CJM
CRIMINAL JUSTICE MATTERS

MADNESS ON TRIAL

Mentally disordered offenders: the court's perspective

Jill Watkins

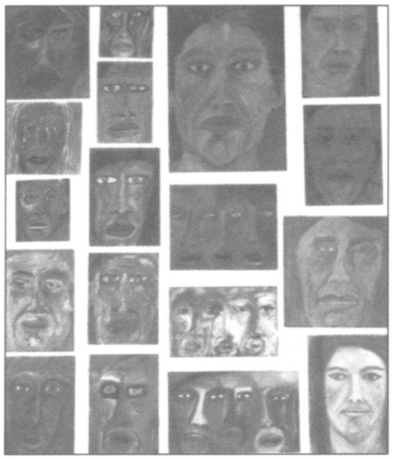
The phrase 'mad, bad or sad' is sometimes used to describe the procession of defendants who appear in Magistrates' Courts. The majority fall into the third category, a few are truly bad, and fewer still are found to be mad.

It is now widely recognised that the mentally disordered offender represents particular problems for all professionals and other court users in the Magistrates' Court. Great progress has been made over the last five years or so in establishing diversion schemes, and eventually funding became available from the Home Office to support these arrangements. My own perspective of the mentally ill whose behaviour leads to their arrest is based upon my experience as a Justices Clerk in a large Inner London Court at Camberwell, serving two South London boroughs, within walking distance of the Maudsley Hospital. A Court Diversion Scheme was established in 1992 to provide the attendance of a community psychiatric nurse every Tuesday, supported by a Psychiatric Registrar from the nearby Maudsley Hospital. Whilst other Inner London Courts, notably Horseferry Road and Clerkenwell have more elaborate schemes, the arrangements at Clerkenwell have worked satisfactorily from the point of view of the magistrates. Many cases which, a decade ago, might have led to repeated remands in custody for mental and medical reports are now disposed of by the passing of a nominal or token sentence, which enables the immediate reception of the accused into hospital.

Powers of the court

The Mental Health Act 1983 provides the statutory framework empowering Magistrates' Courts to order remands to hospital for a report on the accused's mental condition, to make hospital orders after conviction, or to commit to the Crown Court. That court gives the power to make a hospital order coupled with a restriction order which will curtail the defendant's release, and also to remand to hospital for treatment. A significant provision of the Act, sometimes overlooked, is the power given to the Home Office to transfer prisoners, including those on remand awaiting trial, from prison to a mental hospital. This option is particularly useful when the circumstances of the alleged offence, such as a serious accusation entailing a long wait on remand, pending a trial in the Crown Court, coupled with the degree of mental illness, indicate that the period prior to final disposal of the case is more appropriately spent in hospital, rather than in prison.

The majority of the mentally ill who exhibit bizarre behaviour are often charged with the relatively less serious public order offences or minor criminal



damage. An assessment in the court cells, either by the community psychiatric nurse, or the doctor, leading to arrangements for a hospital bed, may persuade the Crown Prosecution Service to withdraw the charge. Alternatively, providing that the defendant's illness is not such as to render him unfit to plead, and that he is relatively lucid in court, he may, with the benefit of the advice of the duty solicitor, be able to enter a plea of guilty. The magistrates may then pass a non-custodial sentence, which will enable him to be conveyed immediately to hospital.

Different considerations apply where the accused faces very serious charges, such as murder, causing grievous bodily harm or arson. The provisions of the Bail Act and the obvious need to safeguard the public from a dangerous offender will inevitably lead to a remand in custody, whilst the case passes through its interlocutory stages on its way to the Crown Court. In these circumstances, where the accused's mental illness is serious, the prison governor may take the initiative, following assessment by a psychiatrist at the prison, to transfer the prisoner to a mental hospital. There he or she can be detained and receive appropriate medication pending the final disposal of the case.

