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A Manifest Injustice?

Jill Peay

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Law Department

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Imprisoning the Mentally Disordered: A Manifest Injustice?

Jill Peay *

Abstract: The paper considers the nature and extent of mental disorder, amongst those who have been justly convicted, within prisons in England and Wales. These levels of disorder, and of serious disorder, are broadly consistent with the international literature. The implications of the presence of so many mentally disordered offenders for the established purposes of imprisonment are explored. Issues of accessing appropriate treatment are reviewed. A number of remedies are discussed, including those of interventions which would significantly reduce the prison population *per se*. The paper concludes that whilst for many mentally disordered offenders imprisonment is the right and proper disposal, for others it is an injustice that they are detained in conditions that may exacerbate their disorders, and for some others their presence in the prison population is a manifest injustice. The paper calls for a fundamental review of the purposes of imprisonment for all offenders, in the light of these observations about mentally disordered offenders.

* Professor of Law, London School of Economics and Political Science. This is a longer version of my public lecture at the LSE given in Conor Gearty's *Law Matters* series on 16 October 2013. I am very grateful for the expert commentary given then by Anita Dockley, the Howard League's Research Director and Dr Tim Exworthy, Consultant Forensic Psychiatrist and a Visiting Senior Lecturer at the Institute of Psychiatry, King's College London. I am also grateful for a number of insightful questions from the audience. Nicola Lacey kindly also read an earlier version of this longer paper and her comments were, as ever, remarkably helpful.

In 1996 Sir David Ramsbotham observed:

There is particularly urgent need for increased provision for the care of those with mental health problems, who make up a larger proportion of the prison population than they would of any other group in the community. What is more, prison can exacerbate mental health problems, which has a long-term impact on the individual concerned and the community into which he or she may be released (HM Chief Inspector of Prisons 1996:5).¹

Given that this situation persists into our current prison population, and has proved remarkably resilient to change over the last two decades, can it be described as a manifest injustice to imprison those with mental disorder?

ESTABLISHING BOUNDARIES

Whilst my starting point is to question the justness of imprisoning those with mental disorder, it is important to set out what I will not be tackling.

First, this paper does not concern the justness of imprisoning those whose mental disorder may have caused or contributed in a significant way to their offending. For these individuals questions can readily be raised about whether their culpability should be substantially reduced or indeed extinguished as a result of their mental disorder. Answering these questions is more problematic since the issue of causation is frequently difficult to establish in individual cases and the empirical literature generally is contested. I have written about this at length elsewhere (Peay 2011). And the Law Commission, in its ongoing programme of work on unfitness to plead, automatism and the special verdict of not guilty by reason of insanity, has also addressed the problems in detail.²

Rather, my primary focus relates to those who have been justly convicted. Is it then unjust to subject those individuals with mental disorder to imprisonment given the possibility, sometimes probability, that imprisonment will either result in their disorder not receiving the quality of treatment they could have received had they not been imprisoned, or exacerbate their disorder or possibly even, in some vulnerable individuals, elicit mental disorder? Indeed, is it unjust to imprison those on whom the psychological consequences of imprisonment are disproportionate to the seriousness of the offending in which they have engaged? Do such emotional costs get lost in the evaluation of what is just because they are

¹ The terms of reference were '[T]o consider health care arrangements in Prison Service establishments in England and Wales with a view to ensuring that prisoners are given access to the same quality and range of health care services as the general public receives from the National Health Service'.

² See <http://lawcommission.justice.gov.uk/>, last accessed on 16 January 2014.

so much harder to measure, or are they regarded as a legitimate, albeit regrettable, side-effect of the proportionate deprivation of liberty?³

Second, I will not be concerned with the lawfulness of the imprisonment of those with mental disorder. Under Article 5 of the ECHR it is lawful to detain people who have been convicted by a competent court (5(1)(a)), and lawful to detain in anticipation of a criminal trial where there is reasonable suspicion that an offence has been committed, or that another will be committed, or that the person will flee before trial (hence the need for remand in custody; Article 5(1)(c)); and it is lawful to detain persons of unsound mind under either provision. The ECHR makes further provision to detain lawfully persons of unsound mind where they do not fall into these categories; but here the detention has to take place in an appropriate environment – that is, a psychiatric institution and not a prison (*Aerts v Belgium 1998*).

Similarly, whilst the Criminal Justice Act 2003 s.142(1) sets out a number of purposes of sentencing to which sentencers must have regard, namely:

- (a) the punishment of offenders,
- (b) the reduction of crime (including its reduction by deterrence),
- (c) the reform and rehabilitation of offenders,
- (d) the protection of the public, and
- (e) the making of reparation by offenders to persons affected by their offences.

s.142(2)(d) states that when a court chooses to make an order under the Mental Health Act 1983 to otherwise dispose of a mentally disordered offender to hospital, then these purposes of sentence do not apply. And from that it can be inferred that they do apply when sentencing a mentally disordered offender under the Criminal Justice Act 2003.

Third, I will not be exploring the concept of justice. Suffice it to say that our conceptions of what is unjust may be easier to determine than what is just. As Tony Bottoms (1998) memorably observed, desert is an asymmetrical concept. Thus, we can probably all agree that the image of the frankly psychotic individual chained in a dungeon, even if he or she has committed an offence of the most heinous nature, would probably stick in our respective craws as morally unjust. But would we, and/or do we, have the same response to the image of a personality disordered offender detained in a modern prison (clean, well lit, with appropriate in-reach medical services reaching the equivalent standard to that available in the outside community)? Does that strike us as unjust? Probably not. And if that individual has been subject to a fair trial, with representation, leading to a finding of guilt in front of 12 jurors and where sentence has followed, imposed by a judge who has heard evidence in mitigation of the offender's personality disorder, we would probably regard their sentence as just. And

³ A point explicitly raised by Nicola Lacey.

particularly so if we can answer satisfactorily the prior question about whether they would have offended but for their disorder. But what of an offender whose underlying disorder may have contributed in some way to their offending but who is then held in conditions in prison where access to adequate treatment for that disorder is problematic? Or where prison exacerbates an underlying condition not related to the offender's offending? Those are more difficult cases.

Fourth, my argument about potential injustice lies primarily in the realms of contravening widely held public values – those of compassion for the sick and disabled, and of support for the needy. I start from the position that this is not controversial. Whilst punitive values undoubtedly inform some elements of public opinion with respect to offenders generally, research has repeatedly shown a more understanding approach to the sentencing of individual offenders once more is known about those offenders and about the efficacy of the various interventions made in the name of punishment (Roberts et al 2012, Roberts et al 2009). Notably, in the 2009 research, 61% of the public responded that, when sentencing someone being treated for depression at the time of the offence, the offender should receive a more lenient sentence in some cases, with 15% saying this should happen in most or all cases. Indeed, politicians of all complexions will refer to 'the mentally disordered' as a group worthy of an alternative approach to mere imprisonment when responding to questions about prison overcrowding; and our political leaders are not noted for their inclination to go against perceived public opinion. In short, my approach will be consequentialist – do good outcomes ensue from imprisoning the mentally disordered; and virtue-based – can we learn to do better in this field?

