Community Care/CPA really make an impact on these underlying social deficits? I become increasingly sceptical, for three reasons. Firstly, there are major shortfalls in some of the services people need - supported accommodation, drug and alcohol services, daycare, psychotherapy. The goal of providing long-term practical and emotional support to mentally vulnerable people in their own homes has rarely seemed so distant.

"Failed to attend two appointments; clearly not willing to take responsibility for own problems; case closed"

Secondly, inter-agency co-operation requires goodwill and a common commitment to the client's best interests. In practice, as we all know, hard-pressed services will go to great lengths to avoid financial responsibility for 'difficult' clients. Thirdly is what I call 'empathy exhaustion' - when services give up on a client. "Failed to attend two appointments; clearly not willing to take responsibility for own problems; case closed", I read in a file recently about a clearly vulnerable man needing help but not playing by social work rules.

'Mentally disordered offenders' are not an easy issue for services, or a popular cause. They test Community Care to destruction. Currently it falls far short of what's needed. The real issue therefore is: can we seriously expect improvements given current prospects for 'welfare' expenditure (including probation and social housing) over the next decade? If not, then either we find a new source of compassionate intervention or we live, monstrously, in Erewhon. ■

Reference

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SICKNESS AND SIN

Mental Disorders, Crime and Criminal Justice

Herschel Prins

The relationship between mental disorders and crime has always fascinated, disturbed and provided controversy. Such fascination, disturbance and controversy come to the fore when notorious cases 'hit the headlines' - from nineteenth century cases such as those of Hadfield and McNaghten to twentieth century *causes célèbres* such as Sutcliffe, Nilsen and Allitt in the UK and Hinckley in the USA. Such examples illustrate the problems not only inherent in defining and delineating the boundaries of mental disorders but the distinctions that may be drawn between sickness and sin. (Prins 1994a). They also demonstrate the problems of reconciling the conflicting perceptions of practitioners of the law, on the one hand, and psychiatry on the other. For the purpose of these brief comments the term mental disorder is used in a broader context than that set out in current UK mental health legislation, namely, Section 1 of the 1983 Mental Health Act, 1983. Disorders, in the sense that I am using the term, embrace a wide range of conditions than defined in the Act. Perhaps mental *disturbances* would be a more accurate term - one that we chose to adopt in our NACRO Mental Health Advisory Committee and in the series of policy papers we have produced. (NACRO, 1993).

'Only Connect'

It is commonly supposed that there *must* be some causal link between certain mental disorders and crime. One immediately thinks of violent crimes against persons or property (such as arson), committed by those suffering from acute episodes of, say, schizophrenic illnesses, particularly if these are characterised by persecutory delusional systems and also exacerbated by substance abuse of one kind or another. (See, for example, Taylor, 1993, Monahan, 1993 and Quinsey, 1995).

In other cases, the relationship seems far less clear-cut, especially when such conditions as psychopathic disorder are raised as a defence. Another example is that of infanticide. Although the law permits exculpation from full criminal liability (responsibility) in such cases through the Infanticide Act, 1938, the grounds for this may not be as clear-cut as some people imagine. The defence may seek to show that the mother was suffering from mental disturbance as a result of the birth or lactation subsequent to it. However, it may also be very apparent that the *social situation* of the mother may be regarded as being of equal importance.

Sometimes, cases occur, in which the defendant's behaviour may appear to have a 'psychiatric' cause, when, in fact, following careful investigation, a physical/organic cause is found. Examples that come to mind are endocrinal and hormonal disturbances, tumours, cerebral 'insults' and accidents and exposure to toxic substances. These we may regard as microcosmal aspects, but there are also problems on a broader scale to be considered; I call these the macrocosmal aspects.

Causal complexities

In the first place, there is no uniformity of view about the direct *causal* relationship between, for example, psychosis and crime (notably the schizophrenias and the affective disorders - see, for example, Modestin and Amman, 1995). In the second place, neither mental disorders nor criminality are static entities and therefore capable of direct comparison. They both suffer from what I have described elsewhere as the 'changing goal-posts' phenomenon. (Prins, 1995).