Lessons from case law

A little used provision is to be found in Section 37 (3) of the Mental Health Act 1983, whereby the court may make a hospital order without convicting the defendant, provided that the alleged offence is imprisonable and the court is satisfied that the accused 'did the act or made the omission charged'. Case law has emphasised that this procedure should only be adopted rarely and with the consent of the accused's legal representative, since the making of a hospital order without convicting a person raises civil liberties issues, and may incidentally serve to minimise the seriousness of the conduct complained of. In one case where a hospital order was made by a court which found that the accused had done the act charged, the allegation was one of indecent assault upon a sixteen year old girl. The defendant suffered from a psychopathic disorder, which entailed delusions interspersed with lucid periods. One of the latter coincided with his appearance before the court when he was well enough to consent to summary trial and plead not guilty. At the date fixed for the trial, the victim failed to attend court because she had not received the notice warning her to do so. Throughout the proceedings, the defendant had been the subject of a remand to hospital, where two doctors had prepared reports, recommending the making of a hospital order. In order to avoid further adjournment, the court obtained the consent of the defence solicitor to the use of the procedure under Section 37 (3). The court received the written statement of the victim and concluded, without recording a conviction, that the accused had done the act complained by the victim. Following consideration of the two medical reports, a hospital order under Section 37 (3) was made, and the defendant returned to the hospital where he had awaited trial on remand.

Should that defendant commit other more serious sexual offences in the future, other issues may arise which may cast doubt on the wisdom of such a procedure

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in this particular instance. Since no conviction has been recorded, it is unclear whether the previous offence would be brought to the court's attention during a bail application in relation to a subsequent charge, where it would be highly relevant.

The criminal justice system is an extremely blunt instrument, in which the criminal conduct of the mentally ill can often appear more or less serious according to the degree of mental disturbance displayed. Court diversion schemes have developed in response to the perceived need to provide a flexible

and multi-disciplinary approach to the mentally ill offender. Similar schemes are being developed in prisons, and also in police stations in a worthwhile effort to reduce the numbers of those whose offending behaviour leads to them being caught up in the criminal justice system. ■

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Continuing care for mentally disordered offenders

Barbara Swyer

People with mental health needs involved in the criminal justice system (CJS) have been the subject of increasing concern over recent years. Growing awareness of the prevalence of mental disorder within the offender population and isolated, but well-publicised, violent offences committed by offenders who also have a psychiatric diagnosis have focused professional concern on the need for access to healthcare for offenders within the community. This has resulted in an overwhelming emphasis on police/court diversion schemes and transfer from prison to hospital, fulfilling what many see as the main objectives of work with mentally disordered offenders: to divert them from the CJS and provide appropriate care for those most in need.

But what is appropriate care? The history of mental health services and the CJS has been so dominated by its involvement with the medical profession that is often assumed that care = hospitalisation. However, what those working closely with offenders know is that there is a significant number of people who will not be diverted or do not require in-patient treatment (either voluntarily or involuntarily), but whose mental health problems impact on their ability to cope within the community. Many of these offenders inevitably end up in the prison system.

The Wessex Project

The Wessex Project in Hampshire is an attempt not only to break the cycle of recurrent imprisonment for mentally disordered offenders, but also to provide a model of team-working focused on meeting the offender's mental health and other needs on release. It is a three-year multi-agency initiative, supported by Hampshire Social Services, the S&W Regional Health Authority, the Department of Health, Hampshire Probation Service, the Prison Service and the Mental Health Foundation. The team comprises a social worker, probation officer and community psychiatric nurse, each funded by the relevant agency, plus a full-time manager, half-time secretary and half-time researcher from Bristol University. The project aims to identify mentally disordered offenders within the population of Winchester Prison (the local prison for the area) and to ensure assessment of need and access to appropriate community mental health services on release. The project is committed to producing reliable data, which can be used to inform practice and planning, and to the belief that release plans should mean exactly that. The first days after release are crucial in setting the standard for future care in the community and therefore plans must be agreed and ready to be enacted *before* the offender has left the prison.

The care programme

Wherever possible this is done using the Care Programme Approach (CPA). The CPA guidance[1] says that, for those with serious mental illness leaving hospital, planning should include all agencies relevant to current and future care; the Wessex Project have extended this to include those leaving prison as the principle remains the same - planning for a person's return from an institution to the community. At its best the CPA provides an excellent framework for an offender-centred plan, the opportunity for the full involvement of the person concerned and for the offender and agencies to make comments and decisions together about future care. The Wessex Project has successfully introduced this process into Winchester Prison with the agreement of the Senior Medical Officer. Offenders with serious mental health problems are invited to CPA meetings which should include all those who are, or will be, involved in their care inside the prison and on their return to the community. The team are committed to a 'no surprises' approach, which means that the value of communication is at a premium, and the offender is kept up-to-date with any development of changes.