Finally, in terms of my boundary issues, there is an existing literature on what is known as 'impact' in sentencing. Christine Piper (2007) and Susan Easton (2008) have contested the issues and very helpfully laid the ground for further work. As yet, the Sentencing Council have not provided any systematic guidelines beyond what is available in their individual offence guidelines and in the guideline 'Seriousness' which deals with the principles underpinning the determination of seriousness.⁴ But beyond being required to have regard to the guidelines and the statutory framework, sentencers have a complete discretion to mitigate sentence as they see fit.⁵ It is perhaps understandable that the Sentencing Council have been reluctant to tackle this tricky area since impact in sentence can take on a relatively wide meaning; that is, any individual factor which may make imprisonment exceptionally harsh and, thus, any given sentence length disproportionate in the way in which it is subjectively experienced by the offender. The literature distinguishes between these factors and those which generally impact negatively on the whole prison population: for example, dreadful prison conditions have already been recognised by a former Lord Chief Justice, Sir Igor Judge, to be a factor that

⁴ Available at <http://sentencingcouncil.judiciary.gov.uk/>, last accessed on 16 January 2014.

⁵ See s.166 Criminal Justice Act 2003.

sentencers ought to take into account when determining the appropriate punitive value of a sentence.⁶ Whilst mental disorder is clearly one such factor that affects individuals, it is the assertion of this paper that the incidence is widespread (which would urge restraint in sentencing generally) and that its manifestations affect different offenders with different diagnoses in different ways (which would urge further mitigation with respect to individuals).

Given that this paper arose from a lecture in a series entitled 'Law Matters', it is worth stressing that it concludes that there are significant elements of injustice in the imprisonment of those with mental disorder, albeit arguably not injustice that could properly be described as manifest. And it arrives at that conclusion through a series of steps. First, it considers the nature and extent of mental disorder amongst the imprisoned population. Second, it briefly reviews the conditions and risks of imprisonment with respect to humane and safe confinement. Third, it examines whether the purposes of imprisonment are jeopardised by the preponderance of mental disorder and its nature amongst those imprisoned. And fourth, it reviews the nature of treatment for mental disorder in prison and the dynamic relationship between treatment in prison, treatment in hospital and the coercive consequences of that relationship. And it concludes by asserting that since mentally disordered offenders are not some easily identifiable or small group within the prison population, we ought to rethink the nature of our prototypical offender. And in so doing, reflect upon the relative unattainability of the stated purposes of imprisonment.

⁶ See his address to the Prisoners' Education Trust in 2007, reported at <http://www.dailymail.co.uk/news/article-491745/Overcrowded-prisons-justify-lesser-sentences-criminals-says-judge.html>, last accessed on 16 January 2014.

THE NATURE AND EXTENT OF IMPRISONMENT OF THOSE WITH MENTAL DISORDER

Table from Fazel and Baillargeon (2010) Table 1 p.958 Prevalence of mental disorders in prisoners in western countries in comparison with the general population.

	Male prisoners	Male population	Female prisoners	Female population
psychosis	4%	1%	4%	1%
depression	10%	2-4%	12%	5-7%
Anypd	65%	5-10%	42%	5-10%
Anti-social pd	47%	5-7%	21%	0.5-1%
Alcohol misuse/dependence	18-30%	14-16%	10-24%	4-5%
Drug misuse/dependence	10-48%	4-6%	30-60%	2-3%
Intell disability	0.5-1.5%	1%	0.5-1.5%	1%
ptsd	4-21%	2%	10-21%	3%

The data above from Fazel and Baillargeon’s table are based on analyses of a number of publications with large scale survey data of imprisonment in western countries compared with the general population. Three issues are of particular note. First, the raised levels of the most serious forms of mental illness; these pose stark questions about the satisfactoriness of the prior demonstration of criminal responsibility given uncertainty about the offender’s capacity (albeit that some incidents of disorder will have arisen post-conviction). Second, the most striking disparity in the figures relates to diagnoses of personality disorder (which now do come under the Mental Health Act’s definition of mental disorder) and of anti-social personality disorder with respect to female offenders. Where a diagnosis partially embraces behaviours that are in themselves criminal, there is likely to be significant overlap between the populations. However, given this overlap, questions about treatment interventions become more problematic since it is not always clear if treatment addresses the underlying disorder or the criminality. Indeed, such disorders are not easy to treat. Ironically, personality disordered offenders will most probably have had full capacity for their offending. Third, the high levels of drug misuse/dependence, which do not fall *per se* under the Mental Health Act’s definition of mental disorder.

To those familiar with the field there is nothing unusual in these figures. Over time or over countries, the problem of the over-representation of those with mental disorder in prison populations has been well known. Gluek's study in 1918 in the US established this, and in the UK, Gunn et al's work in 1978 (see also Gunn et al 1991) is definitive. But the international figures are undoubtedly striking.

These figures are also supplemented by those in the Singleton et al study (1998). The real problem in England and Wales is that there is no recent or proper update of this data. As the Ministry of Justice has observed 'The proportions of mentally ill in the prison population are not measured routinely so the actual change over time is unknown' (MOJ 2013a:10). This is one of a number of areas where we do not collect the relevant data so we cannot draw valid conclusions.

The Singleton et al (1998) study of psychiatric morbidity in prisoners in England and Wales is hardly recent. Based on research in 1997 Singleton et al found personality disorder in the sentenced population at 64% male, 50% female; functional psychotic disorders in the last year at 7% male, 14% female; depressive episodes in past week 8% male, 15% female (and any neurotic disorder 40% male, 63% female); only 34% of male and 45% of female prisoners had not used drugs in the year before prison; perhaps most worryingly for issues of 'just convictions', 5% of the male and 9% of the female population fell at 25 or below on the Quick test of intellectual functioning, that is at the lowest level. In total, only 1 in 10 of the prison population showed no evidence of any of the five mental disorders assessed (psychosis, neurosis, personality disorder, and alcohol or drug dependence).

Table 2 adapted from Singleton et al 1998 (note the figures here are significantly higher for functional psychosis and intellectual disability than in the Fazel and Baillargeon paper above)

	Male prisoners	Male population	Female prisoners	Female population
psychosis	7%	1%	14%	1%
depression	8%	2-4%	15%	5-7%
Anypd	64%	5-10%	50%	5-10%
Anti-social pd		5-7%		0.5-1%
Alcohol misuse/dependence	18-30%	14-16%	10-24%	4-5%
Drug misuse/dependence	66%	4-6%	55%	2-3%
Intell disability	5%	1%	9%	1%
ptsd		2%		3%

Similarly, work by Fazel and Seewald (2012), who used 109 samples based on 24 countries involving 33,588 prisoners, found a pooled prevalence of 3.6% psychosis in male prisoners and 3.9% psychosis in female prisoners. This was consistent with earlier findings: e.g. Fazel and Danesh (2002) of 62 prison studies, which also found 10% of male and 12% of female offenders suffering from depression; and 47% fulfilled the criteria for antisocial personality disorder.

