operates on a very structured timetable designed to help patients conform to structure and take responsibility for their day to day activities’.5

This overarching desire for patients to conform to structure, routine and ideals at the behest of ‘administrative’ staff also reifies our understanding of the ideal-type disciplinary institution, in which there is a meticulous assumption of responsibility for the body and the time of the convict, a regulation of his movement and behavior by a system of authority and knowledge; a concerned orthopaedey applied to convicts in order to reclaim them individually; an autonomous administration of this power that is isolated both from the social body and from the judicial power in the strict sense.6

In practical terms, the efficacy of this disciplinary effect is enhanced by the ward’s layout. The communal area fans out from a “panoptic” security office from within which staff can observe the activities of service users through high glass windows. The corridors leading to bedrooms and treatment rooms are surveilled using closed-circuit television, which is constantly updated. The office is also an administrative hub, containing medical records, “disciplinary” forms, research findings, and so forth, confirming the importance of an offender ‘biography’ if treatment is to be individualised, and effective.

In terms of ward inter-personal dynamics, it became clear early in the study that many patients saw this privileged position of staff as a source of menace. Often, one would observe patients in the communal area responding to the medical gaze with a look of displeasure and concern, as if trying to interpret the talk of staff. Its potential effectiveness as a source of control is buttressed by a further rule that he must never enter. If the service user wishes to speak

5 ‘The Referral Booklet’, op cit., p. 5.
with a member of staff not on the ward proper, he must knock at the door and wait to be seen. But, as Deleuze warns: ‘The final word on power is that resistance comes first…’\(^7\)

For instance, often patients would stand with one foot across the threshold and look around the room whilst conversing with staff. Others might knock only once before leaning patiently against the far wall of the corridor, ensuring that the responding member of staff had to step into the corridor (“their” space) to hear the respective request. Others would flagrantly abuse the right to be seen by constantly wrapping on the door for trivial matters. Staff might complain, ‘He’s trying to wind us up’, before employing the counter-strategy of ignoring the repeated requests until they were prepared to open the door. If the patient was polite, staff invariably co-operated; if he was brash, they would rarely heed the request. In this world of strategy and recalcitrance, it may come as no surprise to learn that resistance towards the aims of treatment was also prevalent.

### 7.2 Does compliance indicate the internalisation of norms?

#### 7.2.1 Methodological considerations

Foucault argues that domination is ‘general structure of power whose ramifications and consequences can sometimes be found descending to the most recalcitrant fibers of society’.\(^8\) This implies that, within the disciplinary institution, evidence of resistance does not mean the patient is extricated from the ‘sometimes’ dominating power of the psy-system. It is also possible that the patient’s fear of incapacititative restraint will compel him to present the

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image of pro-social behaviour. However, the desire to seek release expeditiously through treatment (real best interests) could conceivably become duped adherence to psy-norms at some point. In Chapter 3, it was noted that proving that the internalisation of norms has occurred is methodological problematic.\(^9\) Since the achievement of parole and the potential for domination at the hands of discourse are not mutually exclusive events, when does real therapeutic benefit take hold, if at all?

Rather than be nihilistic, one should endeavour to meet a reasonable burden of proof. If one can say on the ‘balance of probabilities’ that treatment continues to be sought for the purposes of early release alone at all stages of detention, this should be sufficient to make a case to disregard claims of the normative effectiveness of the medical model of rehabilitation, in favour of the patient’s own strategic purposes for presenting as rehabilitated.

### 7.2.2 Observation, self-analysis and the ‘knowable man’

In respect of the mechanics of discipline \textit{qua} the receipt of treatment on the ward and its investment in the panoptic regime, Foucault tells us that the ‘Knowable man (soul, individuality, consciousness, conduct, whatever it is called) is the object-effect of this analytic investment, of this domination-observation.’\(^{10}\) It is in this way that the ‘sciences’ may be instrumentalised and docile bodies inculcated with a view to being made more ‘useful’. As a consequence of the disciplinary institution, ideally, one should expect to see the subject carrying on the work of transformation himself, though this is not necessarily through his being duped as to his best interests, as in the case of

\(^9\) See p. 112.
\(^{10}\) \textit{Discipline and Punish}, supra n.6, p. 305.
subjectivation. Instead, rehabilitation may be the product of a combination of micro-punishments, rewards and the ranking of individuals according to an objective standard of achievement and utility.

Unsurprisingly, one witnesses all of these things at work in the treatment regime on Cannock ward; but, perhaps, one of the most interesting aspects of treatment is that patients are expected to carry out their own transformation in group settings, once the practical skills of treatment have been taught. One nurse confirms:

‘The facilitators of courses do not allow people to sit at the back and the corner, you know, we actively seek participation, and there’s no hiding room... They’ve chosen to be in the room. 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 is 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 if they were doing things like that. Although the facilitator would be trying to draw them in and include them and things like that, they would always be one step back hoping the peers would do it first. There’s more value in that.’

The nurse subsequently provides an example of service user collaboration in his own treatment:

‘...on 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.’

One might moot the possibility that this ‘peer pressure’ is a consequence of objectification through treatment (discipline) or subjectivation (internalisation of norms) over time. But if subjectivation effects are the better explanation, at

11 Service users confirm this nuance of treatment. Mr. C. says, for instance: ‘You’re made to feel like everyone analyses you constantly, including the patients...’ Asked who are more analytical, he replies: ‘More probably the patients...’
some point one might argue that, whilst resistance might still occur, over time resistance will become less valuable to the patient, as the drive to be ‘healthy’ becomes engrained and takes precedence.

However, Mr. H’s decision to refuse food after being on the ward for twelve months (usually, half the length of treatment on Cannock ward) can be compared with Ian Brady (also diagnosed as having a PD), whose being on hunger strike for four years (twice the length of treatment on Cannock ward) prior to 2002, he had said, provided a ‘psychological boost’ in the ‘battle of wills’ with the authorities. In a temporal sense, then, Mr. H’s subsequent adherence to ward policy may have less to do with the internalisation of psy-norms and more to do with his goal-driven behaviour – that is, the interplay of strategy (service users) versus counter-strategy (Cannock ward: refusal to let service users go for dinner; Brady: force feeding) may tell us a great deal about why actors do what they do (in local power relations).

Moreover, from the point of view of collective self-interest, the ordinary actions of patients on the ward to go to the dining room (or to conform once punishment has resolved his resistance to go) may be seen as an example of co-existent strategy, or the importance of solidarity in conformity, in the pursuit of the more long-termist goal of securing parole. In a sense, there is no reason for any service user to undermine the effectiveness of the regime if he is serious about achieving his goal of release. Thus understood, one is arguing that there is little reason to agree with Foucault, that ‘…there is no power that is exercised without a series of aims and objectives. But this does not mean that

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it results from the choice or decision of an individual subject’. 13

It is not apparent that the aforementioned nurse – or any other member of the MDT – would make a claim to the normative power of psy-discourse to explain the conformity of Mr. H., or any other patient for that matter. However, it was suggested that the ward rules, normative expectations and policies precludes one approaching treatment on Cannock ward with a tick-box mentality, as seems to the case in prison. 14 Rather, it was said: ‘It becomes apparent that they respond positively or not.’ This re-affirms that Cannock ward is a typical example of the disciplinary institution, which presents examples of resistance by the patient, perhaps as a competing possibility of normalisation through treatment over time.

But in light of this claim against the ‘competing possibility’, there is an implication in the previous quote that if disciplinary effects – or, indeed, the more potent form of change through duped adherence to norms (which has not necessarily been shown not to be at work thus far) – are to come to fruition, there may be underlying factors which could complicate the ‘ability’ of service users to engage in ways which could lead to his compliance with the regime. Such complications, it is submitted, may relate to the exclusionary criteria which were discussed in Chapter 5, 15 and which, hitherto, had presented more of a barrier admissions. It will also be seen that one must be clear about what one means when citing motivation as either an argument for or against ‘real’ engagement, if one has any chance of understanding the effects of treatment on the client group surveyed.

13 History of Sexuality, supra n.8, p. 95.
14 See the quote of Mr. K.: Chapter 6, p. 192.
15 See pp. 144-50.
7.2.3 Factors potentially complicating behavioural change

7.2.3.1 Intelligence Quotient

Mr. B. was previously documented as having a lower I.Q. than was believed, by some, to make him inappropriate for admission to Cannock ward; for instance, one nurse complains:

‘And we’ve had people in the 60s, and they’re not successful... It’s one of the things I struggle with...’

An entry into his ward round sheet shortly after his admission confirms this fear: Mr. B. ‘stated that he was “thick” and was worried that he would not be able to complete his treatment…and would be “kicked out” at his first CPA’.16 On a number of occasions, he was seen to leave group therapy in distress. However, whilst not wishing to undermine the unpleasantness of his experiences, they are not dissimilar to those of service users with average, or above average I.Q. scores, as Mr. C. confirms:

‘When I first arrived here this time, I got put straight into quite a difficult group. Obviously, people had already done certain other groups, had been here longer; they were using words they’d learned in other groups, and I wasn’t grasping what the fuck they were talking about, and I were getting quite angry with it, struggling because it made me feel quite stupid.’

In fact, in their study of post-discharge data in relation to 81 service users admitted for treatment to the Personality Disorder Unit (Cannock and Ridgeway wards combined) at Arnold Lodge, McCarthy and Duggan show that there is no statistically significant difference in those who are either expelled or disengage on the basis of I.Q. scores.17 On a more political note, for those,

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16 Care Programme Approach meeting – the first of which takes place 3 months into treatment.
such as the nurse quoted above, who remain concerned about the admission of those such as Mr. B., the matter must be viewed in the round:

‘I think that they’re probably better off here than in prison. And one of our patients with a lower IQ who was on a ward previously, and I think he’s better with us, but they’re quite vulnerable, and it’s frustrating for other patients... They often take more training, but they get it in the end... They can frustrate the patient group... I think in an ideal world, there needs to be a facility for people with borderline difficulties with similar programmes, but slower, with more individual practicing.’

(Consultant psychiatrist).

7.2.3.2 High PCL-R score

Another reason why members of this client group may struggle to internalise norms may come from their high level of psychopathy. Mr. H., for instance, has a PCL-R score of 36 (out of 40), well above the cut-off of 25 for the purposes of diagnosis; and Messrs. D & E, who had recently lost leave entitlement for rule-breaking, are highly psychopathic. Hervey Cleckley says:

Despite his excellent rational powers, the psychopath continues to show the most execrable judgment about attaining what one might presumme to be his ends. He throws away excellent opportunities to make money, or to achieve rapprochement with his wife, 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.

