THE TREATMENT OF MENTALLY DISORDERED OFFENDERS WITHIN THE CRIMINAL JUSTICE SYSTEM

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Abstract

This dissertation aims to provide a critical examination of the various types of treatment interventions that affect the mentally disordered offender. This area has seen vast change within recent years, with a number of factors contributing to the desperately high proportion of mentally disordered offenders currently held within prisons in England and Wales. Arguably, focal to debates surrounding the appropriateness of treatment for this group is the care and control dichotomy that has historically undermined successful policy implementation for this group. This dissertation will address the various approaches that have been taken, exploring whether it is possible to balance punishment for their offending behaviour with a need to treat their mental disorder, whilst taking into account concerns with public safety that have increasingly penetrated debates surrounding the treatment of this group. Further, it will propose a number of plausible future policy directions, illustrative of the need to uptake an approach dependent upon both mental health provision and the Criminal Justice System.

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Introduction

The mentally disordered offender presents a dilemma when one attempts to implement legislation with regard to their behaviour. At the heart of debates regarding the mentally disordered offender is the care and control dichotomy. On one hand, it has been argued that there is a need to care for this group through healthcare services that primarily treat their mental vulnerabilities, within the community wherever possible. On the other is the argument that the ownership of this group lies within the Criminal Justice System (CJS), wherein an individual should be punished for their offending behaviour through a custodial term.

This research project aims to evaluate these opposing approaches to the treatment of the mentally disordered offender, drawing upon the failures of healthcare provision within the community and penal institutions, and further the detrimental effects that prison has been found to have upon the wellbeing of this group, with a particular focus on provisions in England and Wales. This is achieved through a literature based dissertation (see Appendix A for a methodological review). As a result of these flaws, it will be argued that there is a need for a change in tact for the treatment of this group, who would benefit from a number of alternative pathways to imprisonment that aim to tackle offending behaviours and treat their mental disorder.

Research Aims

- To provide a critical account of the development of healthcare policy for the mentally disordered offender within the community and penal institutions;
- To explore the nature of prison regime, and the effects that this can have upon the mentally disordered offender; and
- To determine possible future directions for the treatment of the mentally disordered offender within the CJS

The Scale of the Problem

Attempts to improve legislation to meet the needs of the mentally disordered offender are of significance because of the high proportion of offenders who are found to have mental disorder. However, it must be noted that this is not to say that there is a causal link between mental disorder and offending behaviour. It has been found that 40% of offenders who receive Community Orders are suffering at least one diagnosable mental disorder (Khanom et al, 2009). The proportion of prisoners suffering mental disorder is unrivalled by any other social group in England and Wales; Singleton et al (1998) found that 90% of prisoners suffer from at least one mental disorder, with male prisoners 14 times more likely than those in wider society to have

two or more mental disorders comparatively (Social Exclusion Unit, 2004). Whether it is the case that the CJS is working to increase the degree to which mental disorder is experienced or not, what is clear is that this group is in need of provision suited to the treatment of their needs.

Terminology

Throughout this dissertation, the definition that has been used when referring to a mentally disordered person is concurrent with the definition of mental disorder outlined within the 1983 Mental Health Act, unless otherwise stated. Although this definition has since been updated by the 2007 Mental Health (amendment) Act, which defines mental disorder as 'any disorder or disability of the mind' (Mental Health Act 2007, Chapter 12, Part 1), the former definition will be used as the 1983 Act is more commonly relied upon throughout existing literature on the issue.

Mental disorder, under the 1983 Act, is defined as in the following ways:

- Mental Disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind;
- Severe mental impairment means a state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning;
- Mental impairment means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;
- Psychopathic disorder means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

(Note: Mental illness remains undefined within the Mental Health Act 1983)

Thus, a mentally disordered offender is an individual who is deemed mentally disordered that has committed a criminal offence.

Dissertation Structure:

The first chapter of this research project will explore the main changes in health care policy of influence on the wellbeing of the mentally disordered offender. Health care provision for this group has been through a number of distinctive fazes; widespread institutionalisation up until the 1950s, the use of care in the community schemes in the latter part of the 20th century and finally a dependence upon prison healthcare services. Throughout the 1990s recognition was given to the need to withdraw the mentally disordered offender from the CJS as soon as possible in order to give care and treatment in a more suitable location. Yet despite this, there are still a high proportion of mentally disordered offenders held within prisons in England and Wales that are provided with substandard healthcare that is not equivalent to that given in wider society (Sim, 1990; Grounds, 1994; Reed & Lyne, 1997).

To follow within the second chapter will be a focus upon the inappropriate nature of prison regimes upon the mentally disordered offender, by drawing upon sociological and psychological evaluations of imprisonment on inmates. It can be argued that the needs of this group are disregarded, along with the need to treat inmates with humanity, which has resulted in a disproportionately high incidence of suicide and self harm among prisoners (Summers, 2003). Despite the implementation of a handful of policies that attempt to safeguard the wellbeing of the mentally disordered prisoner, problems of overcrowding largely undermine any good work that the prison service does in caring for the mentally disordered offender, working to 'make ill people worse and disrupt the rehabilitation of the mentally disordered' (Lyon, 2005; 1). The effect of overcrowding has brought about a lack of constructive activity for inmates, a lack of contact with family ties and increased risk of victimisation, all of which have contributed to the poor experience had by mentally disordered offenders within the prison system.

The final chapter of this thesis will focus upon possible alternatives to imprisonment for future policy implementation, which arguably could provide a better service framework to meet the needs of the mentally disordered offender. The account will draw upon the worth of the Mental Health Treatment Requirement (under the 2003 Criminal Justice Act), which attempts to provide healthcare services within the community within the CJS. Secondly, the use of specialist Mental Health Courts will be addressed, as such provision increases the likelihood of appropriate sentencing to suit the needs of this particular user group. Finally, the use of Therapeutic Community Prisons, will be discussed as it has been suggested this type of prison regime can be of benefit to not only the wellbeing of the mentally disordered offender, as well as successfully reducing rates of recidivism (Knight & Stephens, 2009).

Chapter One:

The Development of Mental Healthcare Provision for Mentally Disordered Offenders

1.1 Introduction

The rhetoric surrounding the mentally disordered offender has continually changed throughout the development of laws, policies and practice, in light of the complex interface between mental health and criminal justice policy (Harding, 2005). One of the key themes to emerge from the development of Mental Health legislation is the tendency to emphasize a custodial approach to deal with mentally disordered offenders (Vaughan & Badger, 1995). This chapter will explore the key developments in mental health policy over time and the implications this has had on the mentally disordered offender. The analysis will start by discussing the origins of legislative provisions dealing with mentally disordered offenders.

1.2 Origins of Legislation

Arguably, since the origins of legislation that recognised the mentally disordered offender there has been a tendency to use incarceration as a way of protecting the public from harm (Littlechild, 2005). Early legislation surrounding the mentally disordered offender concentrated upon the 'criminal lunatic' (Vaughan & Badger, 1995); in 1482 English common law made it legal to imprison a dangerous lunatic either within their own home or in a local Bridewell Prison, houses of correction used to incarcerate minor offenders as punishment, displaying the long established tradition of separating the mentally disordered from the rest of society in an attempt to protect the public (Littlechild, 2005).

This custodial approach was furthered in the Vagrancy Acts of 1714 and 1744 that allowed Justices of the Peace to lock-up the 'furiously mad and dangerous', again for the safety of the community (Vaughan & Badger, 1995; 22), fuelled by what could be seen as a utilitarian motives. The Utilitarian tradition, most commonly associated with Jeremy Bentham and John Stuart Mill, is based upon the concept of morality whereby actions are assumed to be acceptable if they promote happiness, and unacceptable if an action produces the opposite of happiness (Burke, 2005). Thus, if a crime is committed the Utilitarian approach states that an individual should be punished for the good of the majority. This approach to criminality has not benefited the mentally disordered offender as by assuming an individual should be incarcerated if it is to bring happiness to the greatest number of people (Lyons, 1965), mentally disordered offenders have been dealt with in penal institutions that are inappropriate for their needs.

The 20th century saw a number of changes to policy in relation to the mentally disordered offender due to the development of new experimental treatment methods within the fields of psychotherapy, psychiatry and psychology (Harding et al, 1985). For the first time, through the passing of the 1913 Mental Deficiency Act, a need was recognised to divert the mentally disordered offender from the penal system into institutions where specialist treatment was available to cater for their needs (Vaughan & Badger, 1995). It can be argued that this specialist provision was beneficial in meeting the needs of this group, as although the Special Hospitals were reserved for patients judged to need 'special security on account of their dangerous, violent or criminal propensities' (Section 97, Mental Health Act 1959), this provision made 'their criminal status secondary to their primary need for hospital treatment' (Knight & Stephens, 2009;2), emphasising a humanitarian concern for the wellbeing of the mentally disordered offender that is often overshadowed by penal occupations in more recent legislation (Peay, 2002) (discussed further in chapter 3). This notion of primarily addressing the healthcare needs of the mentally disordered offender was mirrored in 20th century legislation through the 1959 Mental Health Act.

