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Report on the first cohort of prisoners that completed treatment in the Fens Unit, Dangerous and Severe Personality Disorder Unit at HMP Whitemoor

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Introduction

Towards the end of the 1990s, there was a recognition that there was a particular group of men for whom no services were available, in prison or the NHS, that would enable them to reduce the risk that they posed. These men were those with a diagnosis of severe personality disorder whose offending was linked to their personality psychopathology. These men were particularly likely to commit interpersonal offences, including serious sexual and physical violence, manslaughter and murder. The 1999 government manifesto, attempted to address this need and consequently, four high secure units were set up; two in hospitals, Rampton and Broadmoor, and two in prisons, Whitemoor and Frankland, to assess and treat men with severe personality disorder who were deemed to be at being at a high risk of reoffending in a form that would caused significant harm, both physical and psychological to another person. The aims of these units were to —

- ensure high quality detailed risk assessment to protect the public from some of the most dangerous people in society
- provide high quality services for the individuals themselves to improve their health outcomes
- reduce the risk that they pose and enable them to work towards successful integration into the community or to be able to be detained at the lowest level of security without harm to others.

These units became known as the Dangerous and Severe Personality Disorder or DSPD units. Whilst the assessment and criteria for admission to the units were centrally set, as the evidence base of best practice with this client group was minimal, each unit developed different treatment programmes under the scrutiny of an expert advisory panel. Consequently, the make-up of the staff teams differed depending on the treatment being delivered, and consequently the costs of running the units the run; each hospital place costing approximately 3 times the cost of a prison place. Interestingly however, research undertaken as to the characteristics of the men in these establishments indicates that the men in the prison units tend to have committed more serious offences, and that those at The Fens Unit, HMP Whitemoor tend to have higher levels of personality psychopathology and also greater levels of mental health problems than those men in the hospital units (Burns et al, 2010)[1]

The unit at HMP Whitemoor has now completed treatment for its first cohort of prisoners. It is too soon to look at the key outcome data, namely reoffending rates, but there is an overall trend that shows a reduction of risk based on specific risk measures. This is a descriptive article and sets out to describe the unit at HMP Whitemoor and the treatment it offers, and then to use this first cohort of men as an exemplar of how they responded to the service they were offered.

The Unit

The Fens Unit at HMP Whitemoor is not a purpose built unit but is an adapted prison wing. It has no special facilities; cells on the top landing have been converted into individual treatment rooms and offices; association rooms become group rooms during the working day and all other facilities are shared with the rest of the prison. The unit has the capacity for 65 prisoners in assessment and treatment, equally distributed across three spurs and 5 prisoners in progression places. There is also a small crisis suite of 3 safer custody cells and a gated cell. The crisis suite is used when prisoners are in a state of crisis (as often occurs in effective therapy) so that they can access additional support in a smaller unit.

The Prisoners

The men who are most likely to meet criteria for these services are almost always 'a management problem'. Most of the men who have come through the service have been violent in prison, many have spent years in and out of segregation and some have come out of the Close Supervision Centres (CSCs). They have been responsible for numerous assaults on staff and other

1. Burns, T., Yiend, J et al (2010) IDEA Resaerch undertaken in the High Secure DSPD Sites for the Ministry of Justice.

prisoners and regular damage to property by smashing and/or burning out cells. They have caused significant operational management issues for Governors and affecting adversely, the regime/quality of life for the majority of prisoners. Some become psychotic and delusional when they are under extreme stress. All suffer significant emotional distress that the have previously managed by offending and/or developing drug and alcohol addictions by attempting to self-medicate the symptoms associated with their personality disorder. Some have long histories of self-mutilation and suicide attempts. A strategy that such prisoners use, is to be in and out of gated-cells and healthcare; regularly taking overdoses, use ligatures or deep self-lacerations. Prisoners with severe personality disorder are also prone to conditioning staff and several have developed inappropriate relationships with officers, teachers, nurses and/or psychologists.

Offending Behaviours

The men who reach criteria for the service most often begin offending at a young age. They tend to commit a diverse range of offences which increase in seriousness. Their index offences are predominantly murder, manslaughter, extreme violent assaults, rape and/or sexual assault but most have committed more than one such offence. Chart 1 indicates the index offences for the first cohort that completed the treatment programme.

