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Scoping Review of Literature on the Health and Care of Mentally Disordered Offenders

CRD REPORT 16

Scoping Review of Literature on the Health and Care of Mentally Disordered Offenders

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AND
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Policy Research Bureau, London

© October 1999

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ISBN 1 900640 14 7

This report can be ordered from: Publications Office, NHS Centre for Reviews and Dissemination, University of York, York YO10 5DD. Telephone 01904 433648; Facsimile: 01904 433661: email: crdpub@york.ac.uk
Price £12.50

The NHS Centre for Reviews and Dissemination is funded by the NHS Executive and the Health Departments of Scotland, Wales and Northern Ireland; a contribution to the Centre is also made by the University of York. The views expressed in this publication are those of the authors and not necessarily those of the NHS Executive or the Health Departments of Scotland, Wales or Northern Ireland.

Printed by York Publishing Services Ltd.

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PREFACE AND ACKNOWLEDGMENTS

This literature review is one of a series of four funded by the High Security Psychiatric Services Commissioning Board (HSPSCB), all of which are drawing to completion at this time. The four were each on different aspects of the literature relating to mentally disordered offenders, and the research commissioning process was managed by the NHS Centre for Reviews and Dissemination at York (the `CRD'). Three of the four - the other three - were 'systematic reviews'. The procedure for undertaking systematic reviews has been pioneered by the CRD and is now based on a clear set of rules concerning how to judge and evaluate the research literature. However, ours had a rather different remit, and was commissioned as a 'scoping review'. This allowed it a more flexible approach, specifically so that we could establish the broader lay of the land, including a range of good and less good studies and commentaries, in order to establish the bigger picture of strengths, weaknesses and policy development in the existing literature.

This review was thus written as a broad overview, and part and parcel of that was our assumption that the readership (beyond the HSPSBC) would also be varied and not necessarily expert in the field. We have sought to make the text as accessible as possible, which has lead us to include several background chapters setting out the general context, the statutory framework, the nature of existing provision, and so on. Where possible we have avoided technical language or have provided definitions.

Quite apart from the methodological distinction between this scoping review and its systematic siblings, this project has a rather unique and disrupted history, and a number of people have been involved over the course of its development. In the first instance, the HSPSCB funded the Policy Studies Institute (PSI) to undertake the work, specifically a multidisciplinary team including Dr Elizabeth Perkins, Trevor Jones, Sue Arthur, and Dr Ann Hagell. All four of these people subsequently left PSI for different destinations, and the project was transferred in early 1998 to the Policy Research Bureau, where Ann Hagell is now Co-Director. Shirley Bourke Dowling, a freelance researcher who had also been at PSI, also continued to work on the project. All these people involved in the set-up of the project are to be thanked, with a special mention for Sue Johnson who was librarian at the PSI and is now at Social and Community Planning Research.

We are very grateful to the HSPSCB for funding the project in the first instance, and also for bearing with the disruption to the project over its life and for the continued support and interest of Board members, particularly Dr Dilys Jones. We are also grateful to the advisory group set up by the Board, who provided very useful feedback for us, including Pat Edwards, Merseyside Probation Service; Adrian Grounds, University of Cambridge; Professor John Gunn, Institute of Psychiatry; Dr Barbara Hudson, University of Oxford; Jill Peay, London School of Economics; Professor Herschel Prins; and Philip Vaughan, The Wessex Consortium. Discussions with other researchers working in this area have also proved useful and we would particularly like to acknowledge Doug Badger, Paul Williams, and Jean Nursten from the Reading review team.

Finally, the direction and support of Professor Trevor Sheldon, who was at the CRD for most of the life of this project, was critical for the project and many thanks indeed are due to him for his assistance.

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1 OVERVIEW OF THE SCOPING REVIEW

Issues and aims

This scoping review was commissioned by the High Security Psychiatric Services Commissioning Board, as one of four in a series designed to lay out the state of the current literature on mentally disordered offenders.

The **main aim** of the review was to give a broad picture of the key issues in this area, and the extent to which there are important gaps which need further research. It was obvious from the outset that this is a disparate and dislocated literature, and despite the four reviews, there is still a strong need for further overviews. We have only been able to touch on some of the important areas and the chapters in this review do not themselves provide definitive overviews - this simply would not have been possible given the resources of this project.

There were a number of different ways in which this scoping review could have been organised. We chose to look at the state of research in a set of **seven key areas**, although there were other possibilities. The seven areas included: an overview of developments in the field; the statutory framework; existing provision for mentally disordered offenders; descriptions of populations of mentally disordered offenders; causal and preventative studies; pathways into and out of care; and effectiveness research.

The remainder of this overview draws on `Summary Boxes' set within the text at the end of each chapter.

Methods

- The project started with a 'research protocol' outlining our approach, which was peer reviewed by the Advisory Group.
- Having outlined important areas to investigate, we followed a four-part stepped strategy.
- The first stage involved drawing up a preliminary map of the issues in each area.
- The second stage was to identify research reviews in each area, post 1975, if they existed.
- The third stage was to identify the significant and reliable primary studies in each area, particularly if there were no good reviews in existence. We then summarised the results from these studies and highlighted gaps in the literature.

- The fourth stage was to consider smaller, more qualitative studies and policy commentary. In some areas, this constituted the bulk of the literature.

The main conclusions from the seven key areas

Summary: Developments in the field

- Recent policy and practice developments have included the rise in care in the community within the health arena, and an increased emphasis on diversion within the criminal justice system (at least in the early 1990s)

- Other important developments have included a growing emphasis on defining need, both at the level of general service provision, but also at the level of individual needs assessments.

- Multiagency working has become essential within most of the relevant fields to this review, but still poses considerable challenges in practice.

- Recent academic developments have included the growth of forensic psychiatry, and an increased literature on conducting and analysing risk assessment.

- A number of questions arise relating to these new developments in the field, not least the central fairness or unfairness of the system.

Summary: The statutory context

- We reviewed the main tenets of the Mental Health Act 1983, and a selection of other relevant pieces of legislation. We have explored the statutory and legal framework within which MDOs are processed, and identified problems with definitions.

- The statutory and legal context for MDOs has a literature in its own right, although it is disparate and rather obtuse for the non-expert reader. The piecemeal system of development of a legal framework makes it difficult to digest the information available.

- There is a need for some user-friendly overviews crossing borders and boundaries between areas. Some summaries do exist, but these are generally aimed for a specialist academic audience, not a practitioner or non-legal audience.

- Research on the understanding of those involved in different parts of the statutory framework and the criminal justice system (including MDOs) would be interesting and useful and is lacking at the moment.

- The issues raised in this overview of the statutory framework included: does the legislative framework promote fairness of treatment - does it ensure people entering the system through different routes are treated similarly; does it resolve the balance between care and control; and how can the challenges posed by 'untreatable' personality disorder be resolved?

Summary: Existing provision

- Provision varies on a number of dimensions including: whether it is located within the hospital or prison system, a health issue or a criminal justice issue; and in terms of the levels of security provided, from none up to the special hospitals.

- In terms of the available research, some broad overviews exist, but the situation changes all the time, particularly in the current NHS climate of continued reorganisation.

- There is a wealth of empirical data on different types of provision (who is provided for; what it provided for them, etc) but the data are very variable in quality.

- There is also a body of relevant work on how access to provision generally varies according to factors such as homelessness, factors which are more prevalent in MDO populations.

Summary: Descriptions of populations of mentally disordered offenders

- A significant review of the epidemiology of MDOs has just been completed as part of this series of four. However, the aim was rather different from ours, and we looked in this chapter at descriptive as well as epidemiological studies.

- The most significant gaps in the literature came at the very broad and general population-based level, rather than in terms of smaller and specialised populations. That is, the biggest gap in the literature is in terms of patterns of overlap between offending and mental health in the general population.

- The results of this chapter concur with those of the Reading epidemiological review in showing that we know little about the illness characteristics of offenders or the offending patterns of people with illness.

- There is a lack of reviews as well as a lack of primary data in many of the areas covered, but the commissioning of the Reading epidemiological review will result in a considerable addition to the literature. We would suggest that a further review including a range of different types of descriptive data (including qualitative) would be useful to complement the Reading epidemiological approach. A start has been made in this chapter but there is still work to do.

- As the populations under study became more and more specific, there were better data, although there were then problems of comparing studies with each other.

- Many of the characteristics of MDOs in different places within the system failed to address basic descriptive questions about the nature of the sample such as ethnicity and various demographic factors.

Summary: Causal and preventative studies

- There is a vast body of work on predictors of mental health problems, regularly reviewed. Similarly, the literature on predictors of antisocial behaviour is well reviewed.

- It is the interface between the two that provides the problem. Much of the literature that does exist concentrates on violence, which we saw to be neither the only nor the most prevalent offence committed by MDOs.

- Longitudinal research is the most relevant type of methodology to answer the causal questions that arise in this area, but longitudinal studies of MDOs do not exist.

- The research on three groups of risk factors predicting mental health problems and offending were briefly outlined: individual, psychosocial and environmental.
- Where there are empirical studies on the overlap between offending and mental disorder, they have tended to have been on illness leading to offending rather than the other way around (which is a possibility). No recent review and very little empirical research has looked directly at the specific risk factors for the combination of the two problems.

Summary: Pathways into and out of care

- This was potentially one of the most interesting areas covered in this review, but there was a lack of longitudinal data in the field. We could piece together various specific and cross-sectional studies, but funding longer-term follow-up studies of pathways (beyond one simple move within the system) is critical. Very few studies have addressed pathways through the full range of provision, most take a small section only.

- Given the complexity, it was difficult to assess whether or not the system works. There is certainly a level of bias inherent in interactions between MDOs and various parts of the system based on a range of factors (which vary) but the overall effect of this is unclear.

- How many people are in the wrong place? This is also a critical area for some systematic research, looking both at how people got into the wrong place and how they could be helped to move on.

- Further attention needs to be given to the issue of outcomes. What are appropriate and achievable outcomes at different stages in the system?

Summary: Effectiveness research

- Two key questions were identified. The first, of whether intervention or provision is effectively targeted and delivered, has not been answered. There is more research on the second, concerning which specific interventions work with MDOs.

- Treatment of psychopathy and management of personality disorder have received particular attention. There is some limited optimism that interventions (at least with psychopathy) can be therapeutic.

- There is a central problem that interventions are most likely to be successful if they are based on a clearly articulated theory, but theory development in the whole area of MDOs is lagging a considerable way behind.

- New policy initiatives in this area have included 'assertive outreach'.

The research agenda

We concluded that the future research agenda needs to include both (a) things that the research community needs to do for the sake of improving the general academic base, and also (b) things that need to be done to translate good data collection practices into strategies that agencies can use to improve the assessment of needs and services. Development of theory is needed in its own right, but there is also a strong need to contribute to evidence-based practice on the ground.

In terms of improvement of the academic base, we suggested a range of projects including a further set of (more focused) reviews; a large scale epidemiological survey of the overlap between mental health problems and offending; and longitudinal research on pathways through the system for period of years rather than months.

In terms of strengthening evidence-based practice, we suggested various projects including: a programme of work on developing and testing information gathering tools to be used in various settings across the range of provision; a needs assessment exercise across provision types; a national Local Authority survey of definitions in use and their operationalisation, together with descriptions of services and interagency working arrangements; and costs and outcomes analyses.

This scoping review represents a starting point rather than a conclusion. The field of MDOs is a fascinating and complex one, but one in its infancy. A number of significant gaps exist and successful communication across disciplines has not yet been achieved. Continued research investment at this stage in its history should have a considerable effect on the whole area, eventually improving provision at the local level.

2 ISSUES, AIMS AND STRUCTURE OF THE REPORT

Issues and aims

The main aim of this project was to undertake a scoping review of the literature which collated, appraised and synthesized evidence from scientific studies in order to identify the current state of knowledge and provision in the field of the health and care of mentally disordered offenders. The review was intended to give the Research and Development Board of the HSPSCB a broad picture of the key issues in this area, and the extent to which there are important gaps which need further research. The intention was to help with their planning activities and prioritization of a rational, cost effective and relevant research agenda.

An initial sweep of the literature highlighted the main themes and questions to be tackled and these were outlined in the initial 'research protocol' document. In these early stages, the central aim of the project was identified as providing an outline of the key issues addressed by research in the field, the broad kinds of study design used and the nature of the evidence gathered, rather than providing detail of individual projects. The tender document which described the needs of the High Security Psychiatric Services Board stated that the review should map the boundaries and interfaces of existing work and provision so that a new research and development programme could be developed. The overall aim was 'to map out the terrain'. The extent to which existing research was informing policy was also highlighted. From this background, we interpreted the main aim of this project as issue-raising.

The main challenge that we faced was that - by its very nature - this review had a wider remit than the other more specialized reviews in the series. A number of things affecting the nature of the review arose at the outset, including:

- In order to 'scope' effectively, the ground to be covered included *all* provision for mentally disordered offenders. This covers not simply high security provision, but low and medium security provision, provision in non-secure health settings, and of course provision within the criminal justice system including prison psychiatric services and interventions, and probation. The research had to be multiagency in order to be informative.

- Consequently, the research also needed to be multidisciplinary, and we have made use of work not just from the health services but also from criminology, psychiatry, psychology, law, and other related areas.

- The production of explicit Centre for Reviews and Dissemination style 'research questions' with attached hierarchies of evidence and inclusion/exclusion criteria was less appropriate for this project than for the others in the series, because of the wider ranging subject nature and study type of the research covered. However, we certainly did need efficient screening procedures to sift through the hundreds of

articles, books and chapters which are thrown up when the search is as broad as ours needed to be. Our approach is described in the chapter below entitled 'Methods'.

- Where possible, we avoided duplication with other reviews commissioned in the series, but there are places where it did not seem sensible to ignore whole areas being covered by other teams. The main example of this is the chapter on epidemiology, which shows considerable overlap with the work of Badger et al (1998). Because we knew this would be the case, the two research teams kept in regular contact, in order that we produce complementary summaries.

- The report concentrates on the UK literature, and the volume of relevant material has meant that international studies have not been considered systematically. However, some general issues arising in the international literature, rather than results or findings *per se*, have been highlighted for comparative purposes where appropriate.

Structure of the scoping review

After a discussion of definitional issues and of the methods employed in undertaking this piece of work, the next few chapters discuss definitional and legal issues, and set out the main developments in this field over recent years. These are issue raising chapters. Those that follow, on epidemiology, pathways and provision, are empirical, in that they review what is known and what is not known in relation to the issues raised earlier. At the end of the report we draw together a research agenda based on the gaps highlighted by this review of the field. Each chapter in the report concludes with a summary box, containing the main elements of the section.

Summary Box: Issues and aims

- The overall aim of the scoping review was to give a broad picture of key issues in this area, in order to facilitate the planning of a research agenda
- The review covered all types of provision, not simply secure
- The approach was of necessity multidisciplinary
- Following protocols formats designed for systematic reviews was not appropriate as the scoping review was not intended to be definitive, but rather to be issue raising.

3 DEFINITIONS

An initial objective of this scoping review was to clarify what was meant by the term 'mentally disordered offenders'. There were two main sets of problems in defining the term. The first revolved around difficulties with the use of the term 'offender' in this context. The second concerns what exactly we mean by 'mental disorder'. It is clear from the outset that, as Peay (1997) notes in a recent overview, "There is no pure form of mentally disordered offender". Both from the criminological and from the mental health perspectives, there are problems in establishing the reality of either crime or (mental) illness, and differences exist in the extent of overlap or the nature of the relationship between the two. Most significant books and reviews in the field of mentally disordered offending will, of course, begin with a discussion of definitions but these vary according to the purposes of each piece, and there is a lack of consensus. We did not come across any writing that focused entirely on the issue of definitions in their own right rather than as the starting point for further discussion. To that extent, we did not uncover a 'review' in this area.

Offenders

Starting with crime, it has been noted by many in the field that crime is a moving target - depending on the measures used, definitions and corresponding estimates of prevalence vary enormously (eg, see criminological discussions of the 'dark figure' of unrecorded crime, Walker 1995; Coleman and Moynihan, 1996). Officially recorded offences processed by the police represent the tip of an iceberg of antisocial behaviour. In 1995, there were an estimated 28 million crimes against the public and public services, yet in the same year only half a million adults and juveniles were found guilty in court or cautioned (Rutter, Giller and Hagell, 1998).

Focusing on those who have been found guilty thus implies a rather narrow definition. It is obvious that the majority of criminal offending, by people with and without mental disorder, goes unreported and undetected. Definitions based on detected offending will thus refer only to a sub-group of the 'offending population' who have mental disorders and who have become caught up in the criminal justice system. In addition to not being detected, a high proportion of those people deemed 'mentally disordered' who have been accused of an offence are also diverted from the criminal justice system at various stages before conviction. Thus, strictly speaking, they should be termed 'alleged offenders' rather than presumed guilty of the offence (see Duff and Burman, 1994). A broader definition is likely to give better estimates of the health and care needs of mentally disordered offenders as a whole.

Mental disorder

The definition and description of mental disorder is, of course, a whole field in its own right. Various commenters have provided useful discussions about definitions of mental disorder in relation to mentally disordered offenders but without much in the way of clear resolution (eg, Peay, 1997; Monahan and Steadman, 1983). Peay (1997) has pointed out that "definitions of mental disorder act like a concertina,

expanding and contracting in order to accommodate different client groups with little or no coherent theme". Here we are basically concerned with two approaches to definition - legal and medical:

• ***Legal definitions*** are laid down by the Mental Health Act (1983) but in fact are rather vague and fluid. Mental disorder is defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind', and definitions are provided for some of these concepts but not for others. The definitions that are provided do not dovetail with existing psychiatric diagnoses (eg, American Psychiatric Association, 1994; World Health Organisation, 1993), and exclude some cases that forensic psychiatrists might think very important. However, because of the importance of the legal framework for caring for mentally disordered offenders, it is critical that we give due consideration to legal definitions.

• ***Medical definitions*** of mental disorder thus differ somewhat from the legal definitions, and are encapsulated in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, American Psychiatric Association, 1994), and in the *International Classification of Diseases* (ICD-10, World Health Organisation, 1993). Specific behaviours and symptoms have to be noted in order to meet specific diagnoses. Part of the problem of restricting ourselves to studies that have used these criteria is that many will have not, as it is notoriously difficult for those outside the psychiatric and psychological professions to establish accurate diagnoses. We need to consider studies using broader and more `lay' definitions as well, at least in the first instance, but bear in mind how the group so identified would overlap with stricter medical definitions. It is also important to note that mental health ebbs and flows, and individuals will meet the criteria for diagnosis at certain points in their individual histories and not at others.

Mentally disordered offenders (MDOs)

Combining the definitions of offenders and of mental disorder should narrow down our focus, yet in fact it simply highlights some of the main themes which will emerge throughout the review. Writers, pressure groups and researchers have offered a range of possibilities, which vary according to the starting point - some are interested in offenders who also have psychiatric disorders, others in the mentally ill who also offend, others still in those whose mental disorder *causes* offending behaviour, or whose offences (or subsequent treatment by the criminal justice system) lead to mental disorder (eg, depression resulting in attempted suicide). NACRO's definition - perhaps the broadest available - starts very clearly with the offender rather than the disorder because, of course, offenders are their business, not illness. They state that 'mentally disordered offenders' are: "Those offenders who may be acutely or chronically ill; those with neuroses, behavioural and/or personality disorders; those with learning difficulties; some who, as a function of alcohol and/or substance misuse, have a mental health problem; and any who are suspected of falling into one or other of these groups. It also includes those offenders where a degree is mental disturbance is recognised even though that may not be severe enough to bring it within the criteria of the Mental Health Act 1983. It also applies to those offenders who, even though they do not fall easily

within this definition - for example, some sex offenders and some abnormally aggressive offenders - may benefit from psychological treatments.' (NACRO, 1993).

The rather more precise definitions offered by others can be roughly grouped into three types:

- ***Those with a preference for known rather than alleged offending***: For example, the Reed Committee (1992) described MDOs as follows '...a mentally disordered person who has broken the law. In identifying broad service needs this term is sometimes loosely used to include mentally disordered people who are alleged to have broken the law'. The implication here is that it would be better to concentrate on law breaking.

- ***Those who prefer to include 'alleged' offending:*** Guite and Field (1997) define MDOs as '...those with a mental disorder whose behaviour is difficult, dangerous and often against the law'. This is a less exclusive definition, as law breaking is not a necessity. Even more broadly, a report from the Social Service Inspectorate (1996) asserted that 'The term MDO is used here as a short-hand term for the full range of people with a mental disorder - mental health problems or learning disabilities - who come into contact with the criminal justice system or are at risk of offending.' (pi)

- ***Those who prefer a definition based on some meaningful link between mental disorder and offending, rather than just overlap:*** Eastman (1993) criticises the 'over-simplistic notion that mentally disordered offenders are simply the (undifferentiated) mentally disordered who happen to offend'. He defines MDOs as 'those showing the coincidence of mental disorder and antisocial behaviours, rather than offending per se', (which of course begs the question about the definition of antisocial behaviour). His use of the term coincidence in this context is presumably to mean co-incidence (as in co-morbidity) rather than chance.

In practice, some agencies working directly with MDOs are slow to articulate definitions. In 1996, the Social Services Inspectorate of the Department of Health commented that only one of five local authorities they visited for a project on improving services to MDOs had a clear definition of the relevant group of service users in a written strategy document. In one authority different definitions were used by different agencies, leading to considerable confusion.

There are several problems associated with the use of a broad term such as 'mentally disordered offenders'. First, it can carry a pejorative connotation, from the emotionally charged depiction of dangerous and uncontrollable villains by the media to disputes over responsibility and ownership by different agencies and professional groups. This is particularly the case for the group who Coid (1991) called `the new long stay patients' who do not cooperate with community facilities, are frequently hospitalized and are increasingly visible on the streets. Some offenders themselves are reluctant to be

labeled as mentally disordered for these reasons, while others wish to avoid the comparatively longer periods of incarceration that may result from sectioning under the MHA 1983 (Robertson et al, 1994).

Second, a general term like MDOs will mask a considerable amount of heterogeneity. Several authors draw attention to the fact that MDOs consist of several distinct groups, but of course there is some variation in how these groupings are delineated. Vaughan and Badger (1995) offered a set of groups based on met and unmet needs: invisible mentally disordered offenders; offenders with mental health needs; patients whose offences are not officially recognised; and recognised mentally disordered offenders. Another split sometimes used in the literature is between violent and non-violent MDOs.