1.3 1959 Mental Health Act

The theme of custodial hospital care continued within the 1959 Mental Health Act (MHA 1959), which again forwarded the importance of diverting the mentally disordered from the prison system. Article 65 of the MHA 1959 enabled courts to issue a restriction order in conjunction with a hospital order when dealing with dangerous mental offenders, making the individual's release dependent on consent from the Home Office (Harding et al, 1985). This was of significance as not only did it divert the mentally disordered from prisons, the dependence upon Home Office guidance assured that dangerous individuals would be assessed in relation to the risk they could pose to society on release. However, although this attempt to divert was beneficial to some, many mentally disordered offenders remained within penal institutions as their condition was not classified under the remit of the MHA 1959 (Knight & Stephens, 2009), displaying the limited effect the MHA 1959 had in improving mental health care for mentally disordered offenders.

Another key impact of the 1959 MHA was that it changed the way in which psychiatric care was given through shifting the focus of practice, from bound to institutions into a community setting. The then Minister of Health, Enoch Powell, declared a governmental commitment to the closure of old mental hospitals (Powell, 1961), in order to lessen the stigma surrounding mental illness by treating it in the same way as you would a physical illness, based upon the conviction that mentally disordered people were not particularly dangerous (Taylor et al, 1993). One way that this was implemented was the use of an 'open-door' policy within local hospitals (Vaughan & Badger, 1995; 25), which included the removal of physical constraints (locked doors) from

wards. The removal of physical restraints was argued to have been beneficial for the majority of mentally disordered patients who were reported to have been healthier and happier, in line with the belief that physical security has an adverse effect on patient wellbeing (Vaughan and Badger, 1995).

However, there were a number of factors that hindered the effectiveness of the 'open ward' approach to treating the mentally disordered offender, routed largely in a concern about public safety. A further issue with 'open-door' wards was the financial strain that it put on the NHS, who had to employ more staff in order to ensure appropriate care was administered to patients deemed as problematic (Faulks, 1985). It was recognised that some patients were in need of security precautions because of the possible risk they posed to society, which resulted in some offenders known to be suffering from mental illnesses being sentenced to prison, inappropriately placed in special hospitals, or simply left in the community unsupervised (Gostin, 1985), denying them of the right to the intensive care that is often needed to cater for those with mental disorders.

Inadvertently, it can be said that the 1959 MHA acted as a catalyst to the swelling of the proportion of mentally disordered individuals within the UK prison system (discussed further in chapter two). The problems associated with the use of open wards lead to an unwillingness to transfer offenders from prisons into hospitals to treat their disorder. Two years after the implementation of the 1959 MHA, 179 men in UK prisons were transferred from prison to open ward hospitals in order to ensure they received the correct healthcare provision; some 18 years later in 1976, just 30 men received the same treatment (Gunn, 1985), exemplifying the shift to incarcerate rather than hospitalise mentally disordered offenders under the 1959 MHA. This has worked to amplify the stigma of risk surrounding mentally disordered offenders who arguably could be treated in the community (Petch, 2001); healthcare professionals have resultantly practiced in a defensive manner by prolonging an individual's detention within an institution for the protection of the public (Munro & Rumgay, 2000).

Although the 1959 MHA tried to establish community based programmes for the mentally disordered offender, there was little impact of this motion because of a preoccupation with the risk posed by this group to society. Indeed, it was not until the 1990s that any significant changes in healthcare policy were made to benefit the mentally disordered offender.

1.4 The Home Office circular (66/90) and The Reed Report

During the 1990s there was a great deal of concentration upon interventions that provided community based care for mentally disordered offenders. The catalyst for such an idea was the Home Office circular 66/99 (Home Office, 1990) and resultant Reed Report (Department of

Health and Home Office 1992). The Home Office circular 66/99 aimed to evaluate the CJS and associated services responsible for mentally disordered people who commit, or are suspected to have committed, criminal offences (Home Office, 1990). The chief argument of the circular was that, as opposed to prosecuting individuals with mental disorder, the preferred root to be taken should be through the use of Health and Social Services, wherein care and treatment would be given. This new approach to mentally disordered offenders relied upon a multi-disciplinary approach, reliant upon input from the Health authority, Social Services and the judiciary in order to assure the fair treatment of individuals (Home Office, 1990).

Fundamental to the policy was the notion that under no circumstances should an individual be 'remanded in prison simply to receive medical treatment or assessment' (Blowers, 1994:166), recognising the need to support the welfare of mentally disordered offenders through alternative measures to prison such as the use of caution, hospital care and support in the community (Care Programme Approach) (Badger & Vaughan, 1995). However, there is evidence that largely suggests this objective was unfulfilled displayed by continued use of remand in prisons that has worked to criminalise mentally disordered offenders; an evaluation of the treatment of mentally disordered offenders remanded in custody concluding that 'the courts were using remand prisons as social and psychiatric assessment and referral centres' (Cavadino, 1999; 58).

When assessing the importance of the 66/90 Home Office Report retrospectively, it has been said that the promotion of community schemes for treatment was positive by working to raise awareness of the problem and needs of mentally disordered offenders (Jewesbury & McCulloch, 2002). This recognition of a need for interagency co-operation to care for mentally disordered offenders was particularly praiseworthy in displaying an attempt to bridge the gap between the conflicting ideologies of the health and Criminal Justice systems. However, such inter-agency working was fundamentally flawed in practice due to the lack of funding allocated to the application of the policy by the government (Vaughan & Badger, 1995). With the implementation of NHS and Community Care Act 1990, resources available to the Care Programme Approach were limited by demands from other user groups, such as the elderly, who required similar services in the community, meaning funding needed to be dispersed through a number of schemes. Indeed, in 1993 NACRO estimated there was a lack of £54million for maintenance of the existing care in the community programmes, and estimated a possible shortfall of £289million in the proposed funding allocation for future care in the community projects. Financial strain unquestionably effected the implementation of the recommendations outlined within the 1990 Home Office Circular 66/90, to the detriment of the mentally disordered offender who has increasingly been held on remand for assessment, exemplified through the seven-fold increase in the number of mentally ill men and women incarcerated in prisons in England and Wales since the 1970s (Davies, 2002).

In 1992 the Reed Report was published to provide a comprehensive evaluation of Health and Social Services for mentally disordered offenders, establishing recommendations as to how the service could be improved. After an investigation by a joint commission (headed by Dr John Reed), established by the Home Office and Department of Health (HO/DoH), no less than 276 recommendations for improvement were published within the final Reed Report (DoH/HO, 1992). The report was based upon a number of guiding principles suggesting that patients should be cared for with a quality service and care through proper needs assessment (to be completed wherever possible care in the community), and the use of rehabilitation methods that would allow for reintegration into society in a bid to equip them to be able to live 'an independent life' (Vaughan & Badger, 1995; 33).

One of the main recommendations that was issued as part of the report was that offenders who are detained under the 1983 Mental Health Act should be withdrawn from the CJS as soon as possible in order to give care and treatment in the most suitable location (DoH/Home Office, 1992). As a response to this recommendation, a series of diversionary schemes were almost immediately put into place to limit the numbers of mentally disordered people within the prison system, albeit through 'a local and piecemeal fashion', rather than on a basis of a national strategy (Staite et al, 1994; 15).

One example of this, which later became the basis for a number of other diversion schemes, was the North West Hertfordshire Scheme (1985) which recognised that the uncoordinated approach of the various different agencies that dealt with mentally disordered offenders was leading to the incarceration of many whom where in need of care. Resultantly, it implemented a scheme whereby an individual would be assessed in terms of their specific needs through use of a multi-disciplinary panel to provide a quality diagnosis, and fundamentally establish a care programme to support the offender within the community (Staite et al, 1994; 17). The scheme proved a success in improving care facilities for mentally disordered offenders, and indeed was recognised as a positive attribute in the fight to divert individuals away from the CJS, prompting the government to give funding to the founding members of this scheme to promote their work on a national level.

However, despite this promotion, a small number of panel schemes were set up across England and Wales. Although enthusiasm for such schemes was shown, it was again a lack of funding to implement the schemes that acted as a barrier for the panel scheme to be developed and practiced on a larger scale, hindering the progression of effective care practices for mentally disordered offenders. This reoccurring theme of lack of funding suggests that the government does not see the diversion of mentally disordered offenders from the CJS into care as a priority. Indeed, the fact that 90% of prisoners were found to have at least one sort of mental health issue by Singleton et al (1998) some six years after the Reed Report suggests that there has been a lack of

willingness to implement recommendations to divert the mentally disordered offender from the CJS, meaning thousands of individuals have not been given care and treatment required of the needs of their condition.