CHART 1
Index Offences

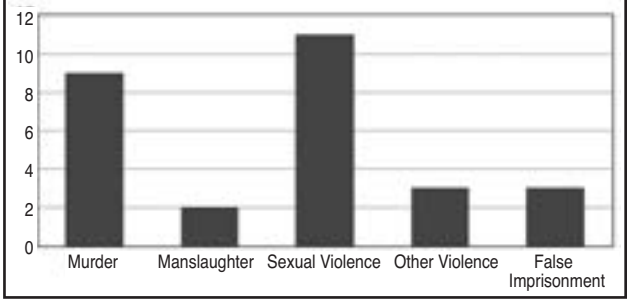
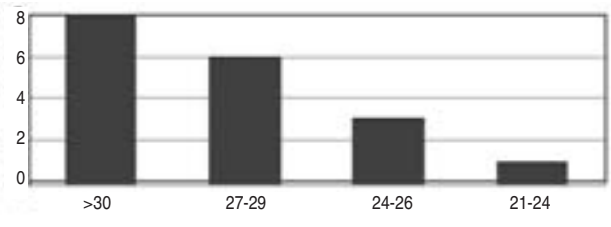


CHART 2
Prisoners' Scores on Psychopathy Checklist (PCL-R Scores)



Assessment

On The Fens Unit assessment is carried out by taking in groups of 6 to 8 men onto the unit. Assessment consists of undertaking a review of all collateral documents available on each prisoner, individual interviews with prisoners conducted by psychologists and a psychiatrist and daily officer-led group-work. The purpose of the group work is to closely observe and record the prisoners interpersonal behaviour and for the prisoners to learn to work in a group and to establish group identity. The process takes 16 to 20 weeks. To meet criteria the prisoner must: —

- ❒ be a high risk of reoffending (measured by Risk Matrix 2000, Static 99, VRS, HCR-20, and SARN)
- ❒ have a severe personality disorder (measured by IPDE and PCL-R)
- ❒ have a link between his personality pathology and the offences he commits (assessed by the combination of detailed offence analysis and clinical developmental history).

Those who reach criteria carry on working together as a group throughout treatment. Those that do not reach criteria or who refuse a treatment place are returned to the referring prison with a detailed assessment report. The following **charts 3-5** indicate the major findings for the first cohort of prisoners who completed treatment.

These statistics indicate that these are a particularly difficult group of men. They present at a high risk of reoffending yet their personality psychopathology would exclude them from standard prison programmes. They are therefore exactly the group that the service was set up to treat.

Treatment Programme

Whilst traditional accredited prison treatment courses work well for many offenders to help reduce their offending behaviours, men who reach criteria for treatment within the Dangerous and Severe Personality Disorder Units have either been excluded from those accredited prison programmes by virtue of their personality psychopathology (PCL-R Score exceeding 28) or have completed standard offending behaviour programmes and yet are perceived to continue to pose a high risk of re-offending. The treatment programme devised was rigorously scrutinised and agreed by an International Group of Experts in this field and thus has been subjected to similar analysis to accredited prison programmes.

As offending behaviour and level of risk is connected to personality pathology, unless that personality pathology is addressed, at times of stress