Thus, even assuming that in England and Wales we are only average for psychosis in our prison population this would mean, of a population of say 75,899 convicted prisoners, some 2,732 people with functional psychosis in prison.⁷ There is thus a well-documented and persistent overrepresentation of people with what everyone would agree to be mental illness – madness – in its most acute form.

Sirdifield et al’s 2009 review of more internationally based literature finds high rates of co-morbidity – indeed Brooker et al (2002) found that as many as 12-15% prisoners have 4 or 5 co-existing mental disorders. Again, given the complexities of diagnosing mental disorder, and the increasing evidence that mental illnesses are not discrete entities but are spectrum based, this should come as no surprise (Adam 2013).

⁷ This assumes a 3.6% prevalence – a conservative estimate on figures above.

The more difficult statistics relate to the significant levels of mental disorder generally in the prison population. If only 1 in 10 of our prison population in the Singleton et al (1998) study showed no evidence of mental disorder in its broadest form, then the argument that is set out below is not one based on the need for exceptional measures with respect to those with mental disorder: it is an argument that applies to 90% of the prison population. In essence, mental disorder is commonplace in prison populations, severe mental disorder and those with complex mental health needs form a significant proportion of the sentenced prison population. And this is something that really should make us reflect on the nature and purposes of imprisonment.

But before I turn directly to that part of the argument, there are three further issues that need to be addressed, all of which relate to keeping prisoners in safe, appropriate and humane conditions. And all three issues apply with greater force to those with mental disorder.

THE CONDITIONS OF IMPRISONMENT

(i) KEEPING THE PRISON POPULATION SAFE

The conditions of detention are relevant not to the legitimacy of the conviction, but to the appropriateness of imprisonment with respect to the purposes it is designed to achieve. Thus, the *Safety in Custody Statistics England and Wales, Update to March 2013* (Ministry of Justice 2013b) reports for a prison population of approximately 83,000 for the 12 months ending March 2013 there were 51 self-inflicted deaths, 22,687 incidents of self-harm, 14,052 assaults and two homicides. In the light of these figures it is hard to argue that prisons are a safe place (even though self-inflicted deaths are down from 94 ten years previously, and suicide prevention policies in the early stages of imprisonment have had a marked beneficial impact). But at 61 per 100,000 prisoners this compares with the general population rate of 8.8 per 100,000 in 2011 (National Confidential Inquiry 2013). Again it is important to stress that we are not exceptional here: suicide in prison is high everywhere, partly because criminal justice systems select into imprisonment those who are already members of vulnerable groups, and partly because the environment and context in which they come into prison exacerbates the likelihood of suicide; albeit 90% is by hanging which is something that ought to be preventable. This enhanced rate of suicide (approximately 7 times) is comparable with other places internationally (Côté 2013). Moreover, as Hawton et al (2013:in press) note in their recent major study of self-harm in prisoners, '[I]n England and Wales, standardised mortality ratios for suicide are five times higher in male prisoners and 20 times higher for female inmates than in general population controls'. But we are unable to know whether fluctuations in prisoner suicides are attributable to the numbers of people detained with mental health problems since

this is another area where we do not collect the relevant data so we cannot draw valid conclusions (see above MOJ 2013:10). However, we do know that, aside from the figures on suicide, levels of self-harm amongst prisoners persist (Ministry of Justice 2013 a and b), self-harm amongst prisoners is substantial and it is associated with subsequent suicide (Hawton et al 2013).

(ii) THE REMAND POPULATION

Another population where arguments about manifest injustice arise concerns the remand population (Kemp 2013 commenting on the European Prison Observatory project). Since these individuals are not held for the purposes of punishment, we need to be very careful about holding unconvicted individuals with mental disorder in a prison setting, particularly given the anti-therapeutic nature of imprisonment. Some argue convincingly that imprisonment is harmful *per se* to an individual's mental health (see generally the Prison Reform Trust). Given that on 26 July 2013 the prison population was 83,223 and there were 829 people in immigration removal centres and the untried remand population makes up approximately 8.8%, this means some 7,323 people were being held pending trial or disposal (International Centre for Prison Studies, World Prison Briefing 2013). Of course, there are also arguments that we hold too many alleged offenders on remand – some of whom are not ultimately convicted. Is this a manifest injustice? If so, it is as true for the mentally ordered as the mentally disordered, albeit that the mentally disordered may suffer disproportionately. The solution seems obvious; the provision of more bail hostels, or to hold in hospital those with mental disorders where such detention is merited on clinical grounds. The 1983 Mental Health Act provisions permitting this are arguably underused given the scale of disorder within the remand population. And do those with mental disorder find it harder to access bail hostels given that reports may need to be written?

Contemporary figures on mental disorder in the remand population are even harder to obtain than those within the sentenced population. However, from the survey carried out in 1997, Singleton et al (1998:7) the authors note:

When asked specific questions about their mental health, 21% of male remand prisoners said they had received help or treatment before entering prison and 15% said they had received such help or treatment since coming to prison. Overall, 1 in 9 male remand prisoners reported that at one time they had been admitted to a mental hospital or ward but rarely had stayed more than six months. However, 5% of the sample group had been admitted to a locked ward or secure unit.

And as Brooker and Birmingham (2009:S3) observe, prisoners with mental disorders can feel very unsafe in prison.

(iii) KEEPING PRISONERS HUMANELY

Again this is not an issue on which I will dwell. I merely note three issues from recent reports by Her Majesty's Inspectorate of Prisons (HMIP).⁸ First, that the physical conditions of imprisonment can be less than ideal: the report from HMP Bristol noted single cells continuing to be used for double occupancy, much of the prison being dirty and complaints of infestations of cockroaches. But it also noted that of 577 prisoners held at the time of the inspection (2013: para 2.35):

The prison had identified 261 prisoners who had declared some form of disability on reception but we were not confident that all prisoners with a disability had been identified. In our survey, prisoners who identified themselves as having a disability reported more negatively than other prisoners about victimisation and feeling safe.

Whilst mental health services were reported as 'good' (2013: para S14) at the prison, with the 17 bed Brunel Unit 'being used effectively for those with significant mental health needs' (2013: para 2.107), questions remain about the general suitability of the conditions for those with mental disorder (and indeed, for all prisoners given the unsanitary conditions).

Second, the lack of resources and the presence of drugs are unlikely to be protective towards those with mental health vulnerabilities. At the recent HMIP inspection at Oakwood, one in seven prisoners reported having developed a drug problem whilst at HMP Oakwood (p.12) yet prisoners complained about inadequate access to even the most basic of toiletries (p.31).

