

MENTAL HEALTH, MENTAL DISABILITIES AND CRIME

Jill Peay

The relationship between mental disability and crime is complex. The familiar question of whether an individual charged with a criminal offence was ‘mad’ or ‘bad’ or a bit of both has long been superseded by more nuanced questions. What is meant by crime? Who can be held responsible for it? How can culpability be assessed for the purposes of punishment in those with a mental disability? Is treatment (and if so of what nature) more appropriate than punishment? And are those with a mental disability more likely to be at risk from the criminal activities of others, or to present as perpetrators of behavior that harms others, possibly in the most serious of ways?

Many of these questions are intractable. But the process through which the criminal justice system deals with those with mental disabilities has been subject to extensive review. The Bradley Report (2009) was an end-to-end examination of the system; it made significant recommendations, many of which have been adopted. The Criminal Justice Joint Inspection (2009) report was similarly critical of the system; and the Law Commission (2013, 2016a and 2016b) has looked at the legal framework for insanity, automatism and unfitness to plead, albeit their recommendations remain merely recommendations. The period of legislative turmoil which did take place concerned amendments to the Mental Health Act 1983 (MHA 1983)¹ which affected offenders with mental disability in more marginal ways than those proposed by the Law Commission. Beyond these policy and legal developments there have been important economic changes. The effects of the recession (Peay 2011a) and the subsequent policies of austerity are hard to assess empirically. But the latter have had a notable effect on police resources, and in a context where some forces have reported up to 40% of their time being spent

¹ See Mental Health Act 2007, and for commentary Peay 2011b

dealing with incidents triggered by mental health issues it is evident that mental disability should loom large in policy thinking.² Finally, it is arguable that the public tone has changed to a more benign and understanding one towards those with mental disability, but certainly the context for any analysis is complex.

This chapter is divided into six sections with a primary focus on England and Wales. The first examines the problematic concept of ‘the mentally disordered offender’. Do such individuals constitute an isolated category meriting special provision, or do the issues raised by this ‘group’ have wider implications for the study of criminology? Are they a minority presence or an awkward presence within the criminal justice system (Peay 2016a)? The second section considers generally issues of mental health and crime. Is there a relationship between the two: does mental disorder cause crime or does involvement in the criminal justice system bring out mental health issues in vulnerable people? Are those with mental disabilities more likely to be victims of offending than perpetrators of it? The third examines the fundamental justification for separate provision, namely treatment. It takes a critical look at evidence for the treatability of the mental disability-offending spectrum, and then focuses on a key problematic group—offenders suffering from personality disorder—who straddle the continuum. There is also a brief examination of the ‘dangerous and severe personality disorder’ (DSPD) initiative. The fourth section tackles some hidden agendas—bifurcation, detention for protective purposes, due process in discharge and release mechanisms. The fifth reviews developments in policy and tries to provide an understanding of the problematic context of the conflicting themes. The themes relate to the way in which therapeutic and risk-oriented objectives have become progressively blurred; the on-going conflict between legalism and welfarism; and the growing role for human rights developments. And the final section formulates some conclusions.

² <http://www.theguardian.com/uk-news/2016/jan/27/mental-health-crisis-huge-increasing-share-police-time-40>

One area where the shifts have been perceptible concerns the relationship between mental disability and risk, a theme which permeates this chapter. Perceiving those with mental disability as a separate category, a perception underpinned by our discriminatory mental health legislation, can play into an unfounded attribution of enhanced risk. Indeed, the reforms to the MHA 1983, which culminated in the Mental Health Act 2007, and which arose in part out of the then government's focus on risk, had the effect of taking mental health law towards penal law and away from health law (see Fennell 2001 and Richardson 1999). This can only have contributed to a perception that those with mental health issues are more a risk to us, than they are to themselves or from us, even assuming that such groupings make any sense. Yet the statistical picture suggests that this perception is misplaced (see Appleby et al 2015), with vulnerability lying primarily with those with disorders, not from them. Notably, the seemingly relentless focus on homicides has shifted with the rescinding of the requirement for mandatory independent inquiries on any occasion where those who had been in contact with mental health services in the previous twelve months went on to kill (Crichton 2011, Peay 1996). And there has been a seeming shift in our perceptions with respect to those from who we are at risk. The frenzied, irrational or psychopathic stranger may have been replaced by terrorist ideologues, albeit that the mental health status of such terrorists never seems far from popular discourse. For both lawyers and clinicians the teasing out, in the context of the most extreme, repugnant and incomprehensible violence, of what is disordered and what is ordered, has been laid bare in extraordinary detail by the Anders Behring Breivik case (Seierstad 2015, Syse 2014, Melle 2013).

Perhaps a kindlier and more understanding era for people with mental health difficulties has been ushered in. Maybe the government's 'What's the story?' assault

on media misrepresentations has borne fruit after all.³ These trends are hard to establish empirically, but anecdotally they are reflected in the responses of mental health law students. With each incoming crop of students I have asked them what two words come into their minds when I say the phrase 'mentally disordered offender'. Ten years ago the concepts were heavily dominated by violence, risk and incapacitation. Most recently, students have used words like vulnerable, needy, treatment and victim. And their responses are reflected in the new title to this chapter. Gone is the reference to the term 'mentally disordered offender' and instead there is a focus on mental disabilities.

1. DEFINITION, INCIDENCE AND IMPLICATIONS

Offenders with mental disabilities are categorically awkward; being neither exclusively ill nor uncomplicatedly bad, such people 'totter between two not always compatible discourses of state intervention' (Webb and Harris 1999: 2). Are they offenders who have mental disorders, or people with mental disorders who have offended? Or both? The category itself also conjures up images of the 'unloving, unloved and unlovable' (Bean 2008:172). Such individuals can be hard to define, challenging to deal with and unattractive to services. It is perhaps not surprising that they have been relegated and isolated, both in theory and practice. But is it right that they be treated separately, in the way that criminology chapters have been historically devoted to issues of gender, race or youth? It is the premise of this chapter that how we deal conceptually, practically, and in principle with those deemed 'mentally disordered offenders' is central to the scope of criminology; treating this as an isolated topic fails to reflect how mental disability infuses discussion of the criminal justice system.

³ <http://www.mediawise.org.uk/wp-content/uploads/2011/03/Whats-the-story-reporting-mental-health-and-suicide.pdf>

Indeed, to argue for the existence of a discrete group of 'mentally disordered offenders' would presuppose a category of 'mentally ordered offenders'. This falsely comforting notion echoes Gilman's (1988) observation that setting the sick apart sustains the fantasy that the rest of us are whole. The criminal law broadly adopts such an approach, presuming rationality where there is no proof of its complete absence. Yet, such a clear-cut division is problematic. Even the notionally reasonable "man on the Clapham omnibus" can experience moments of madness. In turn, scientific advances in our understanding of the structure, functioning, and chemistry of the brain have generated a more medical approach to some limited forms of offending and the neurological syndromes which may underlie them (Eastman and Campbell 2006). In the area of so-called normal offending, defences are rightly advanced or mitigation constructed which draw on elements of 'diminished responsibility', 'unthinking' behaviour, or uncontrolled responses to extreme social stress. Concepts of limited rationality will be familiar to criminologists; the difficulties which stem from offences committed whilst people are under the influence of drink or drugs, or who fail to understand the consequence of their actions, due to immaturity or limited cognitive skills, or who process new information poorly can all intersect with issues of legal/criminal responsibility. Yet few of these individuals would wish for the special treatment that may follow a finding of 'defect of reason' integral to a finding of 'not guilty by reason of insanity'. A finding which absolves such individuals from the punishment which follows a formal finding of guilt but which potentially propels them into a system of compulsory treatment and the associated stigma which surrounds those deemed mad. As Porter (2004) observed, it might be preferable to be criminalized and maintain one's free will than to be psychiatrized and lose it.

People with mental disabilities who have offended find themselves confined in hospitals, prisons, therapeutic regimes within prisons, and, most notably, within the remand population. Underuse of the provisions within the MHA 1983, which permit the diversion of alleged disordered offenders into hospital rather than custodial remand, partially accounts for this enhanced prevalence. But the interactive stress of being charged with an offence if one is already vulnerable

should not be underestimated. Offenders with mental disabilities exist in one shape or form across the entire criminal justice system; indeed, the presence of mental disability 'can affect the normal processes of the criminal justice system at several points' (Hale 2010:145); detention, interrogation, diversion, prosecution, conviction, disposal, treatment, and release can all be affected by an individual's mental state (Criminal Justice Joint Inspection 2009).

