CHAPTER 3

Producing Treatability
Reconfiguring the Subjects of Therapy through Entwinements of Clinical Practice and Mental Health Law

Within initiatives to enhance access to therapy, psychological care is generally presented as something that many people want and who are too often denied access to it (e.g. due to long waiting lists). Yet, there can also be other governmental considerations for enhancing the accessibility of psychological care. In this chapter, I focus on something that the psychological complex (Rose, 1985) itself often configures as a 'matter of concern' (Latour, 2004), namely the diagnostic category 'personality disorder'. The diagnosis is commonly subject to reflexive consideration about its ontological coherence, its legitimacy as a clinical target, and the affective and practical responses of healthcare professionals to people living with it (Bendelow, 2010; Eastman Starling, 2006). Individuals diagnosed with variants of personality disorder associated with antisocial actions have often been involuntarily detained within the NHS and the criminal justice system. There, the disciplinary logics that always infuse psychological care are particularly visible and impactful, with therapy framed partly as a mechanism for addressing antisociality. In the case of personality disorder and its treatment, then, the affordances of an ethic of access can be rather different to those enjoined by initiatives like IAPT.

Ruminations on personality disorder – or personality disorder*s*, given the various subcategories that exist – date back to at least the 19th century (Berrios, 1993; Werlinder, 1978). They are commonly framed as global personality dysfunctions rather than discrete forms of mental illness (such as schizophrenia or depression). Accordingly, personality disorders have long attracted much interest from psychologists as well as psychiatrists. In the United Kingdom, the constructs of antisocial personality disorder (ASPD) and psychopathic personality disorder (psychopathy) have been particularly important within debates about the intersections between criminal justice and mental health (Manning, 2000, 2002, 2006; Pickersgill, 2009a, 2009b; Pilgrim, 2007). Individuals regarded as

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'personality disordered' who have committed criminal offences transgress a range of boundaries: between normality and pathology, victim and perpetrator, and patient and criminal. There are enduring concerns about the medicalising circularity of associating violence or 'criminality' more generally with personality disorders (Wootton, 1959). Still, legal and policy innovations have often underscored rather than dissolved that association.

In the early 21st century, the revision of mental health legislation for England and Wales focused significant attention on personality disorders (Pilgrim, 2007). In 1999, the UK government began to formulate plans for rewriting the 1983 Mental Health Act (MHA) of England and Wales (with Northern Ireland and Scotland having separate legislation). These plans captured the attention of psychiatrists and psychologists, who were keenly aware of the potential for revised policy to reshape practice. However, the possible effects of such governance on framings of pathology per se were less widely appreciated. For decades, ASPD and psychopathy had been widely thought to be resistant to clinical intervention. Yet, as increasingly fractious discussions about the MHA played out, personality disorders came gradually but profoundly to be positioned as plastic rather than more obdurate constructs. In other words, they became treatable.

This chapter tells the story of how that happened. First, I introduce some of the legal and clinical context from which debates about a refreshed MHA emerged. I move then to reflect on key mental health policy developments over the late 1990s and early 2000s, and discuss the associated perspectives of clinicians. I then describe how the policy machinery itself shifted gear to accommodate some professional concerns. The rapprochement between political/policy and clinical goals came to be materially visible in four 'Dangerous and Severe Personality Disorder (DSPD) Units' at existing NHS hospitals and prisons. These sought to treat individuals meeting the criteria for DSPD while at the same time managing the risks they were understood to present to others. Finally, I analyse the culmination of these interconnected debates: a 2007 revision to the MHA, and the growing (though still not universal) belief that personality disorders are indeed treatable. The result was a reconfiguration of the role and accessibility of (predominantly psychological) care for people previously deemed 'untreatable', perhaps most notably within forensic settings. In sum, I demonstrate how the intensions underlying initiatives to enhance access to therapy are not always benign and can transform ideas about the subjects upon which they seek to intervene.

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The 1983 MHA and Therapeutic Pessimism

In 1983, the first major revision to the MHA of England and Wales in more than 20 years was unveiled. Refining and extending much of the content of a 1959 predecessor, the Act was largely steered by the recommendations of an expert committee chaired by Lord Butler of Saffron Walden. Seen by many to be liberal and forward-thinking, the Act they helped to constitute was in turn largely well received (Moncrieff, 2003; Simpson, 1976; Wootton, 1980). This is not to say, though, that the 1983 MHA was appreciated by all and in full. Importantly, it continued a long tradition of allowing courts to order the compulsory detention of offenders with 'mental impairment' or 'psychopathic disorder'. This was to the frustration of some clinicians given their acute awareness of the potential for the punitive practice arising from the ability to detain people in this way. As clinical psychologist Steve Pilling (who went on to become a major figure in UK mental health) reflected, given its 'tautological definition [. . .] it seems quite possible that patients classified as psychopathic could continue to be detained under the terms of the new act as they were under the old' (Pilling, 1983, p. 93).

Nevertheless, the 1983 MHA did technically increase restrictions on the involuntary hospitalisation of convicted criminals (as well as non-offenders). This was well received by many, and Pilling himself noted that that the legislations would reduce 'some of the potential for abuse of powers to compulsorily admit people' (Pilling, 1983, p. 95). Specifically, it introduced what came to be known as the 'treatability test'. This mandated that an offender could only be held in NHS settings subject to the availability of treatment that was 'likely to alleviate or prevent a deterioration of his [sic] condition'. The 'test' thus sought to ensure that a diagnosis of psychopathy was not by itself sufficient for involuntary hospital detention: the disorder also had to be regarded as treatable. Accordingly, the treatability test came to direct the gaze of mental health professionals working with criminal offenders to the ontology of psychopathy, inviting the question: Could 'psychopaths' be treated?