More recently, with the benefit of empirical evidence, McCarthy and Duggan show that, along with impulsivity, psychopathy is highly correlated in treatment non-engagement and rule-breaking at a statistically significant level

*Criminal Behaviour and Mental Health, 20: 112-28. [*Engagement in Medium Secure Personality Disorder Services*]  
18 McCarthy & Duggan, indeed, show psychopathy to be relevant to expulsion and disengagement at a statistically significant level. *Ibid.*  
What is interesting is that, in spite of occasional resistance towards the regime, the overriding ambition was to continue to engage with treatment.

7.2.3.3 Acculturation

Continuing the analysis of McCarthy and Duggan, another interesting finding was that out of the first 100 patients admitted for treatment, those referred from hospital were more likely to complete treatment than those referred from prison. The authors conclude:

‘Patients referred from hospital may have increased acculturation to treatment and have more positive expectations on entering treatment; however, it is also possible that patients referred from prison may demonstrate high levels of anti-therapeutic behaviours, such as guardedness and suspicion, necessary for survival in penal settings that make it difficult to engage in treatment. Anecdotal evidence of successful treatment completion in patients re-admitted to the unit after an unsuccessful first admission would suggest acculturation to a therapeutic environment is an important factor in predicting treatment completion and requires further investigation.’

There was, indeed, evidence of ‘guardedness’ in the initial stages of treatment by the majority of the client group surveyed, and this seemed to correspond to past experiences of prison. Mr. C., for instance, compares the treatment regime in prison with Cannock ward in terms of relations of power:

‘If prison, you don’t walk away from things or you get bullied even more… Here, you walk away, you’re gonna be praised by the staff, by the patients… So, you feel more comfortable doing it. You can open up in meetings..., because no one is gonna exploit it.’

20 ‘Engagement in Medium Secure Personality Disorder Service’, op. cit.
21 37 per cent were expelled due to ‘rule-breaking’ and 35 per cent disengaged from treatment. Prison referrals under s.47 of the MHA 1983 accounted for 85.2 per cent of the sample. Ibid.
And Mr. B. says:

‘In prison, there was some stuff I couldn’t talk about, because if I had I’d probably have been beaten up.’

On the cynicism such experiences create, Mr. K makes this generalisation:

‘...you get different people coming in, and you’ve got a different mindset to them, and they don’t like it. They see it as grassing, but it’s not. You have to take responsibility for yourself and other people. You have to do that in the community.’

Could acculturation to the normative expectations over time merely mask strategic innovation? Speaking of his arrival, Mr. B. is unclear on this:

‘When I first come [sic] here, I asked the lads, what do you need to do to be successful here, and they basically said to me, just keep on talking to people about your problems... But I didn’t do that for a bit, I went on a mad one, punching walls, threw my stereo out of the door...’

What must be pointed out is that guardedness and suspicion continued to describe Mr. B’s engagement with cognitive-behavioural treatment during the period of study. During interview, he confided that he was nervous of speaking about aspects of his childhood which he would find humiliating, and about which he might be derided by the group; but that he was gaining in confidence. In light of the fact that for discipline to have its effects it must be continually put into practice and exercised, a lack of meaningful engagement in treatment due to acculturation factors would damage the potential for the respective patient to benefit from treatment.
7.2.3.4 The (lack of) motivation of the service user

7.2.3.4.1 Internal motivation

Whilst empirical evidence points towards patients being resistant towards the treatment conditions on Cannock ward, acculturation as an explanation may need a recapitulation in light of the effect of patients underlying motivation for engagement. To examine this point further, one might look at the study of Ryan, Plant and O’Malley, who posit that there are two types: external and internal. External motivation to engage in treatment derives from factors that are beyond the control of the patient, and thus includes coercive or legal pressures. Internal motivation derives from self-determination factors, such as the service user’s beliefs and values in relation to his condition and its treatment. In their analysis, the authors found that only internal motivation had a positive impact on treatment engagement. Similarly, Webb and McMurran, in a study of women with borderline personality disorder (BPD), report that ‘those who continued therapy reported significantly more internal reasons to be in therapy’.

In relation to the current client group, Mr. A. was, not uncommonly, described in his pre-admission report as ‘highly motivated’, and was duly admitted for treatment. But he was subsequently returned to prison at his behest five months later. Prior to being discharged, he was asked during interview how he was finding the treatment regime. He replied: ‘Still getting used to it. Still not motivated.’ One would expect that, with the necessary

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internal motivation, a lack of acculturation would not be expected to be fatal to engagement. In telling fashion, however, when Mr. A. was asked what he hoped to get out of treatment, he replied: ‘Don’t know’.

Webb and McMurran suggest that those who discontinue treatment – that is, those who have low internal motivation – ‘may benefit from a motivational intervention before therapy begins’. They draw on the findings of Bornovalova and Daughters who look at the treatment of clients with co-morbid BPD and substance misuse.24 The authors make a number of suggestions to encourage ‘behavioural change’ through therapy (dialectical behaviour therapy (CBT)), including role induction, which might, they posit,

‘promote motivation [internal] to engage in treatment by reducing confusion, clarifying expectations and roles, inoculating patients against disappointment or surprise, and providing them with a better understanding of the treatment process’.25

Put into context, it is not apparent from the account of patient on Cannock ward that they were fully apprised of the onerous duty placed on those admitted for treatment in terms of their engagement. For instance, some claimed that they were told it would simply be ‘hard’. That said, even when the implication is that offenders were better informed of what to expect, the regime is still found to be arduous. One nurse says:

‘…sometimes [they] think, because they have an overview of what’s gonna happen when they get here, they turn up and think that it might be the same as prison – well, I know they do, because, usually, after the first group experience, they’re almost shell-shocked.’

25 Ibid.
However, the initial shock of treatment does not seem to predict treatment non-completion through disengagement or expulsion: consider that the mean number of months at which this has occurred in the past on Cannock ward is 7 months.\textsuperscript{26}

Instead, Sheldon, Howells and Patel, in their examination of the results of 86 service user admissions to Rampton high-secure hospital (Dangerous and Severe Personality Disorder Unit service (DSPD)) between March 2004 and September 2009, reveal that the pursuing of goals other than treatment (‘volitional’ factor) was predictive in some of the 31 cases of non-completion over a five-year period.\textsuperscript{27} One reason for subsequent disengagement could be that the protracted length of stay in DSPD services.\textsuperscript{28} Sheldon \textit{et al.}, indeed, confirm that one belief among those who disengaged was that ‘\textit{they would be released shortly or that they had dealt with these problems before}’.\textsuperscript{29} They go on to cite the latter reason as consistent with previous research.\textsuperscript{30} In the context of the current study, none of the service users surveyed spoke of taking issue with having done the cognitive-behavioural elements of treatment before. But, consistent with the scourge of incapacitative sentencing and the approach of offenders to prison training, external motivation in the form of seeking parole was highly prevalent. By extrapolation, might this suggest that the offender / patient who presents as \textit{internally} motivated, acculturated, and so

\textsuperscript{26} ‘Engagement in Medium Secure Personality Disorder Services’, \textit{supra} n.17.
\textsuperscript{28} Chapter 1, \textit{supra} n.87.
\textsuperscript{29} ‘An Empirical Evaluation of Reasons for Non-Completion of Treatment in Dangerous and Severe Personality Disorder Unit’, \textit{op. cit.} Emphasis added.
forth, really be acting on external pressures when consenting to admission and engaging with treatment over time?

7.2.3.4.2 External motivation

As already alluded to, where motivation to engage in treatment is externally derived, one would expect acculturation factors to have a modest effect on treatment completion, and so, treatment benefit. To reinforce this point, the situation facing service users on Cannock’s sister ward, Ridgeway, might be considered briefly. An Occupational Therapist had this to say about the client group:

‘I think sometimes the step down from high secure sometimes means the patients can be a little unrealistic. I think they see coming here, medium secure, rehab, I’m gonna be out in a year. And, yeah, I guess sometimes they see all the treatments being completed in high secure, Rampton, so I’m just gonna come here and get my leave and get out. I think we try and get across at that stage actually what rehab means. It’s not necessarily just getting leave and going out, being discharged into the community; there’s [sic] lots of treatment.’

Absent the necessary internal motivation, however, many resist engagement, as this nurses attests:

‘They know the system inside out, you know – what do you mean I have to go to problem-solve, that’s against my human rights, I’ve got a headache today.’

By way of counter-strategy, it was said that in future those who wished to use Ridgeway as a step-down facility would be expected to demonstrate the necessary motivation to engage with treatment. This response to resistance is already put into effect in the context of patients transferred from Ridgeway to Cannock ward. For instance, it was said to one man, who was moved
following a disturbance:

‘I went out there and said to him: what are you here for, then? And he says: well, you can’t send me back to prison. So, I said: no, but we can find somewhere for you, if you disrupt this ward, if you do not want to do this work, fair enough, but you won’t be able to stay here...’

(Nurse).

Here, external pressures ensured that he subsequently engaged. Role specification and acculturation was seen to be less relevant in respect of his initial lack of engagement amid his absolute lack of internal motivation. The same may be said of the vast majority of those surveyed on Cannock ward. Consider Mr. H., who had this to say about his motivation for consenting to his first admission:

‘I thought basically that it was an ace card, getting me out of prison, and that this was going to be somewhat easier. But I come here and things weren’t as easy, and I ended up threatening a member of staff. The office windows are now plastic. I ended up putting my fist straight through them.’

His comment leads us to believe that acculturation factors, potentially combined with his impulsivity, were more powerful predictors of resistance initially than was his external motivation to engage, in order to escape the difficult conditions of imprisonment. But, whilst the ‘success’ of his subsequent return to prison and re-admission was certainly aided by his improved acculturation to the environment, without the necessary external motivation (at least absent internal motivation), he may not have returned at all.

Re-consider that Mr. A. chose to leave Cannock ward of his own volition; but subsequently chose not to be re-admitted after his period of reflection. Mr. A. does not explain his lack of engagement – which may be read into his dis-interest in returning – as a problem of acculturation; rather, he is clear that he
lacks motivation. That he lacked internal motivation is clear. Moreover, in contrast to Mr. H., for instance, he also clearly lacks external motivation. But then what conditions are absent in the case of Mr. A. to explain this?