One explanation for this infusion into the criminal justice process relates to the definition of 'mental disorder' in section 1 of the MHA 1983, namely, 'any disorder or disability of the mind'. This definition is one of acute terminological inexactitude: it acts like a concertina, expanding or contracting depending on the context in which it is applied in order to accommodate different client groups with little or no coherence. It is the gateway to hospital, to services and to safeguards. As was pointed out to the Joint Scrutiny Committee on the 2004 Draft Mental Health Bill, the definition was potentially broad enough to include those who smoked cigarettes and would encompass all individuals with personality disorder.⁴ Whether the implications of this had been fully thought through in respect of all of the points at which it would apply to those involved in the criminal justice process is a moot point; but it was clearly intended to include those with personality disorder, and hence those with DSPD, within the ambit of compulsory treatment. Thus, people with mental disabilities are unlikely to constitute a minority group. They will contribute to the totality of offending, interact with all stages of the criminal justice system, and make up a significant proportion of custodial populations.

The statistics support this. The UK prison population, like that of other jurisdictions, displays high levels of disorder both before and during custody (Stewart 2008, Fazel and Danesh 2002, Singleton et al 1998) with the Singleton et al study estimating levels of functional psychotic disorder at 7 per cent for sentenced men and 10 per cent for men on remand. Indeed, only one in ten of the prison population does not experience some form of diagnosable disorder (albeit not all of those who

⁴ See

are diagnosable would qualify for compulsory admission under the MHA 1983, since many have drug and alcohol dependence or experience learning disability without it being associated with abnormally aggressive or seriously irresponsible conduct⁵). Notably, the Singleton et al (1998) study found levels of the more serious mental illnesses which significantly exceed those in the general population (Meltzer *et al.* 1995; Johns *et al.* 2004), even given a growing recognition that psychosis occurs on a continuum rather than being an all or nothing phenomenon. The figures for psychotic disorders were shocking because they were worse even than those found 20 years earlier by Gunn *et al.* (1978) in their survey of the south-east prison population. Moreover, the presence of mental disability generally will contribute to the high levels of suicide and self-harm amongst prisoners; figures for the latest year available show levels of self-inflicted deaths, at 100, and incidents of self-harm at 32,313, persisting and, sadly, increasing despite numerous measures to combat them (Ministry of Justice 2016). Indeed, they are clearly indicative of an inappropriate environment in which to detain vulnerable individuals

Yet at the start of the criminal justice process are these high levels of disorder present? The Bradley Review (2009:38) estimated that the 'number of mentally disordered suspects passing through police stations varies between 2% and 20%'. Given that the definition of mental disorder is so all embracing, it is perhaps not surprising that the variation in its identification in individual suspects is significant. Undoubtedly there is a crystallization effect through the criminal justice process; a process which facilitates greater disclosure or diagnosis of disability, and which in part selectively filters into the system those with disability. Levels of disability identified at the police station have been historically low (Robertson *et al.* 1995; Littlechild 2001), which is worrying since there is a requirement for an appropriate adult to be present when questioning such individuals (Home Office 2015: Code C, para. 3.15-3.19). Indeed, the Code requires officers to be over-inclusive, stating (para 1G) 'When the custody officer has any doubt about the mental state or capacity of a detainee, that detainee should be treated as mentally vulnerable and an appropriate

⁵ S.1(3) and S.1(2A)(b) MHA 1983

adult called.’ Since personality disorder falls within the new definition of mental disorder under the MHA 1983, it remains a mystery as to why appropriate adults are not routinely present at interrogations. Does not the police definition of, for example, an accused with anti-social personality disorder, require them to adhere to these special protections?

Personality disorder is perhaps a telling example of where the mismatch between different agencies’ expectations for, and definitions of, ‘the mentally disordered’ impedes the full protection to which that ‘group’ is entitled in law. It is worth illustrating some of those dilemmas here. Personality disorder (a clinical concept), psychopathy (a trait measurable by the Hare Psychopathy Checklist: Hare 1991) and DSPD (dangerous and severe personality disorder—a political/policy concept) are all terms used when exploring the association between disorders of personality and criminality. And can all be used by the various professions and agencies involved in the criminal justice system. The diagnosis of personality disorder has a long and problematic history, which has continued into the 2013 version of the Diagnostic and Statistical Manual (DSM-5) used by the American Psychiatric Association.⁶ Here, the ten distinct types of personality disorder from the previous versions of the Manual have been retained, but DSM-5 changes from a multi-axial system of diagnosis to one that removes the arbitrary boundaries between personality disorders and other mental disorders. This acknowledges the fundamental similarities across disorders, recognizing that personality disorders are ‘associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life’. But DSM-5 also controversially includes a new alternative hybrid model, based on traits and their severity together with how an individual experiences himself or others. This appears as a separate section of the manual. This hybrid model contrasts with the categories of personality disorder approach embodied in the main manual: it is likely to facilitate further research in the area.

Of the ten personality disorder categories listed in the Manual, it is inevitable that there will be some association between personality and criminality since the concepts are by definition, in varying formats, linked. For example, both “anti-social personality disorder” and “borderline personality disorder” – the latter entails strong impulses to engage in

⁶ <http://www.dsm5.org/Pages/Default.aspx>

reckless and irresponsible behavior – are much more likely to be associated with criminal behavior than, for example “obsessive-compulsive personality disorder”, which has as a feature an excessive interest in lists, timetables and rules. Thus, in much the same way as will be discussed for the category of ‘schizophrenia’, ‘personality disorder’ can be protective rather than criminogenic when its particular form is associated with a reluctance to socialize and a withdrawn lifestyle.

On this side of the Atlantic the 2016 version of ICD 10 (the World Health Organization’s International Statistical Classification of Diseases)⁷ is preferred. And in the UK the approach is different again. Here, the NHS guidance and many psychiatrists think of personality disorder as falling into three clusters: A, B, and C (crudely: the mad, bad and sad). It is cluster B, people who show patterns of behavior that are ‘dramatic, erratic and threatening or disturbing’,⁸ who are thought to have an enhanced risk of offending and thus be more likely to engage with the criminal justice system. Ironically, the cluster approach is not so dissimilar to DSM-5.

Whilst the therapeutic, conceptual, and legal difficulties with personality disorder are manifold (Peay 2011c), and will be returned to later, it is worth stressing here that rarely do those individuals find themselves subject to civil commitment under the MHA 1983. Although those with ‘personality disorder’ may be extremely time consuming of GPs’ energies, it is almost exclusively their involvement with the criminal justice system which brings them to the attention of mental health services (James et al 2002).

Finally, it is worth noting that the lack of a detailed definition as to what constitutes mental disability poses not only challenges for services but also opportunities. One such is a recent development in the controversial use of police stations as a ‘place of safety’ under s.136 of the MHA 1983. Following a number of critical reports (Scott 2015, HMIC 2013, Docking *et al.* 2007) concerning the over-use by the police of their powers, change is in-hand. Both revisions to the statutory power (MHA 2007) to remove an individual from a public place to a ‘place of safety’

⁷ <http://apps.who.int/classifications/icd10/browse/2016/en>: Chapter V.

⁸ <http://www.nhs.uk/Conditions/Personality-disorder/Pages/Symptoms.aspx>

when the person appears to be suffering from mental disorder and in immediate need of care and control have occurred and policy edicts (Department of Health and Home Office 2014) indicate further movement on the issue. For example, the police station is no longer to be used as a place of safety for those under 18 and the police are strongly encouraged to instead take people with mental disability to hospital or to designated place of safety suites. The substantial reversal of the numbers, now favouring hospital over police stations, is encouraging.⁹ Indeed, as part of a revival in the use of diversion (Dyer 2013, Scott et al 2013) after the Bradley Review (2009) some police forces are trialing mental health first responders in police cars – in effect a triage car – which helps divert those with mental disabilities from criminalisation and towards hospital. Moreover, the broader Liaison and Diversion Service for England aims to serve 50% of the population by 2015-16.¹⁰

On the other hand, at a time when mental health services are themselves extremely stretched it is hard to see how offenders with disabilities are likely to secure priority in services unless they pose an evident risk. And in a context where the lack of definitional focus permits a politicized approach to people with disabilities caught up in the criminal justice system, such individuals remain vulnerable to an inconsistent response and an arguably overly punitive response.

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<http://www.hscic.gov.uk/searchcatalogue?productid=19118&q=title%3a%22Inpatients+formally+detained+in+hospitals+under+the+Mental+Health+Act%22+&sort=Most+recent&size=10&page=1#top>

Compare with police detentions 2014-15

<http://www.theguardian.com/society/2015/jun/08/police-detain-fewer-people-mental-illness>

In 2005-6 the bulk of uses of s.136 were at police stations not hospitals, by 2014-15 whilst the overall numbers had increased (with 19,403 at hospitals alone) hospital detentions now significantly outnumber police detentions (for 2014-15: 4,537)

¹⁰ <https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/#cb>

2. MENTAL DISABILITY AND CRIME

Does mental disorder cause crime, does involvement in crime and the criminal justice system cause mental disorder, and are those with mental disabilities more likely to be the perpetrators of crime or victims of it? Indeed, are crime and mental disability not related at all, but simply share common precursors? These straightforward questions are immensely complex to unpack (Peay 2011, Bean 2008). Equally, they may not be the best questions since the critical issue may concern why and in what ways particular symptoms or impairments could contribute to what are complex and multi-factorial causes of crime?

