
Antisocial personality disorder and therapeutic justice court programs

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It has become commonplace for courts to supervise an offender as part of the sentencing process. Many of them have antisocial personality disorder (ASPD). The focus of this article is how the work of specialist and/or problem-solving courts can be informed by the insights of the psychology profession into the best practice in the treatment and management of people with ASPD. It is a legitimate purpose of legal work to consider and improve the wellbeing of the participants in the legal process. Programs designed specifically to deal with those with ASPD could be incorporated into existing drug courts, or implemented separately by courts to aid with reforming offenders with ASPD and in managing the re-entry of offenders into the community as part of their sentence. For the success of this initiative on the part of the court, ASPD will need to be specifically diagnosed and treated. Close cooperation between courts and psychologists is required to improve the effectiveness of court programs to treat people with ASPD and to evaluate their success.

INTRODUCTION

Court specialist sentencing programs have grown to address specific causes of criminal behaviour, such as drug addiction and family violence. This article argues that these conditions are often symptoms of antisocial personality disorder (ASPD) and that court treatment programs should take account of that underlying problem where it exists. The consideration of ASPD might draw together various specialised therapeutic court programs, which deal with underlying causes of crime, in a more cohesive way. It might also ensure that court programs properly relate to the programs that executive government provides before the court process, to divert people from criminal behaviour, and after the court process, to supervise people on bonds or to incarcerate them and supervise their release back into the community.

In order to make this argument, the role of specialist courts will be addressed. Following that, the literature related to ASPD and its diagnosis, prevalence, assessment, treatment and rates of recidivism will be reviewed. Upon addressing each of these issues, the role of courts in treating people with ASPD can be elucidated, including the need for reform rather than rehabilitation, and the efficient use of court resources. However, before endeavouring to make this argument, it is necessary to review the history and rationale behind the implementation of therapeutic jurisprudence.

The rehabilitation model of “treating” criminals was largely rejected in the United States in the 1970s¹ in favour of a retributive/punitive approach. Between 1970 and 2005 in the United States, State

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¹ For example see Duff A and Garland D, “Introduction” in *A Reader on Punishment* (Oxford University Press, 1994), pp 9-10: “By the mid-1970s, the rehabilitative ideal had thus come under serious attack, as had penal consequentialism more generally. The pessimistic belief that ‘nothing works’ became almost as widespread as penological optimism had been in the previous decades.” and Allen FA, *The Decline of the Rehabilitative Ideal: Penal Policy and Social Purpose* (Yale University Press, 1981) p 10 (1979 Storrs Lectures on Jurisprudence) (describing the “substantial” and “precipitous” decline of the rehabilitative ideal in the 1970s). This quote and references are from an unpublished article by Johnston EL, “Mental Health Courts: Theoretical and Empirical Difficulties”. The authors acknowledge the assistance they have drawn from that article for its analysis and background materials and references.

and federal prison populations increased by 628%.² There has been a paler reflection of this approach in Australia. Politicians and the media have used law and order rhetoric as a way to create fear of crime and a perception of a tough response in a populist appeal to their electorates.³ This is good politics and it helps fill the short-term media cycle. It combines fear of crime with simple solutions that differentiate the good public from the bad criminals, saying in effect: “You, the public, are threatened. This is a problem and I can help solve it. They are bad and we shall protect you from them by punishing them and locking them away.” Police media units may contribute to the cycle by providing information to the media, whereby crime stories then have a large role in the daily news. This process has little to do with effective policy to manage crime, as many recidivist criminals are considered to be relatively “punishment immune”. Imprisonment can become a badge of honour to the young and, once endured, its next imposition is expected and accepted. It is not then surprising that upon release many criminals reoffend. A study of 28,584 prisoners released in Australia between 1994-1997 showed that 41% were imprisoned again within the next 10 years, and for those imprisoned for burglary or theft the re-imprisonment rate was 58% and 53% (compared to sexual assault of 21%).⁴ More recently, the Australian prison census (2005) found 60% of prisoners had been in prison at least one other time previously. This proportion was highest for those offenders convicted of property offences or offences against justice procedures.⁵ The evidence from the United States about the effectiveness of imprisonment to reduce crime is debated; however, specialised courts have been proposed and implemented in order to achieve a greater effect per dollar spent. United States research reported in DeMatteo and others:⁶

Suggests that drug courts produce significant cost savings over traditional criminal justice interventions.⁷ For every \$1.00 invested, drug courts produce \$2.21 in benefits to the criminal justice system, and the rate of return is higher when drug courts target higher-risk offenders: \$3.36 for every \$1.00 invested.⁸ All things considered, the net economic benefit to local communities ranges from \$3,000 to \$13,000 per drug court client.⁹

Whatever one makes of these cost comparisons, it is clear that imprisonment is an economically expensive remedy for crime. The average expenditure on incarceration per prisoner in Australia in 2009-2010 was \$275 per day (\$100,375 per annum) including fixed costs, and the real net operating expenditure, excluding capital costs and payroll tax, was \$207 per day (\$75,555 per annum).¹⁰ This high cost becomes ever more problematic when the effectiveness of imprisonment is at issue, which is often the case.

² Stemen D, “New Directions for Reducing Crime” (Vera Institute of Justice, 2007), footnote 1, http://employees.oneonta.edu/ostersf/ReconsideringIncarceration_VeraInstitute.pdf, viewed 27 September 2012, citing Bureau of Justice Statistics, *Prisoners 1925-1985* (Washington, DC: Bureau of Justice Statistics, 1986) and Paige M Harrison and Allen J Beck, *Prison and Jail Inmates at Midyear 2005* (Washington, DC: Bureau of Justice Statistics, 2006).

³ Schulz P and Cannon A, “Judicial Time Lords: Media Direction v Judicial Independence” (2010) 5(1) *The International Journal of Criminal Justice Sciences* 174.

⁴ Zhang J and Webster A, “Research Paper: An Analysis of Repeat Imprisonment Trends in Australia using Prisoner Census Data from 1994 to 2007” (2010), <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1351.0.55.031Aug%202010?OpenDocument> viewed 7 January 2012.

⁵ Australian Bureau of Statistics (ABS) 2005c, “Prisoners in Australia 2005” ABS cat no 4517.0 Canberra: ABS, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0>.

⁶ DeMatteo D, Filone S and LaDuke C, “Methodological, Ethical, and Legal Considerations in Drug Court Research, Behavioral Sciences and the Law” (2011) 29(6) *Behav Sci Law* 806 at 810.

⁷ Belenko S, Patapis N and French MT, *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers* (Treatment Research Institute, 2005).

⁸ Bhati AS, Roman JK and Chalfin A, *To Treat Or Not To Treat: Evidence On The Prospects Of Expanding Treatment To Drug-Involved Offenders* (Urban Institute, 2008).

⁹ Logan TK, Hoyt W, McCollister KE, French MT, Leukefeld C and Minton L, “Economic Evaluation Of Drug Court: Methodology, Results, And Policy Implications” (2004) 27 *Evaluation and Program Planning* 381.

¹⁰ *Report on Government Services (ROGS) 2011*, Ch 8, “Corrective Services”, http://www.pc.gov.au/_data/assets/pdf_file/0015/105315/033-chapter8.pdf viewed 4 January 2012.