The failure to implement the recommendations from the Home Office Circular 66/90 and the Reed report made for a shift in policy direction in the late 1990s. Rhetoric surrounding the Care Programme Approach was replaced with a commitment to change mechanisms within prisons to make for better mental health care provision for inmates.

1.5 Current Healthcare Provisions within Prisons

In the last fifteen years there have been a number of progressions in the field of healthcare within the Prison Service, reflective of the recognition that there was a need to implement strategies to enable the high number of mentally disordered offenders already in the system to stay within existing institutions.

A driving force behind the changes in provision was that there was a number of academics and research professionals who argued for prison healthcare services to be provided by the NHS in order to make the level of care available to prisoners proportionate that available to the general population (Sim, 1990; Grounds, 1994; Reed & Lyne, 1997). Although it has been claimed by the Prison Service that all prisoners have 'access to the same range and quality of services as the general public receives from the NHS' (HM Prison Service, 2002a; section 22), there is evidence to suggest this has not always been the case. In 1997 only 65 establishments (of approximately 140 prisons) were actually found to comply with these standards (Directorate of Health Care, 1998); many inmates were not receiving a sufficient standard of healthcare when compared to the level available in wider society. Of particular concern was the treatment of individuals who were known to be suffering from a mental disorder who did not meet the criteria of the MHA 1983 who were outlined as in need of better assessment and care in order for the service they received to be a similar standard as the treatment received within the community (Her Majesty's Chief Inspectorate of Prisons, 1996).

Resultantly, in 1999 a board made up of members of the NHS and the Prison Service was established in order to discuss the concerns about the existing provisions for mentally disordered offenders within the Prison Service. Until this time most mental health care within prisons was via visiting forensic psychiatrists who were failing to meet the needs of this user group (Birmingham, 2003). This Joint Prison Service and NHS Executive tightened the link between the two services and worked to modernise prison healthcare services through a partnership approach and the extension of psychiatric wards within prisons. The government viewed the purpose of this group to allow for the integration of two agencies in order to provoke the transfer

of skills and knowledge, ultimately to make for consistency in the treatment of mentally disordered offenders. However, the degree to which these two services can be seen to have integrated is received sceptically by some. For example, Grounds (2000) argues that although a partnership has been established conflict may arise due to differences in regime surrounding notions of care and treatment on one hand, and security and control on the other. Indeed, there is some evidence of conflict as there has been a reluctance of some prisons and Primary Care Trusts (PCTs) to carry out needs assessments to identify appropriate services for mentally disordered offenders under recommendation of the joint committee (McGauran, 2001).

1.5.1 In-Reach Mental Health Teams

The concern about the clashing ideologies of the Department of Health and Prison Service is no more evident than through the use of 'in-reach' mental health teams. The application of in-reach teams, that are funded by Primary Care Trusts, aim to provide specialist mental health services to the prison population, similar to that received by the general population based upon the principle of equivalence of care (Brooker et al, 2008;3). An initial source of tension was that the use of the in-reach service was reserved only for the most severely mentally disordered individuals, which was viewed by many of the existing prison staff to be unfair, suggesting the service needed to be extended to help those with 'moderate' needs too (Brooker et al, 2008;5). Further, the definition of what constituted as serious mental disorder was vague, which again made for tension and distrust between prison staff and in-reach teams, hindering the degree to which these services have integrated.

Some have argued that the use of in-reach teams has actually intensified tensions between the Department of Health and the Prison Service (Stephens & Becker, 1994) because in-reach staff are undermined in their working environment because of the strong emphasis on control that the Prison Service prioritises over healthcare provision. For example, the Sainsbury Centre for Mental Health (SCMH) outlined how the use of 'Lockdowns' override other activities, including in-reach appointments, wherein there is a '30-35% non-attendance rate' (SCMH, 2006, 12), which is due to the Prison Service's concern for security and control. The result of a primary concern for control is that mentally disordered offenders are denied access to the appropriate health services, disregarding their human rights, showing that despite the introduction of new mental health strategies within prisons, the dichotomy between care and control remains unbalanced, which continues to hamper the experience of mentally disordered prisoners.

As well as a need to tackle the tensions evident between the respective health and Prison Services, a report by the SCMH effectively summarised further flaws of in-reach services to be 'limited resourcing, constraints imposed by prison environment, difficulties in ensuring continuity of care and wide variations of local practice' (Brooker et al, 2008;5), which have

hindered the effectiveness of this programme. Indeed, in 2003 the Prison Reform Trust noted the functioning of in-reach teams to be limited within the prison system due to staff shortages that equate to just one member of staff to every 322 mentally disordered prisoner, leaving many prisoners without the level of support necessary to treat their disorder. In short, it is apparent that changes to mental health policy within prisons have had 'little effect on the actual experience of mentally disordered prisoners and on the factors detrimental to their wellbeing' (Knight & Stephens, 2009; 3).

1.5.2 NHS Healthcare Provision

The final significant change to healthcare provision affecting mentally disordered offenders occurred in April 2006 whereby the NHS took over the running of prison healthcare services in England and Wales (Mills, 2005a; 89). Being such a recent move, it is difficult to accomplish whether this full integration of services has brought about improved mental health services within prisons, though it has been recognised that success is dependent upon sufficient funding, and the ability of Primary Care Trusts to exhibit competence to supply efficient services to prisons (Keavney, 2003). Recent research has found there to be an increase in the funding of mental health projects within prisons since being under the care of the NHS, though the 11.2% (£20.8million) of the total funding allocated to mental health from the entire prison healthcare budget is still failing to reach the needs of the 90% of prisoners (Singleton et al, 1998) who are in need of these services. With these figures in mind, it is difficult to foresee the state of mental health provision within prisons altering significantly in the near future, regardless of the NHS taking over care within these institutions to better healthcare provision.

1.6 Summary

The development of legislation surrounding the treatment of mentally disordered offenders shows conflict between the respective health and criminal justice systems, which has worked to hinder the service provision for this group who have suffered at the hands of the contradicting treatment philosophies. Although the MHA 1959 did act as a catalyst for the care in the community approach to the mentally disordered offender, the government's commitment to the Care Programme Approach was contradicted by the lack of funding that was assigned to the implementation of such policies, which resulted in a steady increase in the use of imprisonment for the mentally disordered throughout the decades that followed.

The 1990s saw the direction of travel for the treatment of the mentally disordered offender move distinctly into how healthcare mechanisms could be improved within the prison system. Although it has been stated that the best case scenario for the mentally disordered offender would be to entirely remove this group from the CJS, the bid to improve the quality of care over

the last ten years within penal institutions is relatively praiseworthy. However, the application of such policy has been beset with issues of funding, and furthermore an unwillingness for prison regime to champion the welfare ideal over that of security and control, reflected in the poor experience had by mentally disordered offenders in the Prison Service.

The following chapter will discuss the inappropriate nature of prison regime for the mentally disordered offender and the detrimental effect that this has on the welfare of inmates.

Chapter Two:

The Inappropriate Nature of Prison Regime for the Mentally Disordered Offender

'There is no more distressing a mismatch in our Criminal Justice System than mental illness and prison.' (Selby, 2009; iii)

2.1 Introduction

The inadequacies of mental health care provision within UK prisons, as discussed in chapter one, are not the only issues that face the mentally disordered whilst incarcerated. The prevalence of such high rates of mental illness in prison has been recognised to be the fault of an over reliance of the CJS to use custodial sentences (Joint Committee on Human Rights, 2004) which is seeing a number of vulnerable individuals entering custody inappropriately. However it is widely recognised that the prison service is inappropriate for the needs of the mentally disordered offender; this chapter will analyse the reasons why this is so, and the consequences of their incarceration upon offenders.

There are a number of elements that suggest the nature of prison regime also to be ill-suited to the needs of the mentally disordered offender. The effects of day-to-day life within prison, due to the regime that is upheld by this institution, have been found to have a number of detrimental effects upon the existing mental health issues of inmates (Mills, 2005a). Furthermore it has been found to actually initiate the onset of certain mental illnesses such as depression and anxiety due to their experiences within prison (Joint Committee on Human Rights, 2004). One focus of this chapter will be to assess the occurrence of suicide and self harm among inmates, as it is recognised by a plethora of academics, the government and prison officials as a key concern with regard to the welfare of prisoners (HM Prison Service, 2001a, Howard League, 2004). This chapter will also address a number of the problems that work to exacerbate the mental health of inmates such as the incidence and effect of overcrowding, discrimination, isolation from family and friends and lack of privacy, which have all been outlined as key contributors to the poor mental health of prisoners (World Health Organisation and International Red Cross, 2005).