In the United Kingdom, as in many other national contexts, the treatability of psychopathy had been a matter of enduring contention. A minority position, which maintained that therapy was both possible and potentially efficacious, was an established element of clinical discourse. Still, most clinicians seemed pessimistic. Following the 1983 MHA, forensic psychiatrist Adrian T. Grounds succinctly expressed such pessimism:

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> The detention of offenders in the legal category 'psychopathic disorder' in special hospitals for treatment raises a number of critical issues. There are doubts about the nature of the disorder; what constitutes treatment; who is 'treatable'; the effectiveness of treatment; and whether evidence of psychological change implies reduced risk of reoffending. (Grounds, 1987, p. 474)

The treatability test in the Act invited reflection on these issues, as did the influential third edition of the US nosology, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*), published in 1980. *DSM-III* devoted a major section to personality disorders, and the significance this accorded to them was not lost on UK-based health professionals. Its introduction of the category of antisocial personality disorder (ASPD) was particularly interesting to forensic practitioners due to its apparent overlap with the older category of psychopathy. Furthermore, it had a more specific definition than the opaque construct of psychopathic disorder in the 1983 MHA (and of previous DSM articulations of disorders of sociality; Pickersgill, 2012a). Over time, ASPD came to have increasing traction within the United Kingdom.

Previously, many mental health professionals appeared to have regarded individuals configured as personality disordered as a nuisance – people who were far from being proper subjects of the clinical gaze, even as they remained at its margins. Rather, people with personality disorder were often framed as an impediment to the 'real work' of treating people with discrete mental illnesses (as discussed by Cavadino, 1989). Individuals living under the label of personality disorder were frequently excluded from health services and were often explicitly disliked by practitioners. Such disdain was exemplified in an influential 1988 paper, 'Personality disorder: The patients psychiatrists dislike' (Lewis and Appleby, 1988). This was a particular issue for people characterised with ASPD or psychopathy, given the overarching significance of perceived social deviancy in making such a diagnosis. For clinical psychologist Ronald Blackburn (1988), characterising someone with one of those personality disorders was 'little more than a moral judgement masquerading as a clinical diagnosis' (Blackburn, 1988, p. 511).

Still, as noted, personality disorders remained articulable as conditions that could and should be treated. An influential proponent of this view was community psychiatrist Peter Tyrer, a frequent writer on personality disorders. In 1991, Tyrer and colleagues argued:

> One of the important consequences of better classification and awareness of personality problems is the recognition that people with personality disorders suffer considerably and merit help, even if it cannot always be given

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> in a reliable and effective form. In the past, many therapeutic disciplines have tended to regard personality disorders as not really part of psychiatry's province and that they should therefore be separated from 'real' mental illness. This view is often implicit and rarely finds its way into print but is unfortunately common in practice. Views of treatment are now changing. Psychotherapy in particular, which has always maintained that personality disorders are part of its territory, has persevered in attempts to understand and modify the harmful attitudes that dominate the personal lives and relationships of people with personality disorders, and has helped to transfer this awareness to others. (Tyrer et al., 1991, p. 468)

The preceding quote emphasises both the subjective distress suffered by people diagnosed with a personality disorder and the extent to which this could be ameliorated through psychological therapy. These assertions can be read as simultaneously seeking to de-stigmatise personality disorders and advocate for their treatment. Nevertheless, therapy could be 'long, arduous and difficult to complete' (Tyrer et al., p. 468; see also Stein, 1992; Stone, 1993; Yorston, 1999).

As inspiring as Tyrer's comments might have been to some, other mental health professionals were concerned about the evidence for such claims. In the 1990s, the concept of evidence-based medicine was making its presence felt within clinical communities, and the production of 'hard data' to substantiate claims of treatability was enjoined. As a 1998 editorial in the *British Journal of Psychiatry* asserted, 'There is a need for claims of therapeutic success within the field of personality disorder to be rigorously appraised' (Cawthra and Gibb, 1998, p. 8). These comments echoed psychologist Bridget Dolan and psychiatrist Jeremy Coid in their influential 1993 review of treatments for personality disorders commissioned by the UK Department of Health and the Home Office. While Dolan and Coid (1993) expressed cautious optimism about treatability, they also underscored a need for statistically robust trials to provide firm evidence for the effects of interventions. These long-standing, if relatively subdued, tensions regarding the treatability of personality disorders were revitalised at the close of the 20th century as the UK government moved to reconfigure its mental health policy.

The Advent of Dangerous and Severe Personality Disorder

On 15 February 1999, Home Secretary Jack Straw asserted in the House of Commons (1999) that there was

> a group of dangerous and severely personality disordered individuals from whom the public at present are not properly protected, and who are

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> restrained effectively neither by the criminal law, nor by the provisions of the Mental Health Act [. . .] the government proposes that there should be new legislative powers for the indeterminate, but reviewable detention of dangerously personality disordered individuals [. . .] The individuals concerned must have the best possible chance of becoming safe, so as to be returned to the community, whenever that is possible. (House of Commons, 1999)

Soon after, the concept of 'Dangerous and Severe Personality Disorder' (DSPD) began to circulate widely, leading to a wholesale DSPD Programme imbricating mental health and criminal justice.

Emerging from Whitehall, DSPD was, to be clear, not a formal diagnosis. Rather, it was an emergent administrative category for risky individuals. It was widely regarded as having been animated, at least in part, by the July 1996 murder of Lin and Megan Russell by Michael Stone. A prior offender diagnosed with a personality disorder, Stone was involuntarily admitted into De La Pole Hospital, Hull, in November 1994. He was subsequently discharged in January 1995, following a decision that he was no longer eligible for compulsory detention under the MHA (South East Coast Strategic Health Authority, 2006). Media constructions of a dangerous individual abandoned by mental health professionals as a consequence of legal constraints sat alongside broader public fears about violent crime (Freestone, 2005; Manning, 2002; Prins, 2007; White, 2002). Politicians appeared keen to respond to these concerns.