Courts hear daily about the problems that cause crimes and specialist courts have grown in part from frustration in the judicial arm of government, where sentencing was ineffective because it was not addressing the underlying causes of criminal behaviour in offenders who repetitively return to courts. Courts have been trying to develop ways to deal with them more effectively, often with the support of criminal justice departments who appreciate that the “one size fits all” remedy of jail can be an ineffective paradigm. The establishment of specialist courts has sometimes been due to gaps in executive government services which provide alternatives to imprisonment. This article argues that specialist court programs have demonstrated that, rather than just plugging gaps, the involvement of a judicial authority figure can increase the effectiveness of programs in reforming criminals, particularly those with ASPD.

Courts in the United States led the way with the introduction of a drug court in Miami, Florida in 1989. This was in a context of detected recidivism rates being nearly 70% within three years after incarceration for drug offences.¹¹ In addition to offences of dishonesty to pay for drugs, violence and antisocial behaviour can be associated with the use of amphetamines, often in combination with alcohol. Because of the clear linkage between the abuse of these drugs and criminal behaviour, drug courts have been one of the most common specialist court programs with a primary objective of reducing the drug addiction. This is also a convenient objective because it is easy to test the success by urinalysis, which can verify whether or not the offender is complying with one of the primary objectives of the program: to give up their drug of choice.

Once it was accepted that the judicial role could include supervision of criminals, as well as simply sentencing, other specialist court programs developed to address particular problems, including mental illness and domestic violence.¹² The shift in executive government policy away from inappropriate widespread detention of the mentally ill in asylums, to leaving most of them in the community, sometimes resulted in them not having sufficient levels of care and support to effectively manage their conditions. When they committed crimes they were often put in jail with criminals and often without treatment of their mental health condition. Courts developed special lists, with access to psychologists, to try to deal more appropriately with these problems. Assaults in public have always been condemned and punished, but in the home, where they are often more socially corrosive, assaults and related emotionally-abusive behaviours have often garnered less attention. Even where charges have been laid, these are often withdrawn because they are too difficult to prove when the victim understandably will not give evidence against the abuser for various reasons. Specialist courts have been developed to deal with these offences more effectively.

In Australia, a broad range of specialist courts have developed in the last decade. There are drug courts, homeless courts, and family violence courts which provide more effective management of, and treatment for, the particular problems that offenders before the courts pose in each of these areas. Special procedures exist to deal with crimes committed without criminal intent due to mental illness and people who are not fit to instruct their lawyers.¹³ Outside these processes, which are primarily designed for serious crimes, there are specialist court lists, staffed by case workers with psychology training, to assist people coming before the courts for relatively minor offending related to mental health issues (for a summary of specialist courts in Australia see Law Reform Commission of Western Australia¹⁴ and King,¹⁵ and of specialist courts generally see Freiberg and others¹⁶). Lower court

¹¹ Hora P, “Drug Treatment Courts in the Twenty First Century: The Evolution of the Revolution of Problem-solving Courts” (2008) 42(3) *Georgia Law Review* 717.

¹² Walsh C, “The Trend Towards Specialization: West Yorkshire Innovations In Drugs And Domestic Violence Courts” (2001) 40(1) *The Howard Journal of Law* 26; Wolff N and Pogorzelski W, “Measuring The Effectiveness Of Mental Health Courts: Challenges And Recommendations” (2005) 11 *Psychology, Public Policy, and Law* 539.

¹³ For example, *Criminal Law Consolidation Act 1935* (SA), Pt 8A.

¹⁴ Law Reform Commission of Western Australia, *Court Intervention Programs Final Report* (Project No 96, 2009) <http://www.lrc.justice.wa.gov.au/2publications/reports/P96-FR.pdf> viewed 8 February 2012.

¹⁵ King MS, “Therapeutic Jurisprudence Initiatives in Australia and New Zealand and the Overseas Experience” (2011) 21 *JJA* 19.



judges, or magistrates as they are called in Australia, work with experts in the relevant fields, and become self-taught practitioners in what works to solve the problem with the intention of reforming the offenders so as to reduce their recidivism.

David Wexler and Bruce Winick¹⁷ have provided a philosophical underpinning for this problem-solving approach to sentencing (and other aspects of legal work) by describing it as therapeutic jurisprudence. Therapeutic jurisprudence expresses the idea that it is a legitimate purpose of legal work to consider and improve the wellbeing of the participants in the legal process.¹⁸ To achieve that purpose it is both necessary and appropriate for judges to engage with the parties in court in ways that go beyond the traditional adversary paradigm (Cannon,¹⁹ Friberg and others²⁰ and King²¹). Of course this is not without controversy and a robust literature exists criticising the therapeutic justice approach (eg Meekins and Hoffman²²) and in defence of it (eg in relation to drug courts see Hora²³ and more generally Friberg and others²⁴). It is not the intention of this article to contribute to that debate, save to observe that the sentencing of offenders has always been core court business and sentences have often been delayed while a reform process is put in place (a process recognised by the High Court in Australia in 1977²⁵ and now often called a *Griffiths* remand). More recently it has become commonplace for courts to supervise an offender as part of the sentencing process, which is a change of degree rather than work that is different in principle to the traditional work of courts. Some of this has been done using bail conditions but there is also legislative backing for it.²⁶ It is sufficient for the present authors' purposes to take the existence of specialist or problem-solving courts and their various intervention programs as well established. There were 2,559 drug courts in the United States as at 30 June 2010²⁷ and there are drug courts in six of the Australian States and Territories as well as other specialist courts in these and others.

This article is designed to provide readers with an overview of best practice in the treatment of ASPD, a diagnostic term available to individuals aged 18 years and over who meet specified behavioural, interpersonal and affective clinical criteria. On the basis of this knowledge, the application of therapeutic jurisprudence to this group of offenders will be explored. A key focus of this discussion is how the work of specialist and/or problem-solving courts can be informed by relating it to the insights of the psychology profession into ASPD.

SPECIALIST COURTS

The common law tradition is the construct of individual judges in the third arm of government, which by its nature deals with individual problems in an ad hoc fashion. It is timely to consider how these different programs relate to each other and to the alternatives to imprisonment, and to imprisonment

¹⁶ Friberg A, King M, Hyams R and Bagatol B, *Non Adversarial Justice* (Federation Press, 2009).

¹⁷ Wexler DB and Winick BJ (eds), *Essays in Therapeutic Jurisprudence* (Carolina Academic Press, 1991).

¹⁸ Wexler and Winick, n 17; Winick BJ, "The Jurisprudence of Therapeutic Jurisprudence" (1997) 3(1) *Psychology, Public Policy, and Law* 184.

¹⁹ Cannon A, "Smoke and Mirrors or Meaningful Change: The Way Forward for Therapeutic Jurisprudence" (2008) 17 JJA 217; Cannon A, "Therapeutic Jurisprudence in Courts: Some Issues of Practice and Principle" (2007) 16 JJA 256.

²⁰ Friberg et al, n 16.

²¹ King, n 15.

²² Meekins TM, "'Specialised Justice': The Over-Emergence of Speciality Courts and the Threat of a New Criminal Defence Paradigm" (2006) *Suffolk U Law Review* 1 at 19; Hoffman MB, "Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism: The Least Dangerous Branch Becomes Most Dangerous" (2002) *Fordham Urb LJ* 2063 at 2083; Hoffman MB, "Booker, Pragmatism and the Moral Jury" (2005) *Geo Mason L Rev* 455 at 460.

²³ Hora, n 11.

²⁴ Friberg et al, n 16.

²⁵ *Griffiths v The Queen* (1977) 137 CLR 293.

²⁶ For example, *Criminal Law (Sentencing) Act 1988* (SA), s 19B.

