Mental health, social order, system disorder

Nigel South, Rose Smith and **Gill Green** look at the historical basis of the risk reduction agenda and recommend a reassessment.

In a recent study of a Criminal Justice Mental Health Team (CJMHT), it was found that highly professional staff worked with a range of clients with various problems and degrees of chaos in their lives, yet for whom the team could do little (Green *et al.*, 2005). Most presented mental health, substance misuse and related problems but did not meet criteria of diagnosis as having a Serious Mental Illness (SMI) and were therefore not eligible for statutory mental health treatment. Further, as diversion away from the criminal justice system to mental health services or referral to other agencies was a primary aim, there were no easy or prioritised routes to further help — quite simply there were often no appropriate services to refer such clients to. Instead, much of the work of the CJMHT involved providing information to other mental health and criminal justice agencies about the court appearance of the individual, the outcome and the client's current mental state. Follow-up of individuals demonstrated that the psychological, social and economic needs of offenders with underlying mental health problems and those with a history of emotional disturbance were poorly addressed by statutory services and underdevelopment of voluntary services (Green *et al.*, 2005). Aware that this finding was not unique, some obvious questions about 'the system' arose: 'whose' and 'what' needs were being met?

The rise of the risk agenda

If court-based psychiatric assessment is undertaken to ensure the psychological and general welfare of the individual, why is there a dearth of resources and infrastructure to support services to which non-'SMI' clients can be referred? In this study, the question 'who is the service for?' became important because it shifted attention to the 'risk' element of assessment. As well as mental state, assessment must also document any 'risk' posed by the individual. This includes risks to self (through, for example, suicidal ideation and intent, self-harming behaviour, or following substance-use withdrawal) as well as risk to others. The conceptualisation of 'risk' has been politicised and a focus on individual 'risk' to others has led to a conflation with 'dangerousness', the latter being a concept itself imbued with racist undertones (see for example the report into the death of Blackwood or Fernando, SHSA 1998). Legislation such as the *Crime (Sentences) Act (1997)* reflects a shift in the nature of psychiatric involvement with the criminal justice system, linked to a change in psychiatric jurisprudence: "from one based on a welfare model towards a model which focuses on (public) protective sentencing" (Eastman and Peay, 1997: 32).

The process and purpose of risk-assessment have therefore received considerable critical attention, e.g. in relation to unreliability of measurement, but principally in relation to influences on policy and expenditure within criminal justice.

The time in which we live has been characterised by some as 'late-modernity', a period of social exclusion in which the market economy has expanded while simultaneously creating an 'underclass' of the structurally unemployed and marginal. At the same time, widening inequalities, the experience of relative deprivation and the rise of individualism have been cited as contributors to increasing crime (South 2005). One interpretation of the process and purpose of CJMHT-type 'assessment' could apply such analysis in relation to the CJMHT client group who are predominantly unemployed offenders. However such an overview lacks perspective on the nature of interventions and, in this case, the centrality of psychiatry to the CJMHT model.

Governmentality and psychiatry

The work of Michel Foucault has often been employed to throw light on the convergence of psychiatry and criminal justice. Foucault (1977) described the entry of psychiatry into the courts in relation to social changes at the end of the 18th century, when modes of power based on domination through physical force and punishment were replaced by governmental power. 'Governmentality' was the means through which new social relations based on 'disciplinary power' were extended throughout civil society.

Between state (the public) and family (the private) is the notion of the 'social' and it is here that agencies such as education, medicine and the specialism of psychiatry operate. Psychiatry is positioned within the context of 'disciplinary' knowledge and as a 'technology of power', socially constructing concepts of madness, dangerousness and their differentiation from 'normality'.

Mental illness itself is not a stable, scientific category. Foucault traces its construction back to the

'Great Confinement' of 17th century France. Individuals who were 'mad' would have been confined along with the poor. At this point poverty was assumed to be attributable less to economic conditions than individual laziness or weakness. Foucault notes that "in the history of unreason, [confinement] marked a decisive event: the moment when madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group; the moment when madness began to rank amongst the problems of the city. The new meanings assigned to poverty, and all the ethical values that are linked to labour, ultimately determined the experience of madness, and inflected its course" (1965: 64).

Mental illness was therefore commensurate with social failure. Psychiatric intervention via the asylum was meant to substitute for the family — teaching or re-teaching all the necessary values for successful life. Its role was to make normal, to impose order upon disorder.

The CJMHT is a proxy extension of psychiatry into the criminal justice system, representing a form (in Foucault's terms) of knowledge-based power. However, in this instance, it may seem unclear how or to what purpose this 'power' might be realised. For all the expertise, professionalism and goodwill of staff involved, clients still find themselves ending up trapped in the 'revolving doors' of treatment, criminal justice and housing-crisis agencies. As with the asylums and poorhouses of the past, society maintains systems and sites where the troubled and troublesome can be referred and forgotten about.

Challenging the system

In our own time, a framework for services for mentally disordered offenders and others requiring similar services remains elusive (Social Exclusion Unit, 2004). This is despite a long history of committees and reports.

In the context of proposed change to mental health legislation (and a continuing governmental pre-occupation with dangerousness and risk), a critical stance toward the current negative formulation of service governance as risk-management would involve acknowledgement that unmet need has much to do with 'risk', and of more positive models of risk-reduction. The basis for this proposal is the contemporary reality of legislation concerning human rights. Hence the problem of service deficits could be seen in the context of the regime of expectations regarding service standards, equity of access and rights noted by the Audit Commission (2003: 7):

"Despite developments, public bodies continue to struggle to make the connection between human rights, equalities and service improvement. ... Despite the high profile of the [1998 Human Rights] Act ... [h]ealth bodies consistently lag behind other public services. In the criminal justice sector the initial flurry of activity has stopped. This will leave these bodies vulnerable to the risk of challenge because they are failing to protect themselves and will not secure service improvement."

There is the possibility here of using the agenda concerning 'rights, equalities and service improvement' to turn around the focus of risk, placing less emphasis on dangers posed by service users and more on the risks of failure if services are not improved or established. This would mean developing throughcare and aftercare in relation to individual users and diversity of need, so contributing to greater risk reduction.

In a context of prolific increase in measures designed to impose social order, the need for a stronger system of social support is under-addressed. There is a lack of appropriate services, (offering the necessarily flexible and long-term support and staffed by appropriately trained and experienced personnel) able to meet the needs of those with complex and multiple vulnerabilities. The social control net has been widened and strengthened at the expense of the proper care of vulnerable and emotionally disturbed people.

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