Third, instances of inhumane treatment do occur. Most recently, HMIP reported, following a visit to HMP Bronzefield, a women's prison (2013:5):

At our last inspection in 2010 we reported:

The prison held a small number of 'restricted status' women, some of whom had severe personality disorders. Their needs could simply not be met by the prison. One woman, who had exhibited unpredictable and violent behaviour, had effectively been held in the segregation unit for three years with very little human contact or activity to occupy her. The conditions in which she was held seemed likely to lead to further psychological deterioration and were completely unacceptable. There was little evidence that senior staff in the Prison Service had oversight of women segregated for long periods to ensure their conditions were humane. Bronzefield is not an appropriate place for women with these needs and there was a lack of a national strategy to manage women with such complex demands.

We were dismayed that the woman who had already been in the segregation unit for three years in 2010 was still there in 2013. Her cell was unkempt and

⁸ See <http://www.justice.gov.uk/about/hmi-prisons>, last accessed 16 January 2014.

squalid and she seldom left it. Although more activities had been organised for her and better multi-disciplinary support was available, she still had too little to occupy her. Her prolonged location on the segregation unit amounted to cruel, inhumane and degrading treatment – and we use these words advisedly. The treatment and conditions of other women held for long periods in segregation was little better. Much of this was outside the prison’s direct control and required a national strategy for meeting the needs of these very complex women – as exists in the male estate. However, Bronzefield itself needed to do more to ameliorate the worst effects of this national failure.

THE PURPOSES OF IMPRISONMENT

Does the presence of those with mental disorder in such high numbers in the prison population undermine the legitimate purposes of imprisonment? Conventionally, deprivation of liberty, measured out in discrete (or indefinite) parcels of time, constitutes the punishment that the state delivers following conviction where the offence is so serious that only a sentence of imprisonment suffices to match the offender’s misdeeds. And mere deprivation of liberty, as a baseline objective, can arguably be achieved regardless of the mental state of the detainee.

However, the state is properly rather more ambitious in its objectives. As the Criminal Justice Act 2003 specifies,⁹ when offenders are sentenced the judge must have regard to a number of purposes: punishment, deterrence, incapacitation and rehabilitation. And the act of sentencing also fulfils the wider objective of denunciation. But which of these measures are appropriately imposed on those with mental disorder? Again this is not an easy question to answer because of the range and nature of the severity of the disorders experienced by those in prisons. And because mental disorders are not static conditions; they fluctuate over time making even those with more severe disorders amenable to criminal justice interventions at some points. But we can probably agree on one or two starting points.

First, punishment in its purest form, that is punishment without hope of any redemption, is unacceptable for all offenders. The ECtHR has most recently expressed this in a case concerning life without parole:

However, what tipped the balance for me in voting with the majority was the Court’s confirmation, in this judgment, that Article 3 encompasses what might be described as “the right to hope”. It goes no further than that. The

⁹ See above at page 3.

judgment recognises, implicitly, that hope is an important and constitutive aspect of the human person. Those who commit the most abhorrent and egregious of acts and who inflict untold suffering upon others, nevertheless retain their fundamental humanity and carry within themselves the capacity to change. Long and deserved though their prison sentences may be, they retain the right to hope that, someday, they may have atoned for the wrongs which they have committed. They ought not to be deprived entirely of such hope. To deny them the experience of hope would be to deny a fundamental aspect of their humanity and, to do that, would be degrading.¹⁰

For those on determinate sentences criticisms of ‘punishment as retribution’ have significantly less purchase since such retribution has a foreseeable (and hence potentially proportionate) basis. But for those on indeterminate sentences, where detention is reviewed after a set tariff period to determine whether the offender continues to pose a risk of serious offending, the incapacitative element of the sentence can be more problematic for those with mental disorder. Indeed, if ‘pure punishment’ can be regarded as degrading, this in turn raises interesting questions about the capacity of the person undergoing ‘punishment as retribution’ to understand that it is intended to have proportionate limitations.

Second, incarceration for public protection works as well for disordered as ordered offenders, albeit disordered offenders are more likely to have judgements made about them (arguably unjustly, that is, without foundation) with respect to their likely dangerousness. This is an argument that deserves a separate detailed analysis (see for example Szmukler and Rose 2013, Szmukler 2003, Wolff 2006). But, imprisonment following serious offending for the purposes of preventing further serious offending within a reasonable time-frame is not manifestly unjust.

However, once we move into the territory of deterrence, denunciation and rehabilitation the issues become more complex. Here what is required of an offender is rather more than that he or she merely understands that they are being punished or incapacitated. These are objectives that require an element of interaction with the offender (that is, not simply things that are being done to them). And here the question of the offender’s capacity to respond comes into play. Capacity is issue determined – it is not a status test. Thus, whilst one might have the capacity to order a black coffee whilst concurrently being aware of the dangers of drinking too much coffee, the same individual might not have the capacity to engage in a complex financial transaction – perhaps taking out an endowment mortgage – where the risks of so doing are not fully understood. Equally, offenders may have the capacity to plead guilty to an offence without

¹⁰ Judge Power-Forde’s concurring opinion in *Vinter and others v UK* (2013) Grand Chamber Judgment (*Applications nos. 66069/09, 130/10 and 3896/10*) 9 July at p.53. The reasoning echoes that of Laws LJ in the case of *R (Wellington) v. Secretary of State for the Home Department* [2007] EWHC 1109 (Admin) cited in the *Vinter* judgment at para 54 (albeit not subsequently followed in the UKHL).

necessarily having the capacity to respond appropriately to the interventions that follow.

Being more definitive about this is problematic, since I am unaware of any research in this area. But questions could easily be asked both at a high order of generality – are those with mental disorder any more deterrable than those without – and at a much more detailed level of specificity. With respect to the former the evidence on deterrence is relatively weak and largely indicates that it is the risk of being caught and the potential offender’s awareness of that risk, rather than the punishment that follows, which deters (Hough et al 2013). Do those with ‘mental disorder’ have altered perceptions with regard to the risk of being caught? Similarly, with respect to the latter, questions might be asked about the capacity of those with severe learning disability to engage with sex offender management programmes or anger control courses; or depressed or psychotic offenders to recognise the consequences of their actions; or of personality disordered offenders to have the capacity to show and feel remorse; and this may have particular relevance not only in therapeutic settings but also with reference to a decision to release made by the Parole Board. Many other such questions could be asked by type of disorder, not the least of which concern whether drawing such offenders out in group therapy sessions can risk causing harm to other offenders where staff are insufficiently experienced to handle the emerging disclosures.¹¹ This is a highly specialised area. All I would want to do at this point is to challenge the extent to which our conception of a typical offender as the subject of our penal philosophies fits the reality of the prison population with all of the cognitive and behavioural limitations prisoners display; to say nothing of the challenges that inadequate literacy and language difficulties must pose to our prison service. And without responsiveness to these more nuanced justifications for imprisonment, it becomes harder to resist the notion that what we are imposing on some mentally disordered offenders is a form of punishment with little hope (other than that a proportionate time in custody will pass), whereas what we impose on other offenders is a more blended form of punishment. And it is important to remember that on one definition of what constitutes mental disorder, mentally disordered offenders make up 90% of the prison population. In this context, the questions above about the legitimacy of some forms of punishment apply, logically, almost across the entire prison population.

