

Examining disordered offenders within the prison system criminology essay



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As of December 2010, the prison population in England and Wales stands at 84, 896. Staggeringly, government figures estimate that over 70% of prisoners have two or more mental health problems of some kind, and 64% of sentenced, male prisoners have a personality disorder (Singleton, Meltzer and Gatward, 2007). This essay will attempt to find out why so many mentally ill people enter and remain in the criminal justice system, and why diversionary methods are not used as often as they should be. If these figures are correct then it seems clear that large numbers of mentally disordered patients are being held in prison as punishment for offending rather than being diverted away from the criminal justice system and into treatment. This essay will attempt to find out why that should be the case.

Diversion, in terms of mentally disordered patients, means diverting the individual in question to the health services and seeking treatment, rather than prosecution and entering the criminal justice system. Short of outright insanity, (see the M'Naughton rules) no matter how mentally disturbed the offender is, it comes down to whether or not it is in public interest to prosecute. The Crown Prosecution Services ask whether any useful purpose would be served in prosecution, and this can apply to anything from assault to murder (Home Office and Department of Health and Social Security (DHSS), 1975). We can see in the case of Peter Sutcliffe, the Yorkshire Ripper, even when four different psychiatrists told a judge that he was a paranoid schizophrenic, he was sent to prison rather than a secure hospital, as it was in the public's interest to prosecute.

Diversion has arguably been around, though not in its current form, since the dark ages. Roth and Kroll (1986: 100) describe a man ' possessed by evil
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spirits' who goes on to murder three people, yet is not deemed criminal and instead help is sought from 'wise men', possibly early forms of doctors. It was not formally in existence until the late 19th century when the Office of the Director of Public Prosecutions was created, and the power to determine whether it was in public interest to prosecute was introduced.

It is generally argued that diversion is beneficial to the mentally disordered offender. Smith and Donovan (1990) argue the opposite case. They postulate that excusing the offenders is not always in their best interests, especially regarding mentally ill patients still possessing most of their faculties. They believe that if the patient is prosecuted normally, it can help instil a sense of responsibility which may deter them from any further crimes, and reinforce the belief that they are in control of their own behaviour. Diversion may do the opposite and 'reduce their sense of responsibility to adverse effects' (Prins, 2010). Similarly, we must consider the effects of diversion from the views of medical staff. They are forced to look after and care for violent patients. This then leads to the use of 'guards' to make sure order is kept, which could be reminiscent of the prison experience the offender has just come from.

A significant early factor in the failure of the diversion system would seem to be lack of mental health awareness training for front-line police officers, the first people offenders come into contact with. If a police officer is not trained in identifying mental health problems, the diversion process can not even be started. Also, mental health in regards to the law is often not fully

understood by the police, including Section 136 of the Mental Health Act

(MHA) 2007, which give the Police the authority to remove a person

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appearing to be suffering from a mental illness and in need of immediate care or control from a place that the public have access to and take them to a safe place, being a hospital or a police station. A questionnaire regarding police constable's knowledge of section 136 was undertaken in 2002 by Lynch, Simpson, Higson and Grout (2002), which found that 40% of those questioned did not realise section 136 was even a police power, and just 22% had had any training on section 136. Section 136 is immensely important in the diversionary process, as it enables trained medical persons to evaluate an offender before they enter the criminal justice system. On the other hand it is used wrongly on far too many occasions where instead being taken to hospitals, the offenders are merely placed in a police station, which could easily put the offender in an even more uncontrolled state of mind. This is not always the fault of the police but down to the lack of mental healthcare experts available in any given area (The Bradley Report, 2009). The report goes on to say that police stations should no longer be used at all as a 'place of safety'. Prins (2010) claims that offender contact with the police is the 'least developed pathway in terms of engagement with the health and social services'. This needs to change as prolonged time spent in police stations or court can exacerbate the conditions of the mentally disordered patients.

Rowlands, Inch, Rodger and Soliman (1996) found that diversion, when used properly, can be very effective. They looked at a court diversion scheme and a forensic community psychiatric nurse specialist in particular. A year later, not a single patient in their study area with a psychotic illness was in prison, and just 17% overall had reoffended, while most were living safely back in

the community. These figures can be compared to the national figures quoted in the introduction. Rowlands et al. (1996) did, however, conclude that although diversion was better than imprisonment, it was second best to hospitalising the offender, and highlighted the need for a greater number of secure beds and locations. Similarly, Joseph (1992) attributed success to the availability of detailed professional assessments and an increase in inter-service communication. This leads us onto another important point.