As a starting point, it is important to highlight the duties outlined by the Prison Service within their Statement of Purpose so that one can assess if prisons are functioning as they should be. One duty is 'to look after [prisoners] with humanity', and another to 'help [prisoners] lead law abiding and useful lives in custody' (HM Prison Service, 2010). Not only is there a commitment to abide by internal prison standards; as a public institution there is also a duty to comply with the Human Rights Act (1998) in order for the detention of the individual to be ethical under the principle of 'monmaleficence' (the obligation of institutions to do no harm to detainees) (Lee et al, 2005). It has been identified that the prison population has a higher proportion of people with

mental health problems than is found in the general population (Anthony & McFadyen, 2005). Yet despite the need for provision to help this group, the current system has been argued to 'make ill people worse and disrupt the rehabilitation of the mentally disordered' (Lyon, 2005; 1).

2.2 Suicide and Self-Harm in Prisons

Suicide is a problem that frequently penetrates prisons across England and Wales. In 2003 it was found that the suicide rate for males in UK prisons was more than twelve times of that compared to the male suicide rate in wider society (Summers, 2003). Indeed, the prevalence of suicide within prisons rose significantly between the early 1990s and 2003, even in spite of changes in suicide policy; in 1993 there were 47 suicides in prisons in England and Wales compared to 94 suicides in 2003 (HM Prison Service, 2001a, Howard League, 2004). More recently the figure has dropped with a recorded suicide rate in English and Welsh prisons of 60 cases in 2009 (Ministry of Justice, 2010), although this figure is still desperately high.

Although there are some recent statistics available surrounding levels of self-harm (House of Commons, 2009a) in prisons, it is recognised that they are limited because of a lack of standardised methodology to record data, which has made it difficult to permit valid comparisons across prisons and over time (The Howard League, 1999a). However, what is clear is that the incidence of self harm is far greater than suicide in prisons. In the first six months of 2003 there were 7692 recorded cases of self-harm in prisons in England and Wales, which marked a 30% increase compared to the same period in 2002 (Summers, 2003). This number has continued to rise in recent years, with 23,026 self harm incidents recorded in 2008 (House of Commons, 2009a).

Since the Home Office Circular Instruction (CI) 39/73 in the 1970s that reviewed suicide policy in UK prisons it has been noted that 'mental disturbance' is closely linked to elevated risk of suicide whilst serving time in prison (Home Office, 1973). This claim is supported by a strong body of research, including the work of Lloyd (1990) who found when assessing suicide rates a significant number of prisoners (one third) were in receipt of psychiatric treatment prior to their death. More recently, a study found that 72% of those who commit suicide in prison had a history of mental disorder, which was exacerbated during their period of imprisonment (Shaw et al, 2003). Further, a report published in 1993 identified a number of factors associated with risk of suicide and self harm, outlining mental illness to have been an existing problem for approximately a third of those assessed, which when present was viewed as a major factor to lead to suicidal tendencies (Liebling & Krarup, 1993). However, it must be noted the problem of suicide is a complex issue; one cannot simply attribute external explanations for suicidal behaviour such as prison regime, but must take into account 'the different factors and motivations' of the offender 'according to differing circumstances' (McHugh & Snow, 2002; 1)

in conjunction with complex emotional and psychological processes for each individual. Mental illness cannot be distinguished as a single causal factor in explaining suicidal behaviour, but seen as a variable along with the nature of prison regime that exacerbates individual vulnerabilities within prisoners.

2.3 The Sociology of Prisons

Sociological literature on prisons suggests that there is a distinctive prison culture; it is an institution that has attitudes and regimes that differ and segregates inmates from the rest of society (Newburn, 2007). Two classic pieces of research into the effect of prison on inmates, Sykes's *The Society of Captives (1958)* and Goffman's *Asylums* (1961), highlighted the detrimental effect that prisons can have on the prisoner's sense of self, which can lead to feelings of vulnerability in those that are already experiencing mental disorder (Coyle, 2005).

Sykes (1958) argues that there are five forms of deprivation that challenge a prisoner's sense of self, namely the deprivation of; liberty, goods and services, heterosexual relationships, autonomy and of security (Sykes, 1958). Each of these deprivations is of significance as they would usually act as the foundations of an individual's personality, but cannot do so whilst incarcerated due to the distinctive nature of prison culture. For example, the high levels of procedural and environmental security maintained by prisons in England and Wales, outlined as one of the primary roles of the prison service in the Woolf Report (1991), deprives inmates of liberty through 'confinement to the institution… and within the institution' (Sykes 1971; 65), limiting personal identity through strict restrictions on behaviours. Further, the denial of goods and services can also challenge sense of identity in that a prisoner's clothes (once convicted) will be replaced with a uniform that eliminates individuality, showing the nature of prison culture to be that of a people processing institution (Sykes, 1958). The resultant loss of autonomy and self-esteem through incarceration is said to be the result of the various modes of deprivation particularly in those who are already emotionally disordered, worsening anxiety and depression and sapping the strength that is needed in order to survive the boredom of prison life (Mills, 2005a). This problem has not gone unnoticed by the Prison Service, which acknowledged that their Service is at risk of individuals in the prison becoming completely dehumanized (Wheatly, 2002b). Resultantly, within the past ten years there has been an increased focus on developing strategies to support those prisoners with mental and emotional disorders, in an attempt to curb vulnerability and the risk of self harm and suicide throughout prisons in England and Wales (Coyle, 2005).

Goffman's work (1961) was centrally concerned with the effect of imprisonment on an individual's sense of identity. He proposed that prisons are 'total institutions' which require an individual to perform a number of adaptive processes to fit into the norms of his/her

surroundings. Goffman (1961) characterised total institutions as being under the rule of one authority, as individuals having to complete each phase of their daily activity in the company of a large group of others and the maintenance of strict regimes under the official rule of the institution to achieve its aims. Each of these characteristics put the individual under 'psychological assault' (Morgan and Liebling, 2007: 1126), provoking a process of 'mortification of the self' (Goffman, 1961: 6), that is, a change in self perception and identity. Similarly to Sykes's thesis, Goffman suggests that objects important to an individual prior to entering the CJS, primarily 'his body, his immediate actions, his thoughts and possessions' (Goffman, 1961: 31), are violated on receipt into a total institution often leading to psychological trauma and a distorted sense of self worth. Arguably, a mentally disordered offender is already suffering psychological assault through their condition, so placing them within an institution that challenges their fragile concept of self worth is inappropriate (Liebling & Maruna, 2005). Not all theorists agree with this notion, arguing that prison culture can work to improve self-esteem. For example, an opposing view that has been argued is that prison culture can improve an individual's sense of self worth through giving an inmate a sense of belonging and solidarity with their peers, which in turn works to alleviate some of the pains of imprisonment experienced within prison regime (McCorkle & Korn, 1954).

As well as a body of research focussed specifically upon the psychological effects that imprisonment has upon an individual, in more recent years there has been increased research implemented surrounding the operational style of the Prison Service, with particular regard to the effect of overcrowding on the functions of institutions.

2.4 The Problem of Overcrowding

Overcrowding has been recognised as a problem throughout prisons in England and Wales for a number of years, contributing to the poor experience many mentally disordered offenders have whilst incarcerated. Overcrowding has consistently been found to be a major cause of deterioration in prison conditions, working to distort the effectiveness of the Prison Service (Flynn, 1998). The problem is most evident within local prisons with many exceeding the operational capacity of the institution by up to 170%; for example in August 2009 Shrewsbury prison was overcrowded by 179% (NOMS, 2009), though overcrowding also permeates high security institutions to a lesser degree.

2.4.1 Lack of Constructive Activity

One consequence of overcrowding is the inability for the Prison Service to maintain one of its fundamental objectives to rehabilitate prisoners through the provision of facilities to enable prisoners to lead 'good and useful lives' (Prison Rule 3) on release of their sentence. Such

purposeful activities include a variety of educational and work programmes, as well as skills training courses (Coyle, 2005) to reform individuals. However, access to these provisions is hindered by large prison populations, leaving many inmates in the main unmotivated and bored in their day-to-day lives and creating a monotonous environment for inmates. This argument was confirmed by the Prison Reform Trust (2004) which illustrated the extent to which constructive activity was limited; in 2001-2, of a sample of 40 local prisons, just 2 managed to meet their own standards by providing at least 24 hours of purposeful activity a week for inmates.