Whilst those with mental disabilities are overrepresented in the statistics of imprisonment, that is not a basis for concluding that mental disorder causes crime, since the processes of selection and progressive disclosure of disability will account for a proportion of the disproportionality. The scope for selective inclusion of more visible offenders is obvious; combining notions of inept offending with the range of views held by the relevant 'gatekeepers' as to the needs of this problematic group will undoubtedly contribute to a highly skewed criminal justice 'output'. Earlier in the process it is difficult to disentangle the impact of various policies and diversion schemes; on the one hand they serve to filter offenders away from the formal process, while on the other hand the identification of mental disability can have a net-widening effect, whereby people with mental disability become caught up in the criminal justice system and criminalized where other individuals may be treated differently. The intersection of public order offences and mental disability is apposite.

It is, however, important to re-emphasise that surveys of the incidence of mental disability at the earliest stages will be an under-representation as the police, the CPS, and the courts are likely to identify only those with the most obvious symptomatology, while surveys of custodial populations are likely to be over-inclusive since they will count those whose disorders have been exacerbated, or

brought about, by the process of prosecution and punishment. Indeed, a number of those in custody would not be sufficiently disordered to bring them within the ambit of the 1983 Act's requirements for compulsory admission. Similarly, any tendency to remand into custody to obtain psychiatric reports will contribute to this concentration effect. A tension between the desire to obtain treatment for the 'deserving' offender with a mental disability, and protective concerns where that desire may be frustrated, plays itself out amongst a shifting population.

The contribution that mental disorder makes to the totality of offending overall is difficult to quantify. Like juveniles, their offences are frequently highly visible, petty, and repeated; moreover, such offences are not dissimilar to those committed by the 'mentally ordered' (Amos et al 2013). That is not to deny that for some people with mental disabilities their offences are violent; and in some cases homicidal. Yet, the best epidemiological evidence (Swanson et al 1990), which comes from the United States, indicates that those individuals with major mental disorders account for only a modest proportion of the violence committed; in the US the figure is put at around 3 per cent (Monahan *et al.* 2001). Drugs and alcohol issues are much more prevalent precursors to violent crime. Other studies, for example in Sweden, have found not dissimilar low rates for the association between major mental illness and violence (Fazel and Grann 2006). Notably, even studies which report a stronger association between violent re-offending and diagnosed psychiatric disorders (see, for example, Chang et al 2015) identify drug and alcohol-use disorders as markedly most common. Indeed, the dramatically increased 'disorder' effect for violent reoffending in women (double that for men) is, of course, confined to the more limited incidence of female re-offending. In essence, what studies show is that most people with mental disabilities are not violent, and most violence is not committed by people with mental disabilities.

The majority of those who have offended with mental disabilities are to be found not on psychiatric wards but in local facilities supported by health, housing, and social services, or in prison. Properly resourcing these facilities could have a major preventive impact. It is paradoxical, therefore, as Burney and Pearson (1995: 309) observe, that 'a court appearance may be the only way that their needs will

become apparent'. Yet, that very involvement with the criminal justice system may constitute the reason why community services are more problematic to access for these individuals.

Two other issues are important. First, the focus should be not on the relationship between offending and 'disorders' as diagnoses, but between particular symptoms and offending. Schizophrenia is a good example. The bald diagnosis itself is of little help in identifying those who might offend, but even if one descends to sub-classifications, for example, paranoid schizophrenia under the recognized International Classification of Diseases¹¹ the picture remains complex. One might presuppose false beliefs that someone is threatening you or hearing voices telling you to attack another (threat-control-override) might make you more likely to commit an assault, but the evidence is conflicted. In some cases there is a relationship, but in others the outcome may depend more on the nature of the threat, the gender of the person concerned and/or whether negative symptomatology (more common in chronic stages of the condition) is dominant (Stompe et al 2004, Swanson et al 2006). Thus, in some cases, in some people, mental disability can make it less likely that a crime will be committed because of the social withdrawal and passivity associated with the particular stage of the condition. Acknowledging the importance of the role that symptoms play in the life of any potential individual has led researchers to conduct small-scale detailed studies involving individuals immediately after the alleged offending (Peterson et al 2014, Junginger et al 2006). These researchers have equally considered another question; namely, even if you have a mental disability is your offending necessarily linked to it? Both of these studies found only relatively small percentages of offending by those with mental disability related directly to their offending (between 8-17%). In turn, this has supported Skeem and colleagues' (2011) argument that a more sophisticated approach is required to unpack the precursors of offending in those with mental disability. For some, the disability does appear to have a criminalizing

¹¹ ICD – 10- CM Diagnosis Code F20.0, 2016; see

<http://www.icd10data.com/ICD10CM/Codes/F01-F99/F20-F29/F20-/F20.0>

effect; for others, it is more a question of a shared etiology between offending and mental disability. For the shared etiology group, mental disability plays little or no part and offending can be attributed to other common criminogenic factors. Finally, in some cases it is the response to disability -- one of stigma, discrimination and heightened fears -- which is thought to lead to recidivism. Thus, Skeem and her colleagues call for a multi-disciplinary conceptual framework if recidivism is to be reduced in those with mental disability. Such a framework is equally important when thinking about the causes of crime in those with mental disabilities.

Once one starts to be alert to 'mental health' the variety of places and ways in which it manifests itself are legion. Thus, of young offenders in the 13-18 age group, 31% were identified as having a mental health need (Harrington and Bailey 2005). The extensive criminal victimization of people with mental health problems has been, until recently, an under-researched area.¹² Cape (2016), as part of his consideration of the abolition of police bail, has noted the stress of being on long-term police bail and its negative consequences for the mental health of formerly healthy individuals. Bean (2008) has questioned why it is that we understand that victims of crime can suffer from post-traumatic stress disorder, but we rarely consider how those witnessing the violence they themselves perpetrate can equally suffer traumatically afterwards? Such trauma can be guilt induced or, as is more often in, for example, the case of military veterans, attributable to the sights seen and the acts done. The relationship between cannabis use, still formally a criminal offence, and the development of psychosis, remains controversial. Vulnerable individuals and young people are peculiarly at psychiatric risk from some forms of cannabis use.¹³

The intricacies of the relationship between the mind, and the experiences people have, are beyond this chapter's remit; it is simply worth observing two

¹² See the Report by Victim Support and the Institute of Psychiatry at King's College
At risk, yet dismissed,

<https://www.victimsupport.org.uk/sites/default/files/At%20risk%20full.pdf>

¹³ <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx>

matters. First, the links between mental disability and crime, whether violent or not, are extraordinarily complex. And hence the interventions that might successfully follow are not self-evident. Secondly, being able to benefit from psychological therapy does not necessarily imply that an individual is suffering from a mental disability that requires compulsory psychiatric intervention.¹⁴ But some are: and considering where and in what ways treatment for offenders might be appropriate forms the next section.

3.OFFENDING BEHAVIOUR AND TREATMENT

Identifying the right place to deal with people who have offended who also have mental disabilities is both hard and easy. Easy because with the levels of disability amongst the offending population, and with our very narrow mental condition defences (Law Commission 2013), most of those with such disabilities will inevitably be dealt with in the penal system rather than the health system. There simply are not enough beds, enough resources or enough enthusiasm within the health system to take all those who might benefit from a health disposal. Prisons have to cope through a combination of the mental health in-reach services, the principle of equivalence (namely, that primary care services should be as good in prison as in the community) and, as a last resort, the possibility of transfer to hospital for individuals who meet the necessary criteria under the MHA 1983 (Department of Health *et al.* 2001). For some individuals, for whom compulsory treatment is deemed necessary at the point of sentence/disposal, hospital is the only viable option since it is only under section in hospital that treatment can be given compulsorily for mental illness, victimization by other prisoners avoided, and violent or self-harming behavior adequately monitored and controlled.¹⁵

¹⁴ See, for example, those who have experienced female genital mutilation

¹⁵ The UK was found to have violated Article 2 of the ECHR—the right to life—following the killing of one mentally disordered man by another; both had been on

On the other hand, the question of identification is hard since, if the penal system is the default option, it is an option that is peculiarly ill-suited to offering effective therapeutic interventions. As the Home Office recognized as long ago as 1990, 'For most offenders, imprisonment has to be justified in terms of public protection, denunciation and retribution. Otherwise it can be an expensive way of making bad people worse' (para. 2.7). Custodial environments are noisy, stressful, overcrowded, frightening to many and ill-equipped to manage genuine rehabilitative change, whilst community orders have become progressively punitive in their impact under the agendas of successive governments.¹⁶

It is never, of course, clear when dealing with offenders with disability quite what is meant by treatment, or what treatment is attempting to alter—the 'underlying disorder', the offending behaviour, or the link, if any, between the two? Or are these efforts really devoted largely to alleviating the distress and emotional problems individuals suffer, either those pre-existing or post-dating the offending? If it is the likelihood of criminal behaviour *per se*, the justification for treatment will not be confined to a 'mentally disordered' subgroup. These quandaries have not deterred the development of a number of rehabilitative programmes in prison.