The diversionary process cannot work without proper communication between the services involved, such as the police, judges, psychiatrists, social and probation services. The Bradley Report (2009) highlights the fact that the healthcare services in each police station are not run by the National Health Service (NHS), but by each individual force instead. This brings up many issues when moving mentally ill offenders between hospitals and police stations, such as police stations not being subject to the same governance and performance measures as the NHS hospitals. The report suggests 'transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity' and also brings to light the police's difficulty in obtaining information from the NHS. Bradley (2009) also states that the number of people who come into contact with the police is not known as there are no requirements for them to keep statistics. One of the major changes called upon by the Bradley Report (2009) is the introduction of liaison and diversion services in all police stations which would chiefly identify and assess mental disabilities and learning difficulties swiftly and effectively under arrest, and

provide better services for people taken to police stations under Section 136 MHA 2007.

The Crown Prosecution Service (CPS) also has very little contact with the healthcare services. This is worrying because they have to make the decision whether to prosecute a mentally ill offender solely on information received from the police with respect to any charging advice, who are obviously ill equipped to relay such medical matters (The Bradley Report, 2009).

Prosecutors are also reminded that not all mentally ill offenders are ineligible for a caution as without which, the possibility of discrimination appears. It is entirely possible the offenders mental disorder played little to no role in the crime they committed, so why shouldn't they be eligible for a caution. The Bradley Report calls for more conditional cautions for mentally disordered offenders while notifying relevant health authorities.

When looking at this question, it is easy to assume that all the incarcerated mentally disordered people would rather have been diverted to the healthcare services, which links to Smith and Donovan's comments earlier . This is not always the case. Prins (2010) states that there are a number of benefits to the offender if he is dealt with by the normal criminal justice system model. Firstly, hospitalisation orders often result in a much longer length of imprisonment, and if the defendant is declared unfit to plea, immediate, indefinite hospitalization is issued in the majority of cases. Secondly we must consider the possibility of iatrogenic effects brought on by psychiatric intervention. Fonagy and Bateman (2006) tell us that this is down to ' the difference between one's own experience of one's mind and that presented by another person'. Psychiatrists and other mental healthcare

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workers can only use the International Statistical Classification of Diseases and Related Health Problems (ICD), the Diagnostic and Statistical Manual of Mental Disorders (DSM) and past experience to treat patients. The possibilities of worsening patient health comes from the fact that all mental disorders can and are different in so many respects and so exact guidelines for experts to follow are less personal and therefore have room for error. To combat this, psychiatrists must integrate the patient's own experience of mind with their own (Fonagy and Bateman, 2006).

The Bradley Report (2009) highlights the lack of treatment available to mentally disordered offenders in prisons, and questions whether the treatment should be carried out in prisons at all. No longer should inmates be getting their first assessment in jail, they should be assessed for mental disorders or learning difficulties at least once by the courts or the police. Reed and Lyne (2000) explore the inpatient care of mentally ill prisoners, and find it to be wholly unsatisfactory. Of the 13 prisons inspected and the 348 inpatient beds within them, not a single doctor in charge of the inpatients had completed psychiatric training, and only 24% of the nurses had had any mental health training, obviously some disturbing figures. As Prins (2010) states, it is all too easy to blame these shortcomings on a lack of finances, but there must be methods used to overcome them nonetheless. The Bradley Report (2009) also states the need to remove those from prisons with mild or medium mental disorders and introduce many more community based primary mental health services.

The Power of Criminal Courts (Sentencing) Act 2000 lays out the basis for passing custodial sentences on an offender who ' is, or appears to be <https://assignbuster.com/examining-disordered-offenders-within-the-prison-system-criminology-essay/>

mentally disordered.' A medical report must be compiled and considered, as must the likely effect of the sentence imposed and any treatment available for the condition. This act is something all judges and magistrates must know, which makes it even stranger that so many mentally disordered offenders make it through to the prison systems. It would seem that much more intense and thorough psychiatric assessments should be made prior to appearing in court, as to enable the courts to recognize mental disabilities in offenders and help the diversionary scheme become more effective. The Bradley Report (2009) says that information regarding people appearing in court is essential in not only sentencing and remand options, but also whether they are even fit to plea. It goes on to say we should make available the same provisions to 'vulnerable' defendants as we do vulnerable witnesses, as the traumatic courtroom procedures can be very trying on a defendant with a mental disorder.