2.4.2 Victimisation and Increase in Mental Vulnerability

This lack of constructive activity has lead to inmates spending vast periods of time in cells designed for single occupancy, with a stranger for more than 20 hours a day (Coyle, 2005, Prison Reform Trust, 2004). As a result of being held in such close proximity to others, the risk of agitation, depression, bullying and victimisation (Mills, 2005a) are increased, illustrating that prisons are fundamentally failing to meet the duty of care of prisons to protect prisoners from harm from others, and showing the inappropriate nature of prisons for the care of mentally disordered offenders. An example of this occurred in 1994 whereby Chris Edwards, a mentally disordered offender, was kicked to death by his cellmate in Chelmsford Prison (Coyle, 2003). The circumstances of Christopher's death were found to be in breach of Article 2 (the right to life) of the European Convention of Human Rights (1950). As a result the Prison Service was acknowledged as carrying the burden of responsibility of the death of Christopher, displaying the dire consequences that incarceration can have on the mentally disordered offender, who is more likely to become the target of victimisation.

Geary (1980) outlined a further consequence of the lack of constructive activity for prisoners. Geary (1980) suggested that the limited opportunity to participate in constructive activity increases the psychological strain and nervous disposition of mentally disordered prisoners who become increasingly vulnerable, and indeed enhanced the risk of suicide attempts (Liebling, 1992). In 2004 Her Majesty's Chief Inspector of Prisons deemed the provision of care for mentally disordered offenders to be disgraceful because of the inadequate levels of support and stimulation suffered by individuals held in their cells for prolonged periods. It is evident therefore that the problem of overcrowding has in recent years overridden the need to provide a positive and purposeful environment for inmates. By ignoring the needs of the mentally disordered through dealing with people 'en masse, as bodies to be processed' (Coyle, 2005; 18), it can be seen why mentally disordered offenders need to be diverted from the CJS before the point of incarceration.

2.4.3 Disregard for Family Life

The marked increase in the use of imprisonment has made for a growth in prison transfers and prisoners being detained long distances from their home. Within the period from 2003-4 it was recorded that there were 100,000 prison transfers for a population of 75,000 prisoners (House of Commons, 2005) illustrating the instability of location faced by inmates. The high transfer rates for prisoners has a number of detrimental effects on the welfare of prisoners including disruptions to healthcare programs, as discussed in chapter one, but also limits the opportunity for time to be spent with the family. In many cases the humane treatment of prisoners, an aim outlined by HM Prison Service in the Mission Statement, is overshadowed by a priority to 'find a location in which to detain them, with little account taken of whether it is appropriate or not' (Coyle, 2003; 17), with little regard to respecting a need to be close to family. For example, in September 2006 prisoners were on average imprisoned approximately 40 miles from their home, with 10,700 inmates incarcerated over 100 miles from their home (Prison Reform Trust, 2008).

Family is a defining element of a prisoner's individuality, of particular importance for the mentally disordered offender as the family can support a mentally disordered offender through working to alleviate feelings of isolation and lessen feelings of hopelessness and low self-esteem (Sykes, 1958, Toch and Adams, 1989). The Prison Service not only has an obligation to its prisoners to maintain strong family links, respect for family life is defined as a basic human right by the European Convention on Human Rights and the UK domestic Human Rights Act (1998). Despite this, it has been argued for many years that the Prison Service is failing to hold prisoners in appropriate locations, which has increased the psychological strain and nervous disposition of mentally disordered offenders (Geary, 1980), as well as contributing to the risk of inmates self-harming or committing suicide (Mills, 2005b) due to enhanced feelings of vulnerability and isolation from lack of access to family life (Liebling, 1992).

2.5 Policy Response to Mentally Disordered Offenders

Evidently, there are a number of problems that are faced by mentally disordered offenders within prisons that work to increase their vulnerability and worsen mental health. In 1999, an influential report was released by Her Majesty's Chief Inspectorate of Prisons that highlighted the need to make 'weaker' prisoners feel secure within institutions to support their wellbeing (HMCIP, 1999). This series of recommendations was recognised by the Prison Service, which has responded by forwarding a number of strategies in order to improve the state of prisons. Consequently, an annual report by the Prison Service (2003-4) listed a number of initiatives that had been launched, primarily aimed at suicide prevention though also appropriate for the needs of the mentally disordered community within prisons. Their initiatives included the introduction of a number of peer support schemes; strengthened bonds with the Samaritans and similar

support groups; improved training for prison staff surrounding the issue of suicide and mental disorder; and an increase in the number of suicide prevention coordinators (HM Prison Service, 2004). These schemes, along with the change to NHS health care provision in prisons in 2003, are seen to have had a positive effect on prison regime for mentally vulnerable prisoners, with the number of self inflicted deaths having fallen to its lowest rate since 1996, with 60 recorded deaths in prison during 2009 (Ministry of Justice, 2010).

However, although there has been increased support in a bid to ease some of the strains of prison life, there have been criticisms surrounding the level of commitment to changing the state of prisons from the government. For example, despite research that has emphasised the need to place prisoners in institutions close to their families in order to relieve some of the stresses of prison life (Sykes, 1958; Toch and Adams, 1989; Geary, 1980), in 2003 the government rejected a recommendation from the Public Accounts Committee to put prisoners near to their family home suggesting it to be unfeasible and undesirable (Home Office, 2003). By rejecting such recommendations, it is unlikely that visiting will become any easier for inmate's families. This situation has been argued to be down to the current 'target driven culture and practice of the Prison Service' (Mills, 2005b; 15) that often overrides the duty of care that the service owes to prisoners.

Despite the reduced suicide rates in prisons within recent years a number of criticisms have been forwarded surrounding prevention strategies. To the credit of the Prison Service, the increase in support through access to Listener schemes has made for a more personable approach to prevention. However, one of the main modes of suicide prevention that has been forwarded is through minimising ligature points and other objects which could be used to aid a suicide attempt. This type of prevention, albeit a pragmatic technique to reduce the risk of suicide, has been argued to be a 'sterile, artificial line of prevention' (Stern, 1998; 133), of little comfort to individuals in a vulnerable mental state. Such a focus in policy described as 'dehumanising, intrusive practices that are degrading' (Stern, 1998; 133), making questionable the degree to which prisons are committed to their duty of care for inmates. It is not sufficient practice to produce policies such as this to stop suicide if the overall conditions of imprisonment are ill-suited to prisoners who will remain feeling helpless and depressed (Coyle, 2005b), again exemplifying exactly why there is a need to divert mentally disordered individuals away from imprisonment.

2.6 Summary

From the above evidence, it is clear that the existing Prison Service within England and Wales is inappropriate in meeting the needs of members of the prison population who suffer from mental disorder. Not only does imprisonment worsen existing mental illnesses but the dire conditions,

largely as a result of persistent overcrowding, can actually onset a number of mental illnesses, increase an individual's experience of the 'pains of imprisonment' (Sykes, 1958), and indeed, increase the likelihood of an individual self-harming or committing suicide. Although there has been a small degree of improvement in prison conditions through the introduction of new policies, there remain a number of aspects within prison regime that exacerbate mental health conditions including the close proximity of other prisoners, the lack of constructive activity and the lack of contact with the family unit that continually cause distress to mentally vulnerable individuals within prison populations.

With this in mind, it is unquestionable that there is a need to divert mentally disordered offenders from the prison system, as opposed to using it as a 'dumping ground' (Lyon, cited in The Guardian, 2006) for the group that has been described as the group that nobody owns (Webb and Harris, 1999).

The following chapter will therefore analyse alternatives to the use of imprisonment, such as the use of care in the community projects and therapeutic communities that are generally more suited to meeting the needs of this group.

Chapter Three:

Alternatives to Prison for Mentally Disordered Offenders: A Future Direction?

3.1 Introduction

The limited success of healthcare within the Prison Service, and the general acceptance that 'mental health will deteriorate in prison' (Ladyman 2004; 2) as a result of inappropriate regimes, has lead to a need to readdress the treatment of mentally disordered offenders within the CJS. Arguably, the most appropriate way to do this is to assure the diversion of this group entirely from the CJS at the first instance to treat their disorder, rather than adhering to the traditional concepts of punishment that are usually present in UK policy. However, this is unlikely to become a reality due to the increased concentration on the concept of 'risk' that has been forwarded surrounding mentally disordered offenders, who are increasingly portrayed within the media as a threat to the safety of the public. With this in mind, this chapter will consider some realistic alternatives to prison presented by the CJS, such as provisions under the Criminal Justice Act (2003), specialist mental health courts and the use of therapeutic communities that are considered more suited to meeting the needs of the mentally disordered offender. The discussion will begin by examining how risk has permeated discussion surrounding the treatment of mentally disordered offender.