The 'What Works' initiative (Home Office 2001) has had a significant impact on the philosophy of imprisonment, with the focus being largely on treating offending, rather than mental disorder *per se*. Cognitive behavioural programmes for sex offenders, offence-focused problem-solving (e.g., the 'Think First' programme), substance-abuse treatment programmes, controlling and managing anger (CALM), and cognitive self-change programmes for violent offenders, capture the flavour of these initiatives.

remand and held in the same cell in Chelmsford Prison *Paul and Audrey Edwards v The UK* (2002) Application No. 46477/99.

¹⁶ See, most recently, Schedule 16 to the Crime and Courts Act 2013 which has required courts, unless it would be unjust to do so, to include a punitive element in all non-custodial orders.

However, the extent to which treatment endeavours can be both sustained and effective remains questionable. Achieving effectiveness will be jeopardized by three enduring factors: prison overcrowding, the use of short sentences (both of which can disrupt programme completion) and the need to obtain genuine engagement in the programmes by prisoners. Such consent has come to be recognised as critical to the success of treatment endeavours with some offenders (Zlodre et al 2015). Involuntary treatments can have no effect at all, or indeed, be detrimental (Martin et al 2012). Finally, if sentencers believe that imprisonment will secure access to beneficial treatment programmes for persistent offenders, 'ordered' offenders may find themselves at as great a risk as disordered offenders of therapeutic sentencing, further accelerating the problem of overwhelming demand.

Emphasis is also shifting onto the importance of resettlement and providing through-care from prisons into the community. Yet, as Grant (1999) observed, this 'through-care' has had a worryingly narrow focus on crime reduction where multi-agency working has had as its objective pragmatic restraint rather than treatment *per se*. He argues that it is no easy task to support the health needs of less serious offenders while managing the risk they pose and the fear they engender. The shift from broadly-based rehabilitation to offence-specific crime reduction initiatives has also had an impact on Grendon Prison.¹⁷ Genders and Player (1995, 2010) admirably detail the way in which Grendon's therapeutic endeavours and security considerations are difficult to reconcile. Yet Grendon's record of success in *controlling* problematic prisoners is notable. Perhaps, as Genders and Player (1995) point out, the knowledge by all concerned that the rest of the prison system provides a very different form of containment may have a positive effect on prisoner behaviour.

Grendon notably takes prisoners on the personality disorder end of the spectrum of disability, rather than those with mental illness *per se*. Somewhat

¹⁷ Grendon is a secure psychiatric facility within HM Prison Service which accepts prisoners on longer-term sentences who have volunteered to enter its therapeutic community approach.

curiously it was not one of the designated prisons for taking offenders under the DSPD programme. But this might be because its 'voluntary' ethos was at odds with some of the more explicitly coercive objectives of the DSPD programme. A generous interpretation of the history of the DSPD initiative would suggest that it was prompted as much by a concern for the unmet needs of these diverse and unenticing individuals as it did from a concern about their risk to others (Home Office 1999; Department of Health/Home Office 2000). As the Home Office observed, they have

high rates of depression, anxiety, illiteracy, poor relationships and loss of family ties, homelessness and unemployment. They have high rates of suicide and high rates of death by violent means. They have high rates of substance misuse. Their behaviour is often violent. Their behaviour is of immense distress to themselves and they are frequently in the position where they are asking for help and yet finding it very difficult to access suitable help [1999: 34].

There is, thus, considerable conflict in the objectives that policy is attempting to pursue with respect to personality disordered offenders (O'Loughlin 2014). Psychiatrists find themselves in a dilemma, being understandably wary of having to 'treat' 'personality disordered' offenders, where successful interventions are yet to be reliably established, whilst clinicians are painfully aware of the needs of such individuals and their levels of distress. Moreover, 'treatment' is arguably offered by the medical profession as a response to illness – something atypical and unwelcome for an individual. Personality disorder has rather been characterized as something integral to an individual – normal for them – and hence conventional 'treatment' approaches sit oddly when considering interventions with such individuals. Psychologists have entered this morass, but even their enthusiasm may wane if the treatment is primarily containment and control; paradoxically professionals are criticized both for a failure to offer treatment to those they regard as untreatable, and for releasing those they deem successfully treated.

Over the last 15 years, the DSPD programme has become a prime focus for service development and legislative provision with the more inclusionary definition

of mental disorder adopted under the amended MHA 1983. Originally, DSPD individuals were thought to number some 2,400 men and facilities were developed in both prisons and high security hospitals, albeit the maximum number in the programmes fell significantly short of this figure. In the event the hospital based programmes proved resource costly, with the result that the focus shifted to the prison-based programmes; indeed, the Broadmoor facility was closed¹⁸ (O'Loughlin 2014, McRae 2015). To what extent this reveals an emphasis on containment rather than treatment, or else the tacit recognition that treatment may not be successful, is unclear. *Breaking the Cycle* (Ministry of Justice 2010: 37) envisaged an expansion of the programme, and this is now represented by the Offender Personality Disorder Pathway (OPDP), which expands the nature of the offenders included and extends the pathway into community settings. The ambitious nature of this programme should not be underestimated: some 8,007 men in custody and 7,795 men on community orders or on licence are estimated likely to pass the harm-screening test and satisfy at least one of the other five screening criteria; for women the respective figures are 655 and 2,749.¹⁹

On the basis of the DSPD programme, policy makers would be well-advised to be extremely cautious. For that programme, research was initiated, but legislation proceeded without any positive findings. DSPD was not an evidence-based initiative; indeed, it had quickly transformed into a pilot. In any event, how could it have been evidence-led? There was no agreed clinical diagnosis and offenders were admitted who fell outside the specific programme criteria, there was no agreed treatment, no means of confidently assessing when the predicted risk may have been reduced, and no obvious link between the alleged underlying condition and the behavior. In this context could outcomes be agreed upon and evaluated? The 'pilot' programme had

¹⁸ Albeit all three High Secure Hospitals and a number of medium secure units are now involved in OPDP.

¹⁹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418307/OPD_seminar_pres_Mar_2015.pdf

initially recruited volunteers and had controversial results (Tyrer *et al.* 2010); yet, the legislation enacted provided the basis for compulsory transfer and treatment within the hospital system. Testing the latter by the former seemed ill-advised.

At this stage in a national evaluation of OPDP, which only commenced in August 2014, it is perhaps unedifying to describe those engaging in it as falling foul of the Pollyanna principle – namely, a subconscious bias towards the positive. But all of the problems of consent for the hospital-based offenders, and of coercion – explicit or implied – amongst the penal group, may dumbfound its enthusiasts if these problems are not properly addressed.

Thus, treatment issues embody a number of difficulties. First, given the diversity of need, ‘treatment’ may mean many different things—ranging from the administration of anti-psychotic medication to the acquisition of social survival skills. There may be a mismatch between health and criminal justice personnel in respect of the objectives of treatment. Second, if the relationship between the disorder and the offending behaviour is not primarily causal, there is less justification for excusing from punishment, and offenders should remain entitled to protection of their rights as offenders while not being denied access to voluntary treatment. However, if punishment is merited, assessing the degree of culpability in offenders with mental disabilities is more challenging than for those without disabilities, and considering the punitive-therapeutic balance more critical. Third, it is important to recognize that if the individual is found not to be legally responsible for the offending, on grounds of mental disability, then there can be no punishment, only a health-based disposal. Fourth, where an individual is treatable and there is some causal connection between the disorder and his or her offending behaviour, there may be less (or no) justification for continued detention after treatment. Fifth, successful treatment for a disability may have no bearing on future criminality; offenders with mental disabilities should be accorded proportionality in the length of confinement as would offenders without disabilities; release should not be determined on the basis of unreliable predictions of future offending. And finally, the choice between jurisprudential logic, which may sanction punishment for the ‘culpable’ disabled offender, and decades of a humanitarian response endorsing a commonsense

preference for treatment rather than punishment, should perhaps focus rather on facilitating genuinely capacitous engagement with treatment in both contexts. Explicit coercion should only be used for those who do not have the capacity to consent. The need is urgent to enhance the custodial-therapeutic environment to facilitate whatever rehabilitation may be possible on a non-coerced basis. Clearly, if the numerical bulk of disorder-related offending is associated with alcohol and drug use, and/or disorders of personality, then a psychiatric hospital is probably not the best venue for ‘treatment’.

4. PROTECTIVE SENTENCING: PROCEDURAL SAFEGUARDS VERSUS TREATMENT

Reform in the area of the trial of those with mental disorder has been devoted primarily to increasing the court’s sentencing options and not to addressing issues of culpability, albeit the Law Commission (2016a, 2016b) has substantial proposals for the reform of the law of unfitness to plead and has considered insanity and automatism (Law Commission 2013). If implemented the proposals on unfitness will have a significant impact on the fairness of trials for people with disabilities, and will address a number of areas where our current law on unfitness is in conflict with our human rights obligations under the ECHR (Peay 2016a).