Thus, the dilemma is to provide a definition of MDOs which is adequately objective and inclusive, but which is not so broad as to be unhelpful. We have chosen to focus upon a wide notion of `offending' behaviour as antisocial behaviours, or difficult/challenging behaviour, rather than on criminal behaviour per se. After discussions with other review teams, the definition used here included neuroses, psychoses, personality disorder, learning difficulties and mental handicap. Although it might be considered a little controversial, drug and alcohol use were not be considered unless accompanied by other mental disorders. There is some evidence emerging that substance abuse may be a key mediating factor for those MDOs who become violent (eg, Steadman, et al, 1998) but to include this body of work in this review would have made it incompatible with the Reading epidemiology review so it has been excluded. Also, following the epidemiology review, sexual offending will be considered a category of offence rather than of mental disorder.

Health and care

The terms 'health' and 'care' were not defined in the original tender document. For the purposes of the project we have decided that physical health needs or care (except where there is an argument that these should be specifically tailored for people with mental health problems), and issues of obesity, exercise, HIV infection, hepatitis and tuberculosis will not be covered. We concentrated instead on mental health needs and services.

Summary Box: Definitions

- A broad definition of 'offenders' is taken to include alleged as well as known offending. We have included a range of antisocial behaviours and difficult/challenging behaviour, rather than criminal behaviour *per se.*
- We have had to be flexible about definitions of mental health as they vary considerably and to be precise would have led to exclusion of useful research. Definitions are based on legal or medical concepts. We have focused on neuroses, psychoses, personality disorder, learning difficulties and mental handicap. We have excluded drug and alcohol abuse.
- We have concentrated on mental health needs and services, excluding physical health needs.

4 METHODS

Because our intention was to raise issues as well as summarise research evidence, we began with an inclusive rather than exclusive strategy, including some consideration of policy pieces and commentary as well as scientific studies. There were, however, clear pointers that we developed concerning the weight that should be attached to different types of research.

In the first instance, a series of systematic and related literature searches were conducted on the basis of a series of key words identified in the protocol stage of the project. This was an iterative process and the searches were refined and changed as a result of the types of results they produced. These were largely conducted by the librarian at the Policy Studies Institute. For databases such as Caredata ABSTRACTs and the King's Fund library catalogue, searching was for terms identified from their thesauri. For other more general databases (eg, Medline, Mental Health Abstractsk, Social Scisearch, PsychLit) a list of relevant terms was generated on which searches were based. The librarian also searched on-line the resources of the British Library, including the grey literature database SIGLE and the Index to Conference Proceedings using Blaise. Searches were also conducted at the Library of Congress Catalogue which is available on the Internet. In addition, libraries were visited, including Broadmoor Hospital Library, the Home Office Information and Library Service, the Institute of Psychiatry, and the King's Fund Library.

Once the initial literature searches were completed, hand-searches were also undertaken of journals found to be relevant, to check for additional, recent studies slightly outside the remits of the searches. Other journals not appearing regularly in the searches (but which we thought ought to carry relevant material) were also hand-searched.

Given the breadth of the area of interest, these searches threw up a great number of potentially relevant studies. To order and evaluate the work a four-part stepped strategy was employed. At various stages in the process we went back to the searches and ran modifications.

In the first instance, a **preliminary map** of the overall quantity and quality of research relating to each of the areas was set out on the basis of the initial search results and other leads. Even before we started it was clear that in the UK mentally disordered offenders had received more attention since the early 1990s than they had done at any other point in the last two decades. For this reason, we concentrated on literature published after the Butler Report (1975).

After the preliminary mapping exercise, the first concern was **to identify research reviews** (post 1975) of primary literature relating to the key questions of each of the chapters, providing systematic overviews of what has already been done. Certain criteria attached to the identification of reviews. Our initial preference was to concentrate on those with clearly articulated definitions of MDOs in accordance with

psychiatric definitions, in peer-reviewed journals or books that were sent out for review before publication or which attracted significant attention in their fields. Some examples of reviews which meet some (rarely all) of these criteria include: Anderson, 1995 (mental illness and offending); Bailey, 1996 (services for MDOs); Bowden, 1996 (violence and mental health); Drewett and Shepperdson, 1995 (also services for MDOs); Eastman, 1993 (forensic services in Britain); Fahy, 1989 (police and MDOs); Mullen, 1984 (mental disorder and dangerousness); Murray, 1989 (reoffending of MDOs), Peay, 1997 (criminology and MDOs); Smith 1997 (race, crime and criminal justice).

If reviews did not exist, the next step was to **identify the significant and reliable primary studies** and to rely on these. Some examples of particularly significant primary studies in recent years include Gunn, Maden and Swinton, 1991 (on mentally disordered prisoners); Dell et al (1993a and b, study of Holloway); and Maden et al, 1995 (on special hospitals). We have pointed out areas where funding of further reviews might be helpful, and have attempted to draw together the main conclusions from the existing work. However, given the breadth of material we covered, we could not approximate a good review in each of the areas we looked at, and our work should not be considered a substitute for funding of further, more systematic reviews in the areas highlighted as lacking such work. Primary studies vary enormously, and it was very difficult at the outset to be absolutely definite about the exclusion and inclusion criteria. We began with an inclusive strategy and we think that this was appropriate. We did not, for example, restrict our search to studies that only considered a very precise definition of MDOs. To be frank, this would have excluded the majority of the work referred to in this scoping review. We have tried to be clear about reservations we had about studies, and about the particular strengths of the quality work. We had anticipated being more exclusive after the initial mapping exercise, but in most the areas this would have cut out research raising interesting issues. As issue raising was so critical to the scoping review, we have tended to keep things in rather than exclude them. This will make this review a very different thing from the other three in the series.

Finally, in areas where there was a dearth of even reasonable research, we went on to look at **"sub" literature**, consisting of very small studies with less than satisfactory samples, for example, and policy and practice commentary or opinion pieces. In these cases we have highlighted the places where there was a real gap in the literature and have clarified areas for future research.

Summary Box: Strategy

- The project started with a 'research protocol' outlining our approach, which was peer reviewed by the advisory group.
- Having outlined important areas to investigate, we followed a four-part stepped strategy.
- The first stage involved drawing up a preliminary map of each area.
- The second stage was to identify research reviews, post 1975.
- The third stage was to identify the significant and reliable primary studies in each area.
- The four stage was to consider smaller, more qualitative studies and policy commentary.

5 AN OVERVIEW OF DEVELOPMENTS IN THE FIELD

Developments in the field of mentally disordered offenders have been shaped in part by changes and shifts in mental health policy, and partly by shifts in criminal justice policy. The main events over the last twenty or so years have included the Butler Committee report on MDOs (1975); the growth of forensic psychiatry as a discipline in its own right in the 1970s and 1980s; prison disturbances in the early 1990s; publication of the influential Reed Report in 1992; and subsequent central government activity (eg, establishment of a joint DH/HO Advisory Committee on MDOs and a number of other reports). These developments reflect some main themes which we draw out in this chapter.

Recent policy and practice development

Care in the community

A significant development has been the shift in emphasis for all mentally ill patients away from in-patient treatment or incarceration to care in the community. The last couple of decades have witnessed a well-documented period of closure and downsizing of institutionally-based care arrangements. The main intention of deinstitutionalisation was to increase the freedom of the mentally ill (all, not just those who had offended) by promoting the principle of 'least restrictive alternative'. In the UK this is reflected in past and more recent policies (Department of Health, 1989). A least restrictive philosophy also underpins the principles of care outlined in the Final Summary Report of the review of services for this group (Reed, 1992) which stated that their care arrangements should: have proper regard to the quality of care and the needs of individuals; as far as possible, in the community, rather than in institutional settings; under conditions of no greater security than is justified by the degree of danger; so as to maximise rehabilitation and the chances of sustaining an independent life; as close as possible to their own homes and families (Reed, 1992). However, Reed acknowledged that in practice reality 'often falls a long way short of what is desirable' (para 3.1).

This was supported by policy development in the Home Office which has sought to divert as many mentally disordered offenders as possible away from prosecution or penal disposal towards health and social services. The main recommendation of the Reed report was that "...mentally disordered offenders should, wherever possible, receive care and treatment from health or social services rather than in the criminal justice system" (1992, p44), and that "...we see community services...as providing wherever possible for the majority of mentally disordered offenders" (1992, p19). This echoed the important Home Office circular which preceded it (Home Office Circular 66/90) which stated "It is government policy that...careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution...should be considered first.."

An important contextual factor which relates to the provision of care in the community across all client groups and areas of provision has been the substantial learning curve which purchasers and providers

have had to face. One of the key concerns arising from this goal surrounds the provision of specific, alternative services for mentally disordered offenders. There is also a critical lag between the policy which promotes community care and the development or stimulation of suitable services to which mentally disordered offenders can be referred. The Audit Commission (1994) has noted that although the policy of deinstitutionalisation persists with continued hospital and ward closures, there is still evidence of under-resourcing of community services. Fennell (1991) suggests that unless suitable alternative services are found, mentally disordered offenders are unlikely to avoid care in prison.

Diversion

In the 1980s and early 1990s, diversion was to the criminal justice system (CJS) what care in the community was to the mental health system (MHS), and there are considerable overlaps between the two policies (as is witnessed in the Home Office statements in the previous section). Many of the aims of the two policies were similar, to avoid labelling and institutionalising people unnecessarily. Over this period, for example, falls were seen in the numbers of young people incarcerated, and the use of informal warnings and cautions was widely supported (eg, Hagell and Newburn, 1994).

As part of the general support for diversion, during this period the CJS also saw increased emphasis on making community based supervision work as a viable alternative to custody. One result of the development of this policy was the move to bifurcation - one policy for one group, another for another - which, it could be argued, is better developed in CJS than in the MHS. While policies for persistent and hardened criminals became tougher in some cases, those for diverting minor offenders also became more developed.

Defining need

It is clear that defining and assessing need at a broad (rather than individual) level is central to good service provision and has been an issue for some time (Reed, 1992). The importance of multi-agency needs assessments seems to be the consensus. Whether this is workable in practice is debatable. As a result of various government initiatives some headway has been made. For example, Regional Health Authorities undertook a comprehensive assessment of the needs of MDOs in 1993 (Social Services Inspectorate, 1996).

The SSI, however, reported that collecting core data for the foundation of commissioning strategies was largely untackled. A need for core data and evaluation material and its relationship to service provision have been stressed in several places. In a review of the literature on services for MDOs, Drewett and Shepperdson (1995) identified the potential problems that lay ahead for purchasers and providers relating to assessing and meeting needs, multi-agency working and inequalities in funding allocations across the different agencies (see also Prins, 1995). The authors suggest that any particular purchaser would have to decide what level of need would (or should) be met by specialist and generic services, decide how to seek out those in need and how to respond to increasing demands on their services. Presumably,

targeting those in greatest need and narrowing eligibility criteria for services would follow as a consequence of increasing demand and an enduring climate of financial constraints.

There is also the separate issue of individual needs assessments and the development of "care programmes" (Reed, 1992), also referred to as the Care Programme Approach (CPA). Detailed arrangements for the assessment of individuals have largely to be developed, and implementation of the CPA can be patchy (SSI, 1996), but these are essential to reduce duplication and confusion and ensure safe provision, especially on movement from one part of the system to another (eg, discharge from hospital into the community). Cohen and Eastman (1997) conducted a recent review on needs assessment for MDOs, concluding that no single approach could address all of the important issues, and they suggested substituting the term 'perspectives on need' to reflect multiple needs.

Multiagency working

The centrality of multi-agency working at all levels is essential to achieving a seamless service and underpins good practice. However, this is not an easy aim to achieve. The SSI investigation of five local authorities in 1996 reported "inter-agency confusion", although there was evidence of joint working in every authority.

Research on multiagency working is in its infancy but it is of interest to a number of fields including criminal justice, mental health, and child care and protection. Some examples relating to MDOs do exist. For example, in a survey of diversion from custody arrangements in England and Wales, Blumenthal and Wessely (1992) indicated an absence of strategic planning arrangements across different agencies and found an over-reliance on individuals on whose shoulders the success and sustainability of the scheme often rested. Parker (1985) noted that a problem which has endured since the existence of county asylums has been one of who holds the purse strings in meeting the costs of care. Reed (1992) also acknowledged the problem of budgetary separation indicating that fragmentation could introduce disincentives both in the assessment of needs and subsequent provision for mentally disordered offenders. Disagreements and distrust among agencies and organisations were identified by Beese (1995) who noted that changes in responsibility were not reflected in budgetary adjustments - some agencies were faced with increased responsibilities for community-based services such as supervision and aftercare but not given the additional funding to do so.

Recent academic developments

The growth of forensic psychiatry

Reed (1992) noted that the number of forensic psychiatry consultants doubled between the 1960s and the 1990s, reflecting an increased academic interest in the area (eg, Bluglass and Bowden, 1990). New journals have been started, for example the *Journal of Forensic Psychiatry*. This has been paralleled by a growth in forensic psychology (eg, Stephenson, 1992; Hollin, 1989). This has been partly fueled by

interest in miscarriages of justice, resulting in a closer study of the way in which the criminal justice system works at various stages, and the factors that might influence outcomes and progress through it. In addition, a particular interest in violence in recent years has encouraged the field to grow again, perhaps partly as a result of the development of care in the community and a public panic about acts of extreme violence by people being discharged from institutions.

Risk assessment

The discharge of mentally ill and particularly mentally disordered offenders into the community has heightened concerns about the risks this poses to patient safety and the safety of those around them (review by Leong et al, 1991). The assessment of risk is now firmly embedded in policy and has become a 'prime consideration in discharge decisions' (Department of Health, 1994:2), although multi-agency guidance on risk assessment is in its infancy even in the places where it has been considered a statutory necessity (eg, for example, in probation, discussed in Kemshall, 1996). Some of the provisions of the MHA have been referred to as the `risk minimisation approach' (Bailey, 1996). Indeed, risk containment may have taken up if not taken over centre stage altogether, albeit against the same backdrop of assumptions about the therapeutic value of hospital discharge and promotion of patients' independence. Goodwin (1997) points out the conflicts which have emerged as a result of competing policies driven by the divergent aims of promoting independence, managing risk and securing compulsory compliance with treatment measures.

Academically, the topic of risk assessment has been of interest in criminology for several decades now and the literature is fairly well developed. Psychiatry and psychology have been the disciplines to most directly tackle assessments of dangerousness in perpetrators and risk factors in victims, and have been relatively successful in showing how risks are multifactorial and compound (eg, Floud and Young, 1981; Hollin, 1989; Blackburn, 1993; Rutter, Giller and Hagell, 1998). The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk has produced a useful summary of the general principles behind assessing and managing risk in mental health settings, and these are reproduced in Figure 5.1:

Figure 5:1: **General principles behind assessing and managing risk in mental health settings,**

1. Risk cannot be eliminated nor guaranteed.
2. Risk is dynamic and must be frequently reviewed.
3. Some risks are general, others are specific and have specific victims.
4. Interventions can increase risk as well as decreasing it but good relationships make risk management easier.
5. Factors such as age, gender and ethnicity are not very useful in predicting risk in samples with mental disorders.
6. Clinicians should gather information from several sources.
7. Decisions should not be made by one person alone.
8. The outcomes must be shared but confidentiality respected.
9. Patients who are a risk to others are also likely to be a risk to themselves.

Source: Summarised from the Royal College of Psychiatrists Special Working Party on Clinical Assessment & Management of Risk

Questions arising from recent developments

- Is the system arbitrary? Commentors have suggested that the system somewhat arbitrarily decides that some 'offender' patients' should be treated in hospital, whereas others remain in prison. Diversion can be very variable depending on area and local policies. The pathways into care/confinement and treatment of people with mental disorders form the subject of Chapter 10 of this review, and the distinctions between such people accused of a criminal offence and those mentally disordered people who are detained on civil sections (and have never been arrested or accused of an offence) are often seen to be vague and arbitrary. For example, we shall see later that research suggests both groups may end up in the same institutional settings receiving exactly the same treatment as offenders who have been transferred from the police, courts or prison.

- Is the system inflexible? Peay argues that existing arrangements are too inflexible in that they deny access to treatment on the basis of a theoretical separation (between offenders with mental health problems and the mentally ill who offend) which cannot be sustained in practice.

• Care near home or away from home? Within the CJS it is often stressed that it is important to keep people in their own communities to maintain family ties. This is particularly so with younger offenders and might also be expected to be the case with more vulnerable inmates such as the mentally ill. This is probably partly a reflection of the fact that the quality of the average daily experiences do not vary much according to whether you are in a large or a small prison. It is unlikely that you will receive much in the way of rehabilitation wherever you are, so preference would be to remain as close to home as possible. However, within the MHS there are sometimes coherent arguments for removing people from their local areas for treatment, and this because it is possible to provide better services in larger organisations and these may be some way away in the next county. In terms of MH provision, patients do seem to have a better chance of better treatment and facilities if they are contained within a larger environment.

• Is there a need for more effective outreach (community based) work, to reduce the chances of offenders slipping through the service nets? Does this involve improving existing services or designing new ones?

• Is there a need for better practitioner and policy understanding of risk assessment in practice and its *limits?* There is considerable academic debate over the degree of possible accuracy for risk assessment, and what to do with the information generated by predictive schemes (eg, Monahan, 1981), and these have proved difficult concepts to explain to the non-academic audience. Indeed, the Department of Health has itself suggested that the use of simple checklists at all is problematic. In general, risk assessment is as open to bias as any other type of judgment. Key questions about managing risk in practice include (a) how do resources impinge on risk assessment and danger prediction? (b) How are decisions made about the next step after assessment? (c) What is the role of the organisational context? (d) Can people understand that an assessment is only ever a judgment and not a certainty?

Summary Box: Overview of developments in the field

- Recent policy and practice developments have included the rise in care in the community within the health arena, and an increased emphasis on diversion within the criminal justice system (at least in the early 1990s).
- Other important developments have included a growing emphasis on defining need, both at the level of general service provision, but also at the level of individual needs assessments.
- Multiagency working has become essential within most of the relevant fields to this review, but still poses considerable challenges in practice.
- Recent academic developments have included the growth of forensic psychiatry, and an increased literature on conducting and analysing risk assessment.
- A number of questions arise relating to these new developments in the field, not least the central fairness or unfairness of the system.

6 THE STATUTORY FRAMEWORK

As a context for the discussion of literature on patterns of provisions and pathways in and out of care, it is useful at this stage to set out the legislation which constitutes the statutory framework for the review. In fact, it was obvious from early scoping of the literature that the statutory and legal framework within which services for MDOs are organised constituted the primary focus of some writing in this area, as well as being a background issue. This is particularly the case in terms of the interaction between departments with a remit for providing for MDOs. Who is responsible and at what stage? It is important to note that it is not intended to provide an exhaustive account but simply to highlight and briefly describe the main pieces of legislation in the United Kingdom which will be referred to in the following sections.

Legal definitions of mental disorder in England and Wales are laid down by the Mental Health Act (MHA) 1983, and this forms the starting point for our discussion as it is still very much the dominant piece of legislation in this area. The criminal justice system can deal with MDOs in a number of ways, but most will be dealt with under one of the Sections of this Act. Where appropriate, we also consider the effects of more recent statutory reforms such as the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, the Mental Health (Patients in the Community) Act 1995, and the Crime (Sentences) Act, 1997.

Figure 6.1 overleaf outlines the relevance of a selection of various acts to different aspects of MDOs and their interaction with the CJS.

The Mental Health Act (MHA) 1983

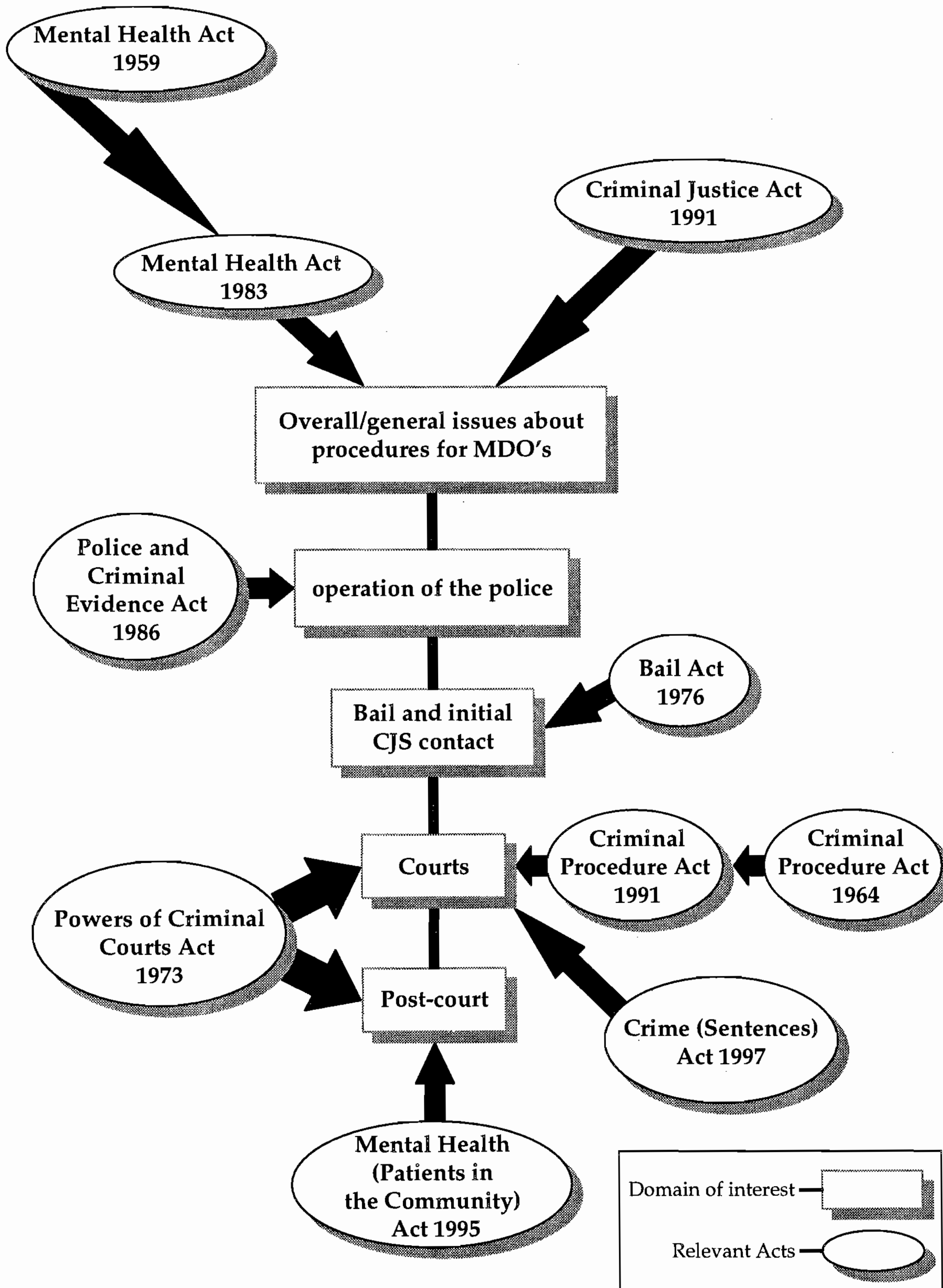
The MHA 1983 was a revision of an earlier Act passed in 1959. The main tenets of the 1959 Act in relation to MDOs were:

- that if an offender was shown to be mentally disordered, then s/he passed straight into the hands of the hospital rather than being treated in the prison system (with some exceptions such as untreatable psychopaths),

- that there was a range of sentencing options ranging from an out-patient hospital order to detention in a Special Hospital, and

- that because offenders were being sent for treatment, there were no time limits (unlike a prison sentence).