CHART 3
The Range of Personality Disorders Diagnosed in the Prisoner Group

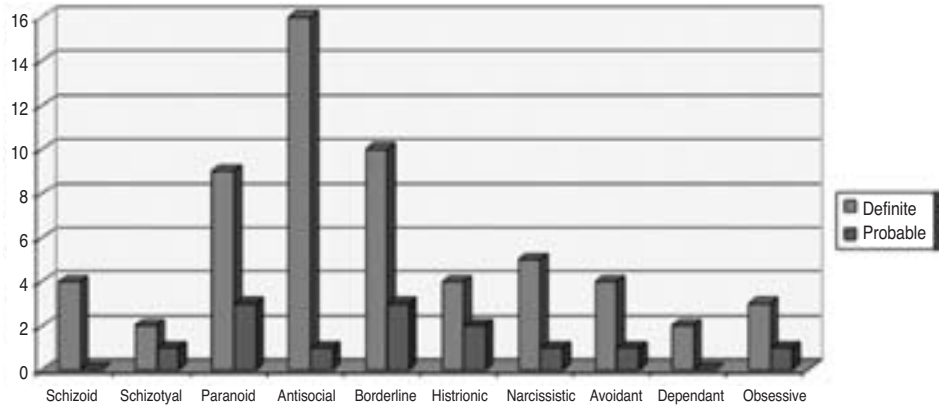


CHART 4
Risk Measures on Risk Matrix 2000

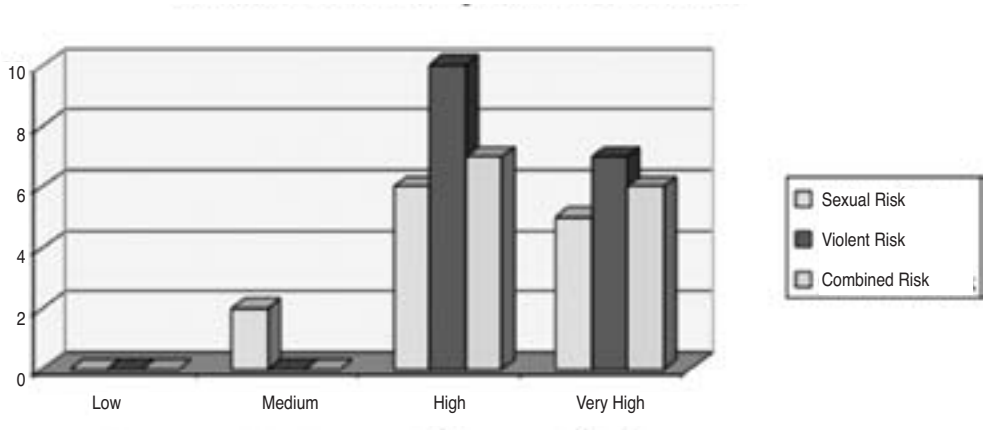
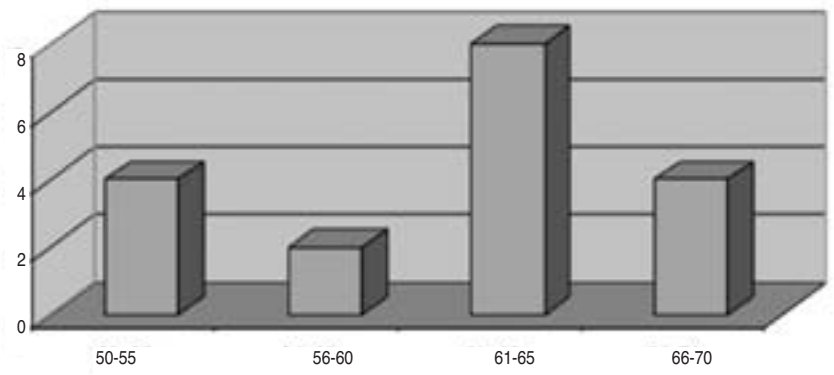


CHART 5
Initial VRS Scores of the Prisoners in this Group



such men will resort to previous behaviours. Therefore for risk reduction that is generalisable across environments, personality psychopathology must be treated and not just managed. Personality disorder is a constellation of coping strategies that a person develops as a response to developmental experience. There are manifest dysfunctions of thinking, feeling, behaviour and interpersonal relationships. As the offending is linked to those areas of dysfunction, the programme aims to address the developmental experiences that generate those areas of dysfunction. Thus throughout the programme on The Fens Unit, those aspects of the personality that lead to offending for each individual are assessed and the remedial therapeutic experiences directly address the aetiological personality characteristics that have resulted in the offending behaviours. Consequently work on each prisoner's offending behaviours is individually formulated to include a developmental psychopathology with detailed assessment of factors that will increase and those that will decrease risk. There is an individual assessment of the motivations to offend, at cognitive and affective levels, defining, directly observing, challenging and recording parallel offending behaviours. Those factors that increase risk for that individual become treatment targets and the interventions are intrinsic to every aspect of the programme. Each of these factors has been identified for each prisoner and these areas are worked on in both formal interventions (described below) and on a daily basis by officers on the landings and workshops who observe and address his behaviours. These daily observations are communicated at debriefing so there is constant monitoring of his behaviours, beliefs and emotional regulation. The offences that the men on the unit have committed are directly interpersonal offences — therefore the treatment model is cognitive interpersonal. This theoretical model is based on a holistic model of human functioning where it is believed that the personality characteristics a person develops are a result of the interaction between genetic predisposition and experience.

The aim is to develop boundaried relationships with prisoners through which they can experience reparative interventions that will affect all aspects of their functioning. This requires that the prisoners experience change *at the level of affect*; this means at an emotional level, not merely on a cognitive and behavioural level. The programme involves the following components —

Individual Therapy (IndT) — This starts immediately the prisoner enters treatment and focuses on the development of an attachment relationship in which the aetiological factors of the personality disorder can be explored and addressed, working therapeutically at the level of affect. This allows the prisoner to experience empathy at the level of affective attunement (feeling with the person) rather than solely at the level of verbal cognitions. During the individual therapy every aspect of the person's life past, present and future are addressed. Importantly, all areas related to offending are thoroughly explored in depth and at an emotional, as well as cognitive level. To work at the emotional level is vital if real sustaining change is to be brought about.

Personality disorder is a constellation of coping strategies that a person develops as a response to developmental experience.

Personality Disorder Awareness Group Weekly sessions for 25 weeks, facilitated by therapists and prison officers. This is mainly a psycho-education group to help prisoners understand their disorders.