The bulk of individuals sentenced with mental disability gain little mitigating effect from their disabilities. The Sentencing Guidelines Council did identify ‘mental illness or disability’ as one of the four factors that may ‘significantly lower culpability’ when the seriousness of an offence is assessed (Sentencing Guidelines Council 2004: para. 1.25). Moreover, recent offence-specific guidelines, see, for example, the Definitive Guideline on Theft Offences, have specified that a medical condition can make a community order with a mental health treatment requirement a proper

alternative to a moderate custodial sentence.²⁰ In general though, the presence of mental disorder can still lead to disproportionately long sentences where paternalistic assumptions about the ‘mental disorder’ element, and protective-predictive ones about the offending element, leave prisoner-patients with more than their ‘just’ deserts. This may arise from either a shift in the community/custody threshold, or from the use of longer determinate sentences or more frequent use of indeterminate sentences by courts when sentencing those with mental disabilities. Notably, those serving indefinite sentences have higher rates of self-harm than those on life sentences.²¹

It is also worth reiterating that, like all offenders, those with mental disorder are overwhelmingly not dangerous. However, some are. Arguments favouring limited special measures have their attractions, if only to deal with that small but worrying group; but their *quid pro quo* is that the preventive rationale should be tempered by procedural safeguards. Similarly, arguments for bifurcation are inherently appealing, where diversion into humanitarian care protects offenders from damaging penal sentences. Yet the implications of these two propositions under our existing arrangements are that the route into confinement – prison or hospital - will affect both the route out, and whether and what treatment will be given.

Concepts of dangerousness and its alleged association with mental disorder pepper the academic literature and the rhetoric of sentencing. Academics and policy-makers have been fiercely divided both on predictive grounds—will it work?—and on questions of rights. The argument embodies the distinction between statistical and legal-clinical decision-making, crudely put, the difference between risk factors associated with groups of people who have common characteristics (much of the risk-prediction literature is of this nature), and the determination of whether any one individual within that group will be amongst those where risk is realized

²⁰ See page 6 of https://www.sentencingcouncil.org.uk/wp-content/uploads/SC-Theft-Offences-Definitive-Guideline-content_FINAL-web_.pdf

²¹ <http://gu.com/p/4mh65/sbl>

(Buchanan and Zonana 2009). These kinds of difficult decisions are faced regularly by courts, Mental Health Tribunals (MHTs), discretionary lifer panels, the Parole Board, clinicians and the executive (see, for example, Boyd-Caine 2010). The findings of research concerning such decision-making bodies are consistent: despite actuarial evidence that would support the release of patients and prisoners, attributions of risk are central, overvalued, and very difficult to refute (Trebilcock and Weaver 2012).

Should offenders be entitled to a proportional measure of punishment? Walker (1996: 7) argues that there may be no such 'right' where individuals have forfeited the presumption of being harmless because they have *previously* attempted or caused harm to others. But how is precautionary sentencing to be limited? And are mentally disordered offenders at greater risk of imposition of such a sentence? These and other issues concerning the use of preventive justice have been extensively reviewed by Ashworth and Zedner (2014), but their analysis of the issues around public health law and issues of liberty as they affect those with mental disabilities is particularly telling.

Dworkin (1977) described the restraint and treatment of the 'dangerously insane' as an insult to their rights to dignity and liberty—an infringement that could be justified not where crime reduction might result, but only where the danger posed was 'vivid'. Bottoms and Brownsword (1983: 21) unpacked this concept into its elements of seriousness, temporality (that is frequency and immediacy), and certainty. Certainty was pivotal to precautionary sentencing, but even a high probability of future offending should become relevant only if the behaviour anticipated involved causing or attempting 'very serious violence'. Thus, the right to a proportional measure of punishment would yield a '*prima facie* right to release for the prisoner at the end of his normal term', and this would apply—in the absence of 'vivid danger'—equally to the alleged 'dangerous offender'. But at this point theory and practice diverge.

The passage of the Criminal Justice Act 2003 with its smorgasbord of objectives (crime reduction, risk management, reparation, deterrence, rehabilitation and deserved punishment) places those with mental disabilities in triple, if not

quadruple, jeopardy. Treatment for their underlying disorders, attempts to reduce independently their potential for crime through measures to change their thinking strategies, and a deterrence philosophy which may impact even less successfully on some offenders with mental disabilities, are all likely to contribute to a greater than proportionate use of incapacitation for those where offending occurs in the context of mental disability.

Under the Criminal Justice Act 2003 community sentences with a mental health treatment requirement have been little used.²² The 2015 figures show that such orders, whether attached to community orders or suspended sentence orders, continue to make up less than one percent of the orders made by the courts.²³ Whilst this is, in part, attributable to the problem of finding a willing practitioner and a consenting patient it does indicate an abject failure to address the level of need in the less serious offending population. At the other end of the spectrum, the introduction of life sentences under section 225(1)(b), where the court is of the opinion that there is 'significant risk to members of the public of serious harm occasioned by the commission...of further specified offences', has drawn more mentally disordered offenders into the net of indeterminacy. Notably, section 225 does not prevent the courts from making a hospital order with restrictions, where an individual satisfies the necessary conditions under the 1983 Act; indeed, only the mandatory life sentence following a conviction for murder has the capacity to trump a potential therapeutic disposal. However, in general, protective confinement is self-justifying and difficult to resist. Finally, it is of concern that the Court of Appeal, in the case of *Vowles*,²⁴ has recently opined that even in cases where an individual's offending is accounted for by his or her disorder, so that culpability may be of the

²² See Table 5 and accompanying text

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/426676/Supporting_CO_Treatment_Reqs.pdf

²³ <https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2015>

²⁴ [2015] EWCA Crim 45

most tenuous, a mixed punitive-therapeutic order under s.45A of the MHA 1983 is to be preferred to the therapeutic disposal under s.37/41 of the same Act (Peay 2016b). The former order allows for Parole Board release, which can entail subsequent recall in the light of the individual's risk increasing. Conditional discharge following a s.37/41 order requires, for recall, deterioration in the individual's mental health and is deemed by the court to be less flexible. Indeed, the Court of Appeal in *Vowles* even went so far as to discourage the costly use (costly to court resources) of interim hospital orders,²⁵ designed to ensure that only those offender-patients suited to hospital should be sent there under the MHA 1983.

5. POLICY DEVELOPMENT IN ENGLAND AND WALES: WHY WE ARE WHERE WE ARE

Policy development in mental health and crime has been chequered. Therapeutic and risk-oriented objectives have become progressively blurred (Rutherford 2010); a conflict between legalism and welfarism is evident; and there has been a growing role for human rights developments. At face value the dominant policy is humane and therapeutic: Home Office Circular 66/90, which formally encouraged from 1990 onwards the placement of mentally disordered offenders, wherever possible, into the care of health and personal social services, received considerable support from both the recommendations of the Bradley Review (2009) and the Ministry of Justice (2010). However, these 'rehabilitative revolutions' are invariably accompanied by riders which stress the need properly to protect the public; such a nuanced approach is captured in *Breaking the Cycle*:

We will work with the Department of Health to divert more of the less serious offenders with mental illness and drug dependency into treatment rather than prison, as long as the safety of the public is not compromised. (Ministry of Justice 2010:2)

²⁵ S.38 MHA 1983

Perceptions and attributions of risk have had a great influence on policy development (Ashworth and Zedner 2014, Seddon 2008). Those who have offended who have a mental disability are most 'at risk' of being perceived as posing an unquantifiable danger, and thus, peculiarly apt for the ubiquitous focus on risk management. As risk is transposed into danger, dangerous individuals are singled out for special attention, and the responsibility for preventing and managing risk is transferred to those professionals dealing with or caring for them (Douglas 1992).

Evidence of this duality in policy can be seen in the development of the DSPD programme (Home Office 1999) and its wider successor, the OPDP (O'Loughlin 2014; McRae 2015). Even if these programmes were started with beneficent aims, acknowledging the neediness and vulnerability of some personality disordered offenders, their impact has been to delay release from confinement and extend control out into the community. Moreover, the introduction in 2001 of IPPs (indeterminate sentences for public protection – now abolished - Annison 2015) and the Multi-Agency Public Protection Arrangements (MAPPA), both of which drew in those with mental disabilities, had clearly protective ambitions.