It seems crucial that at the time of the study, Mr. A. was the only service user serving a fixed-term sentence. Put plainly, this means he knew the date of his eventual and, in fact, imminent, release. This does not mean that he feels there is no utility in engaging with the regime, however:

‘For some people, it’s the right thing to do. And from what I’ve seen with the people with the right mindset, it works really well. As soon as you lose that motivation, or you aren’t willing to comply, it seems to go tits-up… It’s a bit of a pain in the arse… I feel sometimes that makes me want to quit.’

This quote seems to allude to the importance of external motivation to subsequent compliance with engagement. That said, despite his many acts of recalcitrance, Mr. H. appears to couch patient engagement in terms of internal motivation rather than the implied external motivation:

‘We feel as a patient group that if someone comes along just ticking boxes than they get challenged, not by the staff but by the patient. 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. It is hard for ‘em, and to start with you sort of feel people are getting at you, but what you realise is they’re trying to give you some support, to make you see that what you’re doing isn’t right. You’ve come here for help, but you’re not gonna get the help if you carry on as you’re doing.’

Later during the interview, however, in respect of his indeterminate sentence for public protection (IPP), he makes this generalisation:
‘...you know this is your last chance, you sort of have to knuckle down.’

This ‘strategic’ engagement coupled with resistance which is not self-defeating (‘sort of’) obviously describes external rather than internal motivation.

To take another example: Mr. C’s first admission was at the instigation of his prison psychiatrist. He was duly admitted when he presented as motivated during pre-admission assessment (in his own words: ‘I just thought I’ll go for it, see what it’s like). But he was discharged four months later due to a ‘deterioration in his engagement’ as well as ‘intimidation towards staff and patients and an inability to comply with rules’.31 Speaking of his discharge, he admits:

‘The first time, I don’t think I was particularly bothered: I had a release date.’

In fact, Mr. C. has in the past demonstrated that he lacks internal motivation to engage with psychiatric treatment. For example, when it was suggested to him in the community that he might benefit from psychiatric treatment to temper his angry outbursts, he unequivocally refused. He recalls:

‘I was thinking I’m not fucking going there just to get sectioned. I had my freedom then. But then I came to [prison] and ended up getting locked up.’

His route to incarceration was an indeterminate sentence – the first time he had received such a sentence. His CPA Review after 3 months states: ‘[Mr. C] has engaged well with therapeutic treatment programmes.’

Again, in this client group, one could argue that external motivation, in the form of the indeterminate sentence, is a particularly powerful predictor of

31 Taken from a letter sent from his prison doctor to a consultant psychiatrist at Arnold Lodge.
engagement, if not treatment completion. The final issue to be broached is, therefore, whether within the approximate 2 years of treatment on Cannock ward objectivation to the micro-punishments of the disciplinary institution (and the petty resistances which traverse it) become subordinate to increased internal motivation, consequence upon the internalisation of norms unbenownst to the patient?

7.3 What is meant by the phrase “treatment success”?

7.3.1 Earlier release from indeterminate detention

At the time of the aforementioned interview, Mr. C. had been detained for 14 months. He was, consequently, fully aware of the realities of Cannock ward and the dynamics of treatment. He had this to say about group therapy:

‘As soon as you get into groups and start talking with the nurses, it’s like everyone puts a front on. You’ll know, I have seen, that when the RMO’s 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.’

He is also unequivocal about the part external motivation plays in his own engagement:

‘My tariff’s finished. I’m entitled to apply for parole if I want, but I won’t get it, so I’m not gonna fool myself... I’d rather get the treatment and do as much as I can and then go for parole.’

In comparison, others on the ward were unwilling to discuss their engagement on the ward in terms of external pressures; normally, engagement was expressed in terms of internal motivation, or a need to change in accordance
with treatment expectations (psychiatric norms). However, it was commonly accepted that engagement might subsequently inform the Parole Board’s decision as to whether or not to release the respective patient. In this regard, it is apparent that service users know exactly what behaviour must be demonstrated, or strategy implemented, to encourage this result. Mr. E. says, for instance:

‘Obviously, [they] have a responsibility to ensure you’re in the right frame of mind before and that type of stuff before going into the community, because if they don’t assess that and they let you out, and you’re not in the right frame of mind, and something happens, they’re responsible.’

As the term ‘right frame of mind’ might suggest, he denied – contrary to Mr. C’s sweeping assertion – that it is possible to ‘pretend’ in groups, on the basis that ‘Everything’s analysed inside out.’ He goes on to say of the regime:

‘And it’s good as well, obviously, because you get leave as well, so you can do your courses, understand the skills, and put them into practice day-to-day on the ward. Twelve patients, twelve different patients, and you’re gonna come to logger heads at some time or another, and that’s where it shows that you’re using your skills by managing those situations. And you’re being watched doing that, d’you know what I mean.’

Rather than dismiss Mr. C’s contention out of hand, therefore, is it possible that Mr. E’s assertion is evidence of further co-extensive – if unarticulated – strategy amongst patients keen to support the notion of therapeutic capture on the ward. Indeed, one problem with co-extensive strategy is that it is more easily prone to rupture, since, as between the interested actors, there are always ‘multiple forms of individual disparity, of objectives’ within local power
relations ready to be acted on. Consider in this case, notes made on Mr. E. during his CPA Review Meeting, which read: Mr. E. was one of the two patients who took an ‘active dislike’ to one another, each ‘saying the other was not committed to treatment; was putting a front on…’ Does this presuppose, then, that his putting into effect the practice skills taught in the cognitive-behaviour programmes is part of his underlying strategy to effect his release rather than evidence of therapeutic success through the internalisation of norms? In respect of treatment received, Mr. E. details his improvements in the following way:

‘Oh, they’re helping me... 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.’

Evidence of change is confirmed by his CPA Review Meeting notes, which in reference to an altercation on the ward make this observation:

‘...despite provocation [Mr. E] chose not to become involved in this. This should be seen in a positive light as an indication of his expressed motivation’.

In this case, the staff member is suggesting (if impliedly) that his improved behaviour is a consequence of choice rather than emotional stability through treatment received. The intention of the staff member may not have been to undermine the normative aspects of treatment, but it is, nevertheless, appreciated that the use of instrumental violence by the psychopath is consistent with wider accounts of the behavioural manifestations of the disorder. That Mr. E’s might be acting strategically in demonstrating prosocial behaviour is supported by the case of Mr. L. (PCL-R score: 29), who, it

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is said, became ‘aggressive and abusive’ during his CPA Review Meeting until he realised it would serve no purpose; and on Mr. C’s reduction in displayed aggression on the ward, it was said, without directly citing treatment as the precursor: ‘I think he’s realised it’s not going to get him anywhere’.

By citing these examples, one is not intending to wholly rule out that service user’s reduction in aggression is the net result of enhanced emotionally stability through treatment; rather, on the balance of probabilities, it seems the service user is merely observing ward policies that violence will lead to micro-punishments (such as being returned to prison), which will compromise his achieving parole in the long run. Nevertheless, if one wished to cite the examples given as evidence of treatment success, given that the diagnosis of antisocial PD and / or psychopathy is largely synonymous with the penal system, the more reliable source would, presumably, be a reduction in re-offending.

### 7.3.2 Reduced rates of re-offending

McCarthy and Duggan,\(^{33}\) in their study of service users’ responses to treatment on Cannock and Ridgeway wards, demonstrate that there is no statistically significant difference in re-offending rates (59.46%) 5 years after discharge between treatment completers, non-completers or the expelled group; the mean number of total offences committed by each group, for both grave and standard list offences; and the mean survival time to first offence after discharge (793, 670, 707 days, respectively). Coid, Hickey, Kahtan et al. also show high re-conviction rates in a sample of 1,344 people admitted to medium-secure care

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\(^{33}\) ‘Engagement in Medium Secure Personality Disorder Services’, *supra* n.17.
between 1989 and 1993.\textsuperscript{34} Citing a figure of 34\%, this is considerably lower than the sample reported by McCarthy and Duggan. Perusal of the findings, however, show that the risk of re-offending decreases at a statistically significant level when treatment is received in medium-secure care for more than 24 months, but increases significantly with PD (compared to schizophrenia) and psychopathy (compared with mental illness). Reflecting thus on high recidivism rates, Anthony Maden comments:\textsuperscript{35}

> Until recently it was argued that evaluations of forensic services should ignore re-offending. The patient’s health was the sole arbiter of success or failure, with crime an incidental nuisance to be dismissed with a shrug, “c’est la guerre”. Three forces acted to change this state of affairs. First, commissioners wondered why they were paying extra for risky patients if the money had no discernible benefits. Second, victims were given a voice. And third, clinicians realised that offending is rarely a measure of good psychological health; the forensic psychiatrists who ignores recidivism is like the surgeon claiming the operation was a success but the patient died.

Yet, it is not clear why health should not be the arbiter of treatment success if those who commit crimes really are, more or less, psychologically unhealthy. Recall from Chapter 2 that the original task assumed by psychiatry during the nineteenth-century was to improve individual productivity by normalising the mentally unhealthy.\textsuperscript{36} This incorporated psy-discourse within the general mandate of medicine, which sought to secure a discernible benefit in the quality of life of its clients. Instead, the reduction of crime as a measure of treatment success, even within the forensic setting, is a relatively new aspect of

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\textsuperscript{36} See, for instance, p. 57.
\end{flushleft}
the advancement of bio-political controls acting on the perceived best interests of psychiatry. Mullen wishes to counter this effect, reminding us that ‘Protection of the public should be the welcome by-product of improved clinical care, not the goal of such management.’ As to the task of psychiatry, therefore, Foucault – speaking in general terms – is instructive:

We have to imagine and to build up what we could be to get rid of...political “double bind,” which is the simultaneous individualization of the totalization of modern power structures. The conclusion would be that the political, ethical, social, philosophical problem of our days is not to try to liberate the individual from the state, and from the state’s institutions, but to liberate us both from the state and from the type of individualization which is linked to the state.