Sitting under the umbrella of DSPD were people regarded as psychopaths and others meeting criteria for ASPD who were also believed to present a clear and long-term danger to the wider public. Some mental health professionals were highly sceptical about the introduction of this category; clinical psychologist Ronald Blackburn, for instance, argued that the 'idea of a clearly demarcated category of 'dangerous psychopaths' or 'severe personality disorders' represents a disease entity approach which is at best a gross oversimplication and at worst a demonic stereotype' (Blackburn, 2000, p. 2). The political aspect to DSPD was signalled by psychiatrist Peter Tyrer (2001) in his renaming of the category as Jack Straw Syndrome.

Of course, the law has long sought to configure and govern 'risky' or 'dangerous' individuals (Bartlett, 2003). What is pertinent here is that the already broad mandate of the State for defining and managing dangerousness was nevertheless considered too narrow by Straw. He argued that powers for indeterminate detention should be extended, regardless of whether the individual to be detained was currently before the courts. The DSPD proposals therefore represented a radical and controversial step

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by the UK government in the administration of offenders understood to be living with a personality disorder. As such, it also represented a reconfiguration of the activities of mental health professionals themselves.

In July 1999, a consultation paper was released that advanced the possibility of a legislative change that would enable individuals categorised with DSPD to be subject to indeterminate confinement in a special unit within a prison or NHS hospital (Home Office and the Department of Health, 1999). As sociologist Mark Freestone put it, these 'DSPD Units' were intended to be 'a 'third way' between the prison service and the special hospital and as such a unique environment' (Freestone, 2005, p. 450). The Units were to be a place to detain individuals considered to be threats to the wider public while at the same time providing therapy to reduce the risk they purportedly presented.

As an instrument of governance, the DSPD proposals were closely related to the Dutch *Ter Beschikking Stelling* system (de Boer et al., 2008). This was (and remains) an institutional arrangement aimed at managing criminal offenders deemed to be living with particular kinds of mental ill-health, with the aim of decreasing the risk associated with them. The proposed DSPD Units also echoed earlier suggestions made in 1975 by the Butler Committee (McCallum, 2001), and bore a striking resemblance to a recommendation advanced in the so-called Fallon Report (Fallon et al., 1999). Released in January 1999, this detailed the results of an inquiry into drug use, pornography, and possible paedophile activity at Ashworth Hospital (a high-security mental health facility near Liverpool). The report proposed the establishment of special units for individuals with severe personality disorder within prisons and NHS facilities – similar, therefore, to Straw's DSPD Units, and perhaps an inspiration for them (Bartlett, 2003).

Straw's plans were unveiled at a time when significant doubts remained about the treatability of personality disorders. In light of these and with the Stone case in mind, the DSPD Programme was an attempt to remedy the social and clinical problems surrounding individuals configured as severely personality disordered. However, as indicated earlier, the DSPD proposals were widely resented and resisted by mental health professionals (Chiswick, 1999; Eastman, 1999; Haddock et al., 2001; Mullen, 1999; White 2002). Serious concerns were raised by clinicians who were keenly aware of and anxious about their role as agents of social control about a profound shift in professional focus toward public protection. The DSPD Programme was not, however, the only change to mental health policy and practice the government sought to introduce. As the century closed, plans

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were put in place to create what was initially presented as an entirely new MHA for England and Wales – and clinical contestation grew with these.

Changing the Terrain of Mental Health

Toward the end of the 1990s, it was increasingly felt by the UK government that the 1983 MHA needed 'updating'. Accordingly, in September 1998 they charged an expert committee to review the Act. Chaired by lawyer Genevra Richardson, the Committee's proposals – published as the Richardson Report in July 1999 – were widely considered humane and progressive and received favourably by clinicians (Department of Health, 1999b). For instance, the Report enjoined the further enhancement of what was commonly understood to be the 'clear therapeutic ethos' of the 1983 MHA by extending the conditions of the treatability test (Glover-Thomas, 2006; Grounds, 2001).

In November 1999, four months after the release of the Richardson Report, the government published a Green Paper: 'Reform of the Mental Health Act 1983: Proposals for consultation' (Secretary of State for Health, 1999). A key point of agreement between it, the Richardson Report, the DSPD consultation paper, and the Fallon Report was that psychopathy should be removed from the MHA and replaced with the more general category of personality disorder. This was deemed by many to be 'long overdue' (Laing, 2000, p. 223), given that the legal definition of psychopathic disorder was in practice applied to a range of subcategories of personality disorder (like ASPD).

Unlike the Richardson Report, however, the emphasis of the Green Paper was on compulsion: compulsory treatment and compulsory detention. It also rejected many of the Richardson Committee proposals (Bartlett, 2003). For example, in marked contrast to the extension of the treatability test recommended by Richardson, the Green Paper advocated the removal of that test altogether. Furthermore, under its terms, individuals characterised as personality disordered could be detained involuntarily based on risk, irrespective of whether the specific DSPD proposals came to fruition.

Unsurprisingly, then, the Green Paper was heavily criticised by clinicians, as well as by members of the Richardson Committee (Peay, 2000; Szmukler and Holloway, 2000; Zigmond, 2001). As lawyer Nicola Glover-Thomas (2006, p. 32) put it, within the Green Paper, 'risk management has trumped therapeutic endeavour'. Though the 1983 MHA certainly referred to the risk presented by a patient, the Green Paper placed this theme front and centre (Laing, 2000). The foregrounding of risk – and the

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controversy it attracted – characterised the debate on the rewriting of the 1983 MHA over subsequent years.