Figure 6.1 A selection of the relevant legislation for dealing with MDOs



The Butler Committee (Home Office and DHSS 1975) was largely responsible for the revisions which were suggested to this 1959 Act, although the basic tenets of the later act remain similar. The MHA, like the 1959 Act, concerns itself primarily with detention for treatment in hospital and includes provisions for admitting and discharging patients into and from hospital for the purposes of assessment and/or treatment. It contained a revised definition of mental disorder, and changes to the rules for compulsory admissions, procedures for discharge and rights to refuse treatment (Hollin, 1989). One of the key features of the 1983 Act was its attendant emphasis on the normalisation of the lives of psychiatric patients so that they could be treated in as similar a manner as possible to those patients admitted for treatment of other medical conditions. Another significant feature of the 1983 Act was the treatability criteria - that a person should only be detained for treatment if this is 'appropriate' - if it is likely to make a difference.

Three parts of the 1983 Act are worth some detailed description because of the extent to which they are referred to in the MDO literature. The first is the definitions of mental disorder which the Act sets. The second is the civil sections, and the third the criminal sections.

Definitions of mental disorder in the MHA 1983

Section 1 of the MHA 1983 sets out the definitions of some of the key terms. Rather confusingly, it uses a broad generic concept of mental disorder and four defined subcategories which relate to different powers of detention:

(1) For **shorter powers of detention** (eg, for assessment for up to 28 days, the police powers under section 136 and the remand power under section 35) the generic concept of mental disorder applies: mental illness, psychopathic disorder, arrested or incomplete development of mind and any other disorder or disability of mind. A person may not be treated as suffering from mental disorder for the purposes of the Act by reason only of promiscuity or other immoral conduct, sexual deviance, or dependence on alcohol or drugs.

(2) A person may be detained under **longer term powers of admission** for treatment, or subject to a hospital order only if he is suffering from mental disorder in any of the four subcategories. These are mental illness, severe mental impairment, mental impairment and psychopathic disorder. To be suffering from severe mental impairment, mental impairment or psychopathic disorder a person must show abnormally aggressive or irresponsible conduct.

In effect, these do not constitute definitions. In the text of the Act a number of vague or ambiguous terms are used such as `persistent', `irresponsible' and `aggressive'. The subcategories are open to differing interpretation by professionals who are not agreed themselves about how different types of mental disorder should be measured or categorised (eg, regular revisions of the International Classification of Diseases, etc). This of course means that any Mental Health Act cannot be precise,

because it would become dated very quickly, but problems are posed when successive court cases have to continue to interpret the definitions.

Civil sections of the MHA 1983

People who are alleged to have committed an offence may be dealt with either under the civil or criminal sections. If there was no offence (alleged or otherwise) they will not be dealt with under the criminal sections, but it is possible for an alleged offender to be dealt with under civil sections rather than criminal so in practice both types are relevant. In a discussion of the diversion of mentally disordered offenders from the criminal justice system Joseph (1990) provided a helpful summary guide of both the civil and criminal sections of the Mental Health Act 1983 which are outlined in Table 4.1.

Table 4.1 Summary guide to sections in the Mental Health Act 1983

Civil sections	Section number	Duration	Type	Doctors required
	Section 2	28 days	Assessment	2
	Section 3	6 months	Treatment	2
	Section 4	72 hours	Emergency/Assessment	1
Criminal sections				
	Section 35*	28 days	remand to hospital for reports	1
	Section 36*	28 days	remand to hospital for treatment	2
	Section 37	6 months	hospital order (sentence of court)	2
	Section 38**	up to 12 mts	interim hospital order	2
	Section 41	set by court	restrictions on hospital order	2
	Section 47	up to EDR	removal to hospital of sentenced prisoner	2
	Section 48	no limit set	removal to hospital of other prisoners	2
	Section 136	immediate	convey to place of safety	1

* can be renewed twice ** can be renewed for 3 X 28 days after the first 12 weeks

We have highlighted the sections with most relevance for these discussions. Taking the civil sections first:

Section 2 and 4 - Patients are admitted for assessment under these sections if their mental disorder is thought to be 'of a nature or degree which warrants detention in hospital'. The duration ranges from 72 hours in cases of emergency (section 4) to 28 days (section 2).

Section 3 - This provides longer term civil powers of admission for treatment for up to six months but has narrower eligibility criteria in that the patient must be suffering from one of the four categories of definition of mental disorder, and in the case of psychopathic disorder or mental impairment, the treatability criterion must be satisfied. **Section 7** refers to regulations concerning Guardianship.

These types of Sections should be made by an approved social worker *and* one or two doctors (depending on which section), one of whom has to have been approved under the Act, having proved that they have particular skills and qualifications. This could mean, for example, a General Practitioner and a local psychiatrist, or two psychiatrists. This is to ensure that all possible avenues for treatment and care are explored. In practice these regulations are not always adhered to, and one of the team may not be present.

Criminal sections of the MHA 1983

The criminal sections are more numerous, and are generally administered as a result of the combined efforts of the police, courts and prisons. Courts often have an approved social worker to hand in case they decide to dispose of the offender through a civil section rather than to pursue the criminal sections. The sections are rather difficult to simplify as some deal with remand pre-sentence (for assessment, usually) and some with assessment or treatment post-sentence. The criminal sections include:

Section 35 - This remands the offender to hospital for reports on their mental condition, and is a section introduced under the MHA 1983 following a recommendation by the Butler Report (1975) that an alternative to remand in prison be provided where bail was thought to be inappropriate. The order may be made by either magistrates or Crown Courts and it has a maximum duration of 12 weeks. Compulsory treatment is not possible under the provision of this section alone but the Code of Practice produced by the Mental Health Act Commission recommends that in such cases the additional use of a civil treatment order (section 3) be made.

Section 36 - allows the Crown Court to transfer an unconvicted prisoner to hospital for treatment and also has a maximum duration of 12 weeks.

Section 37 - This is a hospital order. The criteria in respect of the definition of mental disorder are the same as for Section 36, but the court must be of the opinion that 'having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section'. Medical evidence favouring a therapeutic conviction is a necessary prerequisite, but not always a determining factor.

A Guardianship order may also be made under section 37 in cases where an offender is convicted of a offence punishable with imprisonment, placing the offender under the guardianship of the local social services department or a person approved by it. In civil and criminal cases the person must be at least 16 years old. Guardianship orders may be made for the same offences and with the same medical evidence as an ordinary hospital order but the treatability criterion does not apply and the condition must be of a nature and degree which warrants reception into guardianship. While the guardian has powers over the patient relating to where they should live, when they should go for treatment, occupation, education and training, and can insist that a named doctor, social worker or other person sees them at home, there is no compulsion on the patient to accept any medical or other treatment on offer.

Section 38 - Under this, an interim hospital order allows transfer of convicted but unsentenced prisoners to hospital and has a duration of up to 12 weeks to be renewed where necessary with a maximum duration of 24 weeks.

Section 41 - is a restriction on a hospital order and is specified by the court (Crown) in order to prevent serious public harm. A restriction order modifies a hospital order and cannot be imposed to mark the gravity of the offence or as a means of punishment. If imposed, it must be either for an unlimited period of time or for a fixed term.

Section 47 - is the transfer of sentenced prisoners from prison to hospital. There must be mental illness, severe mental impairment, mental impairment or psychopathic disorder, with the latter two satisfying the treatability criterion. The duration of the section is up to the earliest date of release and if there is a successful response to treatment the person can be returned to prison to complete their sentence.

Section 48 - allows the urgent transfer to hospital of unsentenced prisoners on a warrant from the Home Office and has no specified time limit. A restriction direction may be attached (section 49) if satisfied that it is necessary to protect the public from harm.

Section 136 - allows the police to convey a person from a place to which the public have access, to a place of safety, if they appear to be suffering from a mental disorder and are in immediate need of care and control. For the purposes of assessment, the detainee must be assessed by a doctor and interviewed by an approved social worker so that any necessary arrangements for care and treatment can be arranged. The powers under this section may be used for persons who have not committed an offence as well as persons who have or are suspected of having committed an offence, but where it is not considered necessary in the public interest to arrest the person for the offence. While there may be different local agreements on a designated place of safety the Home Office Circular (66/90) recommends that a hospital is a more desirable place of safety than a police station.

Other relevant legislation

- The Police and Criminal Evidence Act (PACE) was introduced in 1986 and under this Section 136 of the MHA is technically a power of arrest. Consequently, the person is entitled to have access to legal advice and someone else informed of their arrest. Special procedures are laid down in the code of practice for the Detention, Treatment and Questioning of Persons by Police Officers, issued under PACE which apply to persons thought to be mentally disordered or handicapped. If detained an 'appropriate adult' must be informed and asked to attend the police station. The adult should be present when the person is 'read his rights' and they can request legal advice on the detained person's behalf.

- According to Joseph (1990) The Bail Act 1976 creates an assumption in favour of bail unless one of a imprisonable in order to be remanded in custody. If the accused is remanded on bail the court may order a medical report to assist in their dealing with him for the offence under Section 3(6) (d) and can make whatever condition necessary for the accused such as a condition of residence in hospital. However, the hospital cannot detain the patient if this is an informal admission unless a separate section is also applied to exert the powers of compulsory admission. In addition, all courts may remand offenders for reports after conviction. Magistrates' may remand for 4 weeks on bail without convicting if satisfied that the defendant did the act or made the omission (Magistrates' Courts Act 1980, section 30).

- The Criminal Procedure (Insanity and Unfitness to Plead) Act (CP(I)A) 1991 amended the Criminal Procedure Act 1964. Previously a finding of unfitness to plead or insanity resulted in automatic indeterminate hospital admission under notional treatment and restriction orders. The CP(I)A 1991 was introduced to provide a broader range of disposals than previously existed such as hospital admission with or without a restriction order, a community supervision order, guardianship and absolute discharge. The only exception to the application of these disposals is where the penalty is fixed by law. The procedural amendments introduced by the Act are much along the lines of those recommended by the Butler Committee (Home Office and DHSS, 1975). The Act introduced a 'trial of the facts' which is heard by a separate jury asked to determine beyond reasonable doubt whether the defendant 'did the act or made the omission charged' ie *actus reus*. If the jury find in favour of actus reus this is followed by one of the new disposal options available and does not result in conviction whereas a negative finding is equivalent to a full acquittal. Recent cases, however, have led to an inclusion of *mens rea* elements as well. For a finding of unfitness to plead or insanity the 1991 Act requires written or oral evidence of two doctors and one of these must be 'Approved'.

- The Criminal Justice Act 1991 introduced some radical reforms to the criminal justice system which lay further emphasis on the need to protect the public particularly from those offenders who are convicted of serious violent or sexual offences while simultaneously pursuing the just deserts policy as a principle guideline for sentencing. Thus serious offenders are dealt with more harshly and those convicted of more minor offences given non-custodial sentences wherever possible. One of the overall aims of the Act is to reduce the number of custodial sentences passed without eroding the principle or

practice of public protection from those offenders who pose the greatest threat and danger to public welfare ("bifurcation"). There is a statutory requirement under the Act to obtain a medical report on an offender who appears to be mentally disordered under Section 4(1) but this does not have to be complied with if the court believes it to be unnecessary under Section 4(2).

- A probation order with a condition of psychiatric treatment under Section 3 of the Powers of Criminal Courts Act (PCCA) 1973 requires an offender to be under the supervision of a probation officer for a specified period of six months to three years. They may be made in any court but there is no power to order probation without conviction. The offender may be required to undertake psychiatric treatment for the whole of the period of the probation order, or for part of it. If the offender fails to comply he is in breach of probation.

- The Mental Health (Patients in the Community) Act 1995 has introduced an element of compulsory treatment in caring for those with mental disorders in the community, a feature of care which is absent from both guardianship orders and probation orders. Under the Act a 'supervision application' may be made by the responsible medical officer (RMO) of any patient aged 16 or over liable to be detained under a civil admission for treatment or an ordinary hospital order. A supervision application is not unlike a supervision order given to young offenders. The application is made to the Health Authority providing the after-care services for the patient. There is a statutory duty on the local Health Authority and social services department to co-operate in the provision of after-care for some former compulsorily detained patients discharged to or resident within their boundaries. The 'responsible after-care bodies' (health or social services) impose the necessary requirements such as living at a specified place, when and where to attend for treatment, occupation, education and training and that a doctor, approved social worker, supervisor or other person authorised by the latter has access to the person, wherever they live. A supervisor (or anyone authorised by her/him) has the power to convey the patient wherever he is required to live or attend, a feature of compulsion absent from guardianship orders. However, a similar feature of after-care under supervision and guardianship orders is that there is no power as such to force the patient to accept treatment, but as Hoggett (1996) observes, there is still the recognition that imposing requirements upon the patient brings with it the obligation to provide the patient with at least some services.

Issues arising from the statutory framework

The statutory framework for dealing with mentally disordered offenders is obviously extremely complicated. Because of the interface with the very different world of medicine and health care, there are inherent tensions built in to the system as it stands at the moment, and there are no good, simple overviews specific to the situation for mentally disordered offenders. Within the existing and rather disparate literature on the statutory context, a number of issues arise repeatedly and we have drawn some of these out in this section. They include:

(1) Issues raised by the 1983 Act's emphasis on the MDO as the province of medicine rather than the legal system. Hollin (1989) provided some discussion of the problems that this has led to, including the trial of Peter Sutcliffe, the 'Yorkshire Ripper', where the jury decided Sutcliffe was not mentally ill despite the evidence of four psychiatrists, a result of difficulties with interpreting the legal constructs of mental responsibility and mental disorder, and, potentially, feeling that they needed to dispose a punitive sentence. Hollin wrote 'It is rather hard to resist the view that, in the cold light of day, it is faintly ludicrous to have to debate at great length the normality of an individual who *behaves* towards people in the way which Sutcliffe did. The question of outcome, that is, treatment or punishment, for such offenders remains nevertheless a fundamental moral issue. Whether it is lawyers or psychiatrists who are best placed to decide on that issue remains a question for debate' (1989, p125).

(2) According to Hoggett (1996) the 1983 Act and its predecessor (MHA 1959) reflected a 'deep divide' between treatment in hospital (with the potential for effective legal control) and treatment in the community (with less potential control). Achieving a balance between care and control has undoubtedly been an enduring aspect of the institutional context of care. However, such an endeavour takes on mammoth proportions when the setting is the community.

(3) In a discussion of the inadequacies of the Mental Health Act, 1983 in relation to mentally disordered remand prisoners Akinkunmi and Murray (1997) suggest that although the MHA introduced a number of new forensic assessment options, there was still evidence that most prisoners remained in custody until their case was disposed of by the courts. Mentally ill people should not be taken to hospital by the police unless similar, well people would have been remanded in custody as well. Similarly, people transferred from prison to hospital should not be detained longer than they would have been if they had remained in prison. Yet there are obviously inequities in the system, created in part by the licence given by the statutory framework. This has been referred to as 'too much blurring of the boundaries between criminal and civil powers' (Ashworth, 1992, p304).

(4) The special case of untreatable personality disorder (PD) continues to pose difficulties. There are two main issues here. The first is that the 'treatability' criteria in the legislation mean that many of the most seriously disturbed people do not have their offending addressed but instead are simply incarcerated and then released. Media cases of this type are relatively common, the most recent at the time of writing being the case of Michael Stone who was classified as untreatable PD and who subsequently murdered a mother and her child in Kent. Second, opinions in the medical and psychiatric literature are equivocal and there is some support for the notion that some types of PD are in fact open to limited treatment. This is the subject of current policy debate and changes are likely.

Summary Box: The statutory context

- We reviewed the main tenets of the Mental Health Act 1983, and a selection of other relevant pieces of legislation. We have explored the statutory and legal framework within which MDOs are processed, and identified problems with definitions.
- The statutory and legal context for MDOs has a literature in its own right, although it is disparate and rather obtuse for the non-expert reader. The piecemeal system of development of a legislative framework makes it difficult to digest the information available.
- There is a need for some user-friendly overviews crossing borders and boundaries between areas. Some summaries do exist (eg, Peay, 1997, and to a lesser extent, Hollin, 1989) but these are generally aimed for an specialist academic audience, not a practitioner or non-legal audience.
- Research on the understanding of those involved in different parts of the statutory framework (including MDOs) would be interesting and useful and is lacking at the moment.
- The issues raised in this overview of the statutory framework included: does the legislative framework promote fairness of treatment - does it ensure people entering the system through different routes are treated similarly; does it resolve the balance between care and control; the challenges posed by `untreatable' personality disorder.

7 EXISTING PROVISION

In this chapter we outline current provision for mentally disordered offenders, in particular identifying where research already exists and the issues it has raised. The aim was to start with a complete picture of what is available (at all levels of security), setting the scene for a more detailed discussion of the entry of MDOs into, through and out of various care environments (Chapter 10) - without knowing what is available, it is impossible to evaluate pathways. The chapter illustrates the complexity of the area and the consequent difficulties inherent in improving policy and provision, and the risks associated with generalising from research only based within a small and specialised section of provision.

An overview

Offenders who are perceived to be suffering from mental illness can be treated in a number of different settings with differing philosophies of care and levels of security. The different settings mainly include special hospitals, medium secure units and low or minimum secure care, and in the community. Of course, some mentally disordered offenders may not have been directed into any of these services and simply turn up, repeatedly, in some cases, in regular health and criminal justice systems.

There are some broad overviews of the MDO in various settings, including Bailey (1996), Herbst and Gunn, (1991), Drewett and Shepperdson (1995), and Eastman (1993). The main problems with overviews is that the situation continually changes and reviews become outdated very quickly. It could be argued that there is a need for a rolling programme of reviews (a regular bi-annual review, for example, constantly updating the picture). There is also a wealth of material from primary research in this area, relating to different parts of the picture. The problems in drawing conclusions from the primary research are very much as they have been reported throughout this review and the others in the series - primarily problems with comparing samples from very different situations into which people are obviously selected, and differing definitions of mental disorder and offending.

Combining various sources of information, we can start to put numbers to types of provision (eg, Reed, 1997; DoH Statistical Bulletin 1996; Social Services Inspectorate, 1996), and we can see that these fall into the following broad headings:

- Low security psychiatric provision.
- Medium and interim secure psychiatric provision (these two accounting for approximately 2,000 by 1997 according to the SSI, 1996).
- High secure psychiatric provision (3 special hospitals) (approx 200 a year, total approximately 1000).
- Patients in other parts of the general psychiatric service (estimates vary, as an unknown proportion of the approximately 70,000 in-patient psychiatric beds may meet the MDO criteria).

- Patients cared for in the independent sector (estimates vary - Reed states a figure of 127, but suggests that this is an underestimate, SSI 1996 report estimates 400).
- Patients in prison (sentenced and remanded, again estimates of the proportions who are MDOs vary considerably).
- Patients being supervised by probation.

The first four of these fall within what is often referred to as the 'hospital system' but which we have chosen to call the 'health care system', and the last two can be referred to as the 'prison system' but we have chosen to call it the 'criminal justice system'. Private care is a different issue falling outside both these. We look now in more detail at provision within these broad groups, starting with the non-secure provision and building up to prison.

The health care system

Primary care

There are many individuals and agencies to whom people turn in times of psychological or social distress, such as mental health facilities, housing departments and social services departments (Strathdee and Thornicroft, 1992). However, it is widely acknowledged that general practitioners in particular play a major role in caring for individuals who experience acute and chronic psychological problems (Johnstone et al, 1986; Brown et al, 1988; Strathdee 1992a; Shah, 1992; Goldberg and Huxley, 1992).

In recent years, the shift to caring for people in the community has placed an even greater emphasis on the role of the GP and highlighted the importance of achieving a seamless service and continuity of patient care between primary and secondary provision. Community care has resulted in increased contact with seriously mentally ill patients outside the hospital setting, increased community follow-up following shorter inpatient stay, or indeed, brought about the avoidance of an inpatient stay altogether. Kerwick et al (1997) noted that mental health service developments within primary care have concentrated on multidisciplinary initiatives and the improvement of joint working practices, particularly with community mental health care teams. They add that primary care developments have been achieved at two levels:

- *within the primary care team itself* : to increase the recognition, case recording and management of mentally ill patients (Armstrong, 1996).
- *external inputs to the GP practice*: such as psychiatric clinics in general practices (Mitchell, 1992), or community mental health key-worker liaison, and shared care schemes with GP practices (Goldberg et al, 1996a).