For example, the epidemiology and presentation of mental disorders appear to change over historical time. Disorders that were familiar, in say, the middle ages may not be so prevalent today. Take, for example, the episodic outbreaks of so-called insanity in the form of the 'dancing mania' which were subsequently found to be due to the ingestion of bad or adulterated flour. This resulted in ergot poisoning which produced mental confusion and extreme physical agitation. Disturbed behaviour was sometimes produced by the ingestion of lead and other poisonous substances such as mercury. (Lewis Carroll described the 'mad hatter' in the way he did with good reason - for mercurial poisoning with its psychological consequences was not uncommon at one time amongst those employed in hat manufacture.)

In more recent times, it has been

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thought by some authorities that some mental disorders appear to be the product of living in a more stressful society with its technological advances; examples frequently proffered are so-called post-traumatic stress disorder, Munchausen states and multiple personality disorder. However, when their historical context is examined it is by no means certain that these disorders are as modern as some people suppose.

The relationship between mental disorders and crime is by no means as clear-cut as some people would think.

New and old crimes

If mental disorder is not 'static', the same can be said of crime. After all, crime is only what the law says it is at any one point in historical time. For example, in the nineteen-sixties, we removed from the statute book two forms of behaviour, adjudged at that time to be criminal: (1) some forms of adult male consenting homosexual conduct and (2) attempted suicide. (I am sufficiently 'long in the tooth' to remember, as a probation officer, supervising clients in both these categories in the late nineteen-fifties). The converse is, of course, also true. In the last three decades we have added increasing proscriptions on some forms of behaviour, bringing them within the purview of the criminal law. Examples are: the possession, consumption and the distribution of various drugs, retrospective anti-terrorist legislation and a multitude of road traffic offences.

The general thrust of these remarks has been to demonstrate that the relationship between mental disorders and crime is by no means as clear-cut as some people would think. It is also true that the so-called inverse relationship between the populations of prisons and mental hospitals is not as 'neat' as the late Sir Lionel Penrose once suggested. (The so-called 'Penrose's Law').

Some implications for criminal justice

Research studies undertaken over the past fifty years or so have tended to show that when mental disorders are looked for in penal populations the evidence of connection is heavily dependant upon the skills of the researchers and the population sampled. This has resulted in widely varying estimates. (Prins, 1995). More

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recent and sophisticated studies, such as those conducted by Professor Gunn and his colleagues (Gunn et al, 1991) and those by Adrian Grounds (1991) do show that the numbers of both remand and sentenced prisoners who require both psychiatric investigation and treatment are not inconsiderable. Justified concern about this (and particularly about the over-representation of black people, and, to a lesser extent, women) has been expressed by both government and other agencies. Considerable efforts are now being made to encourage and develop various diversionary activities, including an increase in the formal transfer of prisoners to hospital under the Mental Health Act, 1983. (See Prins, 1994b).

If diversion is going to work effectively, there must be adequate health and social care provision in place; it is by no means clear that this is the case.

Understandable enthusiastic espousal of such procedures should not blind us to the need for caution. There are one or two points to be made. If diversion is going to work effectively, there must be adequate health and social care provision in place; it is by no means clear that this is the case. In relation to formal transfers from prison to hospital it is likely that the sharp increase in their number has placed secure hospitals under considerable pressure. There is also the possibility that a person given a mental health disposal, either before court hearing, or at court, may serve a longer period of 'incarceration' than if afforded a penal disposal. Finally, it is not always wise to assume that an individual should not be held responsible for his or her actions even though they may be suffering from a degree of mental disorder. As indicated earlier, the whole topic is complex and only addressed here in very cursory fashion. Those wishing to pursue it in more detail should find the references cited here of assistance. ■

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