3.2 Media Influence on Perceptions of Risk

Rhetoric about the perception of 'risk' is central to discussions about alternatives to custody for mentally disordered offenders. The common image of the mentally disordered within the media is that they are prone to 'unpredictable and bizarre violence' (Howitt, 1998; 38). This stigmatisation of the mentally disordered is reinforced by a small number of high profile cases, whereby a mentally disordered individual has committed a serious crime whilst in community care, such as the cases of Anthony Rice (H.M. Inspectorate of Probation, 2006a) and Christopher Clunis who both committed murder whilst under supervision within the community in the 1990s (Applin & Ward, 1998), which work to increase public anxiety. Despite the fact that it is has repeatedly been found that the mentally disordered are no more likely to commit violent offences than the general population in similar situations (Prins, 1999; Gray et al, 2002; and Gagliardi et al 2004), legislation in order to reassure the public that something is being done to secure public safety has become a dominant theme of criminal justice law (Fitzgibbon, 2009). Such a tendency can be argued to have resulted in policies that have been ignorant to 'humanitarian concerns' (Peay, 2002; 747), instead focussing on risk-based sentencing policy which has tended to see the mentally disordered offender incarcerated for their crimes in institutions that can worsen their mental state (Mills, 2005a).

In light of the widespread stigmatisation of the mentally disordered, it would be unrealistic to suggest that there should be a reincarnation of 'care in the community' schemes (as discussed in chapter one), as there simply would not be the public support to do so. However, there are a number of sentences that have recently emerged that can be given within the community as an alternative to a custodial sentence, which arguably provide a plausible future direction for the treatment of the mentally disordered offender within the CJS.

3.3 Community Orders (Mental Health Treatment Requirement)

The Criminal Justice Act (2003) is an example of legislation that could provide an alternative to custody for the mentally disordered offender. Reform and rehabilitation are outlined as two of the main considerations of sentencing (Section 142(1)), suggesting a merging of objectives between the respective criminal justice and mental health services (Peay, 2007). Although in some cases it is recognised that an individual needs to be retained within a total institution (Khanom et al, 2009), it has been noted that community sentences can 'provide safe and positive opportunities for offenders with mental health problems or learning disabilities' (Bradley Report, 2009; 91). Critically, the Criminal Justice Act (2003) introduced a generic Community Order; an order that gives a choice of 12 different requirements that can be given either singularly or in combination with another requirement, in relation to the particular offender and the crime that they have committed. This is fundamental to improving the treatment of mentally disordered offenders within the CJS as an alternative to custody; the type of requirement to be fulfilled is assessed in line with notions of classical justice, in that the punishment given is proportionate to the crime (Newburn, 1995), but done so in line with a 'rehabilitative framework' (Bradley Report, 2008; 92).

One particularly applicable requirement to the needs of the mentally disordered offender are Mental Health Treatment Requirements (MHTRs), which can direct an individual to complete a course of treatment under the guidance of a mental health practitioner and/or a chartered psychologist, either within a care home/hospital, or in the community. In order to reinforce rehabilitation, and indeed the punitive aspect of the Community Order through the limitation of liberty, an MHTR is normally combined with a Supervision Requirement, which requires the offender to attend appointments on a regular basis with an Offender Manager or Probation Officer (National Probation Service 2006, Mair et al 2007).

Although the MHTR is listed as one of the 12 requirements of the Community Order, with the potential to improve the well-being of many mentally disordered offenders, statistics into its usage have found reluctance by the Courts to use this requirement, despite an admission by the Magistrates' Association (The Bradley Report 2009; 94) stating 'We have long stated that such offenders should not receive custodial sentences if there are appropriate community penalties

available'. Indeed, the Residential, Attendance, Mental Health, Prohibited Activity and Exclusion requirements made up less than one per cent of the total use of the Community Order in 2006, with the issue of just 725 MHTRs within a twelve month period (Home Office, 2007). The number of MHTRs that have been issued is staggeringly low when one considers the fact that at least 40% of offenders who receive a Community Order have a diagnosable mental health problem (Khanom et al, 2009).

Due to the fact that the Community Order is a relatively new piece of legislation, there is a limited amount of research surrounding the effectiveness of the twelve requirements. A further complication with specific regard to MHTRs is that '72% of those issued are done so in conjunction with the Supervision Requirement' (Seymour & Rutherford, 2008; 14), making it difficult to ascertain which element of the Order has had an effect on the offender's behaviour. The National Audit Office (2008) suggested evidence surrounding the impact of Community Orders in reducing recidivism to be inconclusive as there is a lack of thorough evaluations, highlighting a need for more rigorous research into the nature of community sentences in order to encourage more wide-spread usage, which ultimately would work to divert a mentally disordered offenders from the prison system. That said, there has been a growing concern surrounding the issue, exemplified through the commissioning of The Bradley Report (2009) by the government in a bid to improve the experiences had by mentally disordered offenders in the CJS through a comprehensive analysis of the existing services.

Of the limited research available because of the recency of the policy implementation, one positive attribute that has been highlighted of the use of the Community Order for the mentally disordered offender is based upon cost/benefit analysis compared to the cost of imprisonment. Early indications suggest that, in the best case scenario, £40million per year could be saved in the CJS (Tribal, 2008) through diverting mentally disordered offenders from the prison service into the community, working also to ease the problem of overcrowding that pervades many penal institutions. A further attribute of the MHRT is that there is research to suggest the effectiveness of treatment programmes within a criminal justice setting; the Drug Rehabilitation Requirement (DRR), introduced under the Criminal Justice Act (2003), likened to the MHRT through its dependence upon a multidisciplinary approach, has shown that through the use of a good infrastructure and resourcing a sound therapeutic requirement can be used within the CJS (Khanom et al, 2009). Indeed, the success of DRRs is reflected in statistics surrounding its usage that show it to be used for every one in twenty Community Orders (Home Office, 2007); arguably demonstrating the impact that the MHRT could have with increased implementation.

That said there are a number of obstacles that need to be tackled to increase the usage of the MHRT, perhaps working to explain why there is a shortfall in its use. Of the limited research available, a key criticism of the MHTR is that sentencers are confused as to who qualifies for the

usage of this requirement. Thus, it is recognised that the use of the MHRT cannot stand as the only alternative to prison for the mentally disordered offender as the requirement is only suited to certain cases where the mental disorder is less severe. Green (2003) reviewed the usage of the MHRT, finding that under the existing guidelines only a small proportion of offenders fulfilled the eligibility criteria. However, this is not to say that the MHRT should be entirely discounted; through the implementation of thorough guidelines for practitioners to specify precisely who are suited to the requirement, the use of the MHRT could be implemented with confidence throughout England and Wales.

In 2009, a research project was undertaken on behalf of the Sainsbury Centre for Mental Health (SCMH) by way of interviews with representatives from the courts, probation service and mental health services, to establish their respective understanding and experiences of using the MHRT (Khanom et al, 2009). Notably, the theme of interagency cooperation between the health and CJS was highlighted as imperative to the success of the MHRT requirement, calling a need for 'a shared understanding between professionals and agencies' based upon centralised strategies on protocol and pooled resourcing (Khanom et al, 2009; 37). The research concluded that although there are a number of pragmatic issues that need to be overcome to secure widespread use of the MHRT requirement, 'a community sentence with an MHTR is a potentially viable diversion tool' (Khanom et al, 2009; 37) for the mentally disordered offender.

3.4 Specialist Mental Health Courts

A recent progression in the CJS that could work to benefit the mentally disordered offender, and indeed divert them from custody, is the Mental Health Court. These courts, launched by the Ministry of Justice in July 2009 based on recommendations made in The Bradley Report, give recognition to the need to give better response to offenders suffering from mental illness, moving away from the punitive ideal that is usually displayed by this public body. Although these schemes (which at present are only being piloted) are set within the CJS, they aim to 'give timely access to mental health services' within the community (Straw, quoted on Ministry of Justice website, 2009). Not unlike the other initiatives discussed within this chapter (Therapeutic Prisons and the Criminal Justice Act), central to these Specialist Mental Health Courts is a dependence upon a multi-disciplinary approach; arguably a positive attribute in that concerns for the wellbeing of the offender are being addressed, whilst 'reducing reoffending and increasing public confidence in the Criminal Justice System' (Straw, Ministry of Justice website, 2009).

The model of the Mental Health Court is based upon existing Domestic Violence Courts that also uptake a specialist approach in dealing with crimes of a specific nature. The Domestic Violence Courts, that could be taken as an indicator of the success for the Mental Health Court, have been praised for their specialist approach to dealing with domestic violence, exemplified by a

governmental commitment to extend these programmes through the development of further specialist Domestic Courts, totaling 128 by 2011 (Ministry of Justice, 2009). Further, although Mental Health Courts' effectiveness cannot be truly established due to the recency of their implementation, this move has been welcomed by campaigners for the correct treatment of mentally disordered offenders. For example, Sean Duggan of the SCMH, suggested the worth of the courts providing 'a better way of managing offending by people with mental health problems' (Duggan, Speech Quoted on SCMH website, 2009), lessening the risk of imprisonment.