Various groups of mentally disordered people may have more, less or completely different experiences of primary health care services, for a variety of reasons that are not a central part of their disorder, such as homelessness and ethnicity. To start with, people may not register at all - Rogers and Faulkner (1987)

noted that only two-thirds of section 136 cases in their study were registered with a GP compared with 97 per cent of the general population. It is clear that certain groups such as the homeless find registering with a GP problematic (Bhugra, 1997; Keyes et al 1995), and many of those accepted by GP practices may be staying some kilometers away (Victor, 1992). In terms of ethnicity, Bhui (1997) notes little uniformity in the findings of research on ethnic variations in patterns of consultation in primary care. Many studies have found that psychiatric morbidity is grossly under-detected by GPs in different ethnic groups (Li et al (1994); Loyd and St Louis, 1996). Furthermore, the differential utilisation of GP services across different ethnic groups has been attributed to lower rates of satisfaction; longer waiting times than white patients; further distance from the surgery; absence of same sex GPs and lack of information in the patient's first language (Health Education Authority, 1994; Pilgrim et al, 1993).

As well as factors affecting GP services which may be overrepresented in MDO groups but which are not part of their illness, there are also those factors which *are* part of their illness and which might also affect the quality of the service they receive. Indeed, for some mentally disordered individuals the traditional routes into care are inaccessible because of illness-related factors such as denial, poor insight or cognitive impairment, while others are simply too isolated to come into contact with helping services because of their problematic or bizarre behaviour.

The general psychiatric service

In a rather more targeted fashion, the general psychiatric services can be involved with MDOs in several ways. First, psychiatrists in the general service may come into contact with MDOs as they move around the system, and may refer them on to other services. Second, some MDOs will be treated within the general service on open wards rather than in secure environments.

Only a small proportion of referrals to regional forensic services are made by general psychiatrists (Mendelson, 1992) but that proportion may be rising. A more recent survey of forensic and general psychiatrists in England and Wales indicates increased professional contact by general psychiatrists with the criminal justice system (Blumenthal and Wessely, 1993). Different types of psychiatrists may be involved in different ways - general psychiatrists were more likely to have contact with the CJS at the level of the police station, while forensic psychiatrists were more likely to be involved with the Prison Medical Services.

Caring for the needs of difficult and offender patients at open ward level has been the cause of much concern, partly because of the numbers concerned. In the 1992 report, the Reed Committee estimated that there were over 70,000 in-patient beds for people with mental illness or learning disabilities. In one year (1989-1990) there were 260,000 psychiatric in-patient admissions, of which 7 per cent were people detained under the MHA ("formal" admissions). Other estimates may be a little higher than this. Reed (1997) suggested that some patients cared for in this type of setting might be more appropriately placed in conditions of low security. Grounds (1996) similarly noted that at present, local general psychiatric

services struggle as they attempt either to reject or to manage difficult patients who have combinations of offending histories, violent behaviour, drug and alcohol abuse, personality disturbance and mental illness. Concerns have thus been expressed about the increasing number of violent patients inappropriately placed on open wards (Turner, 1991), and the higher rate of absconding behaviour for detained MHA patients placed in acute general psychiatric units (Falkowski and Watts, 1990).

Low or minimum secure care

The next step up from open wards is low or minimum levels of security. Local low secure provision will consist largely of locked or lockable wards within psychiatric hospitals, and psychiatric intensive care units. In 1992 the Reed Committee calculated that there were approximately 800 beds for mentally ill patients on lockable wards. Care in low secure environments fulfils a number of functions. First, it provides intensive treatment for acutely ill people requiring short-term intervention before returning to the open ward. Second, it also provides longer-term treatment and rehabilitation for people with challenging behaviour (Guite and Field, 1997).

How much provision does this type account for? Beer et al (1997) identified 110 psychiatric intensive care units in a recent national survey, highlighting the diverse nature of provision, particularly in relation to the level of security provided and the type of clients catered for within individual units. For instance, the units varied in size from 4 to 30 beds. Units typically accepted a mixture of informal patients directly from the community, detained patients and referrals from the prison service. A new hybrid model of secure care was described by Cripps et al (1995), comprising a local combined locked forensic/intensive care unit to cater more for offender patients, providing a level of security intermediate between that of an ordinary locked ward and a Regional Secure Unit.

Medium secure provision (Regional and Interim Secure Units)

The Reed report (1992) stated that the NHS was providing about 600 places in Regional Secure Units at that time in addition to places offered in lesser security in locally-based facilities and within normal psychiatric services. A further 300 beds were provided as 'interim' secure units although it is not clear from the report exactly what form these take. In Annex B to the summary of the report it is stated that 'A significant proportion of the patients are admitted following a Court Order, under the MHA or on transfer from prison or a Special Hospital, or on the authority of the Home Secretary. Most of these are treated in facilities outside their district of residence. Predicting demand is therefore difficult, and requires Regional oversight of purchaser intentions to ensure that services will continue to be available as needed.' (1992, p67).

A few years later, the SSI reported that the target of 1000 places in purpose-built, NHS medium secure units was going to be reached by March 1996 (SSI, 1996), with an additional 300 medium and medium/low secure beds being developed in mainstream situations. They stated that there were 450

interim secure beds at the time of their report, plus purchase of approximately 400 medium secure places from the independent sector.

Special Hospitals

In England and Wales, the most secure settings are the three 'special hospitals' (Broadmoor, Rampton and Ashworth), currently known as Special Health Authorities. Their services are commissioned by the High Security Psychiatric Services Commissioning Board (HSPSCB), following the abolition of the Special Hospitals Service Authority in March 1996. The population of the special hospitals has fallen from around 2350 in the early 1970s to 1520 in 1996. In 1992 the Reed report stated that provision was at 1750. An introduction to the ethos, history and politics of the Special Hospitals was provided by Kaye and Franey (1998). Their future has recently come under discussion again at the time of writing, as a result of the Fallon report on Ashworth (Fallon Committee, 1999).

There have been ongoing debates about the actual security needs of patients within the Special Hospitals. Maden et al (1992) suggested that up to half may not require high security. Not dissimilarly, in 1995, a Department of Health needs assessment exercise estimated that 32 per cent of Special Hospital patients needed placements in long-term medium secure care, and 10 per cent needed long-term low secure care. However, Guite and Field (1997) pointed out that although the emphasis is currently on those in need of care at a lower level of security, there were also pockets of unmet need at the higher levels of secure care in settings such as prisons. Reed (1997) reported that of those prisoners who were awaiting transfer to NHS facilities, well over one in five needed high security care.

Adequacy of current levels of provision within the health service

How much of this type of care should be provided? Certainly in the 1970s and 1980s, under-provision at the level of minimum secure care was problematic, with falling bed numbers in local locked provision mainly triggered by the closure of many large mental hospitals, and their decentralisation into smaller units. The introduction of less restricted patterns of care in general psychiatry, the 'open door' policy, and psychotropic drugs brought about reduced contact between medical and nursing staff and difficult/dangerous patients. Psychiatric hospitals and district general hospitals became unwilling to admit difficult/dangerous patients requiring secure care, and in time, the lack of secure care beds became a widespread problem. In an attempt to resolve the issue of under-provision at this level, two official reports in the 1970s - the Glancy Report (Glancy, 1974) and the Butler Report (HO/DHSS 1975) recommended that there should be 1000-2000 medium secure beds and that special funds should be made available to finance service development. The new tier of secure provision was intended to improve services for the assessment and admission of mentally disordered offenders; to relieve the overcrowding in Special Hospitals; and to cater for patients who were deemed too disruptive for the open door services that had developed in the preceding decade. But filling the gap in provision often demanded the creation of a resource from scratch, a task that was further hampered by funding uncertainties and delays.

Not surprisingly, the Reed Report (1992) noted that progress in service development at low and medium levels of security had been slow. The report noted that there were 1163 mental illness beds in some form of local security by 1986 and that this figure had dropped to 639 by 1991. Reed (1997) later reported that over 2000 beds were required to meet the long-term needs of patients transferred from Special Hospitals, the NHS, independent sector secure provision, general psychiatric services and prison transfers. Elsewhere, in an outline of models of needs-led mental health services within community sectors, Strathdee and Thornicroft (1992) proposed that 5 to 10 local secure beds should be provided for mentally ill people per 250,000 population. Reed (1997) estimated that if the mid range was taken (7.5 beds per 250 000 population), the overall figure for the provision of long-term local secure beds in England for mentally ill people would be 1400.

Despite considerable achievements being made in provision recently, the fact is that there still seems to be a perception of under-provision. In 1997, The Mental Health Commission stated that "The Commission is concerned about the lack of provision for patients who need long-term medium secure care in hospital or continuing care in the community" (p183). Certainly the situation has improved somewhat, and recent discussions of the need for longer-term psychiatric care in medium and lower security have resulted in higher estimates of what is being provided (eg, Reed, 1997).

If more places are being provided, why is there still so much concern over provision? The answer must partly lie in the *type* of provision and its location and integration into a whole system of care, rather than simply in numbers of beds. In this respect, possible models of forensic psychiatric provision are still evolving, and Mendelson (1992) noted that the optimum system has yet to be established in this field. The question remains as to whether forensic services should be provided by regional units, district services, or by a mixture of both. While regional services may be centralised, district-based clinics also provide an opportunity for local community contact and psychiatric follow-up. A survey of practice at a regional forensic service by Mendelson (1992 a,b) indicated that preparing court reports formed the bulk of the work of forensic psychiatrists and liaison was mainly with solicitors, prisons and the courts. Only one in ten referrals were from general psychiatrists and only a handful from GPs. Two thirds of referrals were triggered as a result of offending behaviours, the remainder emanating from other behavioural problems. The majority of referrals had previously seen a psychiatrist, suggesting that the service was often a second-line approach, providing advice on cases already known to other services.

The prison system

The Prison Medical Services and prisoner patients

The Prison Medical Service looks after the health of prison inmates and prison staff. The 'patients' are at very high risk of a range of health problems (including self-harm), and this alone means that the service has an uphill struggle. Most prisons now have access to a psychiatrist, who visits on a sessional basis. Prisoners are referred to him or her by the Prison Medical Officer. The efficacy of this service

varies considerably, and it is likely to work better in larger establishments than small. Some larger prisons also have night cover (approximately half, Wool, 1991).

In addition, there are specialist facilities at some prisons, including Grendon Psychiatric Prison, Glen Parva (5 psychiatrists), Parkhurst (hospital wing), and Feltham. In a paper based on a conference presentation in 1991, the then Director of the Prison Medical Service presented a description of these specialised services. In Grendon, for example, there is a self-contained therapeutic community for approximately 25 inmates, although only long-stay prisoners will have this service available to them. There are also services at Grendon for "acute breakdown", which provides assessment. At around the same date, Gunn (1992) published his evidence submitted to the Woolf enquiry into prison disturbances. In this the recommendation was made that *all* prison regions in England and Wales should have an assessment unit, with close links to special hospitals and regional secure units.

Contracted-in services

The Prison Advisory Group supported the move towards the contracting in of psychiatric services from the NHS into prisons, as a means of improving the quality of care for mentally disordered offenders and to facilitate their transfer from custody to psychiatric units. As yet, there is relatively little literature on contracted-in mental health services or dedicated forensic services, which facilitate rapid assessment and transfer of remand prisoners. Some such studies include an evaluation of the Belmarsh Scheme (Banerjee et al, 1995) and of the Bentham Unit (Weaver et al, 1997).

The shape of future provision?

A number of unresolved issues have been raised in the literature on provision. Most of this work is not empirical but is the result of commissioned policy pieces (eg Reed, 1997) or personal experience delivering the system (eg, Kaye and Franey, 1998). These issues will be revisited in subsequent discussions in this review, and include:

- ***Increases in low and medium security capacity*:** We have already summarised the ongoing discussions about the need for more of this type of provision but it is important to acknowledge again that this is a major issue. It is related to the next point:

- ***Increases in longer-term care*:** Caring for mentally disordered offenders who require longer-term psychiatric provision is a key objective of mental health policy. Reed (1997) noted that extant service provision is currently geared towards meeting the needs of patients for up to 24 months, at the level of medium secure provision, and that the Special Hospitals have traditionally provided longer-term care for those who require a high security environment. However, for patients who do not require such high levels of security, extant longer-term psychiatric provision is very limited. Reed concluded that under-provision of longer-term psychiatric care in medium or low security has led to people being detained in inappropriate levels of security or in acute wards when rehabilitative care is more appropriate. Drawing

on a number of sources, Reed outlined the bed numbers in longer-term medium and low security and the likely levels of demand from Special hospitals, NHS and independent sector secure hospitals, general psychiatric service and the prison medical service. This information is presented in Table 7.1 below.

Table 7:1: Possible need for long-term medium- and low-security places

	Long-term low- security	**Long-term medium-security**
Special hospitals	150	490
NHS & independent sector secure hospitals	270	190
General psychiatric service	1400	-
Prison	200	60
Total	2020	740

Reed (1997) outlined the consequences of under-provision of longer-term medium and low secure beds and warned that without adequate levels of provision, patients would continue to be cared for i) in inappropriate levels of security, that were too high or too low ii) in inappropriate settings (acute wards when longer-term care was needed, or in prison when inpatient health care was required. In addition, the lack of resources would undoubtedly slow the throughput of patients at all levels of secure care and create unnecessary delays in admission from courts and prisons.

- ***Strengths and weaknesses of different types of provision*:** There is little consensus about the relative merits of different types of secure environments on subsequent adjustment in the community or on recurrence of offending behaviour, partly because recourse to care in some secure environments may be taken for the well-being of the community, as well as the offender. The literature is sparse and this is an area for future development.

- ***The location of the Prison Medical Services within the Home Office*** and its disconnection from mainstream psychiatric health care services has been recognised as problematic (eg, Bowden, 1976). Conditions for prisoner patients were criticised in a Home Office report on the Prison Medical Services (Home Office, 1990) in which prisons were recommended to 'contract in' health care services from the NHS. The Prison Advisory Group reporting to the Reed Committee (Reed, 1992) suggested that contracting in psychiatric services from the NHS would have a dual effect of improving the quality of care for mentally disordered offenders and enabling prompt transfer of prisoner patients from custody to psychiatric units. As we have suggested, there has been relatively little discussion, assessment and analysis of such contracted-in mental health services or dedicated forensic services to prisons in the literature to date. Banerjee et al (1995) described an integrated service for mentally disordered offenders to Belmarsh Prison. Two post-membership psychiatrists were contracted-in as part of the Belmarsh Scheme and their responsibilities included the preparation of psychiatric reports, providing psychiatric

care to prison hospital in-patients, arranging assessments by catchment area services and expediting transfers to hospital under the MHA. They also provided education to prison staff on screening new receptions and suicide prevention. A key feature of an integrated service such as this is the seamless provision that results from links developed with other key services. For instance, the Belmarsh Scheme had regular contact with the South East London Court Liaison Scheme and Bracton Clinic RSU which provided forensic psychiatric services to local health districts. Other forensic liaison services have been described elsewhere (see Huckle and Williams, 1994; Weaver et al, 1997).

Summary Box: Existing Provision

Provision varies on a number of dimentions including:

- whether it is located within the hospital or prison system, a health issue or a criminal justice issue.
- in terms of the levels of security provided, from none up to the special hospitals

In terms of the available research:

- some broad overviews exist, but the situation changes all the time, particularly in the current NHS climate of continued reorganisation
- there is a wealth of empirical data on different types of provision (who is provided for; what is provided for them, etc) but the data are very variable in quality
- there is also a body of relevant work on how access to provision generally varies according to factors such as homelessness, factors which are more prevalent in MDO populations.

8 DESCRIPTIONS OF POPULATIONS OF MENTALLY DISORDERED OFFENDERS

The first chapters of this review have set the scene for a discussion of the needs of mentally disordered offenders by addressing definitional and statutory issues. We have looked at the range of places MDOs can be located, and at some of the ways that they arrived at different types of provision, and in this chapter we now move on to look at *who* MDOs are - the characteristics of people within different parts of the overall criminal and health systems. Subsequent chapters move on to models of provision and pathways in and out of care. Subsequent discussions of provision need to be firmly based on an understanding of the population of clients as a whole, in all the different situations in which they are found.

There are a number of reasons why this is important, including:

- First, a large proportion of the literature on mentally disordered offenders relates to descriptions of prevalence and incidence of (i) mental disorder in offending populations and (ii) offending in mentally disordered populations, as well as (iii) research on the characteristics of the population of MDOs, in particular in terms of offending patterns, ethnicity, gender, age and social class. It would be an omission to conduct a scoping review of the literature on MDOs without referring to this large body of work.

- Second, epidemiological data play an important role in the investigation of a causal relationship between criminality and offending but are also critical to the planning and provision of appropriate service responses. Accurate prevalence data is vital for service planning in all care settings, at all levels of security. Without knowing, for example, the types of disorders found in the remand population and how those differ from the picture in high security, provision in the appropriate settings cannot be provided.

- Third, and relatedly, the split between purchasing and provision of health and social care services and the evolution of a 'contract culture' relies on prevalence information to map both the need and demand for services. This information informs decisions to purchase services and underpins the contracting process. It should help to make decisions about contracting as efficient as possible. Of course, quantifying need is a redundant exercise unless it is followed by equal enthusiasm to ensure that such needs are served by the appropriate services.

- Fourth, understanding the ways in which people are likely to respond to provision is also important and some hints can be found in the descriptive data. For example, a particularly strong feature of the management and treatment of this group is the extent to which some are either reluctant or compulsory recipients of care, or are non-compliant. Indeed, it has been suggested that avoidance strategies have been

equally adopted and refined by statutory agencies in cases of the treatment-resistant, hard to handle patients.

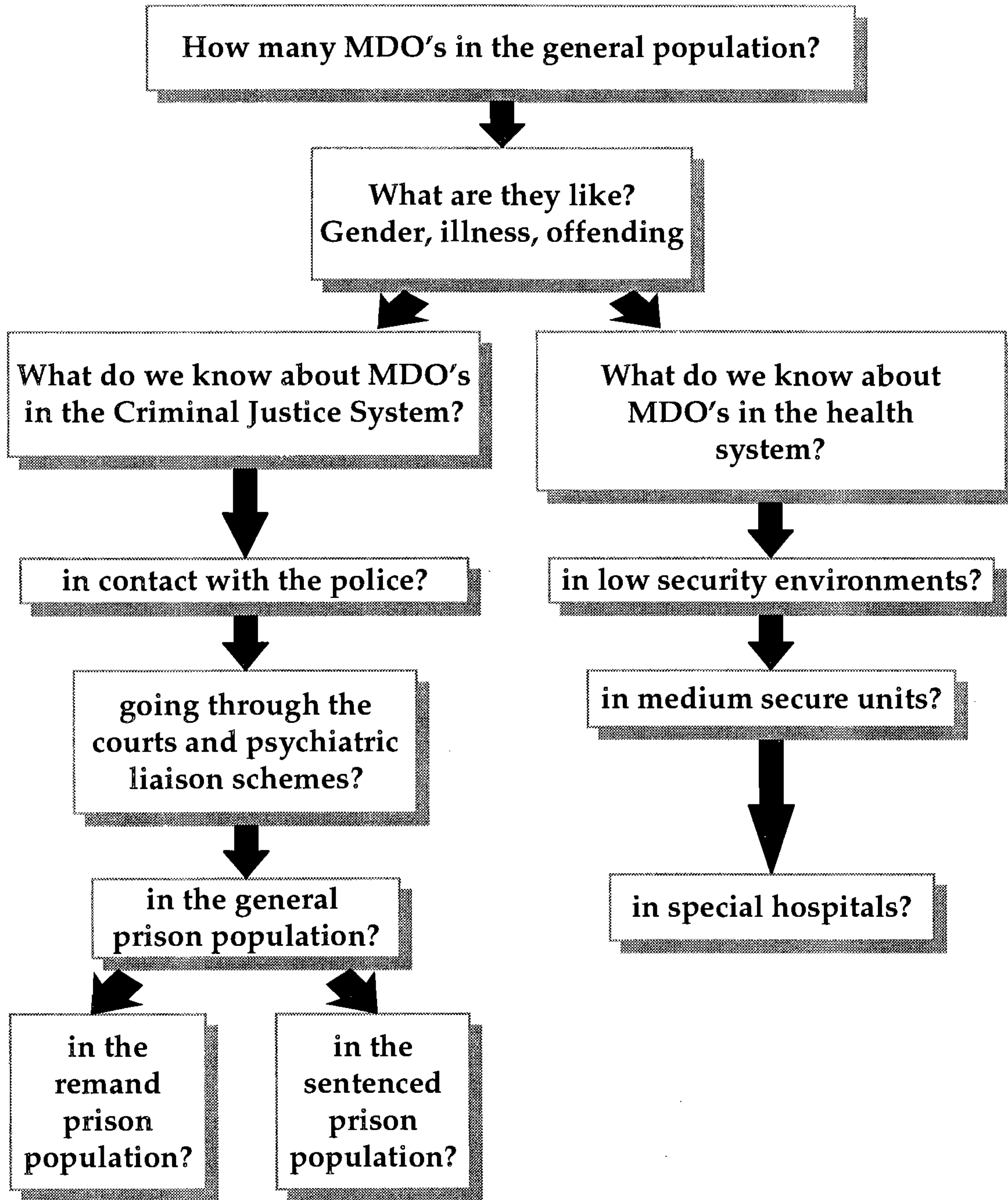
- Finally, this is an area where strong but potentially unfounded impressions of the population are presented by the media and exist in the popular imagination. It is critical that these do not influence provision if they are unfounded, and an objective description of the population is critical as the starting point to confront any stereotypes that might be influential but wrong.

The whole topic of epidemiology is, of course, the topic of another review in this series (Badger et al, 1999), and we refer to their findings where appropriate. The existence of the Reading systematic review is of considerable significance in this whole area, and will prove enormously helpful in planning and provision. Without their review, one of the main findings of this chapter would have been that there was a lack of a single, large and systematic overview. That now exists. However, the approach taken in the Badger et al epidemiological review is somewhat different to our intentions in this chapter, for a number of reasons. To start with, the Reading review was systematic, whereas this is a scoping review and the approaches are different. In addition, we have taken a broad definition of this area including descriptive as well as epidemiological work. We do not claim to have reviewed the former comprehensively, but have probably included a wider range (in terms of quality at least) of generally descriptive papers, in addition to strictly epidemiological studies. Also, the purpose of this chapter was different to that of the systematic review, in that we were assessing the field in terms of the adequacy and relevance of the descriptive findings in terms of understanding issues of need and provision, which meant that we were not always concerned with determining levels of difficulties in the whole population. What we present in this chapter is, thus, a selective review of the epidemiological and descriptive literature, looking at research which can answer questions such as 'Who are we likely to be providing for?', 'What do we know about the needs of individuals at different times?', and 'How will that affect provision?'. In order to elucidate our approach and allow a clear comparison with the aims of the Badger et al systematic review, Figure 8.1 summarises the key epidemiological questions that we consider in this chapter.