²⁷ DeMatteo et al, n 6 at 808 quoting figures from National Association of Drug Court Professionals, "Drug Court History" (2011), <http://www.nadcp.org/learn/what-are-drug-courts/history> viewed September 2011.



itself, so that: “out of the attrition of diverse minds there is beaten something which has constancy and uniformity and average value greater than its component elements”.²⁸

It is clear to many working in a drug court dealing with high-risk serious offenders that their complex needs go far beyond simply removing the addiction, which is in many instances a symptom of a larger problem of antisocial behaviour deeply embedded in their psyche. Drug courts typically use cognitive behaviour programs and a combination of a strict regime of sanctions to enforce agreed boundaries of behaviour and rewards as well as offering encouragement for success. There is a growing body of evidence, mentioned below, that this type of approach can have a measure of success in dealing with antisocial personality disorders. Therefore, it may be that when drug courts are successful it is sometimes because they are dealing with underlying ASPD in addition to the drug addiction.

The same can be said of family violence courts, where some offenders are using violence and other sexually and emotionally controlling behaviour to abuse their partners and families, which is symptomatic of the lack of empathy typical of ASPD. There are often collateral symptoms, such as drug addiction and alcohol abuse. Treatment programs here are moving towards cognitive behaviour therapy and regular judicial supervision and encouragement.

Mental conditions that make a person unfit to plead or unable to instruct their lawyers are usually dealt with by court determination of those matters and, if the non-psychological elements of the crime are established, by the fixing of a term of supervised mental treatment in secure care or otherwise.²⁹ Unless this supervision is conducted under the court, those cases have no relevance here. There is no evidence that people with mental illness are more likely than others to commit crimes, but they are more likely to be arrested than people without mental illness.³⁰ There are specialist courts that provide treatment options to people who are committing often relatively low-level offences which are related to mental health problems. For example, the Diversion Court in South Australia provides case management and access to community treatment options for people with mental conditions who are committing crimes. Of a sample of 461 participants, one-third had a personality disorder and one-third of those had ASPD which, contrary to expectations, did not seem to affect program compliance.³¹ Likewise, experience suggests that specialist court programs dealing with homeless people are populated by significant numbers of people suffering from ASPD.

Since one of the definitional characteristics of ASPD is the commission of crimes, it is to be expected that specialist court programs designed to address recidivist offending, such as drug use and family violence, will be populated by many offenders with ASPD. The point is that ASPD is a factor in the commission of much crime and if we are to construct sensible programs to reduce crime one of the primary problems to be addressed should be ASPD. In order to better understand this necessity, it is of import to first outline the details of ASPD and the associated literature.

ANTISOCIAL PERSONALITY DISORDER

The actions of individuals with ASPD take their toll on our society. Many are likely to repeatedly appear before our courts and, through their irresponsible and remorseless behaviour, cause harm to others. Further, they are also likely to leave a legacy for future generations through the consequences of inadequate parenting styles, criminality, substance use and aggressive behaviour; all possible risk factors for future offending in their children.

Antisocial behaviour as a broad concept is a term typically used to describe a cluster of socially unacceptable actions, often in the context of discussing juveniles, but also applied to adult offenders. It

²⁸ Cardozo BM, *The Nature of the Judicial Process* (Yale University Press, 1921) (30th ed, 1971) p 177.

²⁹ For example, *Criminal Law Consolidation Act 1935* (SA), Pt 8A.

³⁰ Wolff N, “Courts as Therapeutic Agents: Thinking Past the Novelty of Mental Health Courts” (2002) 30(3) *J Am Psychiatry Law* 431; Skeem et al, n 2; Junginger J et al, “Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses” (2006) 57(6) *Psychiatric Services* 879 at 879, 881; Bonta J, Law M and Hanson K, “The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis” (1998) 123 *Psychol Bull* 135.

³¹ McMahon E, “Harder to Engage? Program Compliance of Personality-disordered Clients in the South Australian Magistrates Court Diversion Program” (Unpublished Master of Psychology thesis, University of South Australia, 2007).



is not to be confused with the legal term of “juvenile delinquency” which connotes behaviour that has been recognised within the justice system as being criminal and which has been undertaken by an individual who has not reached the legal age of adulthood. In a psychological context, antisocial behaviour refers to persistent and serious violations of social norms, personal rights and/or laws.³² The range of behaviours subsumed under this definition is extensive, from substance abuse through to assault, although typically the definition refers to habitual behaviours that result in injury to others or arrest.³³ Of course, this definition neglects the proportion of individuals who engage in behaviours of this nature without coming to the attention of law enforcement.

ASPD diagnostic features

ASPD is one of 10 personality disorders currently listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).³⁴ The DSM is the standard classification system used by mental health and other health professionals for diagnostic and research purposes. Unlike other disorders in this category, for a diagnosis of ASPD there needs to be a lifelong history of antisocial behaviour. Antisocial behaviour is a feature of the child and adolescent psychiatric condition of conduct disorder, which is a diagnosis characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. In the current edition of the DSM (DSM-IV-TR), two types of onset for conduct disorder are described: childhood-onset type, when the behaviours are evident in the individual before the age of 10 years; and, adolescent-onset type, when there is no evidence of this pattern of behaviour prior to the age of 10 years. The former type includes those who are considered at greater risk of persistent conduct problems throughout adolescence and ultimately of developing the adult diagnosis of ASPD.

ASPD is characterised by a pervasive disregard, from adolescence through to adulthood, for societal norms and laws and the rights of others. The criteria for ASPD specified in DSM-IV-TR addresses persistent antisocial behaviour occurring from the age of 15 years in individuals who are, at the time of assessment, 18 years old or over (see Appendix – Diagnostic Criteria for 301.7 Antisocial Personality Disorder). A broad range of actions are considered within this diagnostic category, all with the underlying theme of injury to others and/or violation of social norms and laws. Individuals also exhibit consistent and extreme irresponsibility (employment, financial) and demonstrate limited empathy and remorse for the effect of their actions on others. Impulsivity, irritability and remorselessness are also traits featuring prominently in the criteria for the disorder.

A conceptually similar disorder, called dissocial personality disorder (DPD), is defined in the other commonly used diagnostic system, the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems (ICD-10)³⁵ (see Appendix – Diagnostic Criteria for F60.2 Dissocial Personality Disorder). One of the main differences between DPD and ASPD criteria is, for DPD, conduct disorders are specifically ruled out, while evidence of conduct disorder prior to the age of 15 years is one of the key criteria for a diagnosis of ASPD. This is relevant when one considers the emphasis on aggressive behaviour that is required for a diagnosis of conduct disorder in DSM-IV-TR. Physical aggression is typically the purview of males rather than females. It has been acknowledged that this may result in an under-diagnosis of ASPD in females.³⁶ ASPD criteria include deceitfulness, impulsivity and recklessness, which are not features in the DPD diagnosis. DPD criteria also focus on more affective symptoms, whereas the ASPD criteria are primarily behaviourally based. Due to the comparatively limited range of empirical research for DPD, this article will focus on ASPD as it is diagnosed in DSM-IV-TR.

³² Bartol CR, *Criminal Behavior: A Psychological Approach* (Prentice Hall, 2005).

³³ Bartol, n 32.

³⁴ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, text revision, American Psychiatric Association, 2000).

³⁵ World Health Organization, *International Statistical Classification of Diseases and Related Health Problems* (10th ed, WHO, 1992).

³⁶ American Psychiatric Association, n 34.