The Danger of Dangerousness

Notwithstanding the negative reaction to the 1999 Green Paper, the UK government continued with its plans to revise the 1983 MHA and implement the DSPD Programme. In 2001, £126 million had been committed to DSPD service development, and the Programme was being piloted at specialised Units at Rampton Hospital (Nottinghamshire) and HM Prison Whitemoor Prison (Cambridgeshire). The DSPD Programme as enacted was a somewhat diluted version of what had originally been proposed and worked within the ambit of existing legislation. The individual DSPD Units were extremely well resourced, with little expense spared in terms of both their construction and function. High costs were justified in the context of the government's longer-term and imbricated plans for mental health and crime control.

DSPD also formed the explicit focus of a 2000 mental health White Paper, which underscored concerns with personality disorders and dangerousness (Department of Health, 2000a, 2000b). Yet again, the UK government found that its plans were very poorly received. One editorial in the *British Journal of Psychiatry*, for instance, argued that the White Paper was a 'profoundly illiberal document' (Grounds, 2001, p. 387), drawing attention to its inclusion of potentially broader criteria under which offenders could be indeterminately detained via mental health law. A *BMJ* editorial expressed the continuing concerns of clinicians with the government's proposals and highlighted the difficult balance between care provision and risk control (Szmukler, 2001; see also Chiswick, 2001; Gunn and Felthous, 2000). Writing in *The Psychologist*, the 'coercive' dimension to therapeutic work in relation to personality disorders was highlighted by clinical psychologist David Pilgrim and solicitor David Hewitt (2001, p. 527). Readers were reminded that DSPD itself was as a 'politically invented notion' (Pilgrim and Hewitt, 2001, p. 527).

The White Paper was thus criticised across the United Kingdom and in a variety of outlets – and by mental health lawyers as well as clinicians (Peay, 2003). Critique focused on the preoccupation with risk and 'dangerousness' that characterised the document (Buchanan and Leese, 2001) and questioned the meanings of these terms: How would dangerousness be measured? How dangerous would an individual have to be to qualify for the DSPD Programme? How did dangerousness relate to treatability and

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to risk? Representatives from mental health organisations such as the British Psychological Society directly lobbied the government to consider such matters far more carefully (Harper, 2005). However, when in 2002 the government followed up the White Paper with a Draft Mental Health Bill, these persistent (Pfohl, 1978; Wootton, 1959) questions remained largely unanswered.

Curiously, given the government's previous focus on DSPD, the 2002 Draft Bill did not specifically address this category. Still, mental health stakeholders found the Bill to be troubling for a range of other reasons. Not least of these was wording which raised concern that highly antisocial individuals (i.e. individuals who might come under the rubric of DSPD) could more easily be detained involuntarily within mental health services. Significant debate reigned over this point (Pilgrim, 2007). Still, as lawyer Peter Bartlett pointed out, the concept of dangerousness was hardly unprecedented within English and Welsh mental health legislation (or, indeed, to that of many other nations). As such, concerns about social control elided the uncomfortable fact that clinicians had always played a prominent role in configuring and governing deviance. Furthermore, it was 'not obvious' how far the Bill extended existing powers for the detention of individuals who were perceived to be a threat to others (Bartlett, 2003, p. 328). Despite these caveats, Bartlett nevertheless considered the Bill 'badly flawed' (Bartlett, 2003, p. 327) and observed that with it, 'the government managed to achieve a consensus rarely seen in mental health politics. Sadly, the consensus was negative: virtually no one supported the draft bill' (Bartlett, 2003, p. 326; see also Moncrieff, 2003).

Towards Treatability

As debate about the MHA reigned, deliberations regarding the treatability of personality disorders became increasingly apparent. Promissory discourse regarding more efficient and efficacious therapies was instantiated within recently established academic units, such as the Nottingham Personality Disorder Institute, and informal networks and formal associations, such as the British and Irish Group for the Study of Personality Disorder (BIGSPD, formed in 2000). These centres and forums arose from and further animated clinical interest in the aetiology, development, and treatment of personality disorders.

At the same time, public spending on personality disorder services and research significantly increased, supported by bodies such as the UK Medical Research Council, the Department of Health, and the DSPD

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Programme. One emergent sponsor was the National Forensic Mental Health R&D Programme, established in April 1999 (three months before the release of the initial joint Home Office/Department of Health proposals for DSPD). The Programme commissioned literature reviews into the aetiology and management of personality disorders, as well as research on behalf of the Department of Health. In so doing, it became a key funder of personality disorder research.

Still, the proliferation of research and the promise of new treatments for personality disorders did not readily foster a unified front of clinical enthusiasm: views remained mixed (e.g. Chiesa et al., 2000; Haddock et al., 2001; Kendell, 2002). Nonetheless, while some expressed doubts about treatability, an increasing number of clinicians wrote articles and produced commentaries that pointed towards effective interventions. The London-based 'therapeutic communities' at Cassel and Henderson hospitals were, for instance, highly regarded for their effective work with individuals diagnosed with a personality disorder (Manning, 2002). In particular, psychological strategies more broadly were viewed with optimism – partly as a consequence of a growing evidence base (e.g. Bateman Fonagy, 1999; Chiesa Fonagy, 2000; Mullen, 1999). Influential Broadmoor-based psychotherapist Gwen Adshead summed up the view of many when she wrote in 2001 that there could be 'no justification for global assertions that personality disorder is untreatable' (Adshead, 2001, p. 412).

Particular faith was placed in the psychological techniques of cognitive analytic therapy (CAT) and dialectical behaviour therapy (DBT, an approach based on CBT). Hopes for these interventions increased during the first few years of the 21st century, even as the number of RCTs remained low. Pharmaceuticals, such as antipsychotics and antidepressants, were also being used as 'adjuncts' to the psychological treatment of personality disorders (Sushovan Tyrer, 2001; Triebwasser Siever, 2007). This mixing of modalities brought into sharp relief the ontological plurality so often evident within mental health (Helén, 2011; Pickersgill, 2010).