To recap, my argument is that it is not manifestly unjust to impose a sentence of imprisonment on a mentally disordered offender where that sentence has been preceded by a fair process of trial, or by the acceptance of an informed guilty plea. Proportionate deprivation of liberty as punishment is not unjust. But that what happens thereafter (or fails to happen thereafter) might constitute an unjust intervention for particular kinds of offender in particular mental states. And since there always are tensions between the demands of successful treatment and what is

¹¹ A point made by Elaine Player.

required for successful release such dilemmas are likely to be writ large where treatment needs are more visible. These cases are perhaps most poignantly illustrated in those miscarriage of justice cases where offenders have refused to admit guilt and accordingly not been given early release, or released at all after their tariff has expired prior to the demonstration of a miscarriage. Of course, in acute states there are provisions for the transfer of offenders from prison into the hospital system, and this happens regularly, albeit not with the regularity or the speed¹² that some offenders' conditions probably merit. The problem of availability of beds in the health system is an acute problem (see Bhugra 2013; Mental Health Foundation 2013).

There is moreover a coherent retributivist argument that if you have the capacity to offend (that is, you autonomously made choices that had detrimental effects on others) then it is right and proper that you should suffer some intervention for those choices that treats you as an autonomous individual, and does not respond to you wholly and solely on the basis that you coincidentally have a mental disorder. Such an approach affords those with mental disorder the same dignity as those without: there is a proportionate rebalancing by the state of the inequalities caused by the offender.

However, a utilitarian approach to punishment would arguably impact differentially on the mentally disordered offender: first because punishment may be ineffective if it is not understood or if there is no capacity to respond appropriately to the relevant measures of intervention and it may therefore be ineffective to impose it; and secondly because the maximisation of good may entail removing the mentally disordered offender to an environment where medicalisation – treatment of the underlying causes if there are any - may occur. This also requires detailed analysis (see Peay 2011) since the causal relationship between disorder and offending is amongst the murkiest; and it is a relationship made all the more problematic by the fluctuating nature of many mental disorders.

The recent Joint Inspection report by the HM Chief Inspectors for Prisons and Probation (2013: 3-4) places this picture into a bleaker light. They observe that many prisons 'did not pay sufficient attention to the "offender management" functions, namely the rehabilitation of the prisoner and protection of the public'. And that lack of progress in this area 'casts doubt about the Prison Service's capacity to implement the changes required under the Transforming Rehabilitation Strategy designed to reduce reoffending rates, especially for short-term prisoners'. They called for a 'fundamental review'.

Finally, it is notable that the 2007 report from HM Inspectorate of Prisons, 'The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs' has 5 main and 45 supplementary recommendations for change. The extent to which these proposals have been implemented is hard to gauge, but perhaps the time has come for the Inspectorate

¹² A 14day time limit is now enshrined in Department of Health Guidance, although Barlett and Sandland (2013:389) are cautious as to its effectiveness.

to revisit this thematic report. It is unarguable that the persistent presence of mental disorder amongst the imprisoned population challenges the capacity of the prison service to achieve many of its objectives.

TREATMENT ISSUES

(i) TREATMENT IN PRISON

Rehabilitation and treatment are thorny issues. The traditional notion in penal terms is that rehabilitation implies a change in the individual leading to a reduction or cessation in/from future offending. But does rehabilitation have a secondary meaning of treatment for the individual's (mental) disorder? If so, this may be particularly problematic with reference to the coercive aspects of imprisonment. To take an extreme example, would we regard chemical castration as a means of intervening in future sexual deviance as an appropriate punishment, or merely as a possible treatment given the full and informed consent of the offender? And if the latter, would we regard it as acceptable to ask an offender to make that choice in conditions of detention, with the prospect of early release as a consequence/inducement? This would probably make some of us feel uneasy. But transfer the argument to those with mental disorders. When we treat those with personality disorder with their consent are we making bad people who do bad things (anti-social personality disordered individuals) less likely to be bad in the future (that is, by changing their essence) or merely changing their future behaviour? Indeed, can the two be readily distinguished? Or is reversibility the key?

This in turn raises a more difficult question as to whether manifest injustice is an absolute or a relative concept. Two types of discrimination can arise with respect to mentally disordered offenders. The first, which is discussed further below, concerns a failure to provide an equivalence of mental health service to that which would have been provided had the prisoner not been convicted. This arguably makes punishment unjust in its nature: that is, it impacts more harshly on vulnerable mentally disordered offenders because of the further damage that may be done to their mental health or by the failure to remedy what might otherwise be remedied in the community.

But this kind of discrimination cuts equally against other identifiable groups; for example the literature on the impact of punishment by imprisonment documents the various ways in which characteristics that the individual has – old age, youth and gender can all in turn make numerically identical punishments unequal in their impact. These characteristics thus become a basis for mitigating sentence lengths, given offences of similar levels of seriousness. And the Sentencing Guidelines recognise such characteristics, including the presence of

mental illness, as a legitimate basis for adjusting the severity of punishment. So perhaps here, the mentally disordered, or at least that subset with mental illness or disability, are treated equally insofar as is possible (see below).

(ii) TREATMENT IN HOSPITAL

The second kind of discrimination arises out of an arguable medicalisation of criminality which does not, and cannot, apply to those offenders who do not have mental disorders. The argument arises in this way. Those with mental disorder with capacity cannot be treated against their will in a prison setting. This would be exactly the same situation for mentally ordered offenders. However, mentally disordered offenders can be transferred to hospital, against their will, where they can be treated against their will under the terms of the Mental Health Act 1983.

This is particularly important: treatment without consent in a prison setting is not permitted (prisoners must be transferred to a mental health hospital if compulsory treatment for their mental disorders is to be undertaken). In stark contrast, those who refuse physical treatment cannot be treated in prison until they lose capacity – and even then treatment would have to be in their best interests taking into account their known former wishes about the treatment.

Once transferred to hospital, mentally disordered offenders are subject to the same discrimination that affects all compulsorily detained mental patients; that is treatment can be imposed on capacitous individuals. This is an issue that was addressed by the Richardson Committee in 1998. And this argument perhaps cuts most deeply with respect to the detention of offenders with anti-social personality disorder reaching the very end of a determinate sentence, who are then transferred to hospital on the grounds of the nature of their underlying disorder, but with an eye to providing a secure environment to prevent the realisation of a predicted risk. This is not an argument I intend to explore further here. Suffice it to say that these late transfers have become more of a problem since the Mental Health Act definition of mental disorder was extended so as to include those with personality disorder. Such transfers cannot, by definition, extend to those without mental disorder. This is a tricky argument to pursue since ostensibly transfer is on the grounds of medical necessity (and is accordingly not discriminatory but advantageous). However, the question arises as to why, if medical necessity is made out, the transfer did not occur earlier in the sentence? And there are further questions about the viability of the treatment and the likelihood of its success where personality disorder is the principal diagnosis. And, of course, in the absence of treatment success the detention can, under the Mental Health Act, last indefinitely.