ASPD and psychopathy: Differential diagnosis

Research into ASPD has had its fair share of controversy, mainly through concerns raised about confabulation with the clinical concept of psychopathy³⁷ and the DSM-IV-TR classification of ASPD.³⁸ Current DSM criteria focus on behavioural features to diagnose ASPD. In contrast, the core criteria for a diagnosis of psychopathy, as defined on the widely accepted measure of psychopathy, the Hare Psychopathy Checklist, Revised,³⁹ comprise antisocial features along with interpersonal and affective components. Thus, psychopaths may be diagnosed with ASPD, but a diagnosis of ASPD does not necessitate a diagnosis of psychopathy. This is highlighted by figures demonstrating between 50% to 80% prevalence of ASPD in prison populations, while only about 15% of prisoners are likely to receive a diagnosis of psychopathy.⁴⁰

There is a large body of literature devoted to describing those features that distinguish a psychopath from other types of offenders.⁴¹ Differences in behaviour, cognitive and emotional processing, and offending patterns have been reported. There is significantly greater research exploring the clinical construct of psychopathy than there is informing us of effective practice for ASPD, with the predominant view being that psychopathy is a severe type of personality disorder.⁴² The emphasis in diagnosing ASPD on the basis of behaviours related to criminality offers a less precise criteria compared to the more narrowly defined construct of psychopathy, with its emphasis on interpersonal and affective symptoms along with antisocial behaviours. Some have argued that the much broader diagnostic criteria for ASPD results in an overestimation of the disorder in prisoner samples.⁴³ Indeed, research that subsumes psychopaths into the broader diagnostic category of ASPD, it has been argued, could lead to a misunderstanding of the true nature of ASPD.⁴⁴

Prevalence

Prevalence estimates of ASPD vary across studies and across countries, but all find that ASPD is more prevalent among men than women. De Brito and Hodgins⁴⁵ highlight the differences in prevalence rates across several countries and suggest methodological differences across studies could account for some of the discrepancies observed. They also highlight research supporting the notion that individuals with ASPD are less likely to be included in epidemiological studies resulting in a likely underestimation of prevalence in community samples at least. According to the American Psychiatric Association estimate in community samples, ASPD is seen in approximately 3% of males and 1% of females.⁴⁶ Higher rates are evident in specialised populations such as psychiatric patients (3% to 30%) and substance abusers. Among incarcerated offenders ASPD has been found in almost half of males

³⁷ Hare RD, *The Hare Psychopathy Checklist-Revised* (2nd ed, Multi-Health Systems, 2003).

³⁸ Hare RD and Neumann CS, "Psychopathy as a Clinical and Empirical Construct" (2008) 4 *Annual Review of Psychology* 217.

³⁹ Hare, n 37.

⁴⁰ Ogloff J, "Psychopathy/Antisocial Personality Disorder Conundrum" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 519.

⁴¹ Patrick CJ, *Handbook of Psychopathy* (Guilford Press, 2006).

⁴² Cooke DJ, Michie C, Hart D and Clark D, "Searching for the Pan-cultural Core of Psychopathic Personality Disorder" (2005) 39 *Personality and Individual Differences* 283.

⁴³ Ogloff, n 40.

⁴⁴ de Brito S and Hodgins S, "Executive Functions of the Persistent Violent Offender: A Critical Review of the Literature" in Hodgins S, Viding E and Plodowski A (eds), *Persistent Violent Offenders: Neurobiology and Rehabilitation* (Oxford University Press, 2009). Rogers R, Salekin RT, Sewell KW and Cruise KR, "Prototypical Analysis of Antisocial Personality Disorder: A Study of Inmate Samples" (2000) 27 *Criminal Justice and Behavior* 234.

⁴⁵ de Brito and Hodgins, n 44.

⁴⁶ American Psychiatric Association, n 34.



and up to 30% of females. A review of 62 studies across 12 countries examining a total of 13,844 convicted offenders reports 47% of males and 21% of females received a diagnosis of ASPD.⁴⁷ A similar result was found elsewhere.⁴⁸

Assessment

Despite clear criteria, the issue of personality assessment within forensic settings is complicated. There has been criticism of the conceptualisation of ASPD as it is reflected in DSM-IV-TR, mainly due to the current focus on behaviour rather than personality traits thought to be integral to the diagnosis. Lykken⁴⁹ notes that individuals within the ASPD category present different personalities, motivations and attitudes. ASPD is frequently found with co-morbid disorders including substance abuse, anxiety and depression,⁵⁰ and Widiger and Trull highlight that there are 848 ways in which an individual can meet the criteria for ASPD.⁵¹

Blackburn notes concerns regarding potential confounding factors in the assessment of personality disorder in forensic populations, including co-morbidity, the relationship of the diagnostic classification system to the assessment model used, and the reliability and validity of information obtained during assessment.⁵² Other researchers have highlighted the relatively narrow focus of much of the ASPD research in forensic populations, indicating significant deficits in knowledge of how assessment and treatment models for people with ASPD apply to intellectually disabled populations.⁵³

Hogue et al provide a brief overview of forensic assessment of personality disorders, noting the range of instruments developed specifically to assess this disorder against the DSM classification system.⁵⁴ They summarise several issues to be considered when undertaking assessment of personality disorders in a forensic context, including using multiple sources of information, specific measures that take into account tendencies in a forensic population to over-inflate or feign trait presentations, assessment of co-morbid disorders, and the need to complete the assessment in such a way as to have practical clinical utility in informing treatment.

Treatment

The evolutionary nature of clinical diagnosis is reflected in the changes in the assessment and diagnosis of personality disorders heralded in the new edition of the DSM (DSM-V, due for release in May 2013). These changes include changes to the definition of personality disorder, with more personality traits being integrated into the criteria.⁵⁵ One of the unintended consequences of constant evolution in diagnostic criteria, however, is the deficit of empirical research using the current ASPD criteria.⁵⁶ There is a lack of research supporting an effective model of treatment for ASPD.⁵⁷

⁴⁷ Fazel S and Danesh J, "Serious Mental Disorder in 23000 Prisoners: A Systematic Review of 62 Surveys" (2002) 359 *Lancet* 545.

⁴⁸ Singleton N, Meltzer H and Gatward R, *Psychiatric Morbidity Among prisoners in England and Wales* (London: Office for National Statistics, 1998).

⁴⁹ Lykken D, *The Antisocial Personalities* (Lawrence Erlbaum Associate, 1995).

⁵⁰ de Brito and Hodgins, n 44.

⁵¹ Widiger TA and Truell TJ, "Borderline and Narcissistic Personality Disorders" in Sutker PB and Adams HE (eds), *Comprehensive Handbook of Psychopathology* (2nd ed, Plenum, 1993) p 371.

⁵² Blackburn R, "Treatment or Incapacitation? Implications of Research on Personality Disorders for the Management of Dangerous Offenders" (2000) 5 *Legal and Criminal Psychology* 1.

⁵³ Morrissey C and Hollin C, "Antisocial and Psychopathic Personality Disorders in Forensic Intellectual Disability Populations: What Do We Know So Far?" (2011) 17 *Psychology, Crime and Law* 133.

⁵⁴ Hogue A, Dauber S, and Mogenstern J, "Validation of a Contemplation Ladder in an Adult Substance Use Disorder Sample" (2010) 24 *Psychology of Addictive Behaviours* 137.

⁵⁵ Krueger RF, Eaton NR, Derringer J, Markon KE, Watson D and Skodol AE, "Personality in DSM-5: Helping Delineate Personality Disorder Content and Framing the Metastructure" (2011) 93 *Journal of Personality Assessment* 325.