MAPPA is worth considering in some detail since it encapsulates some of the difficulties of clinical professionals working alongside criminal justice personnel. The annual reports for MAPPA (Ministry of Justice 2015) detail the scheme, but in essence they are designed to ensure the identification of serious sexual and violent offenders in the community, the sharing of information among those agencies involved in the assessment of the risk, and the management of that risk as individuals move from conditions of security into the community. MAPPA embrace both registered sex offenders, violent and other sex offenders, either sentenced or disposed of as mentally disordered offenders, and some other offenders whom it is thought may cause serious harm to the public. On 31 March 2015, there were 68,214 MAPPA eligible individuals: 72% were registered sex offenders²⁶ and 26% were categorized as

²⁶ Registered sex offenders subject to notification requirements for life are now eligible for review of this requirement following a declaration of incompatibility by the Supreme Court under s.4 of the HRA 1998: see *R (on the application of F and*

violent offenders (which included those on hospital orders and some sex offenders not eligible for notification requirements). The overwhelming majority in these categories were subject only to ordinary agency management (Ministry of Justice 2015a). However, 1,573 individuals were ‘actively managed’ as they fell into the two highest risk levels.²⁷ Over the course of the year 2014-15, 6,506 individuals were MAPPA eligible for management at this level and 10.5% were returned to custody for a breach of licence.²⁸ Psychiatrists are involved with these two risk categories and, since the passage of the Criminal Justice Act 2003, the various agencies, including Health Trusts, have a duty placed on them to cooperate with the responsible authority in each of the 42 MAPPA areas. Yet a psychiatrist’s primary responsibility is to the health of their patients; and psychiatrists, like other health professionals, have a duty of confidentiality towards those patients, a duty that does not sit easily with the concepts of information sharing embraced by MAPPA. The tensions are evident, and as Taylor and Yakeley observe (2013:12) in respect of information sharing ‘a blurring of professional boundaries may occur at MAPPA meetings, where less experienced health representatives may be unprepared for the – often subtle – pressures placed upon them to disclose information about patients known to them’. Notably, this Royal College of Psychiatrists’ Faculty Report stresses the advantages of obtaining patient consent to disclosure as a way of overcoming some of these confidentiality issues. Where it cannot be obtained disclosure is only justifiable, in the public interest, to prevent a serious and imminent threat to life of the individual or a third party or to prevent or detect serious crime.

Angus Aubrey Thompson) v Secretary of State for the Home Department [2010] UKSC 17.

²⁷ See Table 1, which relates only to offenders managed on 31st March 2015. This figure notably includes all 255 in the ‘other dangerous offenders’ category https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/471408/mappa-annual-report-2014-15.pdf

²⁸ See above, Table 7a.

The policy context clearly embodies both positive and negative messages. On the one hand, calls for diverting those with mental disabilities from the damaging effects of the criminal justice system are longstanding (Bradley 2009).²⁹ Notions of early intervention are also consistent with a philosophy that ‘treatment works’; people can be changed, diverted or protected from inappropriate or damaging experiences. Yet on the negative side, there appears to be a persistent distrust of therapeutic disposals for some offenders with mental disability.

Much of the confusion arises because of the tensions inherent across the continuum both of ordered–disordered behaviour and that of law-abiding–law-breaking behaviour. Notions of care and treatment are seen as appropriate for the seriously disordered, provided this does not arise in conjunction with offending of a worrying nature. Similarly, notions of protection and custodial punishment have been traditionally reserved for serious offenders, again assuming an absence of obvious disorder. Yet these tensions are confounded where it is argued that disorder and offending exist side-by-side in one individual, or, more confusingly still, interact. Of course, part of the difficulty arises from the perception of those with mental disabilities who have offended as being in thrall to their disorders. The notorious Inquiries after Homicide fell into this trap (Peay 1996), notorious because they made an independent Inquiry mandatory wherever a homicide was perpetrated by an individual who had been in contact with mental health services in the previous year, regardless of the links between disability and the death. In turn, mental health practitioners became the focus for blame. As Szmukler (2000:7) observes:

Inquiries ...adopt a model of responsibility that is grossly oversimplified and distorted by retrospective analysis. The offender patient is seen as lacking agency, behaving as an automaton, like an aeroplane out of control. The

²⁹ See also the thoughtful report from Criminal Justice Joint Inspection

https://www.justiceinspectors.gov.uk/cjji/wp-content/uploads/sites/2/2014/04/MDO_Joint_Report_12_2009.pdf

patient is no longer a person with feelings, hopes, intentions or with the capacity for choice.

The resulting amplification of discriminatory practices for such individuals has led in part to calls for capacity-based legislation to apply to both mentally ordered and mentally disordered offenders (Szmukler *et al.* 2010).

The MHA 1983 is the key statutory provision dealing with those with mental disabilities; Part III deals with those involved with the criminal justice system. The Act continues uneasily to embrace both legalism and welfarism. Its emphasis on treating people for who they are has also sat uncomfortably alongside a criminal justice approach which has traditionally emphasized what people have done as the basis for a proportionate intervention. It is therefore notable that the Criminal Justice Act 2003 has the reform and rehabilitation of offenders as one of its five purposes of sentencing (section 142(1)), albeit that offenders disposed of under the MHA 1983 are explicitly exempted from all five purposes (see section 142(2)(d)). An awkward fusion is evident between mental health and criminal justice objectives, with both sets of professionals now being expected to engage in the potentially competing tasks of reformation and risk management. Arguably, this fusion of objectives favours risk management even in those cases where individuals are sufficiently disordered to be detainable under the MHA 1983 (see Peay 2016b).

Finally, the impact of the Human Rights Act 1998 is relevant. The European Convention on Human Rights (ECHR) has had a powerful influence on the relationship between the executive and the continuing detention of those with psychiatric disorders; an influence which has generally permeated discretionary decision-making (Peay 2016a). Yet, the ECHR is not a document that naturally lends itself to the protection of those with mental disorders because it explicitly permits the detention of those of 'unsound mind'. Nonetheless, the first declaration of incompatibility under the Human Rights Act occurred in a case concerning an offender-patient detained in a psychiatric hospital.³⁰ Perhaps this is mere coincidence. But perhaps it reflects the presence of conflicting tensions permeating

³⁰ *R (on the application of H) v Mental Health Review Tribunal* [2001] 3 WLR 512.

the practices of all who work in this field, whether they are based in the police station or at the Court of Appeal (Eastman and Peay 1999).

In short, policy development has been much influenced by a subjective approach to the framing of mental disability and crime: achieving an approach grounded in objective facts has proved elusive. Again, this is unsurprising where disability has been so broadly defined and objectivity itself is inherently vulnerable to a subjective filtering of fears and fancies.

6. CONCLUSIONS

If the basic premise of this chapter is accepted—namely, that individuals with disabilities who have offended are not, and should not be, treated as an isolated category—the conclusions that follow are of broader significance.

First, effort should be devoted to developing a pluralistic model of the criminal justice system. Piecemeal tinkering may provide solutions for the problems posed by specific offenders; it is insufficient as a basis for addressing problems across the ordered–disordered offending continuum. Equally, the temptation to solve problems by addressing only the back end of the process (namely, sentencing and disposal issues) distracts attention from the urgent need for the prior issues of culpability to be resolved on a fairer basis than is currently achieved.

Secondly, the impossibility of identifying such individuals consistently makes a ‘diversion and transfer’ solution unrealistic. Resource allocation needs to be across the board and not only in respect of a limited number of beds for potentially difficult offender-patients. Moreover, as Watson and Grounds (1993) observed, greater liaison combined with overcoming the boundaries between different parts of the criminal justice and health agencies will be insufficient all the time there is a discrepancy in expectations between agencies of who satisfies the category of ‘mentally disordered offender’.

Thirdly, treatment in prison, and in community settings, needs to be properly resourced. The problem here is the use of overt compulsion. Thus, the circumstances in which treatment will be offered, to whom, and what the consequences will be where it is deemed unwelcome, unsuccessful, or inappropriate needs more careful reflection. A pluralistic model would require the same limitations on intervention for all offenders, assuming they have the capacity to consent to treatment or undergo punishment. While adoption of a proportionality-based approach would constitute a sounder foundation for greater fairness between offenders, the risk-based/treatment approach looks set to dominate the field. In turn, the problematic aspects of multi-agency working need clarifying so that all are familiar with the limited circumstances in which confidential 'health' information can be shared in the absence of consent.

Lastly, the justifications are many for singling out subsections of 'disabled offenders' for special treatment. But if one lesson emerges from an understanding of the relationship between mental health and crime it is that people are not their diagnoses. A much more sophisticated and holistic understanding is required. Special treatment can all too readily become special control; and to be seduced by the notion that risk can be managed through the containment of identifiable individuals is to allow discriminatory treatment for that group, while failing to tackle the roots of the problem.

■ SELECTED FURTHER READING

For those wanting a clear and short introduction to the relevant sections of the MHA 1983 relating to remand and sentence, see Ministry of Justice (2008)

<https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-the-courts-mha.pdf>

For a more whimsical introduction to clinical criminology, see Prins 2016. The fifth edition of this book draws together Herschel Prins' unique experiences as a probation officer, psychiatric social worker, academic and member of the Parole Board.

On the problematic relationship between mental disorder and crime see Peay 2011, chapter 4 and Bean 2008 Part 4, for fuller accounts than space permits here.