(iii) COERCION

Another issue concerns the vulnerability of prisoners to treatment coercion. Coercion arising out of the need to be seen to be co-operative where parole is in

prospect applies equally to the mentally disordered and the mentally ordered offender. Prison is an inherently coercive environment and prisoners engage in all sorts of activities they may not otherwise choose to engage in (e.g. attending sex offender treatment courses or anger management or doing jobs compliantly) because they may believe it enhances the prospect of release. But treatment coercion can be seen as greater for the mentally disordered offender where the backdrop of explicit coercion under the Mental Health Act exists.

To what extent is treatment given in prison with consent obtained under coercion? Does taking anti-psychotic medication, which has known adverse effects (obesity, impotence, etc., Zigmond 2011) represent a step change in the effects of coercion constituting a manifest injustice? Certainly the General Medical Council (2008:19) is alive to this difficulty in its advice to doctors on ensuring that decisions are voluntary in paragraphs 41-42:

41. Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. You should be aware of this and of other situations in which patients may be vulnerable. Such situations may be, for example, if they are resident in a care home, subject to mental health legislation, detained by the police or immigration services, or in prison.

42. You should do your best to make sure that such patients have considered the available options and reached their own decision. If they have a right to refuse treatment, you should make sure that they know this and are able to refuse if they want to.

Put more simply, prison is a coercive environment and one which is not obviously compatible with voluntary engagement with treatment. Indeed, since it is already known (Burns et al 2011) that ‘leverage’ amongst mental health populations exists, how much more likely is it to occur in an imprisoned population? We do not know the answer.

This is potentially a classic area of discrimination – and one which the Richardson Committee attempted to address back in 1999; whilst there are no formal legal powers to treat the mentally disordered in prison that do not apply to the mentally ordered (the discrimination Richardson was addressing was largely with respect to civil powers for treating those with mental health problems, and to offenders who are sent to hospital rather than prison), the coercive aspects do have a different impact on the mentally ordered and mentally disordered. Richardson concluded that it would be inappropriate to extend compulsory powers to a prison environment; but coercion is much more difficult to regulate. The medicalisation of criminality may represent another injustice, but an injustice which may not be readily manifest. Medicalisation, both before and after sentence, exposes mentally disordered offenders to both the benefits and perils of

psychotropic drugs; and their mixed therapeutic effects are contested (see Burns 2013, Davies 2013 and, for a perspective from a former drug user, Self 2013).

This argument can, of course, be turned on its head. Imprisoning the mentally disordered can be seen, as has been argued above, as a denial of treatment opportunities because treatment cannot be given without consent in a prison setting. Whilst one might argue (and I have above) that this puts mentally ordered and mentally disordered offenders on the same footing, one might also argue that it is the very nature of mental disorder which may contribute to treatment resistance. Thus, those with mental disorder may be less likely to comply with medical recommendations for treatment. Moreover, if, as Dressing and Salize assert when reviewing the international context, the proportions of mentally disordered prison inmates are rising, then the disadvantage experienced also arguably increases: in this context they quote (2009:802) the observations of the World Health Organisation:

One of the difficulties in keeping mentally ill offenders out of prison is that many countries do not have appropriate facilities to house people regarded as criminal and dangerous. As a result, those with mental disorders are not only forced to stay in prison, but are also deprived of the necessary treatment there (WHO 2005, p.5).

Dressing and Salize are appropriately cautious about the reasons behind this rise, and consider the possible explanatory factors as including issues of deinstitutionalisation from community based facilities (that is the closure of the asylums and their successors), the failure of community care to replace in-patient psychiatric beds, and 'a tendency to shift non-compliant or mentally ill violent patients towards forensic psychiatric settings or the prison system' (2009:802). Whether these apply equally in this country is unclear since we do not even have clear data on the make-up of the mentally disordered prison population over time, so it is impossible to say whether it has risen or not. All we know is that it is consistently disproportionately high by comparison with the levels of disorder in the community.

REMEDIES

What might be done about this?

1. It would be a mistake to think of this solely as a problem of imprisonment; the decision to imprison is only one of a series of decisions in the criminal justice system, so the solution might lie elsewhere. For example, effective pre-trial diversion or post release maintenance of support, care and medication for those who might otherwise return to prison through further offending could have

greater preventive impact (see the Bradley Report 2009; Scott et al 2013¹³). Prisons are not exceptional in being places where those with mental disorder are detained in inappropriate conditions: police cells are another notable example (HMIC 2013).¹⁴ The recent announcement of a £25 million post Bradley pilot placing mental health nurses in police stations and courts in an endeavour to ensure such individuals receive needed treatment and to reduce further reoffending is thus much to be welcomed.¹⁵

2. Andrew Ashworth's proposal from his 2012 'What If...?' lecture should be adopted. He argues that we send to prison those for whom prison is a disproportionate punishment. If we did not send non-violent property offenders¹⁶ to prison but found some form of community intervention and/or reparative measures then we could reduce the prison population overnight. Ashworth (2013: 12) calculates that this would affect 20,000 offenders convicted of theft or handling at the reception stage, 5,000 for fraud and 1,000 for criminal damage, leading to a reduction in the sentenced population of 8% for male prisoners and 21% for female offenders. And because mentally disordered offenders commit broadly the same kinds of offences they populate equally the categories at the lower end of seriousness. This is not an argument based on exceptionalism: it simply recognises that if it is disproportionate to send mentally ordered offenders to prison for offences of property like theft, handling and fraud, then it is likewise disproportionate to do so for mentally disordered offenders.

3. The logic of the argument on the failure of prisons to fulfil their wider objectives argues in favour not only of reducing particular categories of prisoner, but also in favour of significantly reducing the use of imprisonment *per se*. As idealistic as this may sound there is a long history of support for such an approach (see e.g. Hudson 1987, Mathiesen 2006) and, more recently, empirical evidence which could lead to rethinking the balance between community and penal options (Hough et al 2013).

4. Mental condition defences and provisions for unfitness to plead are currently very narrow. The numbers with severe mental illness or severe learning disability in prisons would suggest that these narrow rules may not be being

¹³ A meta analysis of 6,571 studies from 1980-2012. Although only ten studies met the inclusion criteria, they were effective in identifying offenders and had positive criminal justice and mental health outcomes. Effectiveness depended on the model of service delivery, the availability of community service and engagement of offenders with treatment.