The Bradley Report (2009) criticises the excessive use of remand for offenders with mental disorders. It encourages the use of more mental health service provisions outside in the community, but accepts this is not possible at the moment due to current strain on healthcare, and the fear in communities about the frequent reoffending of some mentally disordered people. More 'approved premises' must be created to house people on remand as opposed to placing them in jail, as just 3 out of 101 of these facilities can specifically deal with mentally disordered offenders. It is worth making the point here that in the current economic climate it is questionable whether funding is likely to be made available for either enhanced community provision or further 'approved premises'. On the other hand,

there are studies that show treatment by prison care services is just as, or even more, effective than community hospitals or NHS hospitals. Brooke, Taylor, Gunn and Maden (1996) interviewed 750 unconvicted males in 3 young offenders institutes and 13 adult male prisons. Of the 63% diagnosed with a psychiatric disorder, the largest majority were deemed to be treated best by the prison care health services and transfer to a NHS bed was advised in just 9% of these cases.

Although there is certainly a need for a great increase in mental healthcare services outside of the prisons for diversion to take place effectively, we cannot neglect the mental disorder work that goes on within them. No matter how thorough the screening and assessment processes are, some mentally disordered offenders will fall through the cracks, and some prisoners certainly develop mental illnesses as a result of their prison stay, such as depression. It is vitally important to increase trained staff and facilities both within and outside the prison context.

A report by the Sainsbury Centre for Mental Health found many shortcomings within the diversionary schemes currently in place. These range from a lack of locations leading to certain parts of the country with no help, to the offender's lack of engagement with the services. They estimate just one fifth of the potential national caseload is seen to, and this doesn't even count those who are missed by assessments at the police and court stages. Even worse, those that do get seen often drop out of the system as little is done to ensure they engage with the diversion process. Overall, this report is very similar to the Bradley Report, condemning the poor, current use of diversion with regards to mentally disordered offenders. The main remedy they put <https://assignbuster.com/examining-disordered-offenders-within-the-prison-system-criminology-essay/>

forward is the introduction of many diversion and liaison teams working throughout the country, at all levels of the criminal justice system, as this would be the best way not only to detect the vulnerable offenders, but also help in treating them. To try and combat the usual defence of a lack of funding, they propose all diversionary and liaison teams are jointly funded by both the mental health services and the criminal justice system. The Bradley Report (2009) also goes into some depth about the benefits of a fully functioning diversionary and liaison team, such as ensuring the police can make a fully informed risk assessment at the early stages, and the links that must be made from the prison mental care services to the continued care of a mentally disordered offender post release.

Clearly, the overriding problem with diversion is the lack of assessment and diagnoses before an offender enters the prison system, and a lack of liaison and diversionary services available for when mental disorders are recognized. The Bradley Report (2009) puts forward the need for these services to move back from the court process and into the police stations which can improve the identification and assessment of mental health problems and learning disabilities at an earlier stage, which would also assist and contribute to the increasing communication between all agencies in the criminal justice system, and the healthcare services. This would also enable some mentally disordered offenders to completely avoid the criminal justice system as the police would instantly divert them to the appropriate mental health services, providing the best care for the offender, and reducing the workload of the police and the courts. The amount of prisoners with mental health problems is obviously disproportionate to the society in general, but

many might not display symptoms of mental illness or even develop one until incarcerated. We also must consider whether society wants mentally disordered offenders treated in the community rather than in Prisons, after all, public protective comes first and foremost. Look at the case of Christopher Clunis, a paranoid schizophrenic receiving community care from the psychiatric and social services, who went on to stab a stranger three times in the face. It seems inevitable that these occurrences would be more prevalent with many more psychologically disordered offenders walking the streets,. Of course there is the argument that these individuals would be housed in secure hospitals, but the system is not 100% foolproof, as we can see.

In conclusion, while there are undoubtedly many people in the prison system with mental disorders that do not belong there, with the healthcare system in its current state it is hard to argue mentally disordered offenders would be better off receiving treatment in the community and mental healthcare institutions. The fact is they are underfunded and under developed, there would simply be no room for thousands more patients released from prisons or diverted in the first place. Similarly, there are many mentally ill offenders that would prefer to be dealt with via the criminal justice system because it can often lead to a shorter spell of incarceration, and society's reluctance to integrate mentally disordered offenders into the public. Of course, if these problems can be addressed then diversion can be used as a suitable alternative to prisons for the mentally disordered offender (The Bradley Report, 2009).