Clinicians were urged to forego the notion of a 'fix all' for personality disorder and to concentrate instead on the 'functional assessment' of the condition (Davidson, 2002). The functional approach produced an increasingly modularised view of personality, first by cataloguing an individual's particular 'abnormal' personality features and exploring the distress experienced as consequence of them, second by using those catalogued features as the basis for a complex management plan. This would be 'bespoke' rather than 'off the peg'; individualised but nevertheless drawing on an eclectic array of existing interventions (Hogue et al., 2007; Livesley, 2007).

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At the turn of the century, then, a variety of key actors were beginning to configure personality disorders as potentially plastic – capable of responding to the appropriate and skilled application of therapeutic knowledge. This positivity, though, was not without nuance or caveat. For example, Rampton Hospital psychologist Kevin Howells and his colleagues suggested that different models of disorder lay beneath the assorted treatment strategies, raising questions about appropriateness and efficacy (Howells et al., 2007). Concerns also circulated that many of the treatments touted for a broad spectrum of personality disorder had shown evidence of effects only for the category of borderline personality disorder (Crawford, 2007). Furthermore, as Bartlett (2003) wryly observed, predictions about treatability seemed to relate more to the person doing the predicting than the person about whom predictions were made.

While the mental health professions undoubtedly were moving toward an understanding of personality disorders as treatable, there was by no means a consensus. Conflicting feelings and perspectives continued to circulate, even – as noted by psychologist Tony Lavender (2002) – within DSPD services themselves. Indeed, as a British Psychological Society (2006) report reflected, some doubted whether the concept of personality disorder was useful within clinical practice at all. Yet, it was precisely because the tide of opinion on personality disorders was so clearly turning that some commentators felt compelled to advance concerns and to demarcate limits to therapeutic knowledge and the potential for change.

A Policy Push

While clinicians at the coalface of practice were starting to write positively, albeit cautiously, about the treatability of personality disorders, there was markedly less subtlety in some of the proclamations made by the UK Department of Health and associated bodies. For instance, its National Institute for Mental Health in England (NIMHE) published a report, *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE, 2003a), arguing that personality disorders were treatable. Any remaining doubt about this was regarded as lamentable, and something that a future MHA might address. The controversial proposed removal of the 1983 treatability test was characterised as 'highlight[ing] the need for new community and in-patient services for people with personality disorder' (NIMHE, 2003a, p. 28). Mental health professionals were encouraged to be more open-minded to the potential of treatment in light of this.

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Ten months later, the NIMHE released the provocatively titled *Breaking the Cycle of Rejection*: *The Personality Disorder Capabilities Framework* (NIMHE, 2003b). This aimed 'to challenge the discriminatory association between personality disorder and dangerousness by putting in place services aimed at reducing vulnerability and promoting more effective coping by individuals' (NIMHE, 2003b, p. 10). It further promoted a vision of treatability by painting a more sympathetic picture of people with personality disorder than many others – not least the UK government itself – had in the past:

> In recent years, the emphasis on risk and dangerousness associated with a very small number of people with personality disorder, has obscured the fact that very many people with this diagnosis are highly vulnerable to abuse and violence themselves – and to self-harm and suicide. (NIMHE, 2003b, p. 10)

While the NIMHE document alluded to the MHA in its section on 'The broader policy context', it refrained from more explicit articulation of the interconnections between the assumed clinical antipathy towards personality disorders and the proposed MHA (specifically, the provision that would remove the treatability test). The controversial category of DSPD was not even mentioned. Nevertheless, the influence of both DSPD and the 2002 Draft Mental Health Bill was evident in the list of competencies deemed necessary for clinicians working with individuals diagnosed with personality disorder, particularly skills in 'assessing and managing risk to self and others'. Risk – the leitmotif of the proposed reforms to the 1983 MHA – thus structured the NIMHE clinical guidelines, even as the same document made gestures towards destigmatisation.

The year 2003 also saw the publication of a treatment review commissioned by the Home Office and Department of Health through the DSPD Programme (Warren et al., 2003). The review, conducted by a team of psychologists (including Bridget Dolan) and psychiatrists, aimed to provide an evidence base for 'informing the decisions about the development of services for DSPD' (Warren et al., 2003, p. 8). Building on the prior treatment review by Dolan and Coid (1993), the 2003 'update' came to similar conclusions; namely, that personality disorders were (potentially) treatable, especially through the application of therapies such as DBT and therapeutic community models. Among their five recommendations, Warren and colleagues asserted that 'Greater priority should be given to research into the treatment of personality disorder, given the paucity of the evidence currently available' (Warren et al., 2003, p. 7). The review thus

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contained a message to which both policymakers and many clinicians were receptive: therapy was possible, but more research was needed.

In sum, through 2002 and 2003, the development of policy and clinical discourse on personality disorders brought the treatability of these conditions into sharp focus. Seemingly in recognition of the controversy it had generated, and mindful of its aims to successfully implement DSPD policy, the Department of Health sought to ally itself with practising clinicians. It did this by evoking tropes similar to those that had become increasingly evident within mental health discourse – chiefly those seeking to destigmatise personality disorders and to configure them as treatable – and articulating these within the pages of key policy documents. These texts were aimed, in part, at fostering a more favourable outlook towards the proposed mental health legislation. In the process, the hopes of clinicians were brought more closely into alignment with the aims of policymakers.