Cognitive Interpersonal Group Therapy (CIGT) This is an unstructured psychotherapy group which focuses on the interpersonal relationships between all involved in the groups including the facilitators, making explicit the connection between the behaviours, cognitions and emotions within those relationships and connection between relationships and offending. This group also aims to develop a sense of connection between group members, for prisoners to be able to challenge each other and to allow self to be challenged regarding their distorted beliefs about themselves and others and to find ways to resolve conflict with others in a healthy manner. This group also focuses on the prisoner's ability to take emotional responsibility for his maladaptive behaviours in both the past and in the present by understanding the process of parallel offending and make positive changes to reduce such strategies.

Schema Focused Therapy Group (SFTG) Schemas are underlying beliefs developed through experience which have a powerful (mostly unconscious) influence on behaviour. Groups educate prisoners about distorted schemas which are connected to offending and how these schemas are maintained. Groups will shift from education and awareness-raising to more active challenging of distorted beliefs and methods of behaving in order to maintain these beliefs. Thus this group aims to enable the prisoner to be able

to identify his own patterns of behaving, thinking and feeling (schemas), which contribute to and maintain their maladaptive behaviours; to challenge maladaptive schemas that result in distress and difficulties in life and to change schema-driven behaviours, particularly those associated with offending.

Affect Regulation Therapy Group (ARTG) This starts as educative, raising the prisoners' awareness of their affective states and enabling them to be accurately able to identify the emotions they are experiencing, then shifts towards providing further skills for appropriate regulation of affective states. Prisoners are encouraged to challenge their over-reliance upon one affective state and avoidance of other emotions. Emphasis will be placed as much on those that use repression and dissociative strategies to deal with emotional arousal as on those who appear to have explicitly high levels of emotional arousal. Thus this group aims to facilitate the prisoner to regulate emotion, to recognise when he is diverting one emotion into another and the role of emotional dysregulation in offending. It also aims to help prisoners manage affect adaptively, experience and demonstrate empathy at the level of affect. Importantly it facilitates the prisoner to manage affect more adaptively rather than convert all vulnerable emotion to anger and engage in offence-related fantasy and behaviours. After the group work, there are 10 sessions of individualised skills training and practice sessions to consolidate the group work.

Importantly it facilitates the prisoner to manage affect more adaptively rather than convert all vulnerable emotion to anger and engage in offence-related fantasy and behaviours.

Offending Behaviour Therapy Groups (OBFT) This group deals with all forms of offending, violent and sexual, as they are so often inextricably linked. This groups aims to summarise for the prisoners the work that has been done to date on the man's offending behaviour in individual sessions and in other groups and explores offending patterns. The aims of this group are primarily to enable the prisoners to discuss their understanding of their offending patterns and process, the most likely routes to reoffend and other possible routes to reoffend in a group setting. Group work, in particular, helps them deal with the shame and guilt associated with their offending. It also enables them to become more aware of their own and each others' patterns of parallel offending behaviours, emotional and physical risk factors related to offending and to challenge any remaining distorted offence-related cognitions and beliefs. The group considers individualised triggers to offending, needs met by offending, and how the person learnt that offending could meet those needs. It also addresses the role of violent and sexual fantasy in offending, and goes on to produce an individualised offending formulation and do relapse prevention work. Emphasis is placed on finding non-offending ways of meeting needs that the person finds desirable, acceptable and obtainable, and to develop coping mechanisms that work fast and effectively. Consequently prisoners are able to identify and test detailed relapse prevention plans in practice.

Addictive Behaviour Therapy Groups (ABTG) Almost all of the prisoners on the unit have used dysfunctional strategies to manage affect that have become addictive. Addictive behaviours are seen as a solution to a problem when the real solution was unavailable. This group work addresses all forms of addictive behaviours, not only substance abuse and how they become the perceived need to mask the real need. These behaviours may have had a direct effect on their physiological system such as psychotropic substances (e.g. prescribed or illicit drugs), alcohol, nicotine or an indirect effect by behaviours such as violence, self harm, sexual behaviours, gambling, eating (in excess or starving), and theft. Prisoners will be enabled to recognise the role these addicted behaviours have played and find alternative and more personally and socially adaptive strategies. Individualised Relapse Prevention work is also carried out.

Healthy Sexual Relationships Therapy Group (HSRTG) The Healthy Sexual Relationships Programme is used with all prisoners and is an adapted version of the OBP course, omitting those areas that have already been covered in depth in the rest of the programme. This group concentrates on the sexual beliefs and attitudes held, and how they impact on behaviour. The beneficial role of appropriate sexual fantasy and components of a healthy sexual relationship are also the focus of intense work. The programme aims to develop more healthy sexuality, managing patterns of sexual arousal, increasing healthy sexual interest and focusing on relapse prevention.