Another reason for psychiatry to liberate itself from the state – at least in respect of the label of treatment success it assigns through policy – is that it is self-evident that patients continually refuse through resistance their ‘individualization’ linked to the state. If the result of this means continued high level of re-offending among the client group, then it means that, through the intermediary of what is commonly accepted as treatment success, psy-discourse is likely to animate anti-treatment sentiments lobbied at the offender with PD. But in case this argument is interpreted as legitimising incapacitative restraint, in as much as psy-discourse is being promoted as a medium to improve the offender’s quality of life but not manifest risk to others, it does not. Pragmatically speaking, if recidivism rates remain high, sentencing practices will remain largely unaltered; and the point at issue is that this will be

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38 ‘The Subject and Power’, supra n.32, p. 216. One should accept this quote as indicative of Foucault’s wish to toy with the idea of our self-making rather than his wish to impose upon human autonomy the limits set by our history.
to the absolute disbenefit of patients. It is, therefore, suggested that it is more important to improve working relations between psychiatric staff and clients with PD – which means thinking carefully, and realistically, about what one wishes to achieve through treatment. The alternative of poor relations, coupled with dubious sentencing practices, is likely to have a catastrophic effect on the health and well-being of the client group. In the round, what one must be keen to avoid is propagating an outlook akin to the following account of a psychiatrist’s reaction to the Government’s ambition to introduce incapacitative restraint in hospital: 39

‘They won’t be forcing people like me to supervise, or even look after as in-patients, stacks of untreatable psychopaths, because I won’t be doing it because it’s nonsense. I would try to refuse to do it – I would certainly. I feel it’s going to be difficult as an individual, but as a body we will probably not want to have much to do with it because it just doesn’t make any sense at all. If they’re untreatable they’re untreatable… I mean, the whole thing is astonishingly unworkable.’

Suffice it to say that those who are, instead, highly motivated to treat the client group – such as staff on Cannock ward – will do well to resist, as far as possible, public protectionist-centred treatment ideologies in favour of advocating treatment success in the form of evidence of patients enjoying improved quality of life. In some quarters, this approach has already been muted.

7.3.3 ‘Key performance indicators’

7.3.3.1 A focus on psycho-social functioning

McCarthy and Duggan, after introducing the notion of ‘key performance indicators’ discussed by Hollin,\(^{40}\) describe the possibility that variables other than the ‘primary outcome variable’ of reduction in re-offending may be targeted through treatment.\(^{41}\) These include, suggest the authors:\(^{42}\)

‘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.’

Taking this notion further, one might note that many service users on Cannock ward describe their ‘perceptions and experiences’ as having improved through the holistic treatment regime on Cannock ward. One witnesses, for instance, a reduction in frequency and intensity of self-harm in clients such as Messrs C. and B.; and a reduction in learned helplessness and institutionalisation which many experienced in prison. Take, for example, Mr. G., who states:

‘Until Arnold Lodge came and seen [sic] me, I didn’t expect to get out of prison. I expected to spend my life in prison.’\(^{43}\)

In all such cases, a great deal of stress emanates from the expectation among service users that they will be detained in prison for protracted, if not


\(^{41}\) In fact, in 2003 it was argued that treatment for this group should ‘focus on education and personal development’: NIMH(E) (2003) Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Department of Services for People with Personality Disorder. London: Department of Health, para. 51.

\(^{42}\) ‘Engagement in Medium Secure Personality Disorder Services’, supra n.17.

\(^{43}\) His prison file notes: ‘It was noted that he appeared very low in mood and said that he had no future and nothing to live for. He felt he had another five years to serve and he could not cope with this.’
indefinite, periods, at a cost of ‘normal’ living. For many such clients, who have never before received social support and life skills *qua* rehabilitation, the achievement of key performance indicators such as ‘educational attainment, employment, independent living’ is an internal motivator to engage with the wider aspects of the disciplinary regime.

A good example of this in action is Mr. K.: a long-serving client of Cannock ward, who is believed by patients, and staff, to embody treatment success. At the time of survey, he was living in a hostel for three days of the week, and was enrolled on educational courses at college, which he said he was enjoying. Of course, this is not to assert that both internal *and* external motivation are not acting on his decision-frame to engage; indeed, there is a sense from him that the achievement of key performance indicators may, if not should, lead to an increased chance of parole, consequent upon his demonstrating improved socialisation. The possibility exists that Mr. K. would not engage with key performance indicators in a meaningful way, as with more conventional forms of treatment, were they not perceived to be in his best interests. When Mr. C., for example, was asked if he would be, like Mr. K., willing to spend time in a hostel to develop his skills of independent living, he replied:

‘I’d like to go straight out and live at my dad’s or my mum’s or something, but I’ll go wherever gets me parole.’

This will undoubtedly concern proponents of the medical model of treatment success, that the achievement of ‘key performance indicators’ are not really a measure of success at all. In fact, McCarthy and Duggan claim that a more detailed examination of treatment success can only be achieved by reference to, for one, ‘the *quality* of patient engagement during specific components of
Again, it is argued that treatment success should not be recidivism rates. However, on a more concessionary note, it is plausible that by focusing on ‘key performance indicators’, in combination with systemic behavioural training, the result of reduced re-offending might be achieved. The point can be demonstrated by the example of the schoolchild in the disciplinary school.

A schoolchild who is forbidden from using a pen in their left hand may cooperate with their teacher’s instruction for fear of being punished. When ‘training’ ceases, s/he might continue to exercise the skill of using the right hand to pen or may dismiss it at the earliest convenience. Equally, the ambidextrous child may call upon the new skill accidentally, whimsically or self-servingly. The point being that, each time the skill is repeated, the link between training and performance should converge. Of course, in this example, the conditions and materials for imparting the skill are straightforward. However, in the case of the service user receiving treatment in an institution such as Cannock ward, creating the conditions for the implementation of training is more precarious: he who is ‘at risk’ in the community may have less opportunity or, more importantly, less inclination to act on cognitive-behavioural techniques, because they might not be deemed constitutive of his best interests. Ensuring appropriate social support in the form of key performance indicators may go some way to resolving this. In this respect, it is argued that places such as Cannock ward could play a potentially pivotal role in the rehabilitation of the client group.

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44 ‘Engagement in Medium Secure Personality Disorder Services’, supra n.17. Emphasis added.
7.3.3.2 Parole from hospital: a co-existent strategy

The usual route into the community for those serving indeterminate sentences who have been treated in hospital under s.47 of the MHA 1983 is to be conveyed back to prison, where the offender will await a hearing with the Parole Board. The patient, if successful in his hearing, will be released on licence. However, on completion of his treatment, it is possible to be released from hospital via a first-tier tribunal – mental health upon. By virtue of a s.49(2) ‘restriction direction’ – which is likely to have been imposed as a condition of his diversion – any decision taken to release him must be endorsed by the Secretary of State. In its absence, the usual result for an individual subject to an indeterminate sentence is he will be returned to prison.45 At the time of the study, parole from hospital was yet to happen for the client group surveyed on Cannock ward.

Nevertheless, patients expressed their wish to achieve parole through the ‘mental health route’. This was not only because it implicates the potential to achieve parole earlier; most were also aware that, due to the biting of s.117 of the MHA 1983, after care plans would be put in place, which would assist their rehabilitation in the community.46 Mr. H. elaborates:

‘If you get released from here, you get a massive release package. You go into residential care, where there is someone at hand if you’re having problems all the time. You get a CPN [Community Psychiatric Nurse]. You’re known to social services. You get put on invalidity benefits. You get given so much. You get more chance of being given a house, accommodation, etc. So, the people who leave here, I feel, have more chance of staying on the straight and narrow.

46 Pace the views of Maden (supra n.35), the proposed use of supervised community treatments, under s.25 of the MHA 1983 (as amended by s.17(A)(5) of the 2007 Act), would usually not be engaged, since the section applies only to ‘non-restricted’ patients detained under criminal or civil sections.
However, this place does have a bad success rate. But I feel that’s down to the individuals. They’ve been given the chance. Whether they take it is up to them... But prison, to be quite honest, they just release you. They give you a little bit of wad and they just expect you to go on your own and stay out of trouble. And, normally, when you go out the gates, they wave at you and say: ‘See you later’, because they expect you back in.’

He continues:

‘To be honest, if I left here, I think there’s a big chance of me not going back to prison. But if I went back to prison, I couldn’t guarantee it. I would be quite worried about my future if I went back to prison. I’ve got quite a bad sentence. I’ve got quite a bad record. I’ve tried killing people with my bare hands. And my sentence this time, I [he proceeds to describe his crime], and that’s quite a big sentence. I think those two things together, I’m not gonna be released. I can’t see when I’m gonna be released. But at least this place gives you that little bit of hope. But you have to put the work in to get that little bit of help.’

On this account, the link he forges between desisting from crime and receiving a ‘massive release package’ comes across disingenuously: the fact Mr. H. has no source of emotional or financial support in the community, and his recognition that if he were to return to prison he might not be released, seem more relevant than the desire to put into practice cognitive-behavioural skills he has received in treatment on Cannock ward. Notwithstanding, his having achieved relevant key performance indicators – which should be of practical significance on release – may encourage him, as Foucault would put it, to ‘regulate the cycle of repetition’ of cognitive-behavioural skills.47 Put another way: one has the potential to offer patients such as Mr. H. with an environment in which they may want to act on the skills they have learned to safeguard their prior and current achievement of key performance indicators.

47 Discipline and Punish, supra n.6, p. 149.
In support of this approach to cultivating treatment success, many members of the MDT were also positive about giving patients the chance to be paroled from hospital. One nurse, for instance, says of treatment success:

‘I think [Mr. K’s] ideal, isn't he? If he could get out from here; if he could get paroled from here and get a course at university and get a job at the end of it, that would be absolutely perfect.’

Psychiatrists were more cautious, noting foreseeable practical limitations of the system:

‘I suppose that it would be nice to think we could work with community services and achieve parole from here. And I think for people to be successful in the community, having both mental health support and restrictions, which if you’ve got a life licence and probation are working in conjunction with a reasonably interested community team, I think that’s probably the best way of doing things, because you can set limits for those people and you can offer them support and try and help them manage crises more effectively…’

And:

‘I think it would be a good outcome providing it could be achieved readily; it’s the length of time. People are terribly slow about it, and, as a condition of applying for parole, I say condition, even being recommended for parole, a hostel place has to be acquired and often funding, so then you have the funding of that, which takes a long time to do, and is being funding while they’re still waiting for their [first-tier tribunal – mental health hearing] and for their parole, which takes months, maybe years. If you had the whole ward waiting for parole, I think it would be, I suppose, the reverse side of the coin of people waiting on death row, you know, it just requires unconscionable amounts of money.’