¹⁴ Whilst police stations should only be used on an 'exceptional' basis for those with mental health needs, the report observed that all the evidence indicated that police stations continued to be used on a regular basis with more than 9,000 detentions under s.136 in 2011/12.

¹⁵ See <http://www.theguardian.com/society/2014/jan/04/mental-health-nurses-police-stations-pilot-scheme>, last accessed on 16 January 2014.

¹⁶ The proposal relates primarily to theft and fraud offences; burglary is discounted because it is intended to violate the right to privacy.

applied as they should be (Peay 2010). The Law Commission are currently examining both areas (see above) although there is little overt political enthusiasm for reform. But it is *just* that we should be more ambitious here. As the Law Commission argue, we should not punish those who are not criminally responsible – that is, those who did not have the capacity to be held criminally responsible at the point of their offending;¹⁷ although it is notable that in its further discussion paper the Commission would seemingly require a *complete* breakdown or absence of capacity for normal human rationality or self-control. In asking whether the individual had the capacity to choose otherwise the Commission would be both extending the ambit of insanity whilst coincidentally keeping its threshold very high (Law Commission 2013). In any event such a finding of lack of capacitous offending would not be compatible with imprisonment, since it would not constitute a conviction.

Although not the subject of this paper it should be noted that the majority of criminal cases are resolved via guilty pleas. Guilty pleas emanating from those arguably lacking the capacity to make them would be a problem. Our current rules on unfitness to plead (Peay 2010) are not based on an assessment of incapacity. This would entail an inability to understand and retain relevant information, including the reasonably foreseeable consequences of making the decision to plead guilty, or of making no decision, to use and weigh the relevant information, to retain that information, albeit only for a short period, and to communicate the decision made. Thus, it is possible that a number of those currently in prison have had their pleas accepted on an unjust, albeit not an illegal, basis.

5. Diversion at the point of sentence under the Mental Health Act 1983 is a remarkably underutilised option. For example, of offenders sent to prison in 2008, of whom there were 100,348 (MOJ 2012), only 735 received hospital disposals,¹⁸ a mere 0.73%. Yet, as the figures above reveal, some 3,612 people sentenced to imprisonment that year would have most probably had some kind of functional psychotic disorder¹⁹ And those figures do not take account of all the other individuals suffering from neurotic disorders, depression, personality disorder, those with co-occurring drug and alcohol addictions or those with a severe learning disability. There is thus arguably a considerable underutilisation of hospital disposals at the point of sentence. Quite why this is again remains subject to further exploration as the research base is now somewhat outdated (see Richardson 1993, Laing 1999). Similarly, the use of community orders with a mental health requirement attached under the Criminal Justice Act 2003 is also a much neglected sentencing option (Seymour and Rutherford 2008).

¹⁷ See Law Commission Scoping Paper (2012: para 2.73). They assert it would be ‘fundamentally unfair and unjust to hold someone criminally responsible for their conduct if, through no fault of their own, they lacked the capacity to obey the law’.

¹⁸ This figure comprises 343 s.37/41 (MOJ 2008) and 392 s.37 – DoH (2009); the figures are not exact as the two figures do not cover precisely similar periods.

¹⁹ Caution should be exercised here as this compares the sentenced population with the detained population, but it does use the more conservative European figures on levels of disorder.

6. Mitigation: both utilitarian and retributive theories of punishment could appropriately lead to adjusted measures of punishment (or, indeed, no punishment at all) for mentally disordered offenders. This would be based on their variable potential to respond to punitive interventions or rehabilitative ones, or their capacity to be held partially responsible for their offending, were the criminal law to recognise such a concept beyond the bounds of diminished responsibility manslaughter. The Sentencing Council's Guideline on Seriousness (2004: para 1.25) does point to mental illness or disability as one of the general bases for mitigation; the question is, should more allowance be made given the relationship between the psychological state of the offender and the purposes of imprisonment? It is also possible that restorative justice opportunities might be unjustly denied to those offenders with mental disorder who are perceived to be unlikely to be able to participate in such schemes (or where victims might be less enthusiastic). Indeed, the psychopathically disordered offender, who may be constitutionally unable to experience remorse or express empathy, or who may be unusually skilled at exploiting and manipulating victims in such situations because he or she is able to read others' emotions well, causes further difficulties for such schemes. And some of the international evidence suggests these are the offenders who are most quickly ejected by services.²⁰ Whether such treatment, or indeed denial of access to such services, constitutes discrimination is unclear: but discrimination is unlawful on the grounds of both mental disability, and learning disability and difficulties (Equality and Human Rights Commission 2010) and under the UNCRPD.

Again these arguments are difficult to make where commentators are not in the position of the sentencing judge who hears all of the evidence and is able to witness the behaviour of the offender in court. That said, our sentencing provisions do not always do justice to the individual circumstances of particular offenders. For example, those found guilty of murder, because they were found responsible for the offence at the point of the offence, will have to go to prison in the first instance even if their mental health has subsequently deteriorated. It is a legal requirement that those convicted of murder receive a life sentence of imprisonment and go to prison in the first instance, albeit those who are seriously ill at the point of sentence should be transferred rapidly. But offenders whose capacity may fall something short of full, but who are nonetheless convicted, may not benefit from any allowance for their underlying disorders. One such example might be the case of Nicola Edgington who was sentenced to life imprisonment with a minimum tariff of 37 years, despite having repeatedly called the police prior to her offences warning them that she felt she was, in effect, out of control (see

²⁰ A symposium at the International Association of Forensic Mental Health Services Conference in Maastricht in June 2013 explored some of these issues: see *Assessment and Treatment of Psychopathy in Dutch Forensic Clinical Practice*, a paper presented by Evelyn Klein Haneveld, Wineke Smid, Edwin Wever, Inge Breukel, Vivienne de Vogel, Jeantine Stam and Michiel de Vries Robbé.

IPCC report 2013 and Judge's sentencing remarks²¹). The sentence was upheld on appeal, albeit by that time Edgington had been transferred to Rampton Special Hospital under the Mental Health Act 1983.²²

7. Transfer to hospital: Given the spectrum of severity of unmet mental health needs in prison it is inevitable that some prisoners are detained in prison when they ought to be transferred to hospital. In 2005 it was argued that some 2,100 to 3,700 prisoners were likely to present with sufficiently acute mental health needs that they ought to be transferred to hospital (Rickford and Edgar 2005:44).²³ However, bed capacity within the NHS would not make such transfers remotely possible. Delays in transfer result, making the detention of these individuals in the absence of appropriate treatment facilities arguably unjust. The need for greater provision is self-evident. Moreover, having the power to transfer *only* those prisoners to mental health care on a compulsory basis who lacked the capacity to consent to hospital admission and treatment would free-up hospital beds currently occupied by offender-patients with various forms of personality disorder who retain capacity (see Szmukler et al 2010) who would otherwise be held in prison.