Methodological problems in drawing conclusions from the available descriptive research

Inevitably, the answers to these questions are not straightforward, and before reviewing the data we need to consider briefly the methodological pitfalls they can represent. This is the subject of some discussion in the literature (eg, Monahan and Steadman, 1983; Jenkins and Meltzer, 1995; Fielding, 1996; Mason and Wilkinson, 1996; Smith, 1997). There are five main types of methodological problems encountered in the literature:

Figure 8.1 **Descriptions of populations of MDOs - key questions**



(i) ***Difficulties comparing one population with another.*** Studies describing the same characteristics (eg, rates of psychosis) can sometimes be based on rather incomparable populations (eg prisoners on remand versus people transferred to hospital). Studies consist of various permutations of true and treated prevalences of both mental disorder and of criminal behaviour (see Monahan and Steadman, 1983 for a full discussion of this topic). As we shall see, there is considerable evidence that different subgroups of

MDOs present with rather different problems and care should be taken generalising from studies based on small or selected samples. Many small-scale studies examine specific disorders in particular subgroups of MDOs or in single geographical areas which presents problems of generalisation. Cross-sectional studies are subject to difficulties because of the potential for inaccurate denominator data. Selecting a representative cross-section of inmates from the prison roll rather than selecting only from receptions may result in some groups being over-represented such as inmates serving longer sentences. In addition, Maden et al (1995) suggested that comparisons with international studies pose a number of problems because prison populations may not be comparable. For instance, in the USA the remand population consists of pretrial prisoners and those sentenced to a prison term of less than one year. Even within the UK the Scottish and English prison systems differ.

(ii) ***Difficulties comparing different methods of data collection.*** For example, Mason and Wilkinson (1996) suggest that differences in study designs should be taken into account when drawing comparisons between the OPCS Survey of Psychiatric Morbidity and other prevalence studies such as the National Comorbidity Survey (NCS) and the Epidemiological Catchment Area (ECA) studies, both cross-sectional surveys carried out in the general population in the USA. The authors propose that differences in prevalence rates on diagnostic categories such as major depression may result from the different sensitivities of the interview schedules used across the studies. In addition, results relating to neurotic psychopathology in the OPCS survey produce a weekly prevalence report and therefore may not reflect enduring neurotic symptoms. Problems encountered with methods of data collection are highlighted throughout the review ranging from the use of police custody records (Revolving Doors Agency, 1993, 1994) and prison records (Taylor and Gunn, 1984; Coid, 1988; Mitchison et al, 1994), to variations in applying clinical judgement to psychiatric diagnoses and court medical recommendations (Dell et al, 1991, Rogers and Bagby, 1992, Joseph and Potter, 1993 and Exworthy and Parrott, 1997).

(iii) ***Difficulties of non-response.*** A more general consideration is the universal problem of non-cooperation which plagues epidemiological research (and affects the precision of prevalence figures). For instance, twenty one per cent of the adults selected for interview in the OPCS survey refused to cooperate compared with 21-32 per cent in the ECA study (Regier et al, 1988) and 17.4 per cent in the NCS (Kessler et al, 1997). A high refusal rate (18 per cent) was noted in the cross-sectional study of mental disorder in remand prisoners in the UK (Maden et al 1995), while another UK study of the sentenced population noted a refusal rate of only 6 per cent (Gunn et al, 1991). Furthermore, cross-sectional studies conducted across a number of prisons may be problematic because of the different refusal rates across prisons studied.

(iv) ***Difficulties associated with the study of particular disorders.*** Schizophrenia, for example, is particularly difficult to study (Jablensky, 1986), because schizophrenic disorders indicate a high degree non-uniform clinical manifestations and lack sufficiently specific signs and symptoms; the course of the

disorder is varied and difficult to predict; there are no reliable indicators to facilitate rapid diagnostic screening of population samples, as is the case in some other diseases.

(v) ***Problems posed by policy changes.*** Understanding and interpreting data on rates of psychiatric disorder must occur in the light of other policy changes such as the policy of diverting mentally disordered offenders out of the criminal justice system, and conditions of confinement, into appropriate health and social care settings. A recent survey of psychiatric morbidity in sentenced prisoners suggests that gender differences were likely to have resulted from an interaction of rates of mental disorder among offenders and the operation of procedures at various stages of the CJS to divert MDOs away from the prison system.

It can be argued that there is now a clear understanding of the problems associated with this type of research, but it is less clear that these are acknowledged or adequately discussed in individual research reports.

Overall numbers: MDOs as a proportion of the general population

How many mentally disordered offenders are there in the general population? The short answer to this is we simply do not know. Neither our searches, nor those of the Badger et al team revealed any satisfactory, large scale, British epidemiological studies of how mental disorder and antisocial behaviour overlap in the whole population. In their review, Badger et al note that some epidemiological data exist for other countries but the existence of completely different systems for dealing with MDOs mean that results from other countries cannot be assumed to be relevant for the UK. As they conclude, there are no absolute levels of MDO in any population - the definitions of all the components are relative and culturally determined. The next question is then what do we know about the epidemiology of (i) mental disorder and (ii) antisocial behaviour in this country, and can we extrapolate anything from these data to mentally disordered offenders?

In terms of mental disorder, our search of the literature identified only one cross-sectional study of mental illness or psychiatric morbidity in the general population in Great Britain conducted by the OPCS in 1993. Although the study does not provide information relating to criminality, it does offer a useful comparative picture of the extent and nature of psychiatric morbidity amongst the mass population (combining household and institutional populations), and in turn provides base data from which mental health policy can be formulated. Even so, the precision of prevalence figures are somewhat questionable because, as we have noted, one in five of the adults selected for interview refused to cooperate. Functional psychosis had a prevalence rate of 0.4 per cent in the past year (a rate of 4 per 1,000). This is in keeping with studies that have examined the epidemiology of schizophrenia in Europe (Jablensky, 1986). 14 per cent of adults had a neurotic health problem. The most prevalent neurotic disorder was mixed anxiety and depressive disorder and the prevalence of all neurotic disorder was higher among women than men. The overall rate of alcohol and drug dependence in the past year was 4.7 per cent and

2.2 per cent respectively. Men were three times more likely than women to have alcohol dependence and twice as likely to be drug dependent.

Turning to antisocial behaviour, epidemiological studies of antisocial behaviour in the general population show it to be extremelycommon (eg, Home Office official statistics show that a third of the adult male population will have a criminal record, usually acquired as a young man) although serious antisocial behaviour is much rarer, (Rutter, Giller and Hagell, 1998; Home Office, 1996), but these types of estimates are of little use in predicting numbers where offending will overlap with mental illness.

The combination of *serious* antisocial behaviour and mental illness is likely to be relatively rare as a proportion of the general population. Any degree of precision is impossible. There is a desperate research need here. We concur with the conclusions of the Reading review, in that there are a number of existing large scale longitudinal studies which might be adapted to include assessments relating to the overlap between mental disorder and offending, and pursuing this avenue is likely to be the most fruitful way of filling the research gap.

General characteristics: Gender, illness and offending patterns in MDOs in the general population

Despite the lack of general epidemiological data, there is quite a lot of information about different groups of mentally disordered offenders in different settings. In the next few sections we try to draw this information together. Looking first at the most representative studies, how do MDOs compare to other groups?

Gender

Two questions are important here. First, does the research exist that would determine whether one gender or the other more predisposed to the combination of mental disorder and offending? Second, what conclusions can be drawn concerning whether the genders differ in their picture of mental disorder and offending? Do they commit different types of offences in combination with different types of mental disorder or do they both show a similar pattern? Of course, this cannot be answered by a simple yes or no because of the heterogeneity of male and female MDO populations themselves, and the complexities of the relationship between criminal behaviour and mental disorder. However, there are still some broad patterns emerging from the literature that we will draw attention to throughout the section.

- ***Is one gender or the other more disposed to the combination of mental disorder and offending?***

Given the lack of epidemiological information, it is not surprising that the answer to this question is not conclusively established. Our scoping searches did not reveal an overview of this area except in small references to the topic set within larger reviews. While offending is generally more predominant in male than female populations (Rutter, Giller and Hagell, 1998, Home Office,1997), there has been a historical tendency to relate female offending to psychiatric abnormality. This whole topic is the subject of another review in this series (Lart et al, 1998), and we will briefly summarise the general picture.

There is some limited empirical support that there are higher rates of mental disorder among female offenders than among male offenders (Gibbens 1977). This may be because women as a whole have such a low rate of criminal offending, so that it is more likely that mentally disordered offenders account for a greater proportion of total offending by women (Mendelson, 1991; Maden et al 1995). Indeed, the large cross-sectional studies of sentenced and remand prisoners show that prevalence of psychiatric morbidity is higher in female sentenced and remand populations than in their male counterparts but this could be the result of processing.

- ***Do male and female MDOs show different patterns of MDO?*** The literature seems to support the view that they do, both in terms of the offence and the disorder. It has been reported that they are more likely to have offences of arson or public order, and to have an affective disorder or neurotic problems, whereas men were significantly more likely to be drug or alcohol dependent and to have a mental illness, usually of a schizophreniform type (Mendelson, 1991). In terms of mental illness, these findings are consistent with presentation to general psychiatric services (Olley, 1987) and psychiatric morbidity in the general population (Mason and Wilkinson, 1996). In another review in this series from a team at the University of Bristol (Lart et al, 1998), entitled 'Women and secure psychiatric services: A literature review', the authors concluded that there was evidence that women in secure settings had a different pattern of diagnosis to women. This included higher proportions of personality disorder and borderline personality disorder, compared to higher rates of psychosis in males patients. But, as Lart et al pointed out, women and men follow different pathways into secure psychiatric services, with women less likely to enter through the criminal justice system than men. The effects of differential processing have yet to be untangled.

The gender review by the Bristol team is very useful in this area, but it could be argued that there is still a need for a broader scoping review of the whole issue of gender, offending and mental health, within which the Lart review would be a part. Reviews of gender (and ethnicity, where similar issues are presented) and offending are becoming more prevalent (Heidensohn, 1997), and there is a considerable literature on gender and mental health, but there is a need for an overview bringing these together.

Illness characteristics in MDOs

What is known about the illness characteristics of samples of mentally disordered offenders in the general population? Once again, almost nothing is the answer to this, as there are no adequate British studies to provide the data. Most of this research comes from surveys of various incarcerated populations, as one might expect, and so is covered below.

Offending patterns

What evidence there is shows that patterns of offending by mentally disordered offenders are not exactly as described in popular and press discussions and a description of their offending patterns provides another important piece of background information. What are the most common types of offences committed by mentally disordered offenders? Recent research by NACRO suggested that people with mental disorders were most likely to be committing low-level nuisance offences with the intention of obtaining shelter, food, warmth etc in custody (NACRO, 1993) and public order offences (Robertson et al, 1995). In a US study of police-citizen encounters, Teplin (1985) found similar patterns of crime for mentally disordered and non-disordered persons. Similar findings were identified in other US studies (Monahan and Steadman, 1983; Steadman and Felson, 1984). So, while there is a strong image of the 'psychopath' with a predilection for spontaneous, unprovoked and serious violence, empirical studies of the nature and type of offences committed by people with mental disorders suggests that serious violent offending is rather rare.

However, there is still a tendency to think that offending by mentally disordered offenders is predisposed to be violent (Loeng et al, 1991; Walker, 1991) Heterogeneity in offending patterns is perhaps more likely than overrepresentation of violence. Still, there is some evidence to suggest an overrepresentation of violence for certain diagnostic groups and for MDOs who are charged and restricted. For example, Gibbens and Robertson (1983) reported the offending careers of men who had received hospital orders over a 15 year period and found considerable differences in the criminal histories of patients within different diagnostic groups. They noted an increased incidence of violent offences in the schizophrenic group. A study of violence and psychosis conducted by Taylor and Gunn (1984) showed that schizophrenic men were at a greater risk than the general population of committing violent crime. A recent study by Coid et al (1993) which examined lifetime criminality and psychiatric histories in twins lends support to the view that diagnosis is significantly associated with criminality, as clear patterns of offending for different diagnostic groups were found. Schizophrenic men had a different pattern of offending and were younger at their first conviction. Schizophrenic probands in particular had significantly more convictions across a whole range of offences from violence to drink or drug related offences and were more likely to receive a prison sentence than probands with affective disorder. Furthermore, a temporal component was clearly identified, as criminality followed the onset of the illness for both disorders. However, there may be a problem of interpretation with this study, due to the interactive effects of disorder and the decision to prosecute. In conclusion to this section, existing research suggests that violence might be more elevated for certain rarer types of mental illness, but not for others, and it is a mistake to generalise from one group of MDOs to all of them.

Descriptions of particular populations

What is known about MDOs who are somewhere within the criminal justice or health care systems already, or move from one care/confinement setting to another?

The types of studies that address this question include cross-sectional studies of who is in the population (eg, prison) at any given time, or intake samples looking at consecutive admissions or receptions. The main problem with these types of studies is that they tend to concentrate on one subgroup only (eg, remand or sentenced prisoners, or those in high security provision) or to concentrate on one type of provision only (for example, introducing bias because different prisons take different types of offenders, some health care establishments specialise in treating particular disorders or groups, while other establishments select some patients and reject treatment-resistant or difficult to manage patients). As a consequence, comparing studies and trying to get an overall picture is a little complicated. Even comparisons across studies of similar subgroups present difficulties because of variations in sample selection and method of investigation.

MDOs in the general prison population

This is an area of good research, although studies are sometimes rather separate from each other. Primary research in this area has been active in the last decade. Attempts to locate a link between criminality and mental illness have brought attention to the issue of the prevalence of psychiatric disorders in both the sentenced and remand prison populations in the UK. It is now well recognised that the prevalence of psychiatric disorder in the prison population is higher than in the general population (Gunn et al 1978; Gunn et al, 1991; Maden et al, 1995)[1]. As noted above, recent OPCS data on prevalence rates for psychoses in the general population indicate a much lower rate (0.4 per cent) than in the prison populations (Meltzer et al, 1995). However, the studies discussed below also indicate different prevalence rates amongst sentenced and remand prisoners, illustrating that a homogeneous group of mentally disordered offenders simply does not exist. One of the main limitations of studies of both remand and sentenced prisoners is the lack of comparative data on general remand and sentenced prisoner populations.

MDOs in the sentenced prison population

The most comprehensive study of prisoners with psychiatric disorders in the UK to date has been conducted by Gunn et al (1991) to determine the prevalence of psychiatric disorder and the treatment needs of sentenced prisoners in England and Wales. Other studies identified in our search that include descriptions of sentenced prisoners focus mainly on their transfer from prison to hospital for psychiatric care and treatment.

A summary of studies relating to the characteristics of the sentenced prison population is presented in Table 8.1. Sample sizes are typically small in some of the studies outlined, particularly those relying on transferred prisoners. Statistical bulletins show that these numbers are very small even nationally (Department of Health, 1998).

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[1] Since drafting this review, a new survey of psychiatric morbidity among prisoners in England and Wales has been carried out and published (Singleton, Meltzer, Gatward, Coid and Deasy, 1998) but it was received too late to be included in the detail presented here.

Table 8.1 Studies of the sentenced prison population

Study	Author	Date	Sample	n-female	n-male
Transfer of sentenced prisoners to hospital	Grounds	1960-1983	All first admisstions to Broadmoor – s.72 MHA 1959	26	354
Prison transfers to Special Hospitals since MHA 1983	Huws	1984-1991	All first admissions to SHs – s.47 MHA 1983		
Psychiatric disorder in London's life-sentenced offenders	Taylor	1986			
A survey of sentenced prisoners transferred to hospital in one region	Huckle	1992-1995	Transfers to psychiatric hospitals – s.47 MHA 1983	29 (25)	Cases
The transfer of severely mentally ill prisoners from HMP Wakefield	Hargreaves	1995	SMI prisoners identified from inmate medical records	-	21
Psychiatric disorder in life-sentenced prisoners	Swinton	1991	Male life-sentenced prisoners	-	170
Twenty year of admissions to a special hospital	Woods	197? 199?			

In brief, these studies show that:

- ***Psychiatric disorders of MDOs in the sentenced population*:** Studies of selected samples of sentenced prisoners tend to provide information of variable quality. For example, few of the smaller studies mentioned the use of standardised criteria (ICD-10 or DSM-III-R) for assigning psychiatric diagnoses. Samples that comprised sentenced and remand prisoners were often treated as one group in the presentation and discussion of findings. The most comprehensive picture of psychiatric disorder is provided in a cross-sectional study of the sentenced prison population, conducted by Gunn (1991). Overall, 40 per cent of men and 56 per cent of women had at least one psychiatric disorder. Multiple diagnoses were allocated to around a sixth of both male and female prisoners.

Swinton et al (1994) also used the same data source to examine psychiatric disorder in a cohort of 170 life-sentenced prisoners. In general, the data indicated a similar picture of psychiatric diagnoses in male life-sentenced prisoners (42 per cent) and non-lifers (37 per cent). However, differences were found in the prevalence rates of individual disorders, as the 'lifer' cohort showed significantly higher rates of personality disorder and lower rates of drug abuse or dependence than the non-life sentenced population.

There were slightly lower prevalence rates of neuroticism among 'lifers' whose reports indicated a decline in symptoms with the progression of their prison sentence. The authors also noted that around one in five lifers and non-lifers had a history of previous contact with psychiatric services as adults. Other studies have looked at other aspects of psychiatric disorder in the sentenced population including particular disorders in patients transferred or awaiting transfers (Huws et al, 1997, Huckle, 1997, Grounds 1991, Hargreaves, 1997).

- ***Gender differences in diagnosis of MDOs in the sentenced population:*** Looking at primary diagnoses, in the Gunn study gender differences occurred across all disorders. Men had higher rates of psychosis than women (2.2 per cent compared with 1.1), but lower prevalence rates of neurosis (5.2 per cent compared with 13.2), substance misuse (20.1 per cent and 28.9) and personality disorder (7.3 per cent and 8.4). The gender differences became even more pronounced when multiple diagnoses were taken into account. Women were more likely to have had previous psychiatric contact before the current period of imprisonment and more likely to report treatment with psychotropic medication while in prison.

- ***Demographic characteristics of MDOs in the sentenced population*:** We looked to uncover the extent to which studies had addressed questions of demographic characteristics of sentenced prisoners, but these sorts of data do not seem to be systematically collected. For example, data on age were not routinely provided in the literature, with no comparisons of mean age and age groups by gender and ethnic group (Some exceptions were Grounds, 1991; Huckle, 1997; Hargreaves, 1997).

In terms of gender, data and discussion of gender differences in relation to diagnosis and socio-demographic characteristics were almost completely absent from the studies, apart from the cross-sectional study identified and discussed above. Again, there were just a few exceptions - Grounds (1991) found that the ratio of men to women in a study of transfers to Special Hospitals from 1960 - 1983 was 14:1, yet the corresponding ratio in prisons in 1983 was 31:1. The ratio of men to women was lower for transfers occurring in the period 1984 - 1991. It is interesting that despite the over-representation of women in prison transfers to Special Hospitals, relatively little or no indepth discussion on gender differences occurs in the studies.

Ethnicity: Where information on ethnicity was provided, it was often just a breakdown of the study sample by ethnic group. The most recent study of the transfer of sentenced prisoners to Special Hospitals indicated that significantly more non-white patients than white patients were given a diagnosis of a psychotic illness rather than a diagnosis of personality disorder (Huws et al, 1997).

Marital status, living arrangements and employment circumstances: again, very little data is systematically collected and it is hard to compare studies. Exceptions include Gunn et al, 1991.

- ***The types of offences committed by MDOs in the sentenced population.*** The limitations of prison recording procedures in relation to offences or alleged offences recorded on the inmate medical record (IMR) was discussed by Mitchison, (1994). A particular problem is that once convicted, the offence(s) may not be the same as those recorded on reception, so that data only provide a crude indication of the extent and range of an inmate's offending behaviour. Data often related to more than one index offence where prisoners were convicted of more than one crime. The same studies as those cited again provide data in this area (Gunn et al, 1991; Maden et al, 1994; Grounds, 1991; Huws et al, 1997, Hargreaves, 1997), but we did not identify any reviews beyond that contained in these empirical reports.

MDOs in the remand prison population

Maden et al (1995) conducted a cross-sectional study of the remand population based on the earlier study by Gunn and his colleagues (1991). The purpose of the study was to determine both the extent of mental disorder in the remand population and their treatment needs. Watt et al (1993) had already carried out a pilot study to assess the feasibility of conducting a full-scale prevalence study of psychiatric disorder in a male remand population using a 20 per cent sample of male new remandees to Bristol prison. These and other studies of the remand prison population are outlined in Table 8.2.