One is reminded of the potential coerciveness of the system in the case of Mr. C., who has no wish to receive treatment in the community should he be ‘conditionally’ discharged. He has already absconded from a hostel on conclusion of a previous (fixed term) sentence, demonstrating that the
continuation of the disciplinary regime in the community is primed, like the institution, for resistance. Given that the target must be to offer the service user some sort of reward in order to encourage his repetition of pro-social behaviour in the community, it is not obvious that intervention viewed in an anti-authoritarian light, consequent, for example upon perpetuating continuing isolation from his family, would facilitate this process. It might, therefore, be that key performance indicators, particularly if they border on aftercare, need to be carefully considered, if not tailored to the genuine needs of the service user, to prevent them from being perceived as a form of quasi-compulsion.

That said, since compliance with residential conditions – presumably in conjunction with more neutral forms of key performance indicators, such as educational qualifications or employment – would most likely be seen as more acceptable to the service user than being returned to prison for breaching his parole conditions, the same treatment effect might nevertheless arise. Of course, the extent to which the ‘cycle of repetition’ in these circumstances will produce actual behavioural change is not clear. All that can be said for certain is that external motivation is a strong predictor of treatment retention.48

Thus, perceived irrelevance of treatment may go some way to explaining why many patients (particularly those serving fixed term sentences) transferred under s.47 of the MHA 1983 fail to last the course on Cannock ward. It goes without saying that the potential for key performance indicators to help the internalisation of cognitive-behavioural skills first requires the completion of treatment. Again, the sense that parole is possible from hospital may assist this process. The aforementioned case of Mr. K. confirms why this is the case.

48 This point has been demonstrated in previous research: see, for example, Fiorentine, R., Anglin, M. D., Gil-Rivas, V. & Taylor, and E. (1997) ‘Client Engagement in Drug Treatment’. Journal of Substance Abuse Treatment, 17(3): 199-206.
Consider that at the time of survey, Mr. K. had, in fact, received a favourable response from a first-tier tribunal – mental health, and was awaiting his parole from hospital. Fellow patients on the ward were keenly aware of his process through the criminal justice system, as one might expect. Indeed, Mr. C. states: ‘...he keeps us updated’. Since he hopes to follow the same (potential) path through the mental health route, he is unequivocal about the relevance of Mr. K’s progress to his and others’ engagement with therapy during their time on Cannock ward:

‘[They] lose motivation some people; because they get towards the end 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 [he] gets turned down, we’re gonna think: well, so we’re gonna go back now, may as well go back now instead of wasting energy here...’

Mr. C. is himself a case-in-point: when he previously received a fixed-term sentence, he was, by his own admission, not ‘particularly bothered’ about engaging, since he recognised that there was nothing that could be done about his resistance. Thus, he puts into words what may have been operating on the decision-frame of Mr. A. above, who, it will be recalled, left Cannock ward of his own volition during the course of treatment with only a few months left to run on his fixed term sentence.

Another related factor contributing to the high rate of non-completion on Cannock ward may be that behaviour courses are not currently ‘recognised’ by the Ministry of Justice. In essence, service users engage with treatment on the strength of their confidence that the Parole Board will, first, deem release from hospital to be an acceptable form of parole; and, secondly, accept that the patient’s rehabilitative efforts outside of the prison regime are therapeutically
equable. Mr. E. encapsulates the pragmatism required of those who remain on Cannock ward well:

‘[It’s] good because it does do, d’you know what I mean, it brings you here and it sort of can reduce your risk, and it gives you a chance to at least show you can engage with a treatment programme and still do well, whether your PCL-R score is high or low. At the same time, it’s still difficult because it’s not all recognised. So, even though you are here and you’re getting the foundations, if you do have to go back into the system to do your courses, you can say, well, you can’t say I’m not fit for parole because I’ve done courses on the same sort of level, probably more in depth then I did there, so what’s stopping me here. It’s good in that respect. But because it’s 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.’

For those who do view treatment as a ‘waste of time’ and return to prison as a result of dwindling (external) motivation, Jones points out that this may compromise the service user achieving behavioural change through treatment as a result of a number of complex self-governmental factors. These include: ‘loss of faith in the possibility of change’; ‘…sense of personal failure’ making less likely future engagement; ‘sense of betrayal and exclusion’; and, ‘undermining self-efficacy in previously existing coping strategies’.49

To raise these points with reference to the current context: ‘loss of faith’ would, presumably, mean loss of faith that the system does not in fact have the procedural tools in place to ensure that engagement leads to (expeditious) parole. The sense of ‘betrayal and exclusion’, Jones refers to, might in fact have a complex relationship with a ‘sense of personal failure’, because, first, the system has not delivered parole despite engagement (betrayal); and,

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secondly, the internalisation of this realisation might lead one to feel that he has not *earned* the right to be rewarded, despite having attempted to positively engage with the treatment regime (personal failure). In respect of ‘self-efficacy’, non-completion – even if of one’s own volition – might signify the failure to take ‘responsibility’ to be thought of, in terms of Foucauldian diving practices, as a “good boy” rather than “criminal”. Indeed, Mr. L. tells us of the humanising aspects of treatment in respect of his arrival to HMP Dovegate, when he says it was *the first time in my life I felt I was being treated like a human*; and, similarly, on arrival at Cannock ward:

‘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.’

To take another example, if a service user like Mr. L. were returned to prison *against* his will, he (perhaps viewing himself as the ‘criminal’) now has less chance to receive the plaudits (rewards) that come with being seen to be productive, responsible and self-efficacious (the patient as ‘painter and decorator’; the ‘educated’; and so forth). Into this vacuum of a lack of success (the absence of key performance indicators), antisocial behaviours may return: a sort of ‘after the event reaction’, as Foucault would put it, consequent upon a failure, paradoxically, to determine one’s own future. To give brevity to Jones’ similar point: there is, for the patient, a possible reinforcing of repeating patterns of problematic interpersonal behaviour linked to negative core beliefs and one’s learned history. And, more recently, McMuran & Theodosi suggest:

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50 ‘The Subject and Power’, *supra* n.32, p. 225.
Removal from a treatment programme may increase anti-authority and antisocial attitudes. Interruption of a treatment programme may mean that difficult issues have been raised but the offender has not yet learned the skills for coping with these issues. Drop-out from a treatment programme may mean that the offender has been made to feel confused, lacking in confidence, or worthless.  

To continue the example of Mr. L.: he was transferred from HMP Nottingham to HMP Dovegate for treatment some time prior to being received on Cannock ward. However, his PCL-R score of 25 (again, the cut-off for a diagnosis of psychopathy) alerted staff to the possibility that he might benefit from a more structured treatment regime. After receiving treatment for a few months at HMP Dovegate, he was returned to HMP Nottingham against his wishes. His ‘after the event reaction’ was to threaten suicide and, subsequently, instigate a riot against staff at HMP Nottingham – but not HMP Dovegate, since it will be remembered that, as Foucault puts it, ‘people criticize instances of power which are closest to them’.  

Jones makes much the same point when he says that any affront to self-efficacy (which might be a manifestation of returning the patient to prison despite his having engaged with treatment and obeyed rules) might result in ‘adverse outcomes in another domain’.  

Consider Mr. C., who states:  

‘...here, if you got into an incident with someone, you get aggressive, that other person thinks in their head, I can’t react to this, so they don’t, so that isn’t gonna fuel me anymore.’  

It stands to reason that if demonstrated self-efficacy is ‘rewarded’ by conveying the service user back to prison wherein he will encounter prior, often violent,  

52 ‘The Subject and Power’, supra n.32, p. 211.  
53 ‘Iatrogenic Interventions with Personality Disordered Offenders’, supra n.49.
relations, the possibility of ‘adverse outcomes’ is greatly increased. Another way of asserting, and embellishing this argument, is to note that a treatment culture which focuses on security, perceived lack of safety, pejorative labels and adversarial relations between staff and service users negatively predicts “readiness” to engage in the process of therapeutic change. By which one means, of course, his willingness and inclination to operationalise the cognitive-behavioural skills taught in hospital.

In contrast, to re-state the conditions of Cannock ward, it offers service users an environment which is perceived as safe, non-adversarial, non-pejorative and a disciplinary regime in which there is a focus on quality of life factors (key performance indicators) – even though fused with cognitive-behavioural skills training – which are likely to be viewed as constitutive and positively correlated to the potential to achieve parole from hospital. Conveying a service user who achieves all he is supposed to back to prison may compromise this ideal-type response to anti-social behaviour: a treatment outlook which recognises the potential to improve the quality of life of the self-governing client.

It is an ideal-type response, however, because the achievement of therapeutic benefit does not, and cannot, rely on the fiction of subjectivation to ensure that the ‘deviant’ will self-mend because he ought to. It is, therefore, arguably prudent, in the final instance, to adopt a degree of reserve when discussing the potential to inculcate service users with desired behaviours absent subjectivation effects:

‘...I mean we’re dealing with a difficult group of people, and the reality is we’re not going to get everyone into the community without re-offending. I mean it would be nice to think that, but I know we can’t’.

(Consultant psychiatrist).

On this point, one is minded of the 2010 Royal College of Psychiatrists Annual Conference, in which one paper presented the audience with statistics on the rates of re-offending in the community by those with antisocial PD. Many general, and especially younger, psychiatrists looked on aghast. It would be fastidious to counter these responses by remarking on the high rates of revolving door clients seen in general psychiatry, merely to reinforce the point that all forms of behaviour modification are fraught with difficulty, since it implies ignorance of the underlying raison d’être of discourse in governmental regimes. Namely, only the promise of normalisation by discourse is relevant to its acceptance as truth. ‘We are promised normalization and happiness through science and law,’ Dreyfus and Rabinow point out; ‘When they fail, this only justifies the need for more of the same…’

However, to suggest on this account that psychiatry has failed in the rehabilitation of a complex and difficult client group with PD and / or psychopathy would be insincere. In light of the empirical findings presented in this study, in the final instance the attempt has been to be both deferent to the fact that patients will always seek to act according to their own goals but to also work within this limit the potential for psy-discourse to achieve normalising effects. No doubt, this task would be easier if patients really were duped. Indeed, had Foucault invested in his notion of subjectivation the fruits of empirical research, he would have surely concluded that governmental regimes,

55 Beyond Structuralism and Hermeneutics, supra n.32, p. 196.
both in and outside the institution, struggle in to contend with the inherent recalcitrance of man.
Concluding Remarks – Part II

Part II of this study began with Chapter 4, in which the working method and methodological considerations that would guide data analysis were examined. As part of this process, three avenues of exploration were cited. The first of these was as follows:

1. Understanding decision-making under s.47 of the Mental Health Act 1983 from a variety of professional staff and service users’ perspectives will highlight the adumbration of seeking only the clinician’s (principally psychiatrist’s) viewpoint in previous research.