⁵⁶ Ogloff, n 40.



Australian national guidelines offered to practitioners suggest that the accepted wisdom in managing people with ASPD is to not expect rehabilitation.⁵⁸

More recent ASPD guidelines highlight the emphasis placed on the psychological treatment of other personality disorders, primarily borderline personality disorder, in contrast to the lack of progress in developing psychological interventions specifically for the treatment of ASPD.⁵⁹ These guidelines contain a comprehensive review of the empirical literature pertaining to ASPD and it is noted that, while interventions for ASPD are limited, there have been developments in treatment for some of the components of ASPD. In particular, there is a significant body of literature reviewed concerning the effectiveness of interventions addressing offending behaviour, a core feature of ASPD. In the Australian criminal justice system, programs such as cognitive skills, anger management and communication are widespread. The majority of interventions provided to individuals with ASPD are likely to be delivered within the prison or probation context and are cognitive-behaviourally oriented and group based, with an emphasis on reducing the risk of reoffending. The evidence for the effectiveness of a cognitive-behavioural approach within forensic populations has been reviewed extensively⁶⁰ and, overall, cognitive-behavioural approaches are considered to be moderately effective with both adult and juvenile offenders. These interventions, while originating within the criminal justice system, focus not only on offending specifically, but also on problems with impulsivity, aggression and rule-breaking, which are cornerstones to the symptoms of ASPD. Given the prevalence of ASPD among this population, and the centrality to the ASPD diagnosis of the behaviours addressed, it is fair to assume that these strategies are effective at treating people with ASPD whether or not they have a criminal record.⁶¹

Furthermore, the National Institute for Health and Clinical Excellence notes that support for people with ASPD outside of the criminal justice and health systems, in the United Kingdom at least, is limited.⁶² There is no evidence to suggest that the situation is different in Australia. These individuals are frequently perceived by service providers as disruptive and threatening. In fact, practitioners working in this field are advised to not accept all information provided by a client with ASPD at face value, to set clear limits in therapy, as well as to not expect to like these individuals as a direct result of their manipulative and exploitative presentations.⁶³ By their very nature, people with ASPD may find themselves marginalised and excluded from the very services designed to support them, such as housing, welfare and employment.⁶⁴

One of the key findings is the need to address co-morbid issues when dealing with people with ASPD. However, in its review, the National Institute for Health and Clinical Excellence notes limited evidence of benefits to people with ASPD arising from treatment for drug and alcohol misuse; for example, benefits could be of the same order as for people without a personality disorder. Some researchers have argued for the use of behaviour modification through reward systems as potentially

⁵⁷ Duggan C, Mason L, Banerjee P and Milton J, "Value of Standard Personality Assessments in Informing Clinical Decision-making in a Medium Secure Unit" (2007) 190 *British Journal of Psychology* 515.

⁵⁸ World Health Organization, *Management of Mental Disorders: Treatment Protocol Project* (4th ed, World Health Organization, 2004).

⁵⁹ National Institute for Health and Clinical Excellence, *Antisocial Personality Disorder: The NICE Guidelines on Treatment, Management and Prevention* (The British Psychological Society and The Royal College of Psychiatrists, 2009).

⁶⁰ Landenberger NA and Lipsey MW, "The Positive Effects of Cognitive-Behavioral Programs for Offenders: A Meta-Analysis of Factors Associated With Effective Treatment" (2005) 1 *Journal of Experimental Criminology* 451. Lipsey MW, Landenberger NA and Wilson SJ, "Effects of Cognitive-Behavioral Programs for Criminal Offenders" (2007) *Campbell Collaborative Systematic Review* available at <http://www.campbellcollaboration.org> viewed 27 September 2012. Pearson FS, Lipton DS, Cleland CM and Yee DS, "The Effects of Behavioral/Cognitive-Behavioral Programs on Recidivism" (2002) 48 *Crime and Delinquency* 476. Tong J and Farrington D, "How Effective is the 'Reasoning and Rehabilitation' Programme in Reducing Reoffending? A Meta-analysis of Evaluations in Four Countries" (2006) 12 *Psychology, Crime and Law* 3.

⁶¹ National Institute for Health and Clinical Excellence, n 59.

⁶² National Institute for Health and Clinical Excellence, n 59.

⁶³ World Health Organization, n 58.

⁶⁴ National Institute for Health and Clinical Excellence, n 59

useful for moderate gains. Of course, ASPD comes in many forms. There is currently no measure of dangerousness or severity built into the diagnostic criteria. Those representing the more severe end of the continuum tend to reveal psychopathic traits and are likely to require a significantly modified treatment approach. In England in the last decade, in excess of A\$309 million has been spent on trialling a program for treating severe personality disorder.

Dangerous and severe personality disorder (DSPD) is an administrative category introduced in the United Kingdom in 1999 as a response to the problem of ongoing management of dangerous personality disordered offenders. People with DSPD meet the following criteria:

- they are more likely than not to commit an offence within five years that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover;
- they have a significant disorder of personality;
- the risk presented appears to be functionally linked to the significant personality disorder.⁶⁵

The ambiguities inherent in this criteria are discussed elsewhere.⁶⁶ Nevertheless, clearly DSPD is about a subset of high-risk offenders who are more than likely to also meet ASPD criteria. The program involves the detention of people diagnosed with DSPD. A variety of treatments have been developed and implemented, with most having a strong emphasis on a cognitive-behavioural approach. In their review of the DSPD program, Burns et al conclude that while some effective outcomes have been achieved, overall there lacks a sense of coherency and rationalisation to the treatments being offered under the DSPD scheme.⁶⁷ They identified in excess of 20 different treatment programs being offered across four DSPD sites. Specific details of the individual treatment programs were not offered, although other researchers note that there was a preponderance of psychotherapeutic rather than psychopharmacological approaches used.⁶⁸

The review by Burns et al focused on the operational details of the treatments, including components such as access, intensity and duration of treatments and therapeutic activities. The only measure of treatment efficacy reported was scores on a measure of violence risk, the Violence Risk Scale.⁶⁹ Here, “modest but significant” reductions in scores were reported for the duration of the study, although it was acknowledged that limitations of the study (ie no control group) prevented a causal relationship being identified. The key feature was the total number of hours of treatment and, although not specifically stated, it is assumed the authors found that a greater number of treatment hours was related to greater reduction in risk.

In summary, the evidence of behavioural change is generally weak for this group of individuals presenting with symptoms of ASPD. People with personality disorders do not tend to make easy patients in a treatment context for a number of reasons. Dolan, in her review of these issues, notes that while these people tend to demonstrate poor compliance with therapy, they are also among the highest users of health and welfare services.⁷⁰ Other researchers highlight the opportunities for rehabilitation in antisocial juveniles with a focus on the building of protective factors rather than concentrating only on reducing risk in these individuals.⁷¹ The specific conditions under which therapy gains might be

⁶⁵ Taylor R, “An Assessment of Violent Incident Rates in The Dangerous Severe Personality Disorder Unit at HMP Whitemoor”, Home Office findings (2003) p 10.

⁶⁶ Tyrer P, Duggan C, Cooper S, Crawford M, Seivewright H, Rutter D, Maden T, Byford and Barrett B, “The Successes and Failures of the DSPD Experiment: The Assessment and Management of the Severe Personality Disorder” (2010) 50 *Med Sci Law* 95.

⁶⁷ Burns T, Yiend J, Fahy T, Fitzpatrick R, Rogers R, Fazel S and Sinclair J, “Treatments for Dangerous Severe Personality Disorder (DSPD)” (2011) 22 *The Journal of Forensic Psychiatry and Psychology* 411.