Table 8.2: Studies of the remand population

Study	Author	Date	Sample	n-female	n-male
Violence and psychosis - risk of violence among psychotic men	Taylor	1979-1980	Prisoners remanded to Brixton prison – charged with violent offences and/or held in the hospital wing	-	1,241
Mentally disordered prisoners on remand	Coid	1979-1983	Prisoners remanded for medical reports	-	334 388 remands
Mentally disordered remand prisoners: i) Brixton	Dell	1989	Psychotic and non-psychotic MD groups	-	568
ii) Holloway	Dell	1989	Psychotic and non-psychotic MD groups	196	-
iii) Risley	Dell	1989	Psychotic and non-psychotic MD groups	58	130
The Belmarsh Scheme: transfer of mentally disordered remanded prisoners from prison to psychiatric units	Banerjee	1992	Prisoners first remanded in custody and assessed as requiring transfer to hospital	-	53
Urgent psychiatric transfer from prison in England and Wales: a prison perspective	Anderson	1991-1992	Urgent psychiatric transfers of remand prisoners from Belmarsh – s.48 MHA 1983	-	20 (22 cases)
Waiting for treatment: an audit of psychiatric services at Bullingdon	Resnick	1992-1993	Remand and sentenced prisoners referred to visiting psychiatrists	-	84(R) 55 (S) 5 (NK)
Providing a forensic psychiatric service to Cardiff prison	Huckle	1992-1993	Inmates referred to a forensic liaison psychiatric service	-	49(R) 11(S)

In brief, these studies show that:

- ***Psychiatric disorders in MDOs in the remand population***: These were most comprehensively described in the cross-sectional study by Maden et al (1995) referred to above, and have also been reported by Birmingham et al 1996, Taylor and Gunn (1984), Coid (1988), Dell et al, (1991) and Bannerjee (1995). In general, large proportions of the remand population are found to have concurrent and/or past disorders, possibly as many as two thirds of men (66 per cent) and just over three-quarters of women (77 per cent) (Maden et al, 1995). These are most frequently psychosis such as schizophrenia, anxiety disorders and personality disorder. Multiple diagnoses are common, and there are gender differences (males with higher rates of psychosis and substance abuse, females with more neurosis and personality disorder). In the Maden study, substance misuse was diagnosed as a primary or concurrent disorder in as many as 42 per cent of women and 39 per cent of men. Taylor and Gunn 1984 reported that 9 per cent of their sample showed symptoms of withdrawal from drugs or alcohol. Coid (1988) reported that a characteristic feature of the group was the chronicity of their illnesses and their need for long-term care. However, one in three had a history of absconding from hospital on previous admissions, reneging on out-patient appointments or failing to comply with their treatment.

- ***Offending patterns of MDOs in the remand population:*** Several studies have reported rather complicated results for offending patterns for the remand population (eg, Taylor and Gunn, 1984; Dell et al, 1991; Banerjee, 1995). Taylor and Gunn's (1984) study of remanded prisoners showed a full range of violent behaviour in association with a full range of mental states, but serious personal and life threatening violence was much more commonly committed by psychiatrically normal than by disturbed people. In contrast, arson and violence directed mainly at property were more typically committed by psychiatrically disturbed men. Although just under two-thirds of those charged with or convicted of homicide were psychiatrically normal, the authors still viewed the degree of psychiatric disturbance in the homicide group as high (37 per cent). There was also a higher prevalence rate of schizophrenia among men convicted of homicide (10.9 per cent), arson (30 per cent) and other violent offences (8.9 per cent) than would be expected in the general population (0.4 per cent).

- ***Demographic characteristics of MDOs in the remand population:***: As with studies of the sentenced population the recording of demographic information is sketchy in these studies, particularly in the study by Maden et al (1995) which did not provide comprehensive demographic information for women in the original report.

Age: Prevalence studies of remand prisoners showed them to be in their mid to late twenties (Maden, 1995; Watt et al, 1993; Birmingham, 1996). Dell et al (1991) noted age differences across the psychotic/non-psychotic groups. For example, psychotic men and women were older on average than their non-psychotic counterparts.

Gender: Many of the studies were of male prisoners, but studies of both sexes tended to provide minimal data on gender differences. Dell et al (1991) found gender differences in relation to the decision to accept a prisoner to in-patient psychiatric care. Although psychotic prisoners of both sexes were more likely to be offered a hospital bed, a higher proportion of men than women within the psychotic and non-psychotic groups were rejected admission.

Ethnicity: Not surprisingly prevalence studies showed that the largest ethnic group was Caucasian, followed by Afro-Caribbean (Watt, 1993; Maden, 1995), but there does seem to be an overrepresentation of people from ethnic minorities among MDOs in the remand population. Other studies showed ethnic differences in relation to diagnosis and need for in-patient treatment (Dell et al 1991; Banerjee, 1995).

Marital status, living arrangements and employment circumstances: There is a tendency for the MDO remand population to be more likely to be single or separated than other remandees. (Maden (1995, Dell et al, 1991). Data on their living circumstances are equivocal. Despite evidence of housing instability in some studies (eg, Dell et al; Coid, 1988), in one study a high proportion of men (81 per cent) and women (85 per cent) with a psychiatric disorder reported living in their own home at the time of arrest and only a small proportion of both sexes (1.5 per cent of men and 1.2 per cent of women) were of no fixed abode (Maden, 1995).

Comparison of rates of MDO in the sentenced and remand prison populations

The main prevalence studies clearly showed that psychiatric morbidity in sentenced and remand populations was higher than in the general population, but this was particularly so for remand prisoners. But the picture is also different for particular population subgroups. For instance, we have seen that although the overall prevalence rates of psychiatric morbidity are similar for life and non-life sentenced prisoners, differences are apparent across individual diagnostic categories (Swinton, 1994). The two main prevalence studies of sentenced and remand prisoners revealed that men and women in both populations were equally likely to be assigned more than one diagnosis, but additional diagnoses were far more frequently assigned to male and female remandees than their sentenced counterparts. Overall, a third of the male and female remandee samples were allocated two or more diagnoses compared with around a sixth of the sentenced male and female samples (Gunn et al, 1991, Maden et al, 1994; Maden et al, 1995). This is important because multiple diagnoses are thought to reflect the severity of psychiatric problems suggesting that both the extent and nature of psychiatric morbidity in the remand population is a serious cause for concern.

Conclusions from discussions of prison populations

Why should (a) the prison population as a whole have higher rates of psychiatric morbidity than the general population and (b) why should remand populations be worse off than sentenced populations? The studies reviewed do not fully answer these questions, but there are a number of possibilities raised.

In terms of the first question, the answer could either be a causal link between illness and offending, or a bias in selecting in those with both problems.

The most likely answer is that both a causal link and systematic bias will be found to be contributory - Swinton (1994) argues that the prevalence of serious mental disorder in the prison population is determined by the response of both medical and legal systems, as well as by any underlying rate of offending. In any case, prison prevalences are a poor guide to the relationship between mental disorder and serious offending for the various methodological reasons outlined at the start of this section, including the fact that prison populations do not adequately represent offenders in general.

Of course, a third possibility might be that prisons may themselves lead to mental health problems, casting a long shadow of trauma and disruption on remand prisoners in particular (Maden et al, 1994; 1995). For instance, Maden et al (1995) suggested that the experience of being remanded to prison was itself a contributory factor to the rate of morbidity because of the associated upheaval, disturbance and uncertainty that remandees experienced. In short, a whole host of other factors may be reflected in prevalence figures of psychiatric morbidity in prison populations. The disengagement of many patients from psychiatric services and their tenacious resistance may be equally matched by tenacious avoidance strategies by health and social care organisations. The studies reviewed provide a good general picture of the nature and range of problems across the vast spectrum of mental disorder and offending behaviours, but the data must be interpreted with caution, accordingly.

In terms of the higher rates of problems among the remand populations, explanations have included the increased stress associated with being held in custody but not convicted, and also it may be possible that some of the worst of those cases will not end up in prison at all but will be transferred to hospital.

The characteristics of MDOs in other parts of the Criminal Justice System

Studies of the courts and psychiatric court liaison schemes

In some respects, there is a wealth of studies of the characteristics of people passing through UK based court-based diversion and liaison schemes (Brabbins and Travers, 1994; Joseph and Potter, 1990; Robertson et al, 1995), plus some other work on court reports (Hosty and Cope, 1996). On one hand these studies have a considerable strength in that they tend to have employed structured clinical interviews by psychiatrists. However, it has to be said that it is very difficult to distill the results of these as the schemes are rather different from each other, the required comparisons between disordered defendants and non-disordered defendants are not always made, and where they are the results are often contradictory. In part we have to simply suggest that some work needs to be done sorting out this literature. As far as we can tell there are no good recent reviews. However, we have attempted to draw out the main messages, including:

- ***Psychiatric disorder in MDOs going through court schemes*** The main message on psychiatric diagnoses in these types of samples has been that many studies report high rates of psychosis. This is most frequently schizophrenia (Joseph, 1990; Joseph and Potter, 1993; Exworthy and Parrott, 1993, Robertson et al, 1995; Exworthy and Parrott, 1997). Substance abuse alone, or in combination with other disorders, was commonly reported by other schemes and studies (Cooke, 1991; Brabbins and Travers, 1994; Hosty and Cope, 1996; Rowlands et al, 1996). There are some rather different findings in the literature - in a Scottish study of psychological or psychiatric treatment as an alternative to custody (Cooke 1991) the largest single diagnostic categories were depressive disorders (11 per cent) and anxiety disorders (14 per cent), with alcoholism and drug abuse less common. In this study, the least common single diagnoses were schizophrenia and personality disorder. Various individual pieces of research exist describing very particular local schemes (eg, Rowlands et al, 1996, the Rotherham psychiatric court diversion scheme), occasionally with rather contradictory results in comparison to other studies.

- ***Offending in MDOs going through court schemes.*** Most of the individual empirical studies found in this part of the search presented data on the charge for which the defendant appeared in court, usually providing data on the most serious charge if there was more than one. Despite the different patterns of offending behaviour that emerged from the studies considered, there is consensus over the fact that most defendants have previous convications, ranging from half to two thirds (Joseph, 1990; Exworthy and Parrott, 1993; Rowlands et al, 1996). The most common offence types were public order, criminal damage, theft and deception. However, Hosty and Cope (1996) reported a much higher level of sexual offences than other studies, again raising the problem of comparisons between samples (out-patient referrals to a Regional Forensic Service for psychiatric court reports). The increasing nature of serious offences presenting to psychiatric court liaison schemes has been a cause of some concern in the latter half of the 1990s (Exworthy and Parrott, 1993 and 1997) and it is through that schemes will increasingly fail to cater for the less serious offenders who have mental health problems. The extent to which violent offending featured in the samples varied quite dramatically, from around a fifth to two thirds, with some figures including both violence against the person and violence against property (Joseph and Potter, 1993; Exworthy and Parrott, 1993; Rowlands et al, 1996;). It is clear that violent offenders are more likely to proceed to court appearance than be diverted at the point of police arrest (Robertson et al, 1995; Guite and Field, 1997). There appears to be a growing awareness of the urgent need to conduct psychiatric assessments at court rather than to wait for assessments to be carried out in prison. The concern about an increase in violent and other serious offending in cases referred for psychiatric assessment may result from better detection of appropriate cases for referral or increased awareness of the function and role of court liaison schemes - rather than reflecting an increase in serious offending *per se*. However, this raises concerns about what has happened to the less serious offenders who featured in referrals to schemes in the early 1990s. Have they fallen outside the remit of the court-based liaison schemes, and if so, who is catering for them? Although it seems at a first glance that there is quite a considerable body of research in this area, there are still unanswered questions.

- ***Demographic characteristics of MDOs going though court schemes:*** As we have found with other sections of this chapter, , comprehensive demographic data was seldom provided and comparisons rarely made with non mentally disordered defendants seen before the courts.

Age: where data on age were provided it was typically the mean age and age range. Although most of the studies included men and women, data on age were rarely presented for the sexes separately. Studies with data on this topic include Nicholls and Shaney, 1997; Joseph 1990; Cooke, 1991.

Gender: As one might expect, men were very overrepresented in these court-based schemes and studies, often comprising over 80 per cent (Hosty and Cope, 1996; Brabbins and Travers, 1994) but some noted greater numbers of women than expected - Joseph and Potter (1993) found that women were over-represented in their study sample compared with the sex distribution of medical remands in custody.

Ethnicity: As before, information on ethnic group and place of birth in these studies was sparse. The studies usually report around two thirds of the sample as Caucasian, with a fifth to a quarter being African-Caribbean, and the remainder a mixture of other races and mixed-race (Joseph, 1990; Joseph and Potter, 1993). Sometimes the estimates of the proportion that is white can be higher (Brabbins and Travers, 1994; Hosty and Cope, 1996).

Marital, status, living arrangements and employment circumstances: information on marital status was almost completely absent from the studies. Where data existed, defendants often reported being single or not in stable relationships and socially isolated, but this was by no means the picture that emerged across all the studies. The studies conducted by Joseph (1990) and Joseph and Potter (1993) have noted that defendants passing through the magistrates court in which the scheme was based were more likely to be isolated and socially vulnerable because of the catchment area served by the court. This will not have been a feature of all schemes. The availability of other services in the area will also affect the proportions of certain groups (eg homeless) coming into contact with the local court liaison scheme.

Studies of characteristics of MDOs in contact with the police

This is a major area of the literature, and we cannot do it justice here. In general, these types of studies have relied on trawls of police custody records in different stations over specified periods. Such evidence may be indicative of the scale of police encounters with mentally distressed people, but an obvious limitation is that the definition of mental distress or disorder is often rather loose, and often does not have a time dimension but concentrates only on the current period of contact. Studies that concentrate on a specific episode of detention fail to identify an important group of people with a history of mental health problems but who may not present symptoms during the current episode of detention. Despite this however, these studies provide a wealth of information on the problems of the recognition, response and management of mentally disordered people across a vast spectrum of disturbance, and offending behaviour.

Levels of mental disorder in police contacts: Estimates of the general level of mental health problems found in people in contact with the police vary, the highest being about 7 per cent, other estimates exist at around two-three per cent (Robertson et al, 1995; Berkeley 1995), or lower at about 1 per cent (Brown et al, 1992; Revolving Doors Agency, 1993; 1994;Keyes et al, 1995). The consensus seems to be that the police are fairly adept at identifying the most obvious signs and symptoms of mental illness (Robertson et al 1995).

- ***Types of mental disorders of MDOs in contact with the police***: A major positive feature of the literature in this area is a review by Fahy (1989) of the literature on police as a referring agent for psychiatric admissions. The pattern of disorders found in police contacts generally includes high levels of psychosis with estimates varying between approximately a quarter and a half of detainees with this type of disorder (Dunn and Fahy, 1990; Mokhtar and Hogbin, 1993; Hudson et al, 1995, Spence and McPhillips, 1995). There is some evidence that psychosis is particularly common in the ethnic minority detainees (Dunn and Fahy, 1990). Fahy concluded that only a small minority of referrals for assessment and/or admission to psychiatric care were deemed by others not to have a psychiatric disorder - indicating the appropriateness of police referrals (Rogers and Faulkner, 1987; Fahy, 1989; Mokhtar and Hogbin, 1993; Hudson et al, 1995). Repeat attendance at police stations appears to be related to particular psychiatric disorders such as personality disorder (Spence and McPhillips, 1995) - the authors commented that this is a particularly problematic group who are not well catered for.

- ***Demographic characteristics of MDOs in contact with the police***

Age: data on age varied across studies, but in general, it appeared that police admissions were in their thirties or forties, although black male admissions were younger. Dunn and Fahy (1990) found that Afro-Caribbean male police admissions to psychiatric hospital were significantly younger, on average, (27 years) than their white counterparts (men 35 years, women 36 years), and black female admissions (32 years). The section 136 cohort studied by Mokhtar and Hogbin (1993) were older (42 years), but there was no age difference between this group and the civil admission group. 55 per cent of individuals assessed under section 136 in the study conducted by Spence and McPhillips (1995) were under 40 years. Hudson et al (1995) noted that the age profile of referrals to the CPN police liaison scheme was not unlike the offender population in general. Overall, less than two-thirds of referrals were aged between 20 and 35 years. Comparisons by the Revolving Doors Agency (Keyes et al, 1995) of the mental health cohort with a random comparative sample (7,500 cases) of general police detainees showed mental health cases to be marginally older, on average, (33 years) than general detainees (30 years).

Gender: not surprisingly, men predominated in the general police detainee populations, in mental health cohorts at police stations and in subsequent police admissions to psychiatric facilities (Robertson et al, 1995, 84 per cent male, Hudson et al, 1995, 82 per cent male). However, an exception was the study by Mokhtar and Hogbin (1993) where the male/female ratio in section 136 referred admissions and civil admissions groups was similar. Using a random comparison group of general police detainees, the

Revolving Doors Agency (Keyes et al, 1995) found 74 per cent of male mental health cases compared with 85 per cent men in the general detainee comparison sample. Women were over represented in relation to the use of section 136 (Revolving Doors, 1994; Keyes et al, 1995).

Ethnicity: issues relating to the differential treatment of ethnic minority groups by the police and within the CJS in general have been considered over and again in the literature (Mc Govern and Cope, 1987; Rogers and Falkner, 1987; Dunn and Fahy, 1990; Walker, 1988; Brown et al, 1992; Banerjee et al, 1995 (some of these references have been taken from Dunn and Fahy, 1990). Our review illustrates that there is still a cause for concern about the persistent over representation of black people with mental health problems in contact with the police. Dunn and Fahy (1990) found that although the Afro-Caribbean and African population accounted for 15 per cent of the hospital catchment area in the study, 33 per cent of section 136 admissions were black. However, this finding could in part be explained by differences in diagnoses between the groups. Hudson et al (1995) found that black minority groups accounted for 21 per cent of referrals to the police liaison scheme and comparisons with the general population showed a marked over representation of these groups in referrals. Comparisons as above by the Revolving Doors Agency (Keyes et al, 1995) showed a marginally higher proportion of non-white mental health cases (28 per cent) compared with the proportion of non-white in general detainee random comparative sample (23 per cent).

Living arrangements and employment circumstances: Fahy (1989) commented that police referrals were frequently of socially disorganised, disadvantaged and unsupported individuals - a group typically difficult to treat effectively. Studies reviewed by Fahy (1989) showed that although individuals who came into contact with the police were often both chronically ill and in need of long-term provision, they were also reluctant care recipients, as fewer were registered with a GP, were less likely to attend an out-patient departments and often exhibited high rates of absconding and self-discharge. (Sims and Symonds, 1975 – cited in Fahy, 1989; Szmuckler et al, 1981 - cited in Mokhtar and Hogbin, 1993.)

Social isolation and disadvantage were also common themes emerging from the literature we reviewed. In the Paddington police study (Revolving Doors Agency, 1994), only half of the detainees with mental health problems gave permanent addresses, with most of the remainder in temporary accommodation, sleeping out, or in hostel accommodation. In their most recent study Revolving Doors Agency (Keyes et al, 1995) show a similar picture, as around half of the mental health cohort gave details of a permanent address, most people with local addresses were already known to health and social care service providers.. Fewer than a quarter were formally employed. Mokhtar and Hogbin (1993) found similar trends on socio-demographic variables between the two groups in their study but noted that although both groups were disadvantaged, this was particularly so with the section 136 group. Such patients were more likely to be of no stable abode, living alone, have more criminal convictions and under-utilize community services compared with the civil admission cohort. Hudson et al (1995) also noted high rates of social instability in relation to housing and employment. Less than half of the referrals to the CPN police liaison

scheme had a permanent address, over a third had no fixed abode with the remainder in some form of temporary accommodation and only 13 per cent were employed. Around three-quarters of black and white police referred admissions were unemployed (Dunn and Fahy, 1990).

- ***Types of offences recorded/committed by MDOs in contact with the police:*** According to Fahy (1989), literature reviewed suggested that violent offences are the basis of police contact in only a significant minority of cases. 14 to 26 per cent of police admissions were precipitated by violent or threatening behaviour (Sims and Symonds, 1975; Kent, 1972 - cited in Fahy, 1989). In a comparison with non-police referred formal admissions Kelleher and Copeland (1972 - cited in Fahy, 1989) found that police admissions were more likely to have committed a violent act leading directly to referral. However, none of these patients had committed serious acts of violence and none of the offences committed resulted in charges.

In our review of the literature the studies supported the view that alleged offences by people with mental health problems were typically of a less serious nature. The Revolving Doors Agency (1993, 1994) noted that the mentally disturbed individuals were often arrested for drunk and disorderly behaviour, public order offences, and less frequently, for criminal damage or assault. In another study by the Revolving Doors Agency (Keyes et al, 1995) the authors classified all the cases within the mental health cohort by the nature and history of their offending behaviour. For the purposes of analysis, serious offences broadly included those involving violence to the person, arson or sexual assault. All other offences committed were categorised as 'minor offences'. Overall, two thirds of the cohort were one-off minor offenders or had a record of committing minor offences (three or more offences), some of whom had been charged or convicted in the past for offences of this nature. A sixth of cases were people who had never committed an offence and past arrests were under section 136 of the Mental Health Act, 1983. As few as a fifth of cases committed offences of a serious nature, half of whom had no evident criminal history of offending, but their recent arrest had resulted from a serious offence. Important gender differences emerged, as women were three times more likely to have a history of section 136 than men, and although a higher proportion of women than men were one-off serious offenders, men were almost twice as likely to have a record of serious offending and a record of minor offending. The data also indicated that black people were over represented in the serious offending categories. 22 per cent of the mental health cohort were black but 28 per cent of them had a history of one-off serious offending and 27 per cent had a record of serious offending. Although details of offences do not arise in the study by Dunn and Fahy (1990), triggers for admission referrals by the police show that violent presentations were more common among black and white men. Suicidal behaviours were more common among white people of both sexes, and non-violent presentation more common among black and white women. Spence and McPhillips (1995) show that behaviours causing the police to detain those assessed under section 136 of the MHA were overwhelmingly bizarre, over a quarter threatened self-harm while fewer than 5 per cent had attacked others. Robertson (1995) found different patterns across different diagnostic categories. When compared with all police custody detainees (2,721), Robertson et al (1995) found that the acutely mentally ill (37

detainees) were more likely to have been arrested for Breach of the Peace or Public Order Act Offences. Over a fifth were arrested for violent offences, half of which were offences related to criminal damage. In comparison with defendants regarded as suffering from a major mental illness by court-based liaison psychiatrists, the authors found a fifth of the court-based cohort were arrested for public order or other non-notifiable offences and over half for violent offending. This supports the findings of previous studies showing that more serious offenders are often processed through the CJS. Hudson et al (1995) noted that the most common category of alleged offences for the detainees referred to the CPN liaison service were acquisitive. While around half of all referrals involved violence of some kind, in the initial offence or in the arresting officers' notes, this was attributed mostly to verbal threats of violence.

MDOs in the hospital population

While many studies have detailed the populations of the special hospitals, medium and low secure units, and despite the vast amount of literature on patients in some form of secure care, the task of describing mentally disordered offenders, in the broadest sense, within the hospital or health care system, is still relatively problematic. For instance, little is known about mentally disordered offenders in other parts of the NHS (in general psychiatric units, or in emergency admission wards), or those cared for in secure and non-secure settings within the independent sector. This is partly because of confusions between systems. For instance, Cripps et al (1995) point out that it is not uncommon for a patient to be a community catchment area admission on one occasion and a mentally disordered offender on the next. They argue that what might be seen as two distinct patient groups, i.e. intensive care cases and mentally disordered offenders, might on further examination, be quite similar. For instance, half of the civil admissions under Part II of the MHA to the unit in question had a criminal record, and many of the patients admitted under criminal sections were well known to local psychiatric services. Thus it is important to remember that data on the legal status of patients in hospital settings often masks true rates of underlying offending behaviour, and gives no indication of offending or criminal history.