In contrast to previous research looking at admission decision-making practices to medium secure units, which have privileged the account of psychiatrists, this study also surveyed professionals in the fields of psychology, occupational therapy and nursing, who conduct pre-admission assessments in prisons on those offenders who are being considered for admission. It also widened the scope of enquiry by including the perspective of patients on Cannock ward, whose suitability for admission had previously been assessed in prison. The lack of patient involvement in research is unfortunate, a cost of their apparent subordination to either or both the criminal justice system and the psy-system, in which professional decisions are seen to subsume the decision-frames of those they treat.

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1 See p. 137.
3 These were complimented by informal observations and discussions with nursing staff and health support workers. Patients’ medical records were also read.
On a more theoretical level, incorporation of a wider variety of decision-frames was a methodological imperative of the researcher’s leanings towards Michel Foucault’s rich analysis of power relations. He posits that all individuals have the ability to act upon, or direct, the actions of others through strategy in accordance with the outcome(s) sought. Power, thus, is ‘the means employed to attain a certain end; it is a question of rationality functioning to arrive at an object’.  

This ‘new economy of power relations’, more ‘empirical’ and amenable to investigation in the institution, served as bifurcation from his earlier work, in which the (psychiatric) hospital, or the ‘legitimate source and point of application’ of psychiatry, assigned subjectivity to the speaking individual. Thus conceived, discourse was not ‘the majestically unfolding manifestation of a thinking, knowing subject’, but ‘a totality, in which the dispersion of the subject and his discontinuity with himself may be determined’.

The juxtaposition of these two positions was seen in action in Chapters 2 and 5. In the former, it was noted that psychiatry has undoubtedly achieved a degree of centrality in the care of the mentally disordered, arguably, since the Victorian era. It was seen in Chapter 3 that this is represented in modern psychiatric practice by the position of responsible clinician (RC), which has, hitherto, privileged psychiatry in decision-making matters appertaining, among others, to ‘admission for treatment’. Nevertheless, owing to reforms to the RC role – which prima facie widen the net of professions who can undertake the

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7 Ibid., p. 55.
8 Section 34(1)(a) of the MHA 1983.
role – it was also demonstrated through empirical evidence the inexorability of resistance by professionals within, for instance, psychology and nursing, who have questioned the perceived ‘legitimacy’ of psy-discourse over ‘subjugated’ discourses in treating the personality disordered client.

Chapter 5 demonstrated the potential for professionals to direct, through employment of Foucauldian-type strategy, the outcome of multidisciplinary team (MDT) discussions on the perceived suitability of respective offenders for admission to Cannock ward. It was seen that this strategic element to admission decision-making was borne of the desire, as many of the MDT put it, to be able to ‘cherry-pick’ from those offenders seeking admission in conditions where there are often differences of opinion. Therefore, this study has succeeded in reifying the notion that those in ‘subjugated’ professions may direct decisions concerning patients who, through hierarchy, statute and custom are assumed to be the prerogative of psychiatrists.

However, it was also apparent that too much emphasis had been placed on Foucault’s notion of strategy in local power relations. In particular, it was found that Foucault is largely innocent of the import of status on group decision-making. In sum, whilst the researcher understood that the RC (psychiatrist) is entitled to sign the admission’s document in respect of a particular offender admitted to Cannock ward, after Foucault’s discussion of strategic interplay between actors, it was suspected that competition and self-interest between the various members of the MDT would prove to be the ‘real’ author of the final admission decision. What, in fact, transpired was that the role of RC was often a source of legitimate authority in the admissions forum.
More specifically, as Talcott Parsons claimed, the legitimate authority of the group leader (here, the RC) to make binding prescriptions on the rest of the group was manifest. These binding prescriptions, or ‘cloaked’ strategies, were in the order of ‘persuasion (intentional channel, positive sanction)’ and the ‘activation of commitments (intentional channel, negative sanction’). The latter was particularly pertinent to the current context governing ward admissions, in what was referred to as ‘the bed situation’.

Previous research has identified ‘the bed situation’ when examining admissions to 98 per cent of the total medium secure bed estate in 2004. In this research, the bed situation was understood in terms of the disproportionate number of potential admissions relative to the few beds available to receive them. On Cannock ward, the availability of beds was far more variable. At the time of the study, beds were not filled to capacity, and the need to maintain ‘productivity’ (again, a Parsonian term) to ensure the ward’s continued viability as a service influenced admissions policies. In particular, in the past, certain clients would have been precluded access on the basis, for instance, of being diagnosed as having a psychopathic disorder or a learning disability. More recently, however, as an occupational therapist puts it, ‘...the fact that we know we’re under pressure to fill beds, we have said yes’. This was considered justifiable, largely on the basis that experience had begin to tell that previously excluded groups could, in fact, benefit from treatment and / or the fact admission’s policies needed to be a fluid response to the changing nature of the client group. Consider:

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10 ‘A qualitative Study of Admission Decision-Making, supra n.2.
‘What we’ve observed over the last, I suppose, over the last 5 or 6 years is the mean score of the PCL-R has gone up...about 25, I suspect... So, that’s a feature of mental services in general, where they are now taking more and more severely affected people...’

(Psychiatrist).

In the round, this underlying aspect of admissions meant that the offender’s motivation to engage in treatment was pivotal as to whether or not the RC signed the transfer document (with the MDT’s latent agreement). As one nurse says, pragmatically:

‘...sometimes I think they’re there, they’re not causing any problems, they’re filling a bed, so they keep them there...’

(Nurse).

What is not clear from Chapter 5, however, is how admission decision-making practices would have varied if there had been no issue of unfilled beds. Perhaps, in this respect, there is force to the argument presented by Melzer *et al.*, that ‘the characteristics of units can have a powerful effect on admissions, and thus generalizing from local studies can be hazardous’.11 For comparative purposes, it would have been most useful to have adopted as a working method multi-site research with at least one other medium secure unit. That said, one must point out that this study succeeds in offering moderatum generalisations on the basis of new socio-legal presuppositions about power in group decision-making fora. Therefore, hypothetically speaking, it is possible that, in surveying a multi-professional perspective on another ward, one would have been presented with further evidence of strategic interplay between the various professions on the basis of having the benefit of being able to ‘cherry-pick’

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from the pool of offenders wishing to gain admission. If, on the other hand, beds were not being filled on the alternative ward, the presumption might be, following Chapter 5, that the psychiatrist does, indeed, have legitimate authority to direct his or her team.

Furthermore, this discussion of the leader in group situations shores up another potential as to how decision-making between ego (leader) and alter (rest of the team) would manifest itself if, in the future, the RC role is undertaken by professionals other than the psychiatrist. It was suggested by a psychologist in Chapter 5 that if this occurs the group might lean towards the psychiatrist when decisions were to be made because of the cultural and historical acceptance of psychiatry as the ruling paradigm in mental health care. But would this translate into greater use of strategy by alter as a manifestation of a perceived ‘right’ to have their will felt? Or would it, again, depend on ‘the bed situation’?

Considered in the round, however, these questions reinforce the interesting penumbra of power relations as a methodological framework which the current researcher has introduced for future researchers interested in engaging with the subject of decision-making practices in the forensic mental health care forum – if not beyond.

To the second hypothesis of the study:

2. Extra-personal factors, such as policy considerations, may emasculate the potency of offenders’ strategies aimed at gaining admission to Cannock ward.

Including patient perspectives in the current study was deemed common sense, in that no offender is likely to transfer to Cannock ward under s.47 of the MHA
1983 without his or her prior consent. This naturally led to the question: why do offenders agree to their transfer from prison? Here, the fact that those with PD are usually ‘treatment rejecting’ rather than ‘treatment seeking’ provided an evidential context which made this an important avenue for exploration. With particular reference to the psychopathic client, a further evidential context provided in Chapter 6 was the claim by many staff on Cannock ward that the inherent manipulativeness of this client group made it difficult to assess their motivation for treatment – that is, whether it was externally or internally derived. This study found ample evidence that, among all those who were subsequently admitted for treatment – that is, not least those who were clinically psychopathic – legal and coercive pressures (external motivation) were acting on their decision-frame to consent to treatment following the pre-admission stage.

More specifically, in all but one case, the service users were currently serving either an indeterminate sentence for public protection (IPP) or an indeterminate life sentence under the Criminal Justice Act 2003. The effect of these sentences was first discussed in Chapter 1. In effect, it was stated that the numbers of offenders who had been made the subject of indeterminate sentences since April, 2005 ensured that treatment resources in prison were scarce. The result is that few offenders are able to address their offending behaviour, and thus demonstrate to the Parole Board on conclusion of their minimum tariff that they no longer pose a risk to the public. Mr. G’s experience typifies the problem faced:

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12 The potential for transfer to occur at the insistence of the Secretary of State was noted (see s.47(4) of the 1983 Act). For discussion, see Chapter 1, p. 40.
'You might get a couple of courses at Gartree that you need to do, but there might be a couple that they don’t do there, so you might be transferred. And when you get there, there might be a waiting list of up to two years. It’s not a good thing, really.'

It was demonstrated that offenders are understandably keen to avoid incapacitative restraint, consequent upon not being able to fulfil the ‘treatment’ portion of their sentence. What strategy was identified during interview with clients was directly related to this ambition (or the associated wish to escape the troubling conditions of prison). This was evidenced during the referral stage by, for example, instigating a psychiatric report through one’s solicitor when the prison psychiatrist refused to refer Mr. C. for pre-admission assessment. In the starkest example, however, Mr. D. candidly recalled how he had slanted his answers to a psychological assessment when visited by a psychiatrist in prison in an effort to direct his admission to Cannock ward.