⁶⁸ Tyrer et al, n 66.

⁶⁹ Wong S and Gordon A, *The Violence Risk Scale* (Unpublished manuscript, 2000).

⁷⁰ Dolan MC and Fullam R, “Theory of Mind and Mentalizing Ability in Antisocial Personality Disorders With and Without Psychopathy” (2004) 34 *Psychological Medicine* 1093.

⁷¹ Bartol CR, “Resilience and Antisocial Behavior” in Bartol CR and Bartol AM (eds), *Current Perspectives in Forensic Psychology and Criminal Behavior* (2nd ed, Sage Publications, 2008).

more likely have also been discussed. Martens, for example, reviews multisystemic therapy and finds this approach has demonstrated mixed results in efficacy studies with juveniles presenting with antisocial behaviours.⁷² Multisystemic therapy is a combined intensive approach that addresses potential and identified risk factors in troubled youth while seeking also to bolster existing protective factors. The approach combines family therapy with individual treatment, and therapy is long-term and intensive, usually conducted in the community setting. Martens notes that individuals are more likely to benefit from engagement with multisystemic therapy when motivated for therapeutic change and when free from severe co-morbid disorders. This would be true for most type of therapies and, indeed, for many presenting disorders. Certainly the importance of readiness to change as a key predictor of therapeutic outcome has been extensively addressed in the relevant literature.

Moreover, national treatment guidelines emphasise the inherent duty of care bestowed on the clinician by stating “there is evidence that approximately 50% of individuals who appear to have met criteria for an antisocial personality disorder in their teens or twenties will no longer meet the criteria after the age of 30, with 80% no longer meeting the criteria at age 45”.⁷³ Certainly, considering the longer-term impact of the behavioural patterns presented by these individuals, it would seem sensible to ensure that every effort is taken to help these individuals manage co-occurring disorders and address some of the more hazardous cognitions and behaviours. In this way clinicians can work towards limiting the destructiveness of the impact of these people on society long enough for the ASPD symptomology to remit.

The core group of recidivist offenders often have ASPD

Many factors can lead to criminal behaviour, and many criminals are occasional offenders and do not have ASPD. However, there is some evidence to suggest that those offenders who are consistently reoffending may be influenced by ASPD. According to several studies, about 5% of men have both conduct disorder in childhood, as well as ASPD in adulthood. These individuals are responsible for 50% to 70% of violent crime.⁷⁴ Thiihonen and Hakola note that, in Finland, 60% to 80% of the most serious violent crimes are perpetrated by males with ASPD.⁷⁵ Friddell and colleagues found, in their study of drug use and ASPD, that those with the personality disorder are much more likely to reoffend within two years than those without.⁷⁶ The relationship between ASPD and crime, in this study, held across several confounding factors.

The argument being made here is that courts should recognise a high likelihood of ASPD features in the presentations of frequent and sustained recidivist offenders and adopt appropriate strategies to best deal with them. Specialist courts, such as drug courts, manage offenders after they have pleaded guilty, set clear rules which can be immediately enforced, and can bring praise and encouragement together with case management and cognitive behavioural programs to address addiction. These programs might meet the treatment requirements for individuals with ASPD and their treatment might properly be a role of specialist courts.

⁷² Martens WH, “Multisystemic Therapy For Antisocial Attitudes Juveniles: Suggestions For Improvement” (2004) 48 *International Journal of Offender Therapy and Comparative Criminology* 389.

⁷³ World Health Organization, n 58, p 558.

⁷⁴ Moffitt TE, “Adolescence-limited and Life-course-persistent Antisocial Behaviour: A Developmental Taxonomy” (1993) 100 *Psychological Bulletin* 674; Hodgins S, “Status at Age 30 of Children With Conduct Problems” (1994) 3 *Studies on Crime and Crime Prevention* 41; Thiihonen J, Hodgins S, Vaurio O, Laakso M, Repo E, Soininen H, Aronen HJ, Nieminen P, Savolainen L, “Amygdaloid Volumes Loss in Psychopathy” (Society for Neuroscience 2000 Annual Meeting, New Orleans, La, 4-9 November 2000).

⁷⁵ Thiihonen J and Hakola P, “Psychiatric Disorders and Homicide Recidivism” (1994) 1561 *American Journal of Psychiatry* 436.

⁷⁶ Fridell M, Hesse M, Jaeger M, Kuhlhorn E, “Antisocial Personality Disorder as a Predictor of Criminal Behaviour In a Longitudinal Study of a Cohort of Abuser of Several Classes of Drugs: Relation to Type of Substance and Type of Crime” (2008) 33 *Addictive Behaviours* 799.



A ROLE FOR COURTS IN MANAGING OFFENDERS WITH ASPD

Now that the diagnostic features, the prevalence, assessment, treatment and recidivism rates of ASPD have been addressed, it is possible to highlight the role of courts in assisting with managing the disorder. In order to make the argument that a therapeutic jurisprudence system, similar to that of drug courts, should be implemented for ASPD recidivistic offenders, first, how drug courts facilitate change will be touched upon. The powers of therapeutic jurisprudence, including the inherent community integration, the accountability offered, the positive role-modelling and the perception of fairness will be addressed. Second, this section will discuss the oft-made criticism of systems of this type, by making it clear that ASPD-specific programs would not be a return to the “soft-sentencing” movement, but a successful, rigorous management of persistent offenders with a recognised disorder. Finally, ASPD programs, and their effective use of court resources, will be briefly outlined.

Drug courts work by empowering participants to embrace the change from being an addict to being an empathetic member of the community. In these courts it becomes obvious that the participants are often addicts who also have ASPD. In the legal experience of one of the present authors (Cannon), when a drug court is dealing with an offender with ASPD it is often a dance of mutual manipulation where the offender is telling the magistrate what s/he wants to hear to make the magistrate feel good about the reform project, so that the offender can get a lenient sentence, while the magistrate engages in ongoing discussions that show empathy and encouragement, talking about their family and successes so that the offender feels respected and wanted, and praised for every achievement, clapped and encouraged. The dance continues until the offender either gives up, fails and then goes to jail, or a moment comes when s/he has reached a personal limit, and decides to make a change. In this process the offender is learning empowerment and a changing internal image, from a manipulative drug addict, to an empathetic social being. Change cannot simply be imposed. To be successful it must be embraced by the participant.⁷⁷

Once this change is embraced, the power of therapeutic jurisprudence is multifaceted. Courts have the ability to allow offenders to remain integrated in the community, to increase the accountability of the offender through immediate sanctions, to encourage participants to identify with positive role models, and to increase perceptions of fairness.

First and foremost, therapeutic programs in courts have specific advantages which are not logistically available either to prisons, or to correctional programs administered in the community. Offenders in therapeutic programs in courts remain within the community, albeit often subject to restrictions such as electronic monitoring, so that when they are successful they are already integrated into a community network, whereas an offender released from prison has to be re-integrated. Allowing offenders to remain in the community during their sentence or program can avoid all the issues associated with re-integration and the stress that it causes. It also allows for real-world solutions not often available in institutional settings.