Although the introduction of the Mental Health Court programme holds the potential to divert many mentally disordered offenders from the prison system, it is of course a possibility that the pilot schemes will not produce sufficient results to warrant further funding from the government. For this reason, there is a need to draw upon existing programmes that have been already been shown to be of worth in the treatment of mentally disordered offenders.

3.5 Therapeutic Community Prisons

The mentally disordered offender has long been the subject of debate as to whether they are 'owned' by the CJS or accountable to the mental health services. Traditionally, the 'patient or prisoner?' debate has seen mentally disordered offenders in receipt of either care or control, though within recent years there has been the development of an institutional setting wherein these paradigms co-exist under one regime; suited particularly to the needs of those with severe mental disorder who are not suited to the community approach discussed so far within this chapter. Fennell (1991: 333) pointed out that 'despite current policies of diversion, significant numbers of mentally disordered offenders will remain in prisons, and therefore there is an urgent need to consider how a humane and therapeutic psychiatric service might be provided for within the prison system'. Grendon Underwood Therapeutic Prison is an example of such provision.

The concept behind therapeutic communities was founded during the Second World War whereby it was found that group therapy sessions in small communities were conducive to helping traumatised military personnel recover from their experiences in battle, challenging the more widely recognised psychoanalytical school of treatment that had been heavily relied upon up until this time (Robinson and Crow, 2009). Although throughout the 1960s a therapeutic community approach was adopted in hospitals to tackle the problem of substance misuse, there is just one penal institution in England and Wales that has become dependent upon this regime; Grendon Underwood Prison in Aylesbury. Therapeutic communities have a number of distinctive features, including the fact that these institutions are selective in who is received into their community working to explain at large why this approach to rehabilitation is not more widespread in the current penal system. That said, there is evidence to suggest the worth of the

work of therapeutic communities in tackling recidivism (Cullen, 1994), particularly with regard for the mentally disordered offender, suggesting a need to extend the application of such programmes to benefit the wellbeing of vulnerable individuals within the CJS.

Of significance to therapeutic communities is the use of a multi-professional team of staff that have a wide array of expertise appropriate to the needs of the mentally disordered offender. Notably, both mental health and the criminal justice sectors are represented within the core staff body including nurses, doctors, psychologists, psychiatrists, psychotherapists, social workers and probation officers who work toward a common goal. This arguably avoids the type of conflict that has occurred through the introduction of the National Service Framework to improve healthcare provision in conventional prisons (as discussed in chapter one) whereby tensions between the NHS and the Prison Service have been noted due to conflicting ideologies and perceptions of the function of prison (Grounds, 2000). The objectives adhered to are:

- *'to help each man improve his self-confidence and sense of worth,*
- *to help each man create positive relationships with others, helping him to move towards greater consideration and concern for the feelings and property of others,*
- *To help each man stop committing crimes.'*

(Reproduced from HM Prison Service, n.d.).

Evidently, these objectives differ massively from the more traditional goals of the Prison Service, which have been found criticised as being preoccupied with notions of security and control rather than achieving rehabilitation (Woolf, 1991). For this reason the regime upheld by Grendon can be argued to be suited to the needs of the mentally disordered offender, within an environment that actively seeks to develop self control and personal functioning for inmates (Newell, 1996). The regime consists of core activities such as group therapy meetings up to three times a week, as well as additional sessions such as social skills lessons and cognitive skills training, in a bid to not only reduce recidivism, but also to transform the whole individual to behave appropriately within the context of wider society (Knight & Stephens, 2009).

The concept of empowerment is central to the functioning of Grendon Prison (Campling, 2001), displayed through somewhat unusual staff/inmate relations through which prisoners are viewed as equal in decision making processes about aspects of prison regime. Again, this approach to the treatment of prisoners is particularly applicable to the needs of mentally disordered offenders. This sense of equality rivals the essence of 'total institutions' that continually works to assault the psychological wellbeing of prisoners in the majority of penal institutions throughout England

and Wales (Goffman, 1961) (see chapter two). By encouraging a sense of self worth and responsibility in line with emphasising moral duties to society as a whole, inmates are taught how it is appropriate to act within a community setting, which is beneficial as it prepares them for release into society once their sentence has been served.

On analysing reconviction rates on release from Grendon Underwood, research (Newton & Thornton, 1994; Cullen, 1994) has found the completion of courses of therapy to significantly reduce rates of reconviction on release, illustrating that this therapeutic community is fulfilling one of its main goals, 'to help each man stop committing crimes' (HM Prison Service, undated). Further, Cullen & Woodward (1997) also found a strong relationship bound to time spent in therapy and lower reconviction rates; a period of 18 months of therapy was deemed to facilitate the greatest improvement in behaviour for Grendon graduates. By comparison, conventional prisons are largely failing to rehabilitate criminals with three quarters of young offenders and half of all adults reconvicted within two years of release (Home Office, 2005a: Ch. 11). However, it should be noted that the success of Grendon Underwood must not be solely judged on rates of recidivism; there are major concerns surrounding the validity of official records of reconviction as it is widely recognised that there are significant differences in recorded and actual crime rates within crime statistics whereby there is inevitably a degree of 'wastage' that cannot be accounted for (Home Office, 1995b).

More relevant is the evidence that has been found surrounding the suitability of Grendon in meeting the particular needs of mentally disordered offenders. For example, Genders and Player (1995) found the regime upheld within a therapeutic prison regime to reduce levels of introversion, neuroticism, depression, anxiety and hostility experienced by those with personality disorders. Moreover, this type of regime is successful in tackling some of the failures of conventional prisons through displaying a more inclusive care policy; Grendon is isolated in being the only prison that has made provisions to help those suffering from psychopathy, in contrast to the practices of in-reach mental health teams (see chapter one), which argue the nature of psychopathic mental illness to be beyond help (Knight & Stephens, 2009) disregarding their duty of care to this specific group. In light of such evidence it is therefore unsurprising that in 2004 Grendon was labelled as an 'exceptionally safe prison' (HMCIP 2004; 4) wherein the problem of self-harm is minimal (despite the high amount of mentally disordered prisoners held within the institution), illustrating a strong commitment to their duty of care, and indeed humanity, that is not apparent in many mainstream prison environments.

Although the nature of a therapeutic prison regime is well suited to the needs of the mentally disordered offender, this type of institution has come under criticism. Central to the objections about Grendon is the view that it sits within the CJS as 'a cushy number' (The Times, 2004). Those who criticise Grendon often do so on the grounds of the dessert theory of sentencing

whereby emphasis is put 'upon the moral requirement to maintain proportionality between offence and punishment' (Newburn, 1995; 116). For this reason, questions are raised as to whether incarceration at Grendon constitutes as illustrative of classical justice because of the rejection of authoritive control over inmates and the emphasis on the *patient* rather than *prisoner* ideal (Knight & Stephens, 2009). However, to counteract this argument it should be noted that fundamentally the punishment of prison is the loss of liberty. Thus, punishment is evident within the Grendon Underwood regime as, although prisoners are given sway on many aspects of the regime, it is the prison staff that determine when an individual is judged as having served enough time to fit their crime. Indeed, as Ruck (1951; 8) argued, you go to prison 'as punishment, not for punishment'.

Further, the level of treatment given to inmates has also been viewed as indicative of injustice; it has been argued that 'The balance is wrong in terms of funding for perpetrators and victims' (Elliot cited on BBC, 2002), with little funding being allocated to supporting the victims of serious crimes. Although it is unquestionable that victims of crime should be entitled to support from the CJS, Grendon Underwood is often a cheaper alternative to conventional prison, costing £36,000 per prisoner per year compared to £39,000 per prisoner per year (Howard League for Penal Reform, 2009). Thus, the worth of Grendon Underwood Prison should not be discredited on the grounds of the financial strain put upon the CJS; the cost of the therapeutic community strengthens the case for the diversion of mentally disordered offenders from conventional prisons to this type of institution as it costs less comparatively, as well as reducing rates of recidivism and upholding a regime more suited to the needs of this type of offender.

3.6 Summary

Arguably, this chapter has provided a number of plausible alternatives to custody that are suited to the needs of most, but not all, mentally disordered offenders. The use of the MHTR under the Criminal Justice Act (2003) and the use of specialist Mental Health Courts provide a strong alternative to imprisonment for the mentally disordered offender due to the commitment from both the Criminal Justice and Mental Health systems to treat, rather than simply punish, this group. For those who are deemed unsafe to enter the public sphere, or indeed those whose crime undeniably warrants a custodial sentence, the therapeutic community prison is a worthy alternative to conventional prisons in that it achieves a balanced regime that upholds elements of both care and control.