How to Treat Dangerousness

The alignment of policy and clinical goals was most markedly apparent in the DSPD Units. By the autumn of 2005, four high-security pilot DSPD Units were running, which contained 'some of the most difficult and challenging individuals in society' (DSPD Programme, 2005, p. 27). Two Units were inside prisons (HMP Frankland and HMP Whitemoor) and two were within NHS hospitals (Broadmoor and Rampton). Generally speaking, the prison Units stressed the correctional aspects of the DSPD Programme, whereas the hospitals focused more on its therapeutic dimensions. However, even within DSPD Units, tensions existed between carceral and clinical approaches (Freestone, 2005; Maltman et al., 2008).

In Broadmoor and Rampton hospitals, treatment was administered by multidisciplinary teams consisting of clinical and forensic psychologists, psychiatrists, nurses (who comprised the bulk of the workforce), and a range of other staff (Ministry of Justice, 2011). At Rampton, a psychologist undertook an initial treatment needs assessment (TNA), which preceded a detailed, multidisciplinary formulation and thereafter an 'agreed set of prioritizations of treatment needs' (Hogue et al., 2007, p. 65). Therapies offered included the aforementioned DBT and CAT, with CBT initially particularly emphasised by Broadmoor (Perkins et al., 2015), alongside therapeutic group work and a range of structured skills programmes.

Multiple professionals worked together to simultaneously implement DSPD policy and treat what was seen as the psychological and social deviancy of people categorised with personality disorder. While treatment

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was aimed at reducing offending behaviour, many clinicians were concerned to treat 'the person in personality disorder'. In practice, this meant a more expansive therapeutic vision than a clinical focus restricted only to managing those aspects of an individual that were (in the modularised vision of personality) assumed to be associated with criminal antisociality. It also implied everyday patient life as itself having the potential to generate therapeutic effects. As Broadmoor-based clinical and forensic psychologist David Perkins asserted with colleagues in a paper reflecting back on the DSPD Unit there:

> Day-to-day interactions on the wards play out the PD [personality disorder]- linked patterns of relating to others, and therefore these daily interactions in themselves offer opportunities for corrective experiences. Integrating this with more formal psychological therapy enables a more holistic service and one that helps to integrate a sense of self. (Perkins et al., 2015, p. 16)

While, as we have seen, medication might be used as an adjunct, psychological therapies were salient for the treatment of personality disorders. These were later also emphasised in UK clinical practice guidelines as treatments for both ASPD (NICE, 2009) and borderline personality disorder (National Collaborating Centre for Mental Health, 2009). Several years later, guidance to practitioners working with criminal offenders regarded as personality disordered continued to emphasise psychological approaches to treatment and management (National Offender Management Service/NHS England, 2015). Alongside DBT, CBT – which was commonly employed in the probation service and, as noted, used within Broadmoor – also came to be more widely considered as a noteworthy intervention (de Boer et al., 2008; Maden, 2007). As Armstrong (2002) has argued, CBT can readily be made to serve both punitive/carceral and therapeutic/clinical ends: it is retributive (individuals are held accountable for their antisocial behaviour) while also being rehabilitative (antisocial actions decrease following therapy). It is thus particularly well-suited to forensic mental healthcare.

The nature and role of treatment in DSPD Units underline three central issues. First, these were sites where the goals of policymakers and clinicians were closely aligned: policymakers could be satisfied that the risk dangerous offenders represented was being reduced, while psychologists, psychiatrists, and others were given the time and resources to follow a therapeutic imperative to treat individuals diagnosed with a personality disorder. Second, the autonomy of clinicians within DSPD Units complicates the presumption of the unilateral political capture of clinical goals

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that might be inferred from the previous section. That some psychiatrists and psychologists framed their work as treating personality disorders rather than solely managing risk reveals a more dynamic, though still asymmetric, relationship between the aspirations of policymakers and those of healthcare professionals. Third, the activities of the DSPD Units had subtle yet important implications for wider configurations of personality disorder. With few established conventions regarding the 'correct' way to treat these conditions but with a remit to do so regardless, clinicians in the DSPD Units employed different forms of therapy. The various treatments relied on diverse underlying models of personality disorder, and their juxtaposition thus (re)assembled heterogeneous models of the conditions. In essence, the DSPD Units acted as laboratories within which the ontology of personality disorder could be experimented with, and they played a salient role in configuring the category as treatable.

The Arrival of an Act

Despite these developments, many professionals continued to contest the UK government's evolving plans for mental health law. As we have seen, the 2002 Draft Mental Health Bill did not garner the support the government had hoped. It was, in the end, withdrawn, and another Bill was released in September 2004 (Department of Health, 2004a). Somewhat less controversial than its predecessor, the Bill marginally mollified detractors by reintroducing some treatability criteria for cases where involuntary compulsion was being considered. Despite this move, it was still critiqued for its emphasis on risk. Furthermore, some of its detractors claimed that the Bill ignored, for the most part, the views of mental health institutions. This was interpreted as exemplifying the indifference of the UK government both to the clinicians who would implement the MHA and the individuals who would be under its purview (Brown, 2006).

The government, however, considered that it had 'taken seriously the concerns raised about the first version of the draft Bill' (Department of Health, 2004b, p. 4). Still, it refrained from pushing the second Bill forward. Seemingly in response to the massive criticism levelled against it over the previous seven years, the Department of Health instead made a different move. Specifically, it announced in March 2006 that, rather than completely replacing the 1983 MHA, it would instead amend it (Brown, 2006). Accordingly, on 18 November 2006, a third Mental Health Bill was released (Department of Health, 2006a).

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Predictably, the 2006 Bill was hardly uncontentious, not least since, like its predecessors, it forsook the treatability test. According to the Department of Health, this was because the test had led

> to a false presumption that some – particularly those with severe personality disorders – are untreatable. This means that detention is sometimes not used when it ought to be, even though people with severe personality disorders can be – and are – treated compulsorily under the Act. (Department of Health, 2006b, p. 3)

By removing the treatability test, the legislation arising from the 2006 Bill would, clinicians and others were reassured, 'take away some unnecessary obstacles to practitioners' ability to use the Act where it is warranted by the needs of the patient and the degree of risk' (Department of Health, 2006b, p. 3). In essence, the government was arguing that treatment, largely psychological in nature, was being unfairly denied to people who would benefit from it.