■ REFERENCES

Amos, T., Gordon, H., Gunn, J. Peay, J. and Walker, J. (2013) 'The majority of crime: theft, motoring and criminal damage (including arson)' in J. Gunn and P. Taylor (eds) *Forensic Psychiatry: Clinical Legal and Ethical Issues*. 2nd Edition London: Hodder Arnold Education

Annison, H. (2015), *Dangerous Politics: Risk, Political Vulnerability and Penal Policy*, Oxford: Clarendon Press.

APPLEBY, L., KAPUR, N., SHAW, J., WINDFUHR, K., HUNT, I., FLYNN, S., WHILE, D. ROSCOE , A., Rodway, C., Ibrahim, S. and Tham, S. (2015), *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015*. Manchester: University of Manchester.

Ashworth, A and Zedner, L (2014), *Preventive Justice*, Oxford: Oxford University Press.

BEAN, P. (2008), *Madness and Crime*, Cullompton, Devon: Willan Publishing.

BOTTOMS, A. and BROWNSWORD, R. (1983), 'Dangerousness and Rights', in J. W. Hinton (ed.), *Dangerousness: Problems of Assessment and Prediction*, London: Allen and Unwin.

BOYD-CAINE, T. (2010), *Protecting the Public? Executive Discretion in the Release of Mentally Disordered Offenders*, Cullompton, Devon: Willan Publishing.

BRADLEY, LORD KEITH (2009), *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, London: Department of Health, COI 2009.

- Buchanan A. and Zonana H. (2009) 'Mental disorder as the cause of a crime', *International Journal of Law and Psychiatry* 32: 142-146
- BURNEY, E. and PEARSON, G. (1995), 'Mentally Disordered Offenders: Finding a Focus for Diversion', *The Howard Journal*, 34: 291–313.
- Cape, E. (2016) *What if police bail were abolished?* London: The Howard League for Penal Reform.
- [https://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Publications/What if police bail was abolished.pdf](https://d19ylpo4aovc7m.cloudfront.net/fileadmin/howard_league/user/pdf/Publications/What_if_police_bail_was_abolished.pdf)
- Chang, Z., Larsson H., Lichtenstein, P. and Fazel, S. (2015) 'Psychiatric disorders and violent reoffending: a national cohort study of convicted prisoners in Sweden', *The Lancet Psychiatry* 2, 10: 891–900
- Crichton, J. (2011) A review of published independent inquiries in England into psychiatric patient homicide 1995-2010. *Journal of Forensic Psychiatry and Psychology* 22: 761-789.
- CRIMINAL JUSTICE JOINT INSPECTION (2009), *A joint inspection on work prior to sentence with offenders with mental disorders*, HMI Probation, HMI Court Administration, HMI Constabulary, and HM Crown Prosecution Service Inspectorate.
- http://webarchive.nationalarchives.gov.uk/http://www.justice.gov.uk/inspectorates/hmi-probation/docs/MDO_Joint_Report-rps.pdf.
- DEPARTMENT OF HEALTH, HM PRISON SERVICE, and NATIONAL ASSEMBLY FOR WALES (2001), *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. London: Department of Health.
- Department of Health and HOME OFFICE (2000), *Reforming the Mental Health Act: Part II High Risk Patients*, Cm 5016-II, London: The Stationery Office.
- Department of Health and HOME OFFICE (2014), *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983, Review Report and Recommendations* [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135 and S136 of the Mental Health Act - full outcome.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf)

- DOCKING, M., GRACE, K., and BUCKE, T. (2007), 'Police Custody as a "Place of Safety": examining the use of section 136 of the Mental Health Act 1983', *Independent Police Complaints Commission, Research and Statistics Series: Paper 11*.
- DOUGLAS, M. (1992), *Risk and Blame: Essays in Cultural Theory*, London: Routledge.
- DWORKIN, R. (1977), *Taking Rights Seriously*, London: Duckworth.
- EASTMAN, N. and CAMPBELL, C. (2006), 'Neuroscience and legal determination of criminal responsibility', *Nature Reviews Neuroscience*, 7: 311–18.
- EASTMAN, N. and PEAY, J. (eds) (1999), *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart.
- Fazel, S. and Danesh, J. (2002), 'Serious mental disorder in 23,000 prisoners. A systematic review of 62 surveys', *Lancet* 359: 545-550.
- Fazel, S. and Grann, M. (2006) The Population Impact of Severe Mental Illness on Violent Crime. *American Journal of Psychiatry* 163: 1397-1403
- FENNELL, P. (2001), 'Reforming the Mental Health Act 1983: "Joined Up Compulsion" ', *Journal of Mental Health Law*: 5–20.
- GENDERS, E. and PLAYER, E. (1995), *Grendon: A Study of a Therapeutic Prison*, Oxford: Clarendon Press.
- GENDERS, E. and PLAYER, E. (2010), 'Grendon: Ten Years On', *Howard Journal*, 49(5): 431–50.
- GILMAN, S. (1988), *Disease and Representation. From Madness to AIDS*, Ithaca, NY: Cornell University Press.
- GRANT, D. (1999), 'Multi-agency risk management of mentally disordered sex offenders: a probation case study', in D. Webb and R. Harris (eds), *Managing People Nobody Owns*, London: Routledge.
- GUNN, J., DELL, S., and WAY, C. (1978), *Psychiatric Aspects of Imprisonment*, London: Academic Press.
- HALE, B. (2010), *Mental Health Law*, 5th edn, London: Sweet & Maxwell.
- HARE, R. (1991), *The Hare Psychopathy Checklist—Revised*, Toronto: Multi-Health Systems.

- Harrington, R. and Bailey, S. (2005). *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community*, Youth Justice Board for England and Wales.
- HMIC (2013) *A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs*.
- HOME OFFICE (1990), *Crime, Justice and Protecting the Public*, Cm 965, London: HMSO.
- HOME OFFICE (1991), *Custody, Care and Justice*, London: HMSO.
- HOME OFFICE (1999), *Managing Dangerous People with Severe Personality Disorder. Proposals for Policy Development*, London: Home Office.
- HOME OFFICE (2001), *What Works: Second Report of the Joint Prison/Probation Service Accreditation Panel*, London: Home Office.
- HOME OFFICE (2014), REVISED CODE OF PRACTICE FOR THE DETENTION, TREATMENT AND QUESTIONING OF PERSONS BY POLICE OFFICERS POLICE AND CRIMINAL EVIDENCE ACT 1984 (PACE) – CODE C. London: Stationery Office
- JAMES, D., FARNHAM, F., MOOREY, H., LLOYD, H., BLIZARD, R., and BARNES, T. (2002), *Outcome of psychiatric admission through the courts*, London: Home Office, RDS Occasional Paper No. 79.
- Johns, L., Cannon M, Singleton N, Murray R, Farrell M, Brugha T, Bebbington P, Jenkins, R and Meltzer H (2004) 'Prevalence and correlates of self-reported psychotic symptoms in the British population'. *The British Journal of Psychiatry* 185 (4) 298-305.
- Junginger, J., Claypoole, K., Laygo, R. and Cristiani A. (2006) 'Effects of serious mental illness and substance use on criminal offence.' *Psychiatric Services* 57: 879-882
- LAW COMMISSION (2013) *CRIMINAL LIABILITY: INSANITY AND AUTOMATISM. A DISCUSSION PAPER*
[HTTP://WWW.LAWCOM.GOV.UK/WP-CONTENT/UPLOADS/2015/06/INSANITY DISCUSSION.PDF](http://www.lawcom.gov.uk/wp-content/uploads/2015/06/INSANITY_DISCUSSION.PDF)
- LAW COMMISSION (2016), *Unfitness to Plead Report, Volume 1: Report*
http://www.lawcom.gov.uk/wp-content/uploads/2016/01/lc364_unfitness_vol-1.pdf

LAW COMMISSION (2016) *Unfitness to Plead Report, Volume 2: Draft Legislation*

http://www.lawcom.gov.uk/wp-content/uploads/2016/01/lc364_unfitness_vol-2.pdf

LITTLECHILD, B. (ed.), (2001), *Appropriate Adults and Appropriate Adult Schemes:*

Service User, Provider and Police Perspectives, Birmingham: Venture Press.

O'LOUGHLIN, A. (2014), The Offender Personality Disorder Pathway: Expansion in the Face of Failure? *Howard Journal* 53, 2, 173-192

MACKAY, R. D. (1995), *Mental Condition Defences in the Criminal Law*, Oxford: Clarendon Press.

Martin, M., Dorken, S., Wamboldt, A. and Wootten, S. (2012), 'Stopping the revolving door: A meta-analysis on the effectiveness of interventions for criminally involved individuals with major mental disorders', *Law and Human Behavior*, 36: 1–12.

McRae, L. (2015) The Offender Disorder Pathway: Risking Rehabilitation? *Medical Law Review*

Melle, I. (2013) 'The Breivik case and what psychiatrists can learn from it', *World Psychiatry* 12,1, 16-21

MELTZER, H., GILL, B., PETTICREW, M., and HINDS, K. (1995), *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 1: The prevalence of psychiatric morbidity among adults living in private households*, London: The Stationery Office.