Overall Individual relapse prevention plans will be devised with each prisoner based on their individual clinical formulation related to the connection between those factors known for each individual that will

increase and decrease the likelihood of offending behaviour.

Therapeutic Milieu Treatment within the unit aims at creating the quality of interpersonal relationships and remedial experiences that are believed necessary for people to attain the capacity to develop socially adaptive cognitive, emotional and behavioural responses. The aim is for all staff to develop appropriate relationships with prisoners through which they can experience reparative interventions that will change all aspects of their functioning. All staff engage with prisoners in this way and Schema-Focused Treatment Plans are in situ for all prisoners in order to guide all staff in their interactions with prisoners. Thus, interactions with staff upon the landing are considered as necessary for change as the more formal psychological interventions and prisoners are able to access a high level of support via access to operational staff. Attention is also given to the prisoner's employment to ensure that their job is not maintaining their psychopathology. For instance, obsessive compulsive prisoners are not provided with employment as cleaners since this prevents them from acquiring new ways to manage the emotions that they avoid by cleaning.

Outcomes

Attendance at Therapy Sessions

People with a diagnosis of personality disorder are notoriously difficult to engage in therapy, particularly in an emotionally meaningful way. This is one of the characteristics that gave them the oft quoted label that they were 'untreatable'. The prisoners who completed treatment however were highly engaged in therapy and their attendance far exceeded what would be predicted for this complex and damaged client group (Chart 6). Indeed many men had an attendance rate of over 95 per cent in all interventions. These are not accredited programmes, and there is an expectation but no compulsion to attend the sessions. As is characteristic of this client group, some of the men withdrew for periods of varying length and then re-engaged. Such ruptures in therapy are predictable for this client group, and for most men necessary to establish genuine change. Part of the high attendance rate is attributable to the slow build-up of the therapeutic interventions. Experience indicates that therapeutic engagement is facilitated by the establishment of an appropriate individual therapeutic relationship and the gradual introduction of therapeutic interventions to a maximum of five formal therapy sessions.

Overview of Fens Unit Cognitive Interpersonal Treatment Programme

<table>
<tr><th></th><th>0 - 6 Months</th><th>6 - 12 months</th><th>12 - 18 months</th><th>18 - 24 months</th><th>24 - 30 months</th><th>30 - 36 months</th><th>36 - 42 months</th><th>42 - 48 months</th><th>48 - 54 months</th><th>54 - 60 months</th></tr>
<tr><td>INDIVIDUAL THERAPY</td><td colspan="10">INDIVIDUAL THERAPY
(focuses on the developmental roots of the personality disorder)</td></tr>
<tr><td rowspan="7">GROUP WORK</td><td>PD Awareness (0 - 3 months)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Human Relationships (4 — 6 months)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="9">COGNITIVE INTERPERSONAL GROUP THERAPY
(addresses dysfunctional relationships)</td></tr>
<tr><td></td><td></td><td colspan="6">SCHEMA FOCUSED THERAPY GROUP
(addresses thinking errors)</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td colspan="3">AFFECT REGULATION GROUP
(addresses emotional dysregulation)</td><td colspan="4">OFFENCE FOCUSED THERAPY
(summarises work on offending)</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>ADDICTIVE BEHAVIOURS GROUP</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>HEALTHY SEXUAL RELATIONSHIPS</td></tr>
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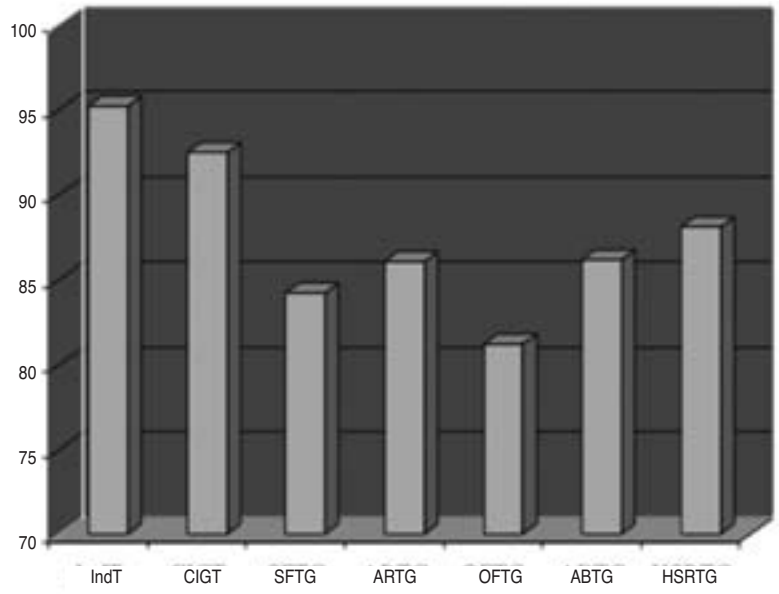
CHART 6
Average percentage attendance of prisoners at each of the formal Therapy Interventions



