Resettling Mentally Ill Offenders

Jonathon E Lynch and **Steven Skinner** describe hurdles to the resettlement of mentally ill offenders, including the prejudices of the public and policy-makers.

This article focuses on the resettlement of mentally ill offenders who have been convicted of serious offences and diverted into NHS medium-secure forensic mental health services. Detention aims to be therapeutic, and often involves medication as well as social therapies, and, gradually, as mental health usually improves, offending behaviour can be addressed and risks to others minimised. The 'challenges' of rehabilitation and reintegration are more problematic for some than others, with relevant matters affecting both the offenders and the professional and voluntary workers who strive to help them. We consider some of the prominent issues here from the perspectives of both the released person, and the NHS forensic services.

Numerous studies have identified the prevalence of mental ill health among prisoner populations, but despite popular notions to the contrary, most mentally ill people are no more likely to offend than anyone else. Professional views have altered through time and experts have concluded that some disorders do increase the risk of criminal acts (Crichton, 1995). However, as Yvonne Jewkes mentioned in the last edition of *CJM* (No.55/2004), numerous media repeatedly attribute negative — especially violent — qualities to mentally ill people, and sensational reports often reinforce stereotypes. Though it might be accurate to assume that many members of the public are influenced, it would be naïve to assume that those in the health services and criminal justice agencies go untouched by these issues.

Options for the combined mental health care and detention of serious offenders have progressed significantly in under two decades. For England especially, the expansion of medium-secure units (MSUs) led quickly to the admission of some who had offended recently and would otherwise have been in 'category A' prisons. Comparatively well resourced, these units have been generally successful in maintaining security, and treating and caring for individuals who, very often, offended as a result of their mental states. However, serious mental illnesses cannot be 'cured', and even after stabilisation the risk of relapse must be considered. Even gradual decreases in security pose ongoing demands on the discretion and decision-making skills of professionals. The additional role of the Home Office is an added complexity compared to the reintegration of other users of MH services, and some delays are inevitable in the processes of consultation.

According to the popular notion that crimes are committed by people who are either 'bad' or 'mad', mentally ill offenders may be considered doubly deviant, but perhaps many are particularly disadvantaged. Certainly, the obstacles to social reintegration can seem immense. Critics proclaim that disposal in secure health care facilities is a 'soft' option that guarantees shorter periods of incarceration, yet length of detention is often commensurate with the gravity of offences — and many hospitalised psychopaths are detained longer than prisoners with equivalent offences (Pilgrim and Rogers, 1999; Peay, 1989). Many of those in MSUs are subject to restriction orders under the 1983 Mental Health Act, so release is predominantly dependent upon professional decisions about the likelihood of recidivism rather than time served in custody. Clinical risk assessment involves the use of information related to mental ill health and harmful behaviours, and can provide an individualised, qualitative feature. However, few could envy those required to estimate the likely progress of not only another individual, but one who is officially mentally ill. Informed, defensible decisions are the order of the day (Grounds, 1995).

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Length of detention can affect issues crucial to successful resettlement. Prior accommodation has usually been lost by the time of release, but some housing services that provide for the mentally ill will reject ex-offenders, and many catering for the latter will reject the former. It may appear that there is a market for such specialised accommodation until one encounters the prejudices and fears that drive protests against new facilities. Just as jurors have rejected expert testimony in prominent cases (e.g. Sutcliffe; Nilsen), the professionals who decide that individuals are suitable for community settings are not considered particularly credible by an anxious and at times untrusting public. The pendulum of 'public opinion'

swings with the climate, and while the lay majority may well be silent, many professionals perceive a 'Catch-22' message: 'be strict and you're inhumane; be caring and you're too soft'. Perhaps this ambiguity explains why the use of force and pain-compliance techniques in the hands-on management of both the mentally ill and offenders seems to attract less social concern than the perceived risks posed by resettlement. This minimal-interventionist stance is quite remarkable given that health, social care and governmental priorities indicate agreement that many in either category are among the most vulnerable and/or marginalized in society (Silver and Miller, 2002).

The Prison Service is ostensibly rigorous in its regulation of employees' behaviour regarding the use of force, and it is the mental health services and the relevant professional regulatory bodies that have some way to go with regard to clear guidelines and national standards of training and intervention.

Assuming a suitable environment is found and adequate funding is in place for resettlement, there can still be additional inter-related problems. If a hostel placement breaks down and the client has to return to hospital there are pressures to manage that place, and to estimate the probability of return within the context of finite resources and immense demands from elsewhere. There is also the difficulty of placement elsewhere when a hostel reaches a decision to evict. This often follows repeated episodes of what the staff consider to be unmanageable or seriously anti-social behaviour, though it may not constitute grounds for recall under licence for those who have been conditionally discharged. Sadly, some suicides have apparently been linked to impending evictions and the difficulties in providing alternative accommodation.

Stress is a key feature in the relapse of many people with serious mental illnesses. Being subjected to repeated verbal abuse from local people might well affect anyone, yet those abused as 'nutters' may actually be more vulnerable. At one medium secure unit where we worked, approximately 15 per cent of admissions to the most secure area were ex-patients who had deteriorated drastically in the community, some describing persecution 'out there' from inhospitable local residents. Strange though it may seem, some people longed for the perceived safety and even tranquillity of a secure mental health unit.

Alcohol and illicit drugs contribute to many mental health relapses, but so does 'non-compliance' with medication. Some users of MH services reserve the fiercest criticism for prescribed medication, citing side-effects that are not only unpleasant but debilitating. Ironically, it is overt side-effects (e.g. tremor, salivation, gait) and not overt signs of mental illness that sometimes attract negative attention resulting in persecution. Cobb (1994) estimated one death per week among those taking these medicines, but with reports linking violent incidents with a reluctance to take them, non-compliance has itself emerged as a social problem (Pilgrim and Rogers, 1999). Proposals to enforce treatment in the community have met with mixed reactions but it seems likely that the government will provide greater powers for some of the social control associated with inpatient facilities to be extended to the community.

Even after lengthy periods, some offenders deemed 'serious' by the authorities will be able to return to social networks and life in the community without too many problems. By contrast, some of those known to be mentally ill, and especially those overtly unwell, may struggle to achieve even a modest anonymity and to live quietly outside an institution. Just as so many mentally ill offenders are ostracised in prison (and referred to as 'fraggles'), the suspicion of many citizens in the community can create a major hurdle to reintegration.

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