In contrast to these overt examples, many were less willing to articulate any strategies that may have been used to direct the conduct of professionals. This implied either that admission decision-making is more often the prerogative of professionals, with service users a passive recipient of care (a binary view of power), or that patients decided it would be imprudent to disclose evidence of what could be construed as anti-social behaviour to the researcher. In the latter respect, pertinent here is Foucault’s appreciation that, within relations of power, there is a degree of second guessing. In sum, strategy may designate:

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.14

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14 ‘The Subject and Power’, supra n.4, p. 224.
Indeed, staff seemed attentive to the possibility that offenders could influence the decision-making fora. One nurse asserts:

‘...these particular individuals know what they’re doing, they know what they’re saying, they have a personality disorder and they’ve got different types of traits, some are more manipulative than others’.

However, not all members of the MDT were comfortable equating manipulativeness with evidence of a disorder; instead, they merely recognised strategy as the makings of a common sense reaction to conditions which the autonomous offender felt were intolerable and wished to change:

‘On IPP, to get out, to get parole, I’m sure you have to show you’ve addressed your index histories and things like that, and this is a place where they can do that.’

(Nurse).

This did not mean that members of the MDT adopted a degree of therapeutic nihilism when it came to treating offenders with PD and / or psychopathy. Rather, it was made explicit on occasion that, providing the service user presented as willing to engage with treatment on admission, it would be appropriate to admit them. It is arguable that ‘the bed situation’ had a part to play in this pragmatism. However, staff argued that this approach to admissions was borne of experience that those who were believed to be potentially consenting to treatment due to external pressures might subsequently develop internal motivation, which would facilitate their rehabilitation. The other plausible possibility was, of course, that service users could continue to adopt strategic innovation during the course of treatment as part of a continued effort to increase their chances of securing early parole. This study recognised this latter quandary of treating the client with PD as a
more theoretical discussion. Thus, the third hypothesis governing data analysis was as follows:

3. Patients do not blindly ‘self-make’ according to psychiatric norms, but act according to rational self-interest.

In Chapter 7, objectification (discipline) and subjectivation (blind self-making) – the co-optive responses to the wider regime of government – were discussed in relation to the rehabilitation of the personality disorder offenders. It was argued that the lack of apparent subjectivation to healthist discourse in prison was due to the problems of resource provision (linked to the overuse of the indeterminate sentence), terse relations between inmates and staff and the absence of psy-discourse to validate the process by which the offender would ‘moderate, limit, regulate his activity’. Instead, on account of the findings, it could be argued that prison training had been approached with a ‘tick-box’ mentality to securing earlier parole:

‘They turn up; they can sit at the back; as long as they’re not upsetting anyone, they will be signed as meeting that course or session, or whatever.’

(Nurse).

At this point, rather than assert that discipline – and the concomitant possibility of resistance by offenders – provided the better account of the regime, it was accepted that once the offender was conveyed to hospital, he might realign himself in the manner presented by Foucauldian ‘dividing practices’ – namely, “good boy” rather than ‘the criminals’; ‘healthy’ rather than ‘insane’ – and that this process would be attentive to the treatment norms of psy-discourse.

16 ‘The Subject and Power’, supra n.4, p. 208.
What was found was that patients claimed to have benefitted from treatment, whilst others asserted that this constituted part of the façade of demonstrating pro-social behaviour for the purposes of earlier release from indeterminate detention. However, adopting the test of 'balance of probabilities', there appeared little evidence that service users were engaging and conforming for reasons other than their external motivation (the chance of subsequent parole if their treatment preconditions were met and therapeutic effect demonstrated). This leads to two tentative conclusions in respect of rehabilitative regimes, such as Cannock ward:

a. Foucault’s apophthegm is the disciplinary institution:

With his notion of the disciplinary regime, one is presented with the potential for normalisation, but also the inexorability of resistance. In all cases, the possibility of resistance implies that the subject would be refusing, as Foucault would put it, ‘a scientific or administrative inquisition which determines who one is’. Contrary to his discussion in The History of Sexuality and, to a lesser extent ‘The Subject and Power’, one could find no evidence that this was hiding the real workings of normalising power or, to put it another way, that duped adherence to prescribed norms in society is emblematic of psychiatric practice. This suggests that objectivation (discipline) rather than subjectivation (false consciousness) is a better descriptor of the ways in which personality disordered offenders may be rehabilitated, because at least one can accept that resistance within the regime is not power masking ‘a substantial part of itself’.  

This shores up the general contention that, as an ideal-type regime, the

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17 Ibid., p. 212.
disciplinary institution continues to fail to eradicate re-offending (once the offender is returned to the community) and continued forms of mental ill-health. If this is to criticise Foucauldian logic, Dreyfus and Rabinow would respond by inviting caution:

His work is still very much in a process of change and refinement. There are areas of uncleanness and sketchiness which can be read either as confusion or, more sympathetically, as problems he has opened up for further exploration, either by his subsequent work or by others.\(^\text{19}\)

Certainly, Foucault was clear that he had never written anything but ‘fictions’; fictions which might, nevertheless, introduce ‘truth-effects within discourse’ for our consideration.\(^\text{20}\) This caveat, as far as possible, has not been ignored in this work. Thus, the true methodological aim of this study has been to incorporate aspects of his analyses of power for purely facilitatory purposes; but also to remain deferent to the ‘fiction’ of his work during the process of theoretical recess, advance and synthesis (if scarcely achieved in that order). It is for another researcher to make a grander claim to Truth.

b. The self-making potential of personality disordered offenders must be read in the context of the (limited) possibilities of the specific disciplinary regime:

This statement means that one’s notion of treatment success when working with personality disordered offenders must always cohere with their potential to engage with treatment for purely strategic reasons. It is largely beyond doubt


that those who remain throughout the course of treatment on Cannock ward do so for reasons related to external motivation (the pressures of the indeterminate sentence). Thus, in the absence of evidence of subjectivation to psy-discourse, it is endemic to the disciplinary regime that the service may demonstrate evidence of having benefitted from the skills taught in the various cognitive-behaviour programmes for subversive means.

Nevertheless, the presence of external motivation to remain on Cannock ward means that the patient receives the whole course of cognitive-behavioural treatment on offer. This may make him more likely in the future to implement the pro-social skills on his release, providing he deems it to be in his best interests to do so. In Chapter 7, one way in which it was said that this could be facilitated is by focusing on cognitive-behaviour therapy and the achievement of what commentators have called ‘key performance indicators’. These are psycho-social makers which include educational achievements, employment and independent living – in the round, quality of life markers which are not, strictly speaking, aimed at normalising offending behaviour.

It was posited that these key performance indicators may act as sources of reward for the service user who continues to implement pro-social behaviour in the community. Over time – though, unfortunately, it is not clear how long – the continued employment of alternative modes of behaviour originating in cognitive-behavioural skills programmes taught in hospital might result in an effective ‘treatment dose’ being achieved. Whilst it was argued that the success of psy-discourse at rehabilitating the client group should not, properly

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speaking, be read as a reduction in re-offending rates, this could be a material effect married to an improvement in the social conditions of the patient’s life.

This is to suggest that the disciplinary regime has an important facilitatory part to play in the process of rehabilitation, but in such a way as to prevent doing violence to the finding that service user self-interest is always a frontier to the absolute dominating effects of psy-discourse (subjectivation). Nevertheless, despite constituting a more modest account of treatment success, its effectiveness may only be known if the administrative hurdles precluding parole from Cannock ward can be removed for this group of offenders. Hitherto, upon concluding treatment, the patient has been conveyed back to prison, even if his tariff has expired. The point was made in Chapter 7 that to do so could potentially endorse prior unproductive responses to terse power relations and difficult social circumstances. Moreover, the service user, now being outside the remit of s.117 of the MHA 1983, will not receive an individualised aftercare package which could help facilitate his reintegration into the community.

This latter point is noted to be a general condition of (potential) rehabilitation in both the penal and forensic healthcare disciplinary regime. Its absence, therefore, in the current penal system serves to highlight the unfortunate, if not unethical, mismatch of coercing service users into treatment absent adequate community support. No doubt, a lack of resources and financial impediments continue to wear the ground here. Suffice it to say that there is much to consider about the ways in which society seeks to govern, and indeed support, service users with PD. In support of current government
policy, one suggestion advanced, exclusively by psychiatrists, was to relocate personality disorder wards into prisons:

‘One thing I do wonder with the service...is that it would probably be a more viable option to bring the services into prison and find a way of engaging staff in prison, and changing outlooks so you could deliver the same treatments in prison. And in a way it might be less stigmatising to patients who have the capacity to make choices, and you could deliver a lot more, and disengagement in a prison setting – if they stopped coming for a while and they’re on the wing and they’re not there, and someone else is introduced in the group, it’s much easier to manage that.’

From an administrative point of view, this would have the benefit of encouraging joined-up thinking between the National Health Service (NHS) and the Ministry of Justice, as Mr. E. points out:

‘Because the NHS don’t work alongside prisons and probation and the Home Office, they’re sort of kept out of the loop, whereas if you were in prison, it would be here, it would be done, they’d be parole hearings, they’d be everything going on and working, because that’s how it’s always been. But whereas from here, because of a lot of stigma that comes from these types of places, from mental illnesses, that’s all you hear in the papers; you never hear of any of the good stuff that goes on... No one wants to take responsibility and put their neck on the line and say, right, I’ll parole you from there, because if it goes wrong, it goes back to that man who made the decision.’

Although, by implication, this idea has some merit, it is not clear how it would reduce the current problem of potential incapacitative restraint faced by those in the study. External legal pressures deriving from the indeterminate sentence, coupled with the desire among offenders to seek the most favourable conditions of imprisonment (perhaps, again, by slanting responses to the relevant psychological assessments) would further burden already scarce treatment

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23 See Chapter 1, 1.3.3.1.
resources. This is in respect of the forensic (medical) staff willing to work with the client group; availability of prison space; and individualised, potentially expensive, aftercare. The result, in theory, would be that more offenders diagnosed with PD would be denied the sources of rehabilitation that may improve the quality of their lives.\footnote{24} Furthermore, and related to this, as was seen in Chapter 6, if the offender with PD was also subject to an indeterminate sentence, he might because of his stigmatising diagnosis be prevented from participating in cognitive-behavioural courses that could lead to his earlier release from prison, if not his rehabilitation.\footnote{25}

Therefore, amid these limitations of the disciplinary institution and of the apparent limitations to normalising deviance in society, it is unsurprising that governmental regimes are locked in a state of perpetual reform, resulting, in equal measure, periods of optimism and despair as to the rehabilitative effects it succeeds in achieving. Whilst the indeterminate sentence is the latest – and most controversial – reform, it is, arguably, no more than a renewal of the early 1990s reform process, when the task of the reformer was to improve ‘impoverished regimes’ for the ‘quality of life’ of inmates, focusing in part on self-betterment through the delivery of structured programmes.\footnote{26} Relying on the promise of rehabilitation by the human sciences, and on the notion that, as Foucault put it in relation to the coupling of discipline and government (bio-power), ‘on the soft fibres of the brain is founded the unshakable base of the

\footnote{24} For a rights based discussion of the impediments to treatment facing offenders with PD, see McRae, L. (2009) ‘Assessing the Viability of Treatment Rights for Prisoners with Personality Disorder: Substance or Substantive? Personality and Mental Health, 3: 172-82.