The treatability test was not completely abandoned, however. Rather, it was reconfigured into the 'appropriate treatment test'. Similar to the 1983 treatability test, this revised set of criteria for detention included the key qualification that treatment should be readily 'available' rather than merely being a theoretical possibility. The appropriate treatment test would, apparently, call for 'an holistic assessment of whether appropriate treatment is available, not focused only on the likely outcome of treatment' (Department of Health, 2006b, p. 3). Psychological therapies were explicitly highlighted as coming within the purview of what the legislation would define as 'medical treatment', since 'To exclude them would be inconsistent with the reality of mental health care and might inadvertently encourage the use of medication even where there are more appropriate alternatives available' (Department of Health, 2006b, pp. 2–3).

By removing the treatability test and replacing it with the appropriate treatment test, the Department of Health sought to ensure that people who 'should' be involuntarily detained could be legally held, but with safeguards in place: at least some kind of treatment needed to be available. Nevertheless, what, precisely, a 'holistic assessment' entailed was unclear. So, too, was the procedure for establishing – or formally contesting – whether a particular treatment was 'appropriate'. Moreover, many commentators were concerned that the Bill illegitimately conflated 'appropriate' with 'effective' treatment; in other words, that individuals could be detained as a consequence of *some* kind of treatment being available, irrespective of whether it was the *right* kind.

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Despite these concerns, the Bill was eventually passed with some modifications. Thus, after almost a decade of political wrangling, a revised MHA for England and Wales was given Royal Assent on 19 July 2007. In marked contrast to the original plan for a radical reconstruction of the 1983 Act, the 2007 legislation was an amended and revised version of its predecessor. The chief detractors of the Department of Health were, for the most part, more or less mollified. Not surprisingly, though, some discontentment continued to be registered (Prins, 2007).

Personality Disorder Is Treatable

On 22 June 2007, one month before the 2007 Act received Royal Assent, the National Forensic Mental Health R&D Programme officially closed. Given the emerging consensus on the treatability of personality disorder, the UK government seemed no longer to feel the need to continue to invest so significantly in research through this dedicated mechanism. As Frankie Pidd of the Department of Health's National Personality Disorders Development Programme commented in an article co-authored with psychologist Janet Feigenbaum:

> The evidence base has emerged over the past two decades to indicate that personality disorders are treatable. A range of psychological therapies has been shown to be the most effective treatment for personality disorders, though medication can have some additional effect in reducing the severity of symptoms. (Pidd and Feigenbaum, 2007, p. 8)

In highlighting this emergent evidence base, the comments above also tell a story of epistemic progress – reflected too in a British Psychological Society report on treatments for personality disorder (BPS, 2006), alongside various other opinion pieces and research articles. Though Pidd and Feigenbaum accepted that some clinicians might disagree, they asserted that this was based on a 'false belief' (Pidd Feigenbaum, 2007, p. 7) and, worse, one that would increase the stigmatisation of individuals diagnosed with a personality disorder. Pidd and Feigenbaum therefore evoked a discourse of destigmatisation, consistent with the trend in the mental health professions since at least the 1990s (Pilgrim Rogers, 2005), which was especially apparent in recent years in discourse centred on personality disorders. In so doing, Pidd and Feigenbaum presented not only a therapeutic imperative to work with individuals labelled thusly but a moral duty as well.

More widely, journals such as *Psychology, Crime and Law* devoted entire issues to contributions on personality disorder, many of which illuminated

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the treatability of these conditions. As highly regarded psychologist Peter Fonagy noted in the introduction to one special issue, clinicians should 'celebrate the emergence' of 'effective' interventions (Fonagy, 2007, p. 3). For internationally celebrated personality disorders expert John Livesley, the literature was now 'clear that personality disorder can be treated' (Livesley, 2007, p. 28).

Beyond Treatability

If today personality disorder has been authorised as treatable, with psychological therapies underscored as central modalities of intervention, so too has the category come to be increasingly 'psychologised'. In line with the wider trends in clinical psychology discussed in Chapter 1, practitioners increasingly speak through an idiom of 'complex emotional needs' or 'personality difficulties' (Trevillion et al., 2021). This includes within forensic contexts (Moran et al., 2022; NHS England, 2023a). Such talk moves further away from what many see as the more psychiatric language of 'disorder'. However, this de-medicalising shift would have been unimaginable without the efforts made to configure personality disorders (or difficulties) as treatable in the first place (and not least by psychiatrists), and thus as a proper target of psychological intervention.

Over time, services have increased, and the policy focus on personality disorders has expanded even further beyond the criminological considerations that once anchored so much debate (McBride, 2017). Yet, the widespread reconfiguration of these categories as treatable never led to a panacea. The patchy provision of psychological care for people characterised as having a personal disorder remained (Royal College of Psychiatrists, 2020; The Consultation and Advocacy Promotion Service, 2011), and stigma and discrimination endure (Bax et al., 2023; Bonington Rose, 2014). Moreover, there are indications that the appropriate treatment test resulted in an increase in length of involuntary detentions for people diagnosed with a personality disorder who are based within the criminal justice system (O'Loughlin, 2014). The ramifications of an ethic of access, then, are not necessarily always positive or straightforward.