Change in Behaviour

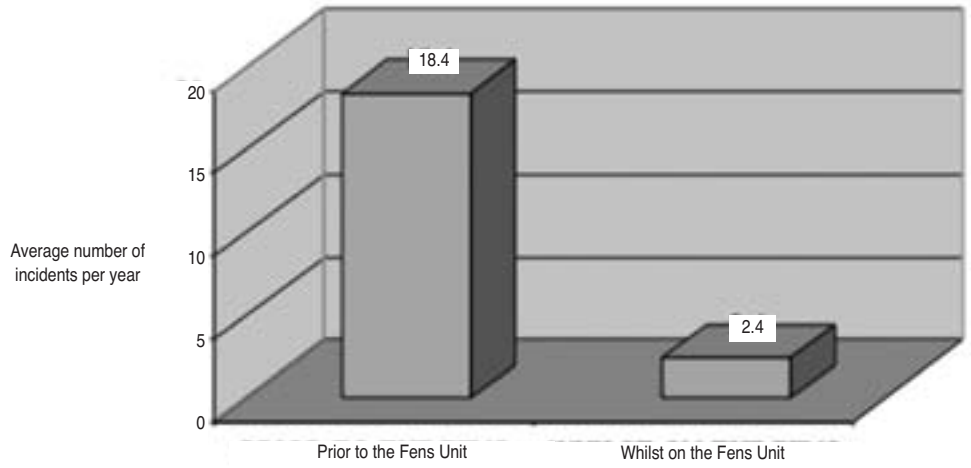
Almost the men on the unit had problematic behaviours in prison prior to coming into treatment. The interpersonal difficulties that these men had in the outside world become more intensified within a prison environment. This can lead the men to at best become belligerent and refuse orders and at worst be verbally and physically aggressive. Several of the men had also previously taken hostages. The first cohort of men was a particularly difficult group, as they were sent as the unit opened. Almost all had been in repeated or constant segregation for several years before coming onto the unit.

Whilst being on the unit the interpersonal behaviours of these men improved over time as relationships developed and thus dynamic security increased. Also the approach to these men was very different in that explicit communication was used with them by all staff with whom they had contact.[2] The number of incidents per year that this group of prisoners was responsible for perpetrating reduced dramatically. It has been argued that this dramatic reduction in number of adjudications can in part be accounted for by a greater level of tolerance to verbal abuse. This is accepted; however, in many ways the greater number of staff can lead to more incidents as officers are constantly observing prisoners and will pick up on and challenge minor incidents that may not be seen on other wings. On the unit, all refusals to follow a direct order, serious verbal aggression and all physical acts of aggression, against others or against property are subject to adjudication.

The figures available prior to coming onto the unit are almost certainly an underestimation due to unavailability of all records, whereas whilst on the unit every incident has been recorded. Nevertheless, even counting those incidents that were previously recorded, it can be seen that that is a highly significant reduction in such incidents per year after transferring to the unit. Prior to coming on the unit these prisoners were jointly responsible for an average of 18.4 aggressive incidents per year (considerable underestimation due to missing data). After coming onto the unit the same prisoners were jointly responsible for an average of 2.4 aggressive incidents per year. This was calculated by summing the average number of incidents per year across all 18 prisoners both prior to and after coming onto the unit. This, of course, represents a significant reduction in both the costs of suffering, to officers, other prisoners and the prisoners themselves and also a large financial saving in terms of cost of staff time of sick replacing property and compensation.

2. Murphy N., & McVey, D (2010) Fundamental Treatment Strategies for Optimising Interventions With People with Personality Disorder in Treating Severe Personality Edited by Naomi Murphy & Des McVey. Routledge: London.