8. One argument that bears some consideration concerns the conditions in which prisoners are held – conditions which may either actively exacerbate their health problems or conditions where their existing health problems do not receive the standard of care they would get were they not subject to imprisonment. With regard to the former the regime which imprisonment necessarily entails (or entails under our current forms of imprisonment) is unlikely to foster the conditions which will enhance recovery – privacy, the maintenance of supportive social networks, and certainty about one's future prospects.²⁴ But these apply to all offenders regardless of their pre-existing vulnerabilities. With regard to the latter, if it were true then it could validly be argued that imprisoning such offenders would constitute an injustice: the punishment entailed in a prison sentence is supposed to be the deprivation of liberty, and not a further detriment to the health of the individual through lack of access to services. This argument is largely no longer contentious, and in April 2006 prison health care was transferred to the NHS.²⁵ However, in a recent study of mental health in-reach services in England

²¹ Available at

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CDIQFjAA&url=http%3A%2F%2Fwww.judiciary.gov.uk%2FResources%2FJCO%2FDocuments%2FJudgments%2Fsentencing-remarks-r-v-edgington.pdf&ei=6R4WUrm2FqOy7Abv_oHQCw&usq=AFOjCNEdHHIEJSpImu-zg8SQBiCuTGFm9Q&bvm=bv.51156542.d.ZGU, last accessed on 16 January 2014.

²² *R v Edgington* (2013) EWCA Crim 2185.

²³ Drawing on estimates compiled by Dr Adrian Grounds.

²⁴ I am grateful to Dr Tim Exworthy for this point.

²⁵ See also the Council of Europe's 2006 *European Prisons Rule*, available at <https://wcd.coe.int/ViewDoc.jsp?id=955747>, last accessed on 16 January 2014, and the Equality Act 2010.

and Wales, Tim Exworthy and his colleagues (Forrester et al 2013) concluded that although provision has improved over the last 10-12 years,

mental health in-reach services still fall far short of community equivalence and there is wide variation in service arrangements that cannot be explained by prison size or function (2013:326).

Indeed, in some prisons, albeit largely low security establishments, there was no mental health in-reach team at all. Thus, equivalence of health care remains a policy aspiration and does not reflect the reality of care in all prisons. Tim Exworthy has argued that what is required is an AAAQ approach – health care that is 'available, accessible, acceptable and of good quality' (Exworthy et al 2011). Lines (2006) has similarly argued that what is required is not equivalence of standards but equivalence of objectives and outcomes. This is pertinent since one might argue that it is manifestly unjust to provide equivalence of care (that is X number of nurses per 1,000 of population) when the need is much greater among a given population. As Forrester et al (2013:332) observe, the Sainsbury Centre has calculated that spending provision in prison is currently up to 4-7 times greater than in the community per head, but it ought to be up to 20 times greater given the level of documented prisoner needs. Exworthy et al (2012) have argued that this is not just a question of resources, but of a need for enforceable standards including a right to the highest attainable standard of health.

Finally, I accept that for some offenders a sentence of imprisonment might provide an opportunity to access both mental and physical health services that were not accessed in the community (Byng et al 2012) or not provided in the community; this is notably the case for Black and Ethnic Minority Offenders and for men with depression (HM Inspectorate of Prisons 2007). But whilst it may be advantageous for such groups to gain access to services via prison, it is unjust for others to be denied access as a result of imprisonment. There is a difference between failing to access something that was available in the community but is available in prison, and being unable to access something that is available in the community, but to which access is denied by reason of imprisonment.

CONCLUSIONS

Many prisoners perceive themselves to be unjustly convicted. By definition, they will also consider themselves unjustly punished. Whether we should objectively have greater concerns about the position of mentally disordered offenders in prison, with respect to the justness of their circumstances and location there, regardless of the justness of their convictions, has been the subject of this paper. Imprisoning the mentally disordered can be a *manifest* injustice, but whether it is

depends upon the circumstances in which their conviction came about, what kind and severity of mental disorder the prisoner is suffering from, what treatment is available in the prison for their disorder, and whether they are *able* to give voluntary (non-coerced, fully informed) consent to that treatment. There are also questions about the legitimacy of a sentence of imprisonment (which apply both to the mentally ordered and mentally disordered offender, but which have much greater purchase with respect to those with mental disorder) in the light of an individual offender's capacity to respond to the overarching purposes of imprisonment. Where that capacity is limited, as it is in many cases, questions can be asked about the justness of imprisonment.

There is no easy solution to this. It is clearly not a question of just moving mentally disordered people out of prisons and into hospital: this is too superficial a response and one too frequently made by those who are asked to respond to the problems of an overcrowded and rising prison population. And in any event, for a proportion of mentally disordered offenders prison is the right, proper and proportionate sentence for them – they are justly in prison.

Despite the occasional political pronouncements about mentally disordered prisoners it is overly optimistic to assume that there is any great political will in this area to change matters; the persistence of the problem defies such optimism. The Bradley Review (2009) has almost certainly had a beneficial impact with its clear restatement of longstanding government policy that mentally disordered offenders with acute mental health problems should be diverted away from the criminal justice system; and with its emphasis on securing access to services wherever they are located. But asserting an objective and putting it into practice are a gulf apart. Mentally disordered offenders are not a constituent group who agitate for their needs (albeit they have more capacity to agitate than those with mental illnesses in civil detention); and they are not a group for whom agitation by others is easy. The best efforts of the Law Commission to engage and continue to engage with the areas of both unfitness to plead and the law of insanity and automatism are to be applauded, but whether any parliamentary time would be made available if firm proposals were to emerge is doubtful. Similarly, a number of judicial initiatives to enhance the prospects of a fair trial for those of questionable capacity have been most welcome.

Part of the problem derives, as Dressing and Salize (2009: 807) observe from their survey of 24 countries in the EU and EFTA, from a failure to document the nature and extent of the imprisonment of those with mental disorder:

None of the included countries provides regular national statistics on the frequency of mental disorders of prisoners or on the availability or frequency of psychiatric treatments.

In England and Wales admission screening takes place, and there is assessment on release by a general physician, but this is insufficient properly to diagnose and estimate the prevalence of mental disorder in prison. Perhaps everyone familiar

with the system accepts it is widespread and thus there is no impetus fully and repeatedly to document the problem. Yet there is widespread agreement that

substance abuse, personality disorders and chronic psychotic disorders are found more frequently in prisoners than in the general population. The restriction of freedom, the prison setting in general or specific environmental factors in prison are potential mental health hazards. In particular, the early phases of imprisonment must be recognized as periods of high vulnerability (2009:809).

For many mentally disordered offenders imprisonment is not a manifest injustice, yet for some it is. And it is certainly an affront to our common notions of justice that this situation persists. HM Chief Inspectors of Prisons and Probation have called for a 'fundamental review' with respect to short term prisoners.²⁶ Perhaps it is time for a review of the purposes and efficacy of imprisonment itself.

²⁶ See above at p.13.

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