The Wessex Project is a good example of how the CPA can be used to ensure that an often forgotten section of the mentally-distressed public access appropriate services. Good multi-agency work requires a clear focal point - both in terms of systems and practice. The CPA can provide the system focus, ie the tool with which to make 'continuing care' a reality for offenders with serious mental health problems, but, if the project team has learnt one lesson in its two years' work, it is that without a clear practice focus the CPA quickly becomes a reactive, and sometimes defensive, exercise.

Working together

But how can the services involved with mentally disordered offenders create an environment in which multi-agency working, in the true sense of joint

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responsibility and shared care, can flourish? What all practitioners and managers know is that successful multi-agency working is time-consuming and requires a persistence and tenacity often not called for elsewhere. Assumptions abound that agencies are willing and able to look at a person's needs in the widest sense and that workers are clear and confident about where their responsibilities, as keyworkers or otherwise, lie in relation to the offender, other agencies or the public. This is not always the case and in many ways it is not hard to understand why. Health and social services are continually bombarded with the need to control resources through prioritising and to respond to those in acute phases of serious mental illness. The Prison Health Care Service does not enjoy parity with the NHS, neither in status nor management; it is clear that its remit lies in treatment whilst the prisoner is within the prison walls. The Probation Service has moved toward a greater focus on offending behaviour and the supervision of serious offenders. What this adds up to is a tension within and between agencies who are now instructed to form partnerships and work together[2] while continually having to revise their eligibility criteria.

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Continuing care

For the mentally disordered in the majority of England's prisons there will be no CPA process to smooth their path back into society, and no highly coordinated multi-agency plan for continuing care to protect them or the public. The focus of public attention has encouraged the search for immediate results, which is why diversion and hospitalisation have become the hub of work with mentally disordered offenders. But it is important to remember that what is required is 'continuing care' and that there is no less of a need for proper planning between agencies whether an offender be outside or 'inside'.

For many of the more seriously disordered who do not require in-patient treatment, the CPA, used with confidence, is an ideal tool to structure planning in prison and in the community. What the Wessex Project has shown is that where agencies communicate, are client-centred and committed, access to appropriate services on release becomes a reality and continuing care can work. ■

References

1. NHS Executive HSG(94)27
2. Home Office Circulars 66/90 and 12/95

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CASE STUDIES

Steven is a 32 year old man who often becomes emotionally distressed and angry, finding relief by setting fire to buildings. On conviction for arson he received a six month probation order. The Wessex Project initiated a Care Programme involving input from a psychologist, a CPN and Steven's probation officer. Steven needed a lot of support in finding accommodation, because of the nature of his offence, but has now found accommodation with friends, and is working.

Adam is a 22 year old man referred to the Wessex Project when remanded in custody on charges of burglary and possession of an offensive weapon. At that time he was hearing voices and experiencing severe feelings of paranoia. The Wessex Project worked with Adam while he was remanded and then on bail, ensuring that he attended court. The project organised a psychiatric assessment for Adam and then put together a package of care including supported housing and appropriate psychiatric follow up. Adam is now attending further education college and gaining new skills.

- Nearly 2000 men in Winchester prison have been interviewed by the Wessex Project over the last two and a half years.
- Over 250 men have received some sort of help from the project.
- Sixty men with mental health needs have had community care packages or Care Programmes set up for them on release from custody.
- One in four men entering Winchester newly sentenced reported a history of some kind of mental health problem. The largest category was depression (11%), followed by self harm or suicide attempts (7%). Two per cent of sentenced men reported a history of psychotic illness or psychotic episode.
- Those with a history of mental health problems were older, were more likely to be convicted of a violent or sexual offence and much less likely to be convicted of a drugs offence. They were also more likely to have previous convictions and to have received both community and custodial sentences in the past.