Fully developed drug court programs additionally bring with them all the tools of community-based corrections programs. They have case workers who manage the offenders, and assist with criminogenic factors such as housing, parenting, employment and, of course, drug abstinence programs and urine testing. They use cognitive behaviour programs that have been shown to be moderately effective on people with ASPD. What courts add to these forms of treatment that is not available in community corrections programs, or prison, is the involvement of a judicial officer. This brings several important aspects to the reform process. One is immediate accountability, another is pro-social modelling from a reverent authority, and another is encouragement and praise. The offenders report to court regularly and are praised for success by a high-status independent role model and by applause from their peers. It is obvious that encouragement and praise has a significant effect on drug court participants. But in dealing with people with ASPD, encouragement is often not enough

⁷⁷ King M, “Should Problem-Solving Courts be Solution-Oriented Courts?” (Paper presented at the 31st Congress of the International Academy of Law and Mental Health, New York, 28 June to 4 July 2009), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1725022 viewed 13 February 2012; Winick BJ, “Therapeutic Jurisprudence and Problem Solving Courts” (2003) 30 *Fordham Urb LJ* 1067.



to bring change. Clear boundaries are required and these must be promptly and fairly maintained, thus highlighting the benefit of these programs where sanctions can be immediate.

As alluded to above, an important function from the court's perspective is to allow the offender to develop a relationship with a powerful role model who is empathetic and fair. This may help to confront the negative dominant role models in their past and address anti-authority attitudes. The court tradition, with its observance of due process, the appearance of fairness, as well as actual fairness and consistency, is important to gain the confidence of participants and their commitment to the process. The processes of rewards and recognition, through stages of reduced restrictions as the offender earns them, culminating in a graduation ceremony, with a certificate and the judge shaking the participant's hand (or hugging them in more demonstrative jurisdictions), mimic similar ceremonies that are the rites of passage for successful people. In one author's experience (Cannon), in drug court it is common to see surprise and pleasure from participants who have never been praised before.

The difficult task of addressing persistent criminality is likely to be assisted by a role model who takes a respectful and measured approach to teach people with ASPD that other people can be trusted, that they do care and they will, with fairness and consistency, reward good behaviour, so that the offenders with ASPD themselves can develop empathy and concern for others. Recent evidence from the New South Wales Drug Court shows that intensive judicial supervision of participants improves program outcomes⁷⁸ and this is consistent with evidence from the Delaware Drug Court program that high-risk offenders (defined as offenders with ASPD, a prior history of drug treatment, or both) performed much better with high levels of judicial supervision,⁷⁹ but that high levels of supervision do not make a great deal of difference to low-risk offenders⁸⁰.

Increasing perceptions of fairness are also thought to be a major power of therapeutic jurisprudence systems. The research of Lind and Tyler established a clear correlation between perceptions of fairness of process and satisfaction, rather than satisfaction just being determined by the effect of the outcome on the person.⁸¹ Perception of fairness was heavily influenced by whether people had an opportunity to be heard,⁸² and influences whether they are likely to be law abiding.⁸³ Courts uniquely bring together opportunities to provide a combination of treatment and a perception of fairness that may have success in reforming people with ASPD who are committing crimes. This does not mean that with the implementation of a specific system for ASPD these individuals will all "go straight". Those who work in the legal sphere are always ready for disappointment when dealing with persistent recidivistic offenders. Success is incremental and should be measured in those terms.

The key factor to consider when dealing with people with ASPD is that it is clinical condition, rather than simply a behavioural choice. Although substance use is often associated with ASPD, some of the fundamental issues that underlie both conditions is poor decision-making, a lack of coping skills and poor problem-solving.⁸⁴ Therefore, as drug courts have achieved success with those that abuse substances, it appears equally as important to have court programs tailored to managing the spectrum of traits for those with ASPD. The overlap between ASPD and charges of substance use, theft, domestic violence and other high-risk-taking and nuisance crimes is prominent, and without further

⁷⁸ Jones C, "Intensive Judicial Supervision and Drug Court Outcomes: Interim Findings from a Randomized Controlled Trial" (2011) *Crime and Justice Bulletin, Contemporary Issues in Crime and Justice*, No 152.

⁷⁹ Festinger DS, Marlowe DB, Lee PA, Kirby KC, Bovasso G and McLellan AT, "Status Hearings in Drug Court: When More is Less and Less is More" (2002) 68 *Drug and Alcohol Dependence* 151.

⁸⁰ Marlowe DB, Festinger DS, Lee PA, Dugosh KL and Benasutti KM, "Matching Judicial Supervision to Clients' Risk Status in Drug Court" (2006) 52 *Crime & Delinquency* 1; Marlowe DB, Festinger DS, Dugosh KL, Lee PA and Benasutti KM, "Adapting Judicial Supervision to the Risk Level of Drug Offenders: Discharge and 6-Month Outcomes from a Prospective Matching Study" (2007) S4 *Drug and Alcohol Dependence* 88S.

⁸¹ Lind EA and Tyler TR, *The Social Psychology of Procedural Justice* (Plenum, 1988) p 29.

⁸² Lind and Tyler, n 81, p 220.

⁸³ Tyler TR, "Legitimacy in Corrections" (2010) 9(1) *Criminology and Public Policy* 127.

⁸⁴ World Health Organization, n 58, pp 555-558.



development of specialised court programs targeting ASPD, this ongoing relationship will continue.⁸⁵ In that regard, a therapeutic jurisprudence approach specific to ASPD would thus focus on reforming the poor decision-making, lack of coping skills and poor problem-solving, rather than rehabilitating people with ASPD in the traditional sense.

Reforming people with ASPD not rehabilitating them

“Rehabilitation” properly describes a restoration of reputation⁸⁶ rather than a change in character. Some might argue that implicit in the term “rehabilitation” is an assumption that the person is inherently good and by kindness can be restored to that state. This may be a relevant assumption for atypical offenders but is perhaps less applicable for recidivist offenders with ASPD. People with ASPD by definition regularly depart from society’s norms and, from a legal standpoint, need to be reformed so that they are changed sufficiently to refrain from criminal behaviour. They may see kindness in isolation as weakness and an opportunity for advantage, without it being an agent for change. Just as kindness alone will not change people, neither will punishment alone. From a legal perspective, for change to occur in those with ASPD, a long-term structured approach that consistently and firmly reinforces a safe, stable and empathic environment is required. For recidivism to be reduced it is vital that clear boundaries are set, practical assistance is provided, and the individual perceives a sense of autonomy in decision-making and court/treatment outcomes.⁸⁷ Thus, a firm but fair approach is critical.

We should not reduce all punishment to terms of simplistic reductionism of time in prison compared to time lost by the victim.⁸⁸ Sentencing involves competing demands of personal deterrence, general deterrence, victim satisfaction, community protection and punishment. Court-administered intensive programs such as drug court are a form of sanctioning and should be recognised as such. At the start of a drug court program offenders are typically in electronically monitored home detention, stay clean of drugs and alcohol, which is monitored by regular urine testing, and are returned to jail if they do not comply with the program requirements. It is not unusual for drug court participants to withdraw from the program and go to jail because they find doing their time in jail easier than the rigorous demands of the drug court. The same would be likely of a program specific to ASPD. It is common in drug court programs for about 60% of offenders to be removed from the program and sentenced to immediate imprisonment. Where participants are successful, they are on a path to reform achieved by intensive programs, which are a form of punishment, but often can achieve reduced rates of recidivism compared to imprisonment. This is a better outcome, most importantly, for the community, as well as the offender and his or her family.

Sensible sentencing is not simply a choice between punishment or rehabilitation. We now understand from the work of the psychology profession, how manipulative and difficult to treat people with ASPD can be. Specialist reform programs in courts are an opportunity to move beyond a dichotomy between kindness or punishment.