CHART 7
Comparison of the average number of aggressive incidents per year prior to coming onto the unit with their time on the unit



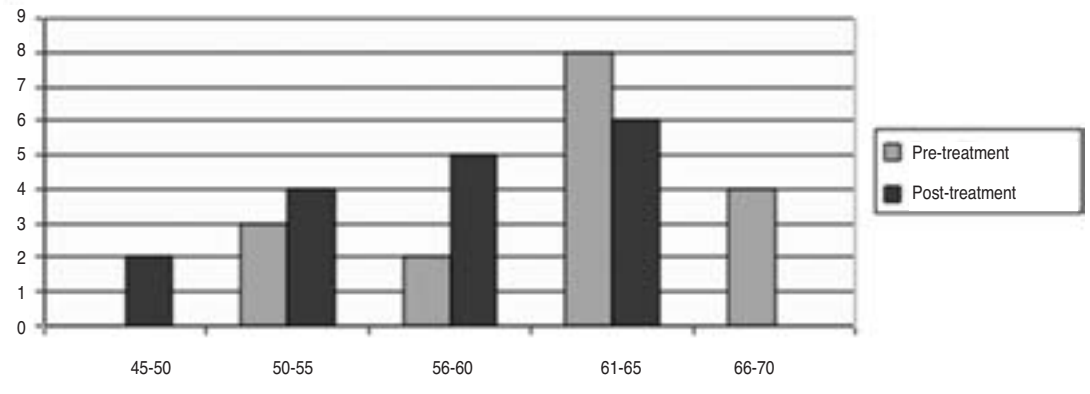
Reduction in Risk as Measured by Formal Risk Measurement Tools

Effective risk assessment and risk management are crucial to public protection and to the reduction of harm to potential victims. It is also crucial for an service such as the DSPD service that is accountable to the public, and exposed to legal liability and media scrutiny.

The Violence Risk Scale[3] (Wong, S.C and Gorden, A.,1996) was designed to assess the risk of violent recidivism for incarcerated offenders. It consists of 6 static historical factors and 20 dynamic factors. The dynamic factors can be used to measure changes in risk level as a result of treatment. Dolan and Fulham (2007)[4] researched the predictive validity of this tool. The results indicated that those with the lower scores on dynamic factors were less likely to reoffend in the 12 months post-treatment. The findings for the 17 of the 18 men who were assessed post treatment how that there was a significant change in the scores(Chart 8).

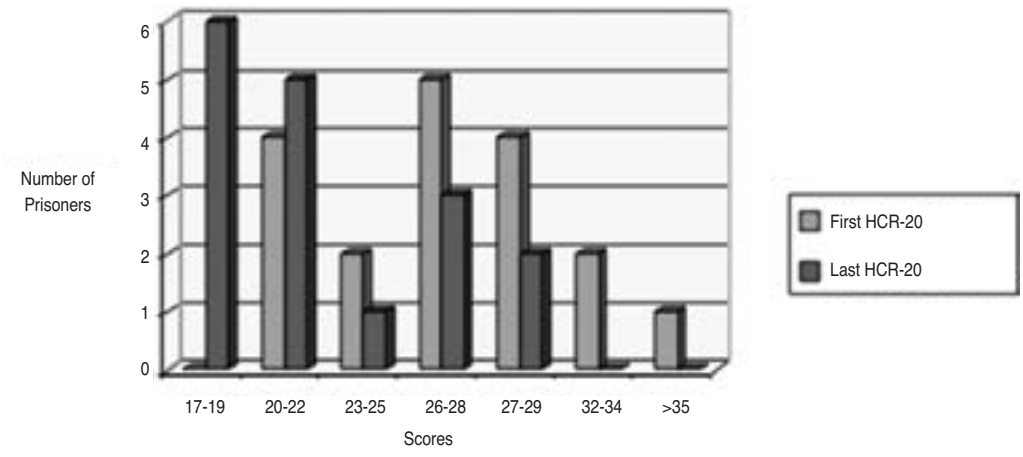
The Historical-Clinical-Risk Management-20 (HCR-20)[5](Webster, Douglas, Eaves, and Hart, 1997), is a

CHART 8
Changes in VRS scores after Treatment (Lower scores showing Improvement)



3. Wong, S.C & Gorden, A.,(1998-2003) Violence Risk Scale. Available from authors. Dept of Psychology. University of Saskatchewan, Canada. S7N 5A5 or at http://www.psynergy.ca
4. Dolan, M. & Fullam, R. (2007). The validity of the Violence Risk Scale second edition (VRS-2) in a British forensic inpatient sample. The Journal of Forensic Psychiatry and Psychology, 18, 381-393.
5. Webster, C.D., Douglas, K.S. Eaves,D., & Hart, S.D (1997), HCR-20 Assessing Risk for Violence. Burnaby BC. Canada : Simon Fraser University.