Studies of the Special Hospitals

The clearest description of MDOs in the Special Hospitals that we have come across are the chapters in Kaye and Franey (1998), particularly Orr (1998) and Taylor (1998). Taylor delivered a particularly succinct description based on various empirical studies including her own (her citations omitted):

> "About two thirds of the men and half of the women have schizophrenia; about one quarter of the men and one third of the women have a severe personality disorder, within the legal classification of psychopathic disorder; and most of the remaining small group have a behaviour disorder in conjunction with mental retardation or severe retardation. Two thirds of the men and 80 per cent of the women have a history of childhood loss of a parent or similar disruption; preliminary figures suggest up to 80 per cent of the women and just over 50 per cent of the men have suffered *prolonged* physical abuse, sexual abuse or both. Over 90 per cent of the 1500 or so men and 75 per cent of the 300 or so women resident in any one year have been convicted of a grave criminal offence, about two thirds homicide or other serious personal violence, 15-20 per cent arson or fire-setting and around 10

per cent of the men explicit sexual offenders; among the technical non-offenders a similar range of behaviours short of homicide had triggered admission. All are compulsorily detained. The average length of stay for men with a mental illness or personality disorder is about 7.5 years, for the women around 10 years, and longer for people with one of the mental retardations". (Taylor, 1998, p138).

Studies of Medium Secure Units (Interim and Regional Secure Units)

Numerous studies of medium secure units have been undertaken over the last twenty years. It was generally expected that such units would act as a key resource for Special and general hospitals and for prisons, by relieving general services of chronic difficult to manage patients and prisons of mentally disturbed individuals. Although the studies discussed look mainly at admissions or referrals to medium secure units, one study by Mendelson (1991, 1992) looks at referrals to a regional forensic service, of which only a proportion will have requested an admission assessment. It also provides some insight into the pattern of work and the nature of referrals to such services.

- ***Patterns of disorder in MDOs in medium security*:** The majority of the studies we came across were retrospective case-note studies, and thus entail a number of limitations. For instance, data collection relies on the quality of the information already in the case-notes so that inaccurate and incomplete information can be problematic. Even where psychiatric diagnoses have been recorded many studies fail to specify the use of a standardised classification system for assigning diagnoses, such as the ICD-10, DSM-III-R or other classification criteria. Consequently, only studies that have mentioned some form of standardised classification system are discussed in relation to psychiatric disorder. The most comprehensive picture of patients and provision in RSUs and interim secure units was provided by Murray (1996) in a recent national point prevalence survey of all patients in the NHS medium secure system. At the time of the survey, three quarters of the patients were diagnosed as suffering from psychotic illnesses, mostly schizophrenia, 12 per cent suffered from neurotic disorders or other forms of mental illness. Fewer than 9 per cent had a psychopathic or antisocial personality disorder and around 1 per cent had a primary diagnosis of mental impairment. Data on psychiatric disorder differed according to the source of admission. For instance, psychopathic disorder represented only 6 per cent of remand admissions but 23 per cent of Special Hospital transfers. Others have also found high levels of schizophrenia (eg, Offen and Taylor, 1995; Gudjonsson and MacKeith, 1983), but some have reported higher levels of personality disorder (Offen and Taylor, 1985), although in this study this was rarely a primary disorder and there was some reservation about reasons for assigning the diagnosis.

In a study of female admissions to an RSU over a six-year period, Smith et al (1991) found that the typical female admission was a young personality disordered woman with a long history of deliberate self-harm and alcohol abuse. In contrast, psychosis was the predominant diagnosis in male admissions. Over half of men and a third of women suffered from schizophrenia, a statistically significant difference. Although, not significant, men (14 per cent) were more likely to have an affective disorder than women (9 per cent). 40 per cent of women and 30 per cent of

men suffered from a personality disorder, attributed to the likelihood that personality disordered men remained in the penal system. The behavioural history of men and women was also compared indicating that women were more likely to have a history of alcohol abuse, and showed a highly significant excess of all forms of self-harm compared with men.

- ***Legal category and status of MDOs in medium secure units*:** Into what legal categories do the majority of the in-patients in medium secure units fall? Not surprisingly, the majority are mentally ill patients, mostly detained under sections of the MHA 1983 (eg, Murray, 1996). Treatment orders with restrictions on discharge (section 37/41, section 47/49 and Criminal Procedure (Insanity) and Unfitness to Plead Act), combined to form the largest group at the census date (47.9 per cent, Murray, 1996). Assessment and urgent treatment orders pending a final court outcome (ss. 35, 36, 38 or 48/49) formed one of the smallest groups by comparison (12.6 per cent). Hospital orders without restrictions accounted for 17.3 per cent of patient while admissions. Overall, 77.8 per cent of patients were detained under Part III sections of the MHA, 13.7 under Part II sections, with the remainder under non-MHA orders (bail with a condition of residence, probation with a condition of inpatient treatment and governor's order) and informal admissions (those not bound by any form of legislative detention or supervision at the time of their admission). Other studies of individual units also reflected the predominance of mentally ill patients, and Part III MHA orders, reflecting the high proportion of patients coming through courts, prisons and Special Hospitals, with the balance often in favour of control and confinement through the use of restriction orders (Kennedy et al, 1995; Higgo and Shetty, 1992; Bullard and Bond, 1988).

- ***Types of offence recorded or committed by MDOs in medium secure units*:** Serious and violent offending feature strongly in patients cared for at this level of security, particularly patients coming from a remand environment (Murray, 1996; Kennedy et al, 1995). Relatively few patients are categorised as non-offenders and different patterns are noted for different ethnic groups and for both sexes. The severity of offences can be notable. Murray reported that 56 per cent of all current patients had committed homicide or another major offence such as serious assault, rape or arson. Smith et al (1991) noted that female admissions to the unit differed from male admissions in that they comprised mainly difficult to manage patients, who repeatedly committed acts of self-harm and destructive property offences such as arson. Men had a stronger history of violence, acquisitive property offences and sexual offending, while women had a stronger history of arson. These findings were mirrored in a study of sexual differences in referrals to a forensic psychiatric service by Mendelson (1991, 1992). Females were less likely to have and index offence and typically presented problem behaviour rather than offending behaviour at referral. Apart from arson, they were less likely than men to have a history of dangerous behaviour. In comparing ethnic differences on admission to a RSU, Cope and Ndegwa (1990) found no significant differences in relation to individual index offences. However, white admissions were less likely than Afro-Caribbeans to have a recorded index offence (74 per cent compared with 91 per cent) or a criminal history (75 per cent compared with 98 per cent).

- ***Personal and demographic details*:** Once again, studies provided little or no information on basic demographic details with only a handful providing comprehensive details.

Age: The NHS medium secure units seem to cater largely for patients in their thirties (Murray, 1996; Higgo and Shetty, 1992; Smith et al, 1991; Bullard and Bond, 1988; Gudjonsson and Mackeith, 1983). A study of ethnic differences in admission to an RSU by Cope and Ndegwa (1990) showed some interesting age differences. White and Afro-Caribbean men had a similar mean age (33 years and 32 years), but a highly significant age difference was found between British born (mean age 26 years) and migrant Afro-Caribbeans (38 years). The remaining studies consistently found admissions in their early to mid thirties, on average (Bullard and Bond, 1988; Gudjonsson and Mackeith, 1983).

Gender: only one study conducted by Smith et al (1991) has looked specifically at women admitted to medium secure units. Although other study samples often include women, differences in characteristics are seldom examined by gender, and the issue of gender differences is rarely explored. This may in part result from the fact that the numbers of women in medium secure provision in general, and in individual units in particular, are small compared with men. Smith et al (1991) noted that although women in psychiatric hospitals outnumber men, the picture is rather different in medium secure units, and special hospitals. They add that the purpose and function of RSUs may explain why male admissions predominate. The 3:1 ratio of men to women found by Smith (1995) was lower than other studies (Cope and Ndegwa, 1990; Murray, 1996). Other studies in this area include Kennedy et al (1995).

Ethnic group: Although there are a growing number of studies on medium secure units, relatively few have concentrated specifically on the issue of ethnicity and have often failed to give basic details of the ethnic composition of the samples studies. Given the long-rehearsed concerns of the over-representation of some ethnic groups suffering from psychiatric disorders; their over-representation in the CJS and at all levels of secure care, this omission is particularly lacking. In the most comprehensive study of NHS medium secure care, Murray (1996) found evidence to support the view that Afro-Caribbean patients were over-represented in this area of secure provision. In addition, Asian first admissions (6 per cent) did not reflect the regional Asian population (10.4 per cent in 1991). Kennedy et al (1995) found that there were no differences in terms of ethnicity between the long-stay and non-long-stay group, but ethnic differences within groups were not considered. In a study of ethnic differences in admission to a RSU Cope and Ndegwa (1990) also found Afro-Caribbeans over-represented in admissions to the unit. Although the overall population of the West Midlands Region was only 4 per cent, the authors found that 38.3 per cent of admissions to the unit were Afro-Caribbeans. The data also suggested that Afro-Caribbean men were more likely to be over-represented in admissions than Afro-Caribbean women. For instance, 42 of the 103 male admissions were Afro-Caribbean (41 per cent) compared with 2 of the 12 female admissions (17 per cent).

Marital status, living arrangements and employment status circumstances: few studies provided information on marital status. Kennedy et al (1995) found no significant differences in marital status between long-stay and the comparison group of patients. Over half the long-stay and less than half the comparison group were single at admission. Around a third of both groups were separated or divorced. A relatively low proportion of both long-stay patients (a sixth) and non-long-stay (a fifth) were married or cohabiting at the time of admission.

Kaul (1994) observed that admissions to the secure unit were predominately young, single males from broken homes with poor educational backgrounds and predominantly unemployed. Kennedy et al (1995) found that all the long-stay and most comparison group patients were unemployed (31) at the time of admission or the time of arrest. However, long-stay patients were significantly more likely to be in temporary accommodation or have no fixed abode than the non-long-stay group. Cope and Ndegwa (1990) found little difference in marital and employment status between Afro-Caribbean and white admission with many white and Afro-Caribbeans single or divorced and all but three of the total number of admissions were unemployed. However, there was a significant difference in living circumstances, with 70.7 per cent of Afro-Caribbeans living alone at admission compared with only 40.4 per cent of white admissions. Mendelson (1991, 1992) noted a fair degree of social stability in relation to living arrangements, as only one case referred did not have a fixed address, and half were living with a partner or family. However, women were significantly more likely to experience social stability than men.

Characteristics of MDOs in minimum or low secure units

A particular challenge in meeting the needs of mentally disordered offenders is to ensure that patients are treated in an appropriate environment, balancing the elements of care and confinement in a manner which is responsive to an individual's changing needs. As we saw in the previous chapter on provision, the recognition of low secure care as a specific form of provision has been a relatively recent development. The difficult task of bridging the gap between the ordinary locked ward and regional secure care has been the subject of much debate and discussion (Gallwey, 1990; Hayes and Soliman, (1991); Mendelson, 1992; McClintock and Evans, 1995; Cripps et al, 1995; Weaver et al, 1997).

It would seem that one of the difficulties in outlining the characteristics of patients catered for in low secure care is the inherent lack of clarity in relation to what constitutes this type of provision. For instance, in a recent UK-wide survey of psychiatric intensive care facilities, Beer et al (1997) suggested that amongst the 110 units identified nationally, there were as many differences as there were similarities. The terminology describing the units varied, including: extra care wards, intensive care, high dependency, psychiatric intensive care, locked wards, close supervision units and low secure care units. Adopting one term such as locked ward would be inaccurate, as one in five units identified only locked their doors when necessary. On the other hand, one in ten of the units were built to medium secure specifications or above. 43 per cent of the units accepted detained patients only, while the remainder also accepted informal patients. Units generally accept patients from a number of sources such as, prisons,

courts, police, Special Hospitals, RSUs and general psychiatry. Even the terminology used to describe patients has caused confusion, particularly in relation to changing needs, such as the progression from acute to chronic disturbance, and the point at which a patient might be classed as 'forensic'. In a study of one health region by Cohen and Eastman (1997), they noted a remarkable diversity across the 10 close supervision units. Indeed, the units were so different from each other that applying a single label to them was thought to be misleading.

So, we cannot be very definite about the characteristics of patients in these kinds of settings. Some trends can be identified, but again a good review is necessary in this area.

- ***Psychiatric disorder*:** Not surprisingly, schizophrenia was the most common diagnosis identified in the studies reviewed (eg, Cripps et al, 1995; Cohen and Eastman, 1997; McClintock and Evans, 1995, Mitchell, 1992; Hayes and Soliman, 1991). However, affective disorder tended to be more common in this population than in other populations discussed above (apart from the general population). Although the pattern varied across studies, personality disorder and substance misuse were more or less the most prevalent disorders, and also featured significantly as concurrent disorders. Multiple diagnoses are indicative of the severity of psychiatric disorder but also point to problems of effective treatment and management.

- ***Legal classification and category*:** The studies show that criminal section admissions differed greatly across units, reaching up to a maximum of around a third of the admissions (Cripps et al, 1995 - one third; Hayes and Soliman, 1991 - one third; Cohen and Eastman, 1997 - one fifth, McClintock and Evans, 1995 - 4/39). In Cohen and Eastman's (1997) study of 105 patients occupying beds on the study census date the overwhelming majority of patients were defined as mentally ill, and the remainder had a personality disorder. Hayes and Soliman (1991) observed that the patients catered for in their facility were similar to patients cared for in medium security. James et al (1990) found a significant difference in legal status on admission between the violent and non-violent patients admitted to the high dependency unit. Violent patients were significantly more likely to have been admitted compulsorily but it was not clear whether patients were primarily detained under civil or criminal sections of the MHA.

- ***Types of offences recorded or committed*:** Cohen and Eastman (1997) did not give details of offending or criminal behaviour but presented data on violent and non-violent anti-social behaviour prior to admission. Overall, more than half of the patients had been involved in some form of anti-social behaviour immediately prior to admission, most of whom reported involvement in violent or dangerous behaviour. Cripps et al (1995) provided details of the index offence for patients admitted to the unit under criminal sections of the MHA. The most common index offences were assault (35 per cent), acquisitive (24 per cent) and arson (13 per cent). However, other serious offences including homicide, rape and stabbing were also included in the list of offences. Cripps noted that the two groups of patients catered for on the unit were not mutually exclusive, particularly in relation to offending behaviour. For

instance, half of the patients admitted to the unit on civil orders, and thus classed as 'non-forensic' had criminal records arising from previous offending behaviour. Furthermore, many of the patients admitted under civil sections were well known to the local psychiatric services. Data on offending was not provided by Mitchell (1992) in his survey of intensive psychiatric care units in Scotland but admission source data confirmed that a fifth of residents surveyed had come through the police or the courts. The younger patients were noted to have repeated brushes with the police. The authors concluded that younger patients surveyed were comparable to those described in US studies (Bachrach, 1992) with treatment resistant schizophrenia, who manifest impulsive and self-destructive behaviours, frequently fall foul of the law, are highly mobile and participate poorly in prolonged in-patient and out-patient treatment.

- ***Personal and demographic details***

Age: The mean age of admissions in the McClintock and Evans (1995) study was 41 years, ranging from 18-68 years. Other studies noted a lower mean age, usually of patients in their thirties. In the study by Cripps et al (1995) the average age on admission was 33 years, similar for both sexes, with an age range between 17-72 years. Hayes and Soliman (1991) noted that the mean age of admissions was 34.5 years. James et al (1990) found a significant difference in the age of violent and non-violent admissions. The violent group were more likely to be under 25 years ($X2 = 7.32$, $df = 1$, $p = 0.0068$). Mitchell (1992) that although intensive psychiatric care beds in Scotland were equally occupied by patients under and over 30 years, there was a trend towards increasing occupancy by the younger age group. This group were difficult to manage because of their tenacious treatment resistance coupled with their tendency to abscond, and have repeated brushes with the law, before readmission to intensive psychiatric care.

Gender: Low secure facilities tend to exhibit lower male to female ratios, moving more in the direction of those seen in general psychiatric provision, The lowest male to female ratio (1.6:1) was noted by Mitchell (1992) who conducted a survey of residents in 13 units across Scotland. Higher ratios of men to women could be expected in 'hybrid' facilities that cater more for forensic patients. Cohen and Eastman (1997) noted a low male to female ratio of just 2:1 on the census date of the study. No data comparisons were made by gender. McClintock and Evans found a higher male to female ratio of 3:1. In a study of admissions to a special care unit over a three-year period, O'Grady found a roughly similar male to female ratio of 2.7:1. James et al (1990) found an equal distribution of male and female admissions to the high dependency unit and an equal distribution of both sexes in the violent and non-violent patient groups. Despite the wide range of violent activity recorded (including violence against staff, violence against other patients, incidents of self harm and violence against property), the study did not examine or discuss the types of violent incidents attributed to men and women, or whether there were discernible patterns of violent activity amongst the sexes. Cripps et al (1995) noted the highest male to female ratio of under 5:1 which could result from the relatively high proportion of referrals from prisons and courts (35 per cent).

Ethnic group: James et al (1990) noted that there were no significant differences in relation to ethnicity across the violent and non-violent groups studied. Nonetheless, data suggested that Afro-Caribbean patients were probably over-represented in both groups (30 per cent of the violent group and 21 per cent of the non-violent group were Afro-Caribbean). Cripps et al (1995) found that Afro-Caribbeans were also over represented in admissions under civil (37 per cent) and criminal sections (23 per cent), but this was particularly marked in cases of civil admission to the unit. Data on marital status, living circumstances and employment circumstances were almost absent and are not worth reporting here.

Conclusions

Despite some large-scale surveys in recent years, there is still a clear need for a series of reviews bringing together the studies and themes raised in this chapter. While some coherence has been reported (for example in the general prevalence of psychosis in higher levels of security) there is a great deal of contradictory evidence. It is most likely that this is caused by differences in study designs and samples. There is also a great need for a broader overview, looking at the differences between different levels of security as well as between MDOs and others within any one level. There is little sense in the literature of the bigger picture. Finally, the relationship between being in different types of setting and the ebb and flow of mental disorder needs to be established or at least tracked so that differences between those in different types of care can be better understood.

Summary Box: Description of population of mentally disordered offenders

- Referring back to Figure 8.1 this review found that the most significant gaps in the literature came towards the top of the diagram, rather than towards the bottom. That is, the biggest gap in the literature is in terms of patterns of overlap between offending and mental health in the general population.
- The results of this chapter concur with those of the Reading epidemiological review in showing that we know little about the illness characteristics of offenders or the offending patterns of people with illness.
- There is a lack of reviews as well as a lack or primary data in many of the areas covered, but the commissioning of the Reading epidemiological review will result in a considerable addition to the literature. We would suggest that a further review including a range of different types of descriptive data (including qualitative) would be useful to compliment the Reading epidemiological approach.
- As the populations under study become more and more specific, there were better data, although there were then problems of comparing studies with each other.
- Many of the studies of characteristics of MDOs in different places within the system failed to address basic descriptive questions about the nature of the sample such as ethnicity and various demographic factors.

9 CAUSAL AND PREVENTATIVE STUDIES

Background

There is a vast body of work on predictors of mental health problems (eg, Cadoret et al, 1985; Robins and Rutter, 1990; Harrington 1993; Frombonne, 1995;) and also of antisocial behaviour (eg, Farrington 1995). The areas are regularly reviewed (for a recent review on antisocial behaviour see Rutter, Giller and Hagell, 1998). Many of the risk factors turn out to be similar. However, there is much less on predicting the interface or untangling the relationship between the conditions. This is obviously partly because of the rarity of the combination in the general population and the heterogeneity of mentally disordered offenders.

It is important in the first instance to clarify that antisocial behaviour and criminal offending cover a range of behaviours, many of which are not violent. The broader context for this is that offending is overwhelmingly committed by men and largely consists of theft-related behaviour. As we have already seen, much of the antisocial behaviour by people with mental health problems (at least among those who are not incarcerated) is petty and non-violent. However, the literature in this area (and the public interest) has mostly been on violence. The area is fraught with methodological difficulties, but it does seem that some of the risk factors for violent behaviour may turn out to be different from those for other types of antisocial behaviour. For example, a greater proportion of violent crimes is committed by males than acquisitive crime (Graham and Bowling, 1995; Home Office, 1996). There is some limited evidence that violent crime has a lower heritability component than acquisitive crime (Brennan et al, 1996; Bohman et al, 1982; Brennan and Mednick, 1994). On the other hand, with respect to many of the risk factors, it seems that violent crime is associated with higher levels of risk, rather than very different patterns of risk (Farrington, 1991; Lipsey and Derzon, 1998). So, we are left not really understanding the differences between violence and other types of antisocial behaviour, but some care should be taken in generalising from studies on different types of offending to all types of offending.

Causal pathways

There are a number of questions about causality that can be applied to the issue of the link between mental health and antisocial behaviour. Research is unlikely to address all or most of these questions, but instead will tend to concentrate on a small part of the story:

- What predicts the combination of mental disorder and crime?
- Does mental disorder itself cause crime? On its own or as part of a constellation of factors?
- Or does antisocial behaviour cause mental illness? On its own or as part of a constellation?
- Do they each contribute to the *perpetuation* of the other condition as well as (or instead of) the initiation of each other?
- What helps in promoting desistence?
- What is the role of treatment?

Given that these are causal questions, and that we are investigating conditions that vary with the developmental lifespan, it is clear that the most useful research will inevitably be longitudinal. There is now a considerable body of literature deriving from internationally known longitudinal studies, and the data are considerably richer now than they were a few decades ago. These studies include, for example, the British National Child Development Study, other UK studies (eg, the Cambridge Study of Delinquent Development), the New Zealand studies (Christchurch longitudinal study, the Dunedin Health and Development Study), the Scandinavian studies (ProjectMetropolitan), the American studies (National Youth Study), etc. The main problem with these projects is many of them are still not old enough to be clear about pathways beyond early adulthood. For example, in some of the Scandinavian work, a new group of adult onset women offenders is starting to emerge as the cohort develop into its 30s (Kratzer and Hodgins, 1996). In addition, there are several good but shorter-term projects yielding more specialised information, such as the McArthur Foundation risk assessment study (Monahan, 1996; Monahan and Steadman, 1994).