\footnote{25} One is reminded, for instance, of the experience of Mr. E: ‘I’d rather come here, because in prison you’re not gonna get the help you need. And some of the courses you get in prison, because of your PCL-R score, they wouldn’t really put you on courses.’

soundest of Empires’; the process of reform cannot help but incorporate the ‘scientific’ logic that rehabilitation will be achieved by subjugating the deviant into new modes of behaviour within the institution. What is forgotten, however, is that the notion of the political “double bind,” which is the simultaneous individualization and totalization of modern power structures’, only makes sense because of the paradoxical pre-condition of the deviant’s continuing refusal to accept the logic of the human sciences project. Liebling is an example of the advocate of rehabilitation through reform on the merits of the dubious political “double bind”:

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).

Those who, like the current author, suspect that political “double bind” is poor in form and sparing in methods might find merit in Sykes, who warns: In the prison, power must be based on something other than internalised morality and the custodians find themselves confronting men who must be forced, or cajoled into compliance.

On this account, perhaps the indeterminate sentence (certainly when coupled with the potential for incapacitative restraint) is a response to the recognised

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28 ‘The Subject and Power’, supra n.4, p 216.
limitations of the disciplinary regime and *bio-power* in achieving normalisation. Perhaps after the optimism of commentators such as Foucault, Marx, Goffman and Parsons, the usually noble and well-meaning pursuit of behavioural manipulation deserves a recapitulation. Pursuant to the findings, and claims, of this study, it is the logic of Cohen which is arresting. Some seventy years ago, it was he who portended the truth of the Foucauldian ‘disciplinary’ regime:  

Let us abandon the light-hearted pretension that any of us know how all cases of criminality can be readily cured, and ask the more modest and serious question: to what extent can criminals be re-educated or re-conditioned so that they can live useful lives? It would indeed be illiberal dogmatism to deny all possibility and desirability of effort along this line. Yet we must keep in mind our human limitations.

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**Appendix 1** – Information sheet for service users

EXPLORING WHY SOME WITH PERSONALITY DISORDER ARE ADMITTED TO ARNOLD LODGE FROM PRISON

INFORMATION ABOUT THE RESEARCH – 10 December, 2010
(Version 2.0)

**Part I**

I would like to invite you to take part in a new research study. The findings of the research will form part of a PhD thesis. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others if you wish.

The research is aimed at increasing knowledge as to why some service users with personality disorder are accepted for treatment at Arnold Lodge while others remain in prison. You have been asked to participate as you have been through the referral process in prison, and because you have a personality disorder. In total, approximately 10 service users will take part in the research.

Your participation in the research is entirely voluntary. I will follow ethical and legal practice and all information about you will be handled in confidence. Any complaints you have will be addressed. The details of these points are
included in Part II. If you do not wish to take part in the research, it will not affect the care you receive or your legal rights. If you wish to take part in the research, you will be asked to sign a consent form.

If you choose to participate, you will be invited to take part in an interview with me. The interview is expected to last for around 1 hour, but you can leave earlier if you wish. You will not be asked to participate in the research at a later stage. If you participate in the research, after the research is over you can receive a copy of the research findings if you wish.

If the information in Part 1 has interested you and you are considering participating in the research, please read the additional information in Part II before making any decision.

Part II

The research: The research is funded by the Economic and Social Research Council. As part of this research project takes place in a secure psychiatric unit, it has been looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by Leicestershire, Northamptonshire and Rutland Research Ethics Committee on January 14, 2009.

If you wish to participate in the research, you will be asked to take part in an interview with me. The interview is expected to last about 1 hour, but you may leave earlier. Once the interview is finished, you will not be asked to participate in any further interviews. But I can send you a summary of the findings of the research if you wish to see them.

Consent: If you wish to participate in the research, in accordance with REC guidance, you will be asked to sign a consent form. You will receive a copy of the signed and dated form and the original will be retained by me for the Study
records. A further copy will be filed in your institutional file and a signed and
dated note made in the notes that informed consent was obtained for the study.
If you do not wish to take part in the research, you do not have to sign the
consent form. If you do not take part in the research, the care you currently
receive or future care, or chances of release, will not be affected. You can also
leave the interview at any time. If you choose to withdrawal from the study
after it has begun, you can choose whether any information you have given up
until your withdrawal can be used in the research.

If any amendments need to be made to the way the research is conducted, these
amendments will be looked at by the Research Ethics Committee. You may
need to sign a further consent form if any changes affect your participation.

**Who will know you are participating?** I will keep your information in
confidence. This means I will only tell those who have a need or right to know
that you are participating.

**Collection and storage of data:** I would like to record the interviews using a
Dictaphone, so that I do not miss any of the important information that you
might give. There is a chance that responses you give may be quoted in the
research. If you are happy for me to do this, you will need to acknowledge this
in the consent form.

All information which is collected about you during the course of the research
will be kept in strict confidential, and any information about you will have your
name removed so that you cannot be recognised. Where a computer is used to
store your data, it will be protected by a password so that no-one else can
access it but me.

**Use of the results:** It is possible that the results of the research will be
published. If so, your name will not be used. Even if the results are not
published, your name will be kept in strict confidence and no one else but me
will have access to it. You are welcome to a copy of the final research or you
can have a copy of the summary findings.
In compliance with regulations and in accordance with the University of Nottingham Research Code of Conduct, I will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If I become unable to maintain the study records, a second person will be nominated to take over this responsibility. The study documents shall be finally stored at secure facilities at the University of Nottingham.

**Compensation for harm:** It is not expected that you will come to any harm as a result of taking part in the interview. In general, if you happen to feel unwell, you can stop the interview at any time. The University of Nottingham has taken out an insurance policy to provide indemnity in the event of a successful claim for proven harm. There are no special compensation arrangements and you may have to pay your own legal costs.

**Complaints:** If you have any concerns about any aspect of the study, you can contact me (Leon McRae, School of Law, University of Nottingham, University Park, Nottingham, NG7 2RD), and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through your care institution. A member of staff will be able to help you with this.
Appendix 2 – Information sheet for professional staff

EXPLORING WHY SOME WITH PERSONALITY DISORDER ARE ADMITTED TO ARNOLD LODGE FROM PRISON

INFORMATION ABOUT THE RESEARCH – 10th December, 2010
(Version 2.0)

I would like to invite you to take part in a research study, which forms part of a PhD thesis.

The research is funded by the Economic and Social Research Council. The proposed research project has been approved by Leicestershire, Northamptonshire and Rutland Ethics Committee on January 14, 2009. At this point, I have not been given any personal details about you by your care team. You are to decide whether you wish to participate in the research or not, free from pressure.

The aim of the research is to increase understanding of why some service users with personality disorder are admitted to Arnold Lodge under section 47 of the Mental Health Act 1983 from prison. You have been asked to participate in the project as you have been involved in the pre-admission decision-making process in respect of the making of hospital directions.

Your participation would involve an interview with me. It is possible that a further interview will be required in light of primary analysis of all the data.
You can leave an interview at any time. If any data has been collected up until that point, it is your decision whether it is subsequently used in the research project, including any quotations.

If you wish to participate in the research, in accordance with REC guidance, you will be asked to sign a consent form. You will receive a copy of the signed and dated form, and a further copy retained by me for the research file. If any amendments need to be made to the way the research is conducted, these amendments will be looked at by the Research Ethics Committee. You may need to sign a further consent form if any changes affect your participation.

I will follow ethical and legal practice and all information will be handed in confidence. Any complaints you have will be addressed.

**Who will know you are participating?** I will keep your information in confidence. Only those who need to know will be told of your participation.

**Collection and storage of data:** I would like to record the interviews using a Dictaphone, so that I do not miss any of the important information that you might give. If you are happy for me to do this, and potentially to quote from this data, you will need to acknowledge this in the consent form.

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you will have your name removed so that you cannot be recognised. All data will be stored on a password-protected private computer at the University of Nottingham, so that no one can access it but me.

**Use of the results:** It is possible that the results of the research will be published. If so, your name will not be used. Even if the results are not published, your name will be kept in strict confidence and no one else but me will have access to it. You are welcome to a copy of the final research or you can have a copy of the summary findings.
In compliance with the University of Nottingham Research Code of Conduct, I will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If I become unable to maintain the study records, a second person will be nominated to take over this responsibility. The study documents shall be finally stored at secure facilities at the University of Nottingham.

Compensation for harm: It is not expected that you will come to any harm as a result of the interview during the interview. The University of Nottingham has taken out an insurance policy to provide indemnity in the event of a successful claim for proven. There are no special compensation arrangements and you may have to pay your own legal costs.

Complaints: If you have any concerns about any aspect of the study, you can contact me at your convenience, and I do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.
Appendix 3 – CONSENT FORM – 10th December, 2010 (Version 2.0)

Location: Cannock ward, Arnold Lodge
Participant’s Name:

Title of Project: Exploring why service users with personality disorder are admitted to Arnold Lodge from prison under s.47 of the Mental Health Act 1983

Name of Researcher: Mr. Leon McRae

Please initial box

1. I confirm that I have read and understand the information sheet Version 2.0, dated 10th December, 2010 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree to the interview being recorded or transcribed by hand, and for responses I give in the interview to be quoted in the research project and any related project.

4. I understand that the data collected during the study may be seen by the public if the study is published. I understand that it may be looked at be members of the University of Nottingham, regulatory authorities or the NHS Trust, where it is relevant to my taking part.

5. I agree to take part in the above study
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*When completed:* 1 copy of the form for the participant; 1 copy for the research file