With regards to the DSPD Programme more specifically, this initially continued to expand following the 2007 MHA. By 2008, alongside the original four high-security units, four medium-security units and some community services for DSPD were in operation (de Boer et al., 2008). The costs, though, were significant. Following the 2008 financial crisis and a 2010 general election, the Conservative-led UK government came to

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reflect on just how much cheaper it was to undertake the treatment of offenders with a personality disorder within prisons rather than hospital-based DSPD Units (Department of Health/NOMS Offender Personality Disorder Team, 2011). The DSPD Programme was thereafter scaled down, before finally coming to an end in 2013 (Tyrer et al., 2015). In its wake, the Offender Personality Disorder (OPD) Pathway was launched (O'Loughlin, 2014). This 'is a set of psychologically-informed services operating across criminal justice and health' (NHS England, 2023a). Upon establishment, the OPD Pathway sought to expand access to treatment while, in the eyes of some, diverting resource away from special hospitals (Player, 2017). It, too, has had subjectifying effects, helping to further circulate psychological and psychiatric concepts within the criminal justice system (McBride, 2017).

As for the MHA, it is – again – being reconsidered. In 2017, an Independent Review of the Mental Health Act was announced, chaired by Professor Sir Simon Wessely of King's College London. A resulting 2018 report highlighted, among other issues, a rise in detentions under the 2007 Act (Wessely, 2018; see also Wessely et al., 2018). Wessely argued that 'looking back we can see that some of the decisions taken by government leading up to the 2007 Act were an overreaction' – with the concept of DSPD implied as an example (Wessely, 2017, p. 7). Subsequently, a further Mental Health Bill was promised (Department of Health and Social Care and The Rt Hon Matt Hancock MP, 2021), although this was acknowledged to have progressed more slowly than expected (Department of Health and Social Care, 2021). A draft Bill was ultimately published in June 2022 (Department of Health and Social Care and Ministry of Justice, 2022), and the following month a Joint Committee on the Draft Mental Health Bill was appointed by the House of Commons and the House of Lords to consider it in more detail. In January 2023, the Committee published a report responding favourably to some elements of the Bill (Joint Committee on the Draft Mental Health Bill, 2023). This included how the Bill had reconfigured the appropriate treatment test in light of the critique it had attracted: to underscore therapeutic benefit rather than merely the availability of therapy. However, despite high hopes, the year 2023 concluded with no announcement that the Bill would make its way into law. This was to the considerable chagrin of many clinicians and people with lived experience of mental ill-health (BPS Communications, 2023; Mind, 2023).

With the arrival of another (Labour) government in 2024, a revised Mental Health Bill was produced in November of that year (Department

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of Health and Social Care, 2024). This was generally met with optimism, after several years of frustration. One of the actions that the Bill aimed to achieve, and perhaps a legacy of the political and legal debates discussed earlier, was 'supporting offenders with severe mental health problems to access the care they need' (Prime Minister's Office, 2004, p. 84). As a news item in the *BMJ* remarked, mental health charities, on balance, 'hailed' the Bill, yet nevertheless 'emphasised the need for investment in services and buildings' (Dyer, 2024, p. 1). These concerns were mirrored by clinicians (Goddard, 2024), who – like Roman Raczka, President of the British Psychological Society – highlighted the need to invest specifically in the therapeutic workforce as part of programme of funding (BPS Communications, 2024). At the time of writing, the Bill has not yet progressed to law. Accordingly, its ramifications for access to care and the ontology of personality disorder remain ambiguous.

Configuring Law and Practice

Reported inside journal pages, argued through presentations in large conferences and small seminars, and attested to by healthcare professionals, claims about the treatability of personality disorder resound powerfully through clinical discourse. This chapter has explored how personality disorders came to be broadly deemed legitimate sites of effective therapeutic action – how they became 'treatable'. In doing so, I have sought to highlight how in some cases access to therapy can be shaped by interlocking penal and clinical concerns in the context of disquieting political demands.

While law is a powerful tool for ordering the social, debates over legislative changes cast into sharp relief the ambiguities legislative mandates and processes are designed to manage. They also illustrate how law participates in configuring the ontologies of the entities upon which it acts (Cloatre, 2013; Seear, 2020). Attempts to rewrite the 1983 MHA directed attention to long-standing problems associated with the category of personality disorder and those characterised with it, animating clinical discourse. Moves to remove the treatability test from the Act to facilitate detentions were particularly controversial, resulting in backlash against successive bills. Yet, revised legislation seemed more palatable after those plans were diluted and individuals labelled with personality disorder were reconfigured as patients who could – and should – access therapy. While the government profited from this revised understanding, so too did clinicians who had long held that belief – including through professional

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acceptance and direct support in terms of funding and employment opportunities (Manning, 2002).

Professional perspectives can, at times, have significant influence on mental health policies (Grob, 2008; Prior, 1991; Schatzman Strauss, 1966), and in the United Kingdom practitioners mobilised alongside others to contest and eventually influence the 2007 update to the 1983 MHA. In so doing, they shaped the law that would govern their practice. This underscores the capacity of clinicians to purposefully torque the psychological matrix (Rose, 1985) wherein they operate, and which itself subjectifies them and configures the nature of their professional work. We can see too that while mental health law, policy, and practice sometimes operate antagonistically (Greig, 2002), they are also reciprocally configured, with potentially significant effects on the persons acted upon by these (Pickersgill, 2013).

Access to therapy is not just about providing more services or enhancing throughput within these of people seeking psychological care. It also entails the classification and subjectification of particular people as in need of therapy (Hacking 1995, 2002), with the disorder to which they are ascribed configured as malleable through the application of therapeutic expertise. The significant shift vis-à-vis treatability that occurred for personality disorders has been a direct consequence of the interactions between, and reciprocal contouring of, professional and policy debates, moral and epistemic discourse, and law and clinical action. Attention to these reveals how regimes of normativity (Pickersgill, 2012b), mental health praxis, and the psychological per se can be (re)configured together. This, in turn, implies urgency for even deeper consideration of what kinds of legislative and therapeutic futures we want.

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