MINISTRY OF JUSTICE (2008) *Mental Health Act 2007: guidance for the courts on remand and sentencing powers for mentally disordered offenders.*

MINISTRY OF JUSTICE (2010), *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* Cm 7972, London: The Stationery Office Ltd.

MINISTRY OF JUSTICE (2015), 'Multi-Agency Public Protection Annual Reports 2014/15', Ministry of Justice, Statistics Bulletin.

MINISTRY OF JUSTICE (2016), *Safety in Custody Statistics, England and Wales. Deaths in prison custody to March 2016, Assaults and Self-harm to December 2015.* Ministry of Justice Statistics Bulletin. London: The Stationery Office Ltd.

- MONAHAN, J. and STEADMAN, H. (1983), 'Crime and Mental Disorder An Epidemiological Approach', in M. Tonry and N. Morris (eds), *Crime and Justice: An Annual Review of Research*, Vol. 4, 145–89, Chicago: University of Chicago Press.
- MONAHAN, J., STEADMAN, H., SILVER, E., APPELBAUM, P., ROBBINS, P., MULVEY, E., ROTH, L., GRISSO, T., and BANKS, S. (2001), *Rethinking risk assessment: The MacArthur study of mental disorder and violence*, New York: Oxford University Press.
- PEAY, J. (ed.) (1996), *Inquiries after Homicide*, London: Duckworth.
- PEAY, J. (2011a) 'Recession, Crime and Mental Health' *Papers from the British Criminology Conference*, 11, 3-19 <http://www.britsoccrim.org/v11.htm>
- PEAY, J. (2011b), *Mental Health and Crime*, Routledge: Abingdon, Oxon.
- PEAY, J. (2011c), 'Personality Disorder and the Law: Some Awkward Questions', *Philosophy, Psychiatry and Psychology*, 18(3): 231–44.
- Peay, J. (2016a) 'An awkward fit: defendants with mental disabilities in a system of criminal justice' in M. Bosworth, C. Hoyle and L. Zedner (eds) *Changing Contours of Criminal Justice: Research, Politics and Policy*. Oxford: OUP
- Peay, J. (2016b) 'Responsibility, culpability and the sentencing of mentally disordered offenders: objectives in conflict.', *Criminal Law Review* 152-164
- Peterson, J., Skeem, J., Kennealy, P., Bray, B. and Zvonkovic, A. (2014). How often and How Consistently do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental illness? *Law and Human Behavior*. 38, 5, 439-449
- PORTER, R. (2004), 'Is mental illness inevitably stigmatizing?', in A. Crisp (ed.), *Every Family in the Land. Understanding prejudice and discrimination against people with mental illness*, London: Royal Society of Medicine.
- PRINS, H (2016), *Offenders, Deviants or Patients? An introduction to clinical criminology*, 5th edn, Hove: Routledge.
- RICHARDSON, G. (1999), *Review of the Mental Health Act 1983*, Report of the Expert Committee, London: Department of Health.

- ROBERTSON, G., PEARSON, R., and GIBB, R. (1995), *The Mentally Disordered and the Police*, Research Findings No. 21, London: Home Office, Research and Statistics Department.
- RUTHERFORD, M. (2010), *Blurring the Boundaries: The convergence of mental health and criminal justice policy, legislation, systems and practice*, London: Sainsbury Centre for Mental Health.
- Scott, D., McGilloway, S., Dempster, M., Browne, F. and Donnelly, M. (2013) 'Effectiveness of criminal justice liaison and diversion services for offenders with mental disorders: A review.' *Psychiatric Services* 64, 9, 843-849
- Scott, K. (2015) 'S136 of the Mental Health Act 1983 and human rights violations: police procedure and the practice of using custody as a 'place of safety' for vulnerable individuals.' *Criminal Law Review* 130-141
- SEDDON, T. (2008), 'Dangerous Liaisons: Personality disorder and the politics of risk', *Punishment and Society*, 10: 301–17.
- SENTENCING GUIDELINES COUNCIL (2004), *Overarching Principles: Seriousness*, Final Guideline, London: Sentencing Council
- SINGLETON, N., MELTZER, H., and GATWARD, R. (1998), *Psychiatric morbidity among prisoners in England and Wales*, Office for National Statistics, London: The Stationery Office.
- Skeem, J., Manchak, S. and Peterson, J. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism. *Law and Human Behavior*, 35, 110–126.
- Stewart, D. (2008) *The problems and needs of newly sentenced prisoners: Results from a national survey*. London: Ministry of Justice
- Stompe, T., Ortwein-Swoboda, G. and Schanda H. (2004) 'Schizophrenia, delusional symptoms and violence: The threat/control-override concept reexamined', *Schizophrenia Bulletin*, 30:31-44
- Seierstad, A. (2015) *One of Us*. New York: Macmillan Farrar, Straus and Giroux.

- Swanson J, Holzer C, Ganju V, Jonjo R (1990) 'Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys', *Hospital and Community Psychiatry* 41: 761-770
- Swanson. J., Schwartz, M., Van Doren, R., Elbogen, E., Wagner, R., Rosenheck, R., Stroup, S., McEvoy, J. and Lieberman, J. (2006) 'A national study of violent behaviour in persons with schizophrenia', *Archives of General Psychiatry* 63:490-499
- Syse, A. (2014) 'Breivik - the Norwegian Terrorist case', *Behavioural Sciences and the Law*, 32, 389-407.
- Szmukler, G. (2000), Homicide Inquiries: What sense do they make? *Psychiatric Bulletin* 24, 6-10
- SZMUKLER, G., DAW, R., and DAWSON, J. (2010) 'A model law fusing incapacity and mental health legislation', *Journal of Mental Health Law*, 11–22.
- Taylor, R. and Yakeley, J. (2013) *Working with MAPPA: guidance for psychiatrists in England and Wales* Faculty Report FR/FP/01 London: Royal College of Psychiatrists
- Trebilcock, J. and Weaver, T. (2012) 'Everybody Knows That the Prisoner is Going Nowhere: Parole Board Members' Views about Dangerous and Severe Personality Disorder in England and Wales'. *International Journal of Criminology and Sociology*, 1, 141-150
- TYRER, P., DUGGAN, C., COOPER, S., CRAWFORD, M., SIEVEWRIGHT, H., RUTTER, D., MADEN, A., BYFORD, S., and BARRETT, B. (2010), 'The successes and failures of the DSPD experiment: the assessment and management of severe personality disorder', *Medicine, Science and the Law*, 50: 95–99.
- WALKER, N. (ed.) (1996), *Dangerous People*, London: Blackstone Press.
- WATSON, W. and GROUNDS, A. (eds) (1993), *Mentally Disordered Offenders in an Era of Community Care*, Cambridge: Cambridge University Press.
- WEBB, D. and HARRIS, R. (eds) (1999), *Managing People Nobody Owns*, London: Routledge.
- Zlodre, J., Yiend, J., Burns, T. and Fazel, S. (2015), 'Coercion, Competence and Consent in Offenders with Personality Disorder' *Psychology, Crime and Law* 1-16

- Annotated weblinks

Mental Health Cop: A police officer's blog and information sources on policing, mental health and criminal justice.

<https://mentalhealthcop.wordpress.com/>

The National Confidential Inquiry into Suicide and Homicide by Mentally Ill People:

based in Manchester this site produces reports, projects, papers and statistics

<http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci>

[/](#)

Mental Health Law on line: a resource for legal materials on mental health law and mental capacity law in England and Wales

http://www.mentalhealthlaw.co.uk/Main_Page

A publication from the British Psychological Society, Division of Clinical Psychology

on understanding psychosis and schizophrenia

<https://www.bps.org.uk/system/files/user->

[files/Division%20of%20Clinical%20Psychology/public/understanding_psychosis](https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/understanding_psychosis)

[is - final 19th nov 2014.pdf](https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/understanding_psychosis)

The Royal College of Psychiatrists: Report by Taylor, R. and Yakeley, J. (2013)

Working with MAPPA: guidance for psychiatrists in England and Wales

Faculty Report FR/FP/01 London: Royal College of Psychiatrists which

includes hypothetical clinical MAPPA case studies

<http://www.rcpsych.ac.uk/pdf/FR%20FP%2001%20-%20final2013.pdf>

- Essay questions
1. Offenders with mental disabilities are categorically awkward; being neither exclusively ill nor uncomplicatedly bad, such offenders ‘totter between two not always compatible discourses of state intervention’ (Webb and Harris 1999: 2). Discuss.
 2. What relationship, if any, is there between mental disorder and crime? What might mental disorder add to the factors that can lead to criminal behaviour?
 3. Does the law discriminate against offenders with mental disabilities, and if so, in what ways? What explanations are there for this?
 4. Why do so many offenders with mental disabilities end up in prison despite policies aimed at diverting such offenders, wherever possible, away from such regimes?
 5. Why has the detention of those with dangerous and severe personality disorder proved so problematic?