Efficient use of court resources to treat ASPD

Judges and magistrates are expensive and in their sentencing role should concentrate their efforts where the greatest need exists. Since most offences are committed by relatively few offenders, it is appropriate that specialist programs be used for these offenders who are at high risk of reoffending; and because many of them will have ASPD, the programs should be tailored to treat it. From a purely economic perspective, court programs can be justified where they provide an alternative to immediate imprisonment and their cost of achieving any reduced recidivism is less than the cost of imprisonment in achieving the same reduction in recidivism. In a proper economic calculation, the nature of future crimes and their cost to the victims, and to the criminal justice system in investigating and prosecuting

⁸⁵ Ward T and Maruna S, *Rehabilitation: Beyond the Risk Paradigm* (Routledge, 2007).

⁸⁶ Maruna S, “Judicial Rehabilitation and the ‘Clean Bill of Health’ in Criminal Justice” (2011) 3(1) *European Journal of Probation* 97.

⁸⁷ World Health Organization, n 58, pp 555-558.

⁸⁸ Schulz and Cannon, n 3.



them, should be included in the calculation. On a purely economic basis, the figures quoted early in this article amply justify the view that drug court programs which target recidivist offenders as an alternative to immediate imprisonment should be a mainstream part of sentencing and should be extended to specifically treat offenders with ASPD.

The reform of criminals is not just an economic benefit. The cost and benefit of every social interaction cannot be calculated in dollars. Offenders with ASPD frequently cause harm beyond economic loss to all who interact with them and especially those in close relationships with them. The benefits of programs that offer pathways to reform are likewise greater than just the economic benefit; these programs will help to preserve and strengthen the social fabric.

CONCLUSION

The argument in this article is that programs involving intensive judicial supervision, such as drug court programs, are in fact often effectively treating offenders with ASPD. This should be recognised and court programs should be tailored specifically to treat offenders with ASPD and used where they can be most effective. As well as treating people with ASPD in sentencing programs, courts can have a useful role in managing the re-entry of offenders into the community as part of their sentence, typically on parole. The Compulsory Drug Treatment Correctional Centre in New South Wales uses a judge to provide supervision of sentenced prisoners undertaking the program and during their parole upon release.⁸⁹ Re-entry courts, which supervise the transition of prisoners from jail to the community, are also well established in the United States and this allocates judicial resources to high-risk recidivist offenders.

Court programs should also seek to reform domestic violence perpetrators with ASPD. Domestic violence may be one of the causes of intergenerational crime and condemning violence in the home by effectively enforcing criminal sanctions against it, while reforming abusive parents, will have a long-term pay-off by reducing bad role-modelling for children with the potential to reduce crime in the next generation. Other court programs, such as those designed to deal with homelessness and mental illness, should also identify participants with ASPD and put in place strategies to deal with it.

This will require changes to existing programs. ASPD will need to be specifically diagnosed and treated. There will need to be close cooperation between courts and psychologists to improve the effectiveness of programs to treat people with ASPD and to evaluate their success. Aptitude in pro-social role-modelling will need to be a criterion for judicial appointment, at least for involvement in these programs and judges will need appropriate education in the psychological principles relevant to treating people with ASPD.

At the moment, entry criteria for specialist courts have been developed around the problem they are specifically designed to address. Entry criteria that assess readiness for change for offenders with ASPD will need to be developed. No doubt these will take account of the established decline of the incidence of ASPD with age.⁹⁰ This is consistent with judicial experience that most offenders “grow out of it” by their mid-twenties, but those who do not mostly continue to offend until their late thirties or early forties, when another large percentage, in the contemplation of middle age, decide they are “too old for it” and have had enough. Consistent with this, court programs targeting ASPD might give priority to young offenders, because reforming them before a career of crime (at least until middle age) brings the greatest economic and community benefit. This is not to suggest that no programs be offered to criminals between their mid-twenties and forties, as bringing forward the end of their criminal activity, or reducing it, is a benefit worth achieving, if it can be done at a lower cost than imprisonment.

If antisocial characteristics are a result of conditioning, then when that behaviour crosses over into criminal behaviour it is rational to seek to reform the individual as well as to punish him or her.

⁸⁹ Dekker J, O'Brien K and Smith N, *An Evaluation of the Compulsory Drug Treatment Program (CDTP)* (New South Wales Bureau of Crime Statistics and Research, 2010), [http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/L20.pdf/\\$file/L20.pdf](http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/L20.pdf/$file/L20.pdf) viewed 10 February 2012; King, n 15 at 25.

⁹⁰ World Health Organization, n 58, p 558.



Effective reform of recidivist criminals will need to address those with ASPD and courts have a role in that, both as gate-keepers in determining sentence and, in appropriate cases, as agents of reform as part of those sentences. Courts should be primarily used to assist in the reform of high-risk recidivist offenders.

The primary measures of the effectiveness of the criminal justice system should be victimisation rates and imprisonment rates. In a well-run system crime will be declining at the same time as the need for the expensive option of imprisonment is also reduced.

APPENDIX

Diagnostic Criteria for 301.7 Antisocial Personality Disorder (DSM-IV-TR)⁹¹

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
 - (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
 - (3) impulsivity or failure to plan ahead;
 - (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults;
 - (5) reckless disregard for safety of self or others;
 - (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
 - (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another;
- B. The individual is at least age 18 years.
- C. There is evidence of Conduct Disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Diagnostic Criteria for F60.2 Dissocial Personality Disorder (ICD-10)⁹²

- A. The general criteria of personality disorder (F60) must be met.
- G1. Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or "norm"). Such deviation must be manifest in more than one of the following areas:
- (1) cognition (i.e. ways of perceiving and interpreting things, people and events; forming attitudes and images of self and others);
 - (2) affectivity (range, intensity and appropriateness of emotional arousal and response);
 - (3) control over impulses and need gratification;
 - (4) relating to others and manner of handling interpersonal situations.
- G2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations (i.e. not being limited to one specific "triggering" stimulus or situation).
- G3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to under G2.
- G4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.
- G5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, although episodic or chronic conditions from sections F0 to F7 of this classification may co-exist, or be superimposed on it.
- G6. Organic brain disease, injury, or dysfunction must be excluded as possible cause of the deviation (if such organic causation is demonstrable, use category F07).
- Comments: The assessment of G1 to G6 above should be based on as many sources of information as possible.

⁹¹ American Psychiatric Association, n 34.

⁹² World Health Organization, n 35.



Although sometimes it is possible to obtain sufficient evidence from a single interview with the subject, as a general rule it is recommended to have more than one interview with the person and to collect history data from informants or past records.

It is suggested that sub-criteria should be developed to operationalize behaviour patterns specific to different cultural settings concerning social norms, rules and obligations where needed (such as examples of unresponsibility and disregard of social norms in dissocial personality disorder). The diagnosis of personality disorder for research purposes requires the identification of a subtype (more than one subtype can be coded if there is compelling evidence that the subject meets multiple sets of criteria).

B. At least three of the following must be present:

- (1) Callous unconcern for the feelings of others.
- (2) Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
- (3) Incapacity to maintain enduring relationships, though having no difficulty to establish them.
- (4) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- (5) Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.
- (6) Marked proneness to blame others, or to offer plausible rationalizations for the behaviour bringing the subject into conflict with society.

Comments: Persistent irritability and the presence of conduct disorder during childhood and adolescence, complete the clinical picture but are not required for the diagnosis.

It is suggested that sub-criteria should be developed to operationalize behaviour patterns specific to different cultural settings concerning social norms, rules and obligations where needed (such as examples of unresponsibility and disregard of social norms).