In each of the methods discussed that aim to divert the mentally disordered offender from the prison system a multi-disciplinary approach is fundamental in reducing reoffending and treating the offender in a suitable manner. It is arguable that the Criminal Justice Act (2003) and Mental Health Courts in particular are representative of a shift in governmental ideology about the

mentally disordered offender; the focus seems to have become concerned with not just attributions of risk for the protection of the public, but further the welfare of mentally disordered offenders who are in need of support to aid their well-being. Further, the notion that a mentally disordered offender is treated through *either* care *or* control is no longer adhered to in much of the current policy, whereby it is recognisable that the objectives of the Criminal Justice and Mental Health services have become less paradoxical, and indeed, concurrent with each other.

However, there are undeniably a number of practical issues that need to be addressed, in particular with regard to the use of the MHRT, for practitioners within the Criminal Justice and Mental Health Services to increase their usage of Community Orders for the mentally disordered offender. The process by which community based schemes will replace the use of imprisonment will by no means be a fast one, with public safety still a key attribute to much of the policy surrounding the mentally disordered offender, but the shift toward policies that reflect a need to divert this group from penal institutions is nevertheless a positive one.

Conclusion

From the arguments discussed in this dissertation, it is evident that the appropriate means by which to deal with the mentally disordered offender is a contentious issue. Through the analysis forwarded in each of the chapters, I would argue that my research aims were fulfilled. Within the first chapter, which aimed to provide a critical account of healthcare provision for mentally disordered offenders, it was found that despite frequent changes in the type of strategies to deal with this group, the healthcare needs of mentally disordered offenders have been sidelined by a trend to place mentally disordered offenders within penal institutions, whereby their health needs become secondary to their categorisation as an offender. The second chapter, which intended to scrutinize prison regime and the effect that is has upon the mentally disordered offender, successfully did so; through drawing upon the sociological and psychological examinations of prison regime it was clear a number of factors, largely rooted in the problems of overcrowding and the emphasis on the control ideal, worked to worsen mental disorder and increase the prevalence of self harm and suicide amongst inmates. With regard to the final chapter of this dissertation, I would argue that the examination of the MHTR (Criminal Justice Act 2003), the development of more Specialist Mental Health Courts, and the use of Therapeutic community prisons provide a number of reasonable policy choices that could be made within the CJS in order to benefit the needs of the mentally disordered offender.

There are a number of themes that have reoccurred within policy that have contributed to the poor experience the generally had by the mentally disordered offender within the CJS and healthcare services. In light of this, drawing upon the literature reviewed within this dissertation, a number of recommendations can be made. Notably, central to the success of these recommendations is a need for the government to not only recognise that the current policy is failing this user group, but furthermore to commit to implementing change by allocating the appropriate degree of funding for action to be carried out by the necessary services.

Improved Education Regarding the Nature of Mental Disorder

The perception of the potential risk posed by the mentally disordered to society has historically overshadowed the need place this group within a setting most suited to their needs. This trend still prevails now, highlighted within the Bradley Report (2009) whereby legal practitioners admitted to tending to incarcerate due to a lack of understanding regarding mental disorder and the sorts of sentences appropriate to the needs of the mentally disordered offender. With this in mind, it is arguable that there is a need to educate all governmental providers of the nature of mental disorder in order to reduce the stigma faced by this group, perhaps through a mandatory training course, which in turn could change public perceptions of this group. Furthermore, the establishment of specialist Criminal Justice Mental Health Teams could ensure the

implementation of such training in order to educate on issues surrounding this group, and indeed raise the profile of the current problems in policy (Bradley Report, 2009).

Improvement of Mental Health Care within Prisons

In light of research that revealed the poor state of mental health services available to the prison population, it could be argued that there is a need for a drive for equivalence with that in wider society, with particular concentration on in-reach services that need to be extended to meet the needs of all with mental disorder. Further poor relations between NHS and prison staff, largely rooted in differing ideologies surrounding the care/control dichotomy, need to be improved in order to enable the care of inmates to become a primary consideration in the treatment of this group. This could be achieved through the implementation of a statutory requirement for prison officers to complete thorough mental health awareness training. Although it seems unlikely that in the near future the mentally disordered offender will be removed completely from penal institutions, there is a need for their mentally disorder to become a primary focus of prison policy, rather than secondary to their classification as an offender, in order to ensure that this user group is treated with humanity.

Additionally, a further recommendation that could make for more thorough suicide prevention policy based upon the principle of humanity; arguably there is a need to strengthen support schemes, such as the Samaritans 'Listener' schemes, as opposed to simply removing ligature points. There is a need for proactive policy regarding suicide and self-harm prevention as opposed to the current reactive policies in place.

Need to bring about a Partnership Approach

During the 1990s, a need for a multi-disciplinary approach in dealing with the mentally disordered offender was first outlined within the Home Office Circular 66/90 and the Reed Report (1992). In spite of repeated recognition that there is a need to improve the relationship between the Prison Service and health services, it would seem that there is still an unwillingness of these services to integrate fully (Green, 2003). Further, if there was to be a shift toward the care programme approach within the community, there is a need to strengthen the somewhat piecemeal approach to dealing with the offender when they have been diverted from the Prison Service. As outlined within the Bradley Report (2009; 124) 'there is no one organisation that can be held responsible for this population'. Thus, a national framework, in charge of the relevant government departments, agencies and organisations, is recommended in order to bring about robust legislative arrangements that will improve the accountability of the treatment of the mentally disordered offender. This recommendation has been outlined within the Bradley Report (2009); it advises the need to implement a National Programme Board that would

improve Criminal Justice Mental Health Teams (currently under NHS supervision), improve liaison and diversionary schemes and availability of information between the collaborative agencies in contact with this group to make for a consistent approach.

Development of Alternatives to Imprisonment

Chapter Three of the dissertation explored the relevance to future legislative directions for the treatment of the mentally disordered offender by evaluating the worth of alternatives to traditional custodial sentences. As outlined within the Bradley Report (2009; 92), 'Prison does not have to be the default position for many offences', with the Criminal Justice Act (2003) in particular acting as a plausible alternative to imprisonment for this group if the relevant government bodies issued clear guidance on the use of the MHTR. The use of the Mental Health Court also lends itself to more appropriate sentencing for the mentally disordered offender, which could see diversion from terms in imprisonment

As previously noted for some individuals, due to the severity of their crime, a custodial sentence is unquestionably necessary. A recommendation to be considered for serious offenders with mental disorders is the need for better provision of mental health services within the prison system, and access to the appropriate treatment, rehabilitation and resettlement services on release from serving their custodial term. Further, the development of therapeutic community prisons should be considered as a plausible alternative to more traditional prison cultures, due to its suitability to the needs of the mentally disordered offender and the fact that it is a cost effective method of dealing with this group. Although there has been an increase in the use of the therapeutic community regime, with the development of some therapeutic community wards in a select number of prisons in England and Wales, arguably the expansion of this type of provision would benefit the mentally disordered offender within the CJS.

Appendix A

Methodology

The chosen method of research for this project was a literature review of existing academic research surrounding the issue. The literature review is a type of secondary analysis whereby the researcher draws upon existing data in order to formulate their own arguments. I felt the literature review was most suited to my research needs as it enabled me to thoroughly explore available research on the treatment of mentally disordered offenders, in order to formulate well informed arguments about issues to be addressed within my thesis.

A decision was made to focus my research upon textbooks, journal articles, internet websites, Home Office reports and newspaper articles that raised issues of relevance to my research aims. For this reason, my research was largely conducted through use of the Loughborough University Library Catalogue and online journal websites. On the whole, resources were readily available as the treatment of the mentally disordered offender is a highly debated subject that has come under much academic research.

Although I am aware that the use of this type of secondary research is not without its flaws, fundamental to the decision to base my thesis on secondary research is the sensitive nature of this subject and the fact that much of my research would have to be conducted with vulnerable individuals, which would pose a number of barriers throughout my research. For example, it would be difficult to gain ethical clearing to enter a prison for the necessary amount of time to witness the effects that prison regime has upon the mentally disordered offender. Further, such primary research would have taken up an extensive amount of time, and indeed expertise (Bryman, 2004), which are not suited to the time frame given to complete the project or the level of my experience in conducting research projects.

A criticism of the literature review I felt important to bear in mind when completing my dissertation is that research findings can be misrepresented within some publications; it is necessary to take into account the conditions of production of the research, and further ensure not to 'assume that the meaning of the data is as the original researcher intended' (Seale, 2004; 364). For these reasons, I tried wherever possible to cite from published books as opposed to using internet resources, which can present bias arguments founded on little substance (Reardon, 2006). That said, the internet was particularly useful with regard to my final chapter as it enabled me to access recent reports which would have been unavailable if I had just used published textbooks.

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