CHART 9
Changes in HCR-20 Scores after Treatment
(Lower scores showing Improvement)



violence risk assessment scheme intended for use in forensic psychiatric, civil psychiatric, and prison institutional and community settings. Its purpose is to structure clinical decisions about the likelihood of violent behaviour. The HCR-20 provides significantly improved valid predictions over previous testing methods. The HCR-20 is an example of a Structured Professional Judgment (SPJ) risk assessment instrument. Clinicians gathers qualitative information about the person being assessed, guided by the HCR-20, and the results are used to make treatment decisions. Whilst the historical factors cannot change, the clinical and risk factors can change; the lower the score the lower the risk of violence. In a prospective study of 41 long-term sentenced offenders in two high-security prisons, Belfrage et al (2000)[6] found that the historical scale was of little use for high-risk men, but that there was a high predictive value for the clinical and risk management scales. These two scales can provide more sensitive discrimination for high-risk groups. Chart 9 indicates the change in HCR-20 scores over the period of treatment on the unit of the 17 men that were able to be assessed post treatment. All bar two men showed reduction in the clinical and risk scales on the HCR-20 over the period of treatment.

Progression

All men in the first cohort came to the unit from dispersal prison or segregation. Of the 18 prisoners, 9 were Cat A prisoners. Of those 9 men, 5 have been decategorised, and another man had received local recommendation for decategorisation and is awaiting the decision of the Central Team. One man has gone to hospital for further treatment, one is waiting for a specialist hospital place, and two will remain in the dispersal system. Six men have been moved to Cat B establishments and a further 5 are awaiting places at Cat B prisoners. Two men are currently on medical hold for physical health problems but they will be leaving the dispersal system. One man, who had previously spent most of his sentence in segregation and who, just prior to coming onto the unit, could not be unlocked without a Senior Officer and 6 officers, was discharged into the community at the end of his sentence where he has lived safely for more than 18 months.

Financial Saving By Treating These Prisoners

Much as been talked about the cost of a place on a DSPD unit. Prison DSPD places are far less costly than hospital DSPD places but are also less costly than placing men regularly in segregation or in Close Supervision Centres (CSCs) to which many of the men in this first cohort were destined had they not been placed on the unit. If these prisoners had not received treatment the ongoing cost to the public would almost certainly have included costs of replacing broken or burnt property, cost of staff time due to recovery from injury and related stress, and cost of regularly moving these prisoners as most prisons did not hold them for long periods. Two of the group of 18 were on 'lay-down'. Although not a current prison practice, these two Cat A men, prior to coming onto the unit, were

6. Belfrage, H., Fransson, G., & Strand, S. (2000). Prediction of violence using the HCR-20: A prospective study in two maximum security correctional institutions. *The Journal of Forensic Psychiatry*, 11, 167– 175.

moved every month as they were too violent for any prison to manage for a long period of time. This is extremely costly as any movement of a Cat A prisoner involves the use of a specialist van and a minimum of a driver and a relief and a Senior Officer and two other officers as escort. In some cases, it also requires police escorts. Whilst on the unit, all the men in this cohort of prisoners remained for the full period of their treatment. This in itself represents a considerable saving in the cost of moving such prisoners. Thus the estimates shown below are a considerable underestimate of the savings made by to the public finance by treating these men on the unit and by reducing their risk so that after treatment they can be held in lower levels of security.

Approximate average cost per place prior to treatement	Approximate average per place during treatment	Approximate average per place after treatment
£97,000 approx	£92,000 approx	£44,000 approx

Summary

This paper describes the first cohort of 18 men have completed the treatment programme at The Fens Unit HMP Whitemoor and the outcome of that therapy. These men that were previously considered 'untreatable' and who regularly dropped out or gave only surface compliance to interventions had an extraordinarily high attendance in both individual therapy and groups. There was considerable change in the way that these men related to all staff on the unit and a highly significant reduction in the number of aggressive incidents they perpetrated in custody. There was also a significant reduction in the dynamic factors of formal risk assessment tools. Research indicates that such a reduction is predictive of a reduction in likelihood of reoffending. Some men have changed sufficiently to be able to safely move on to prisons at lower levels of security; one man has been living successfully in the community for more than 18 months and others are now able to be detained more safely in the dispersal system and engage in programmes from which they were previously excluded.

Importantly, the quality of these men's lives have been greatly improved — bringing to mind Winston Churchill's quote of exactly 100 years ago in 1910 when he said that the civilisation of a society can be judged by the way it treats its prisoners. The treatment on The Fens Unit has brought to many of these extremely troubled and troubling men, a far better quality of life in that it has treated their psychological distress, which previously they managed by self-medicating with drugs or equally addictive behaviours such as sexual abuse and violence. Although much has been written about the financial cost of such a service, for those on The Fens Unit, despite the apparent high cost, the unit constitutes a considerable saving when measured against the cost to the public of keeping such prisoners in custody prior to being on the unit. Treatment also leads to a considerable financial saving in the cost of keeping these prisoners in custody after being on the unit and in the potential for safer rehabilitation and eventual discharge from custody.