Groups of risk factors

Traditionally the risk factors for mental health problems and antisocial behaviour difficulties are grouped into three separate categories, although the distinctions between the categories can seem arbitrary and the categories interact. Researchers seeking to predict either of the main problems of interest have tended to concentrate on individual level factors, psychosocial factors and broader environmental factors. We look very briefly at each of these three types of risk:

Individual risk factors predicting mental health problems and offending

The individual risk factors for mental health problems tend to include parental psychopathology, early onset of other problems such as hyperactivity, occasionally IQ (although the findings are very equivocal), occasionally physical health (similarly equivocal). Mental health problems vary in terms of the importance of biological substrates - these are more likely to be important in forms of psychosis than in some forms of, for example, depression (eg, Rutter, Taylor and Hersov, 1994; Frombonne, 1995) Evidence for gender effects is seen in many illnesses and also, as we have seen, in MDO, but the nature of the relationship varies by disorder. For example, there are differences between males and females with schizophrenia (males earlier diagnosis, worse prognosis) (Werry and Taylor, 1995), and depression (eg, Bebbington, 1996).

Many of the same factors are implicated in offending (eg, Farrington, 1995). In a recent comprehensive review, Rutter et al (1998) listed the following factors with an established role in the development of antisocial behaviour: hyperactivity, cognitive impairment, especially verbal and planning skills, temperamental features such as impassivity and sensation seeking, and a distorted style of social information-processing. Conduct disorder is an early predictor of a wide range of poor adult outcomes (Robins and Rutter, 1990). Research on these areas is now well-developed, particularly from the longitudinal studies. The evidence is increasingly clear that biological substrates are implicated in most

of these individual factors, but that this does not imply any predetermination of outcome. Genetic research has become very central in psychiatry over recent years and causal models have been developed which allow for sophisticated relationships between nature and nurture (eg, Plomin, 1994; Plomin and Bergeman, 1991; Plomin et al, 1997).

Psychosocial risk factors predicting mental health problems and offending

Adverse psychosocial and family circumstances are implemented in a full range of mental health problems and offending. It is not yet entirely clear to what extent they *cause* disorder rather than *perpetuating or accentuating* existing problems. There is certainly evidence for a clear role for life events in the aetiology of depression, but in terms of conduct disorder, young people with problem behaviour seem to go on to have higher levels of life events, a reverse causal chain (Champion, Goodall and Rutter, 1995). The key psychosocial indicators for behavioural and mental health problems have included family backgrounds factors, family discord, abuse or neglect, and coercive parenting (Patterson 1982; Cicchetti and Carlson, 1989).

Environmental risk factors predicting mental health problems and offending

The relationship between various socioeconomic and community level factors and later adult outcome is less clear than the data on individual and psychosocial risk factors. This has been partly due to the methodological difficulties posed in doing research of this type. Poverty and social disadvantage indicate increased risks for almost all types of disorder, but many of the effects are seen to be indirect (Conger et al, 1992). Area differences have certainly been implicated in antisocial behaviour (eg, Clarke, 1985).

Ethnicity has posed a research challenge in all these areas (eg, Smith, 1997; Nazroo, 1998). Discussion of the role of ethnicity as a causal factor is always controversial, which has to some extent affected the quality of the debate. Generalising from different ethnic minority groups within or between countries is very dangerous, as there have been vast differences in the histories and experiences of different groups in different countries. It is clear that there is evidence of substantial bias in the processing of ethnic minorities through a variety of different services and systems (eg, Berthoud et al, 1998) but there is also evidence for differences in underlying rates of different disorders. These differences are then exaggerated by bias. The question remains as to what causes the differences in the first place. Factors could potentially include living conditions, unemployment, family risk factors, or other constellations.

The relationship between mental health problems and offending

There is little doubt that this relationship is not clearly understood (Prins, 1986, 1990; Peay, 1997). That there is a relationship was demonstrated to some extent in the epidemiological and descriptive work discussed in a previous chapter, but the evidence even that there is an association is not overwhelming. Hodgins and Cote (1993) concluded from a comparison of representative samples of prison inmates that there was no evidence to support the hypothesis that the MDO inmates had more convictions or more

convictions for violent crimes than non-disordered inmates. Certainly, looking at it another way, the vast majority of people with mental health problems do not offend, and similarly a large proportion of people with antisocial behaviour problems do not have mental health difficulties.

The bulk of the work in this area has concentrated on the role of mental illness in causing offending rather than the other way around, although it is possible to hypothesis that the stress of dealing with the criminal justice system may lead to certain disorders (eg depression). Past mental health has a long history as an indicator of adult adjustment (see, for example, Modestin and Ammann, 1995; Harrington et al, 1991). This research has particularly concentrated on predictions of violence (eg, Steadman and Cocozza, 1974; Quinsey, 1979; Soothhill et al, 1980, Steadman, 1983; Monahan and Steadman, 1994; Bowden, 1996).

There are a number of factors which seem to make it more likely that a mental health problem will lead to crime or violence. These are primarily (a) failure to take medication for a psychotic disorder (Monahan and Steadman, 1994, and a number of enquiries, eg NE Thames Regional Health Authority, 1994, Chrisopher Clunis report, section 14.2) , and (b) multiple diagnoses including substance abuse (Swanson, 1994; Steadman et al, 1998). The most persuasive models for predicting serious violence are those that indicate people with certain predispositions to act violently, in situations where conditions are unsupportive, in combination with the availability of potential victims.

Very little work has looked at the specific risk factors for the combination of the two problems.

Psychopathy

Peay (1997) points out that there is a tautology inherent in making an association between psychopathy and crime, as part of the legal definition of the former includes the latter. The legal definition is not necessarily the one that would be accepted by all working in the field, and Peay notes inconsistency in classification and identification. Hart et al (1994) provided a succinct description of the key characteristics of a psychopath as:

> "Grandiose, egocentric, manipulative, dominant, forceful and cold-hearted. Affectively, they display shallow and labile emotions, are unable to form long-lasting bonds to people, principles or goals, and are lacking in empathy, anxiety, and genuine guilt or remorse. Behaviourally, psychopaths are impulsive and sensation-seeking, and tend to violate social norms; the most obvious expressions of these predispositions involve criminality, substance abuse, and a failure to fulfill social obligations and responsibilities" (1994; p81).

In the Hart et al study, statistical analysis showed that controlling for other factors such as criminal history, psychopathy offered an independent effect on predicting violence in 231 male inmates released from prison. Those in the top third of the psychopathy ratings were almost four times more likely to commit a violent crime.

Conclusions

Epidemiological and descriptive research has gone some way to showing the extent of the overlap between different types of criminal behaviour and mental health problems, although as we have seen, that literature has certain gaps that would help to clarify the extent and detail of the association. The causal literature would seem to be fairly extensive in some areas of interest, but patchy in others. The particular focus has been on mental disorder and violence, and large, rigorous longitudinal studies are being conducted in this field which will become classics when they are completed. As part of those studies (eg, chapters in Monahan and Steadman, 1994), a series of useful brief reviews have recently been conducted on different aspects of the association. It would seem that it is far from axiomatic that violence and mental health should be linked, although some key risk indicators stand out.

However, in other areas, such as the link between disorders other than psychosis, and crime other than violence, the research is much more sketchy and further reviews would be useful. In terms of the literature on predictions of concurrence of disorder and crime, we found very little indeed.

Summary Box: Causal and preventative studies

- There is a vast body of work on predictors of mental health problems, regularly reviewed. Similarly the literature on predictors of antisocial behaviour is well reviewed.
- It is the interface that provides the problem. Much of the literature that does exist concentrates on violence, which as we have seen is neither the only nor the most prevalent offence committed by MDOs.
- Longitudinal research is the most relevant type of methodology to answer the causal questions that arise in this area, but longitudinal studies of MDOs do not exist.
- The research on three groups of risk factors predicting mental health problems and offending were briefly outlined: individual, psychosocial and environmental.
- Where there are empirical studies on the overlap between offending and mental disorder, it has been on illness leading to offending rather than the other way around (which is a possibility). No recent review and very little empirical work has looked directly at the specific risk factors for the combination of the two problems.

10 PATHWAYS INTO AND OUT OF CARE

In some ways, the evidence from the literature points to fairly predictable systems of care and confinement catering for particular groups and individuals, with different levels of need, at different points in time. For instance, locked wards and intensive care units tend to take patients from the community or open wards, the majority of whom are informal patients or detained on civil sections, while medium secure units and special hospitals cater more for people referred by the courts or from prison.

However, predictable does not mean simple. The pathways into, through and out of care are very complicated and it is a major challenge to draw together a clear overview. Presumably partly as a result of this complexity, very few studies have addressed the whole issue of pathways. Most take a small section (entry to the system through the courts, for example, or the role of diversion schemes). Most of the areas that form sub-sections in this chapter are whole research areas in their own right so a considerable element of distilling and sifting had to take place to arrive at this overview. The amount of work in this area is vast, but it is piecemeal and very variable in quality.

Some key questions will be addressed in this section such as:

- What are the different routes into care, and what are the consequences of taking different routes?
- Are trajectories gender specific, specific to different ethnic groups, diagnostic categories or types of offending behaviour?
- What factors control the passage of mentally disordered offenders into, through and out of care?

The first section, preceding the discussion of these issues, provides contextual data on changes and trends in the formal admission and detention of patients under various parts of the MHA, 1983.

Some recent trends and changes

- **Admissions under the MHA 1983 rose in the early 1990s and have leveled off recently:** A recent Department of Health statistical bulletin on in-patients formally detained in hospitals under the MHA, 1983 and other legislation for England (Department of Health, 1998) indicates that formal admissions to NHS facilities (including the secure hospitals) and private mental nursing homes increased steadily up to 1990 and peaked in 1994-95 to 25,600 before leveling off to 24,200 in 1996-97.

- **Most admissions are civil not criminal, and civil hospital admissions have risen:** Most admissions are under Part II of the act (civil), within which the biggest increases have been in Section 3

(admissions to hospital for treatment). Part III admissions accounted for only 11 per cent of all formal admissions in 1986 and less again (8 per cent) in 1996-97.

- **Recent gender changes in admissions:** Male admissions as a proportion of all formal admissions increased from 46 per cent in 1986, to 51 per cent in 1991-92, increasing again to 54 per cent in 1996-97 when male formal admissions outnumbered female admissions. This trend reflects the higher rate increase in Part II male admissions than female admissions. In contrast to Part II admissions, the ratio of male to female admissions under Part III of the MHA has always been male dominated, with men accounting for 87 per cent of all formal admissions arising from court or prison disposals in 1996-97.

- **Increase in Sections 135 and 136:** Apart from a fall off in both male and female place of safety detentions in 1993-94, there has been an increase in the numbers of male and female detentions under section 135 and section 136.

An overview of pathways

Figure 10.1 is taken from the Reed Report and summarises pathways into care.

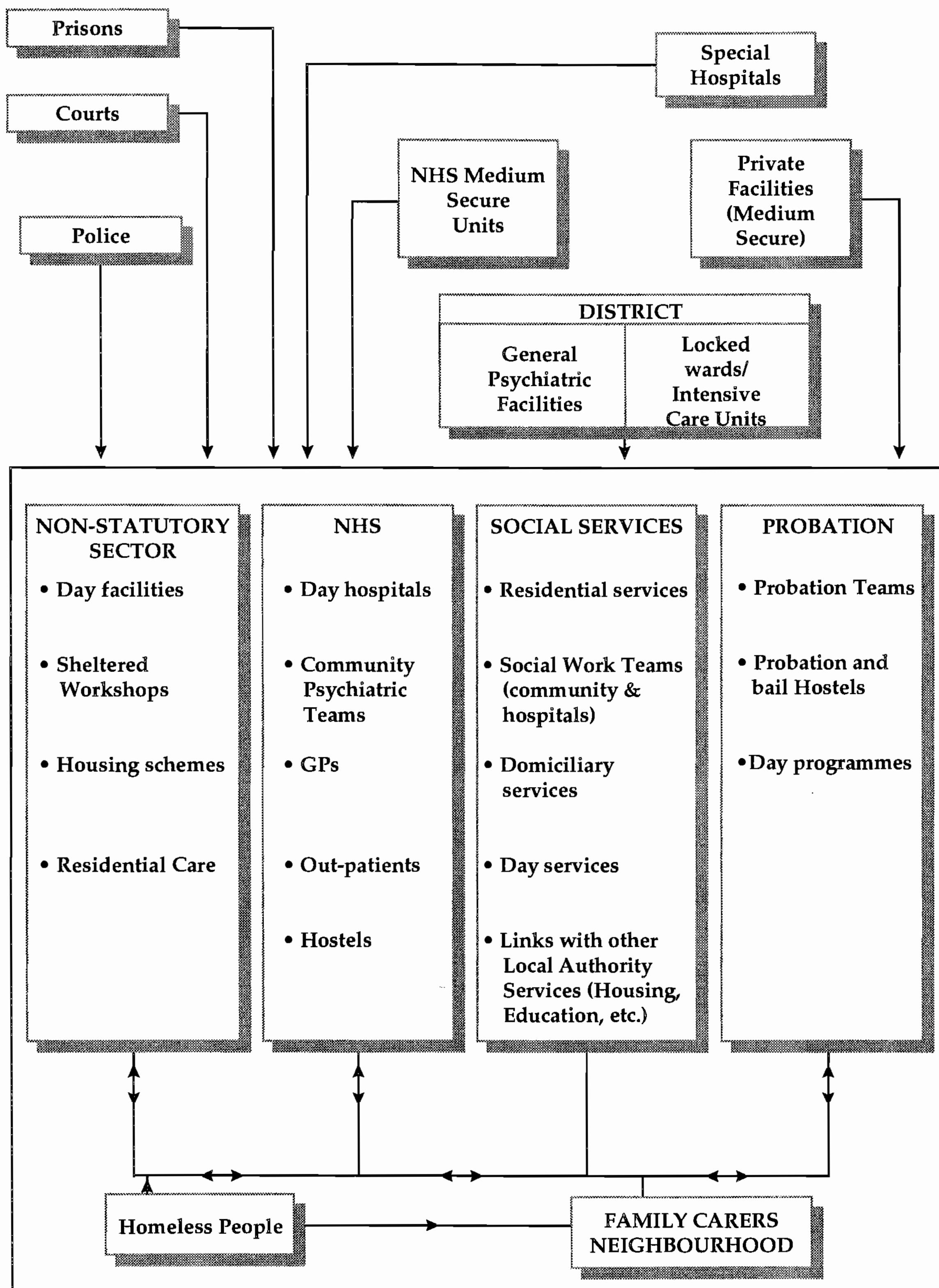
Entering care through the criminal justice system

The first point of contact for some people will be through the criminal justice system, usually through the police in the first instance, then on to the courts in the second if they are not diverted away by the police. In terms of formal admissions, this is not the most common pathway, as we have already seen - only 11 per cent of admissions under the MHA 1983 were criminal. However, contact with the police can take a number of forms and affects a great many people. Also, the routes in through the CJS may be very influential on how the patient is subsequently treated and there is a great deal of research in this area. In this section of the chapter, we look first at research on police interactions with MDOs, then at what happens when MDOs are processed through the CJS, and finally we discuss the factors affecting MDOs interactions with the CJS, such as gender and illness characteristics.

Police reactions to MDOs

The police are frequently in contact with people as a result of a concern for their mental health rather than in their sole capacity as law enforcers, and the conflicts this poses for them has been of considerable interest to criminologists over recent decades. Their gate-keeping function is a role that has been endorsed by the Home Office and the DoH (Home Office Circular 66/90; Reed Committee, 1992). The reason why their contact is so important is simple - accurate and timely detection of disorder, and implementation of swift service response, underpin the care and support system and the chance of making a difference to the lives of MDOs.

Figure 10.1: Varieties of contacts and care options for MDOs



As we saw in the chapter on epidemiology, only a small proportion of the people the police deal with are seen to have mental health problems (Brown et al, 1992; Revolving Doors Agency, 1993, 1994, Keyes et al, 1995). However, for many MDOs this is a familiar point of contact. The main two groups the police will deal with are those who are arrested for their offending behaviour and who are also thought to have a mental disorder, and those who may not have offended but show signs of disorder and need to be taken to a place of safety. What can the police do if they think someone has mental health problems? What happens next as a result of these actions? There is a considerable body of research on why the police have contact with MDOs in the first place (eg, the reasons for arrest), and what they do next (eg, proportions admitted to hospital or diverted). Much of the work in this area involve reviewing police custody records (eg, Keyes et al, 1995; Revolving Doors Agency, 1993, 1994, Keyes et al 1995; Berkeley 1995), and the largest study of this type that we came across involved examination of 30,034 custody records (Keyes et al, 1995). There are some methodological problems inherent in using custody records, because of the ways that mental health problems are defined and recorded, being rather clinically inexact, and custody records inevitably miss the ebb and flow of mental health problems (eg, Robertson et al, 1995 showed that a fifth of a mental health cohort were asymptomatic detainees with a history of psychotic illness). These types of reservations need to be borne in mind when evaluating the state of the research in this part of the field.

- ***Reasons for arrest in the first place*:** Cherrett (1996) noted that the most obvious group of mentally ill individuals arrested by the police are those detained under section 136, but in fact more are arrested on suspicion of committing a criminal offence and subsequently found to be mentally disordered in some way. It has been suggested that patients attract police attention as a result of a combination of bizarre behaviours, such as nudity, wandering in traffic or bizarre speech, if these occurred in combination with committing offences (Fahy, 1989). It is possible that the presence of mental disorder increases the chance of an arrest by about half (Teplin and Pruett, 1992). In a study of 1,691 detainees in one police area showed that approximately one per cent had mental health problems recorded, and in half of these cases Section 136 was used. This estimate of approximately half of those with mental health problems being processed with Section 136 is fairly widely supported (eg, Berkley, 1995). How well can the police detect disorder? The data are a little equivocal. Makhtar and Hogbin (1993) commented that earlier studies did not show that the police were any *less* effective at recognising disorder than general practitioners.

- ***Admissions to hospital*:** The police can admit people directly to hospital, either for security, treatment or assessment, and they can do this formally or informally (although the majority, perhaps as much as 90 per cent, are formal admissions). There is an enormous body of work in this area including comprehensive reviews (eg, Fahy, 1989). Strictly speaking, detainees under Section 136 should be seen by a doctor and an approved social worker (ASW), in order to make effective arrangements for treatment and care. Estimates of how many people arrested either under Section 136 or for a criminal offence, and who are then subsequently admitted to hospital, provide a variable picture of between a fifth and two

thirds (Rogers and Faulkner, 1987; Spence and McPhillips, 1995; Fahy et al, 1987; Dunn and Fahy, 1990; Mokhtar and Hogbin, 1993). Other sources suggest that up to 90 per cent of those detained under the section may need a hospital admission (Cherrett, 1996). A number of issues have arisen including regional differences in the rates of referral to hospital; the ratio of formal to informal referrals; the role of Section 136 as an agent of social control; ethnic variations.

- ***Characteristics of police-referred psychiatric patients:*** For those who *are* sent to hospital, is this the fairest outcome? For example, vulnerable individuals may be more likely to be referred to psychiatric care by the police. Police referred admissions are noted for their tendency to reject or opt out of treatment programmes, to self-discharge or abscond from care, and fail to maintain contact with psychiatric and other community support services thus increasing the likelihood of repeated contact with the police (Fahy, 1989; Mokhtar and Hogbin, 1993). Certainly there are some common demographic and clinical characteristics of those referred by the police, including that they have high rates of psychosis and often have previous histories. Psychosis is common, the most usual presenting disorders being schizophrenia and major depression. Probably as a result of the high illness threshold operated by the police, police referrals often require emergency treatment. Also potentially as a result of high thresholds, Section 136 admissions are often socially disordered and unsupported, and are more likely to have committed a violent act leading directly to referral. Studies in this whole area include Rogers and Faulkner, 1987; Fahy, 1989; Mokhtar and Hogbin, 1993; Keyes et al, 1995; Robertson et al, 1995. However, there is also some evidence that the despite having a fairly high threshold for hospital referrals, the *most* serious cases are processed on through the CJS. These would include those with sexual assaults etc (Robertson, et al, 1995).

- ***Other outcomes*:** Other mentally disordered detainees may be charged and processed further into the CJS. The Revolving Doors Agency (Keyes et al, 1995) indicated that up to a third of mentally disordered detainees were transferred to another police station or proceeded to a court appearance, and Hudson et al (1995) noted a similar finding.

- ***Diversion*:** Some detainees are processed back out of the system without further action. For many this may be a good outcome. However, there are growing concerns about the fate of a third group of mentally disordered police custody detainees who are not disposed of through health or criminal justice systems, but who may still have substantial mental health needs. Robertson et al (1995) commented that diversion out of the CJS does not necessarily mean diversion to psychiatric care. The Revolving Doors Agency (Keyes et al, 1995) found that in spite of evidence of some form of mental health problem, up to a third of detainees were returned home or released from police custody without any action taken to establish links with health and social care agencies. Community psychiatric nurse (CPN) police liaison schemes have begun to target detainees who are not ill enough for inpatient admission but who could be referred to outpatient forensic or generic services, or specialist services such as drug and alcohol centres. In a study of a forensic psychiatric nursing service to police in Birmingham, over a third of detainees

with mental health problem were admitted to hospital informally or detained under a section of the MHA, and another quarter were referred to outpatient services). Similarly, another liaison service in London found that a third of referrals to the scheme were admitted to hospital, often under a civil section of the MHA, but many more were referred to community health or social care services (Hudson et al, 1995).

- ***What proportion are already known to the services?*** Some will enter care via the CJS because of their offending behaviour, but may still be known to local psychiatric or primary care services. Many studies have shown that the majority of court-referrals for psychiatric assessment, have a history of previous psychiatric contact or in-patient admissions (Joseph, 1990; Joseph and Potter, 1993; James and Hamilton, 1992; Exworthy and Parrott, 1993; Rowlands, 1996, Exworthy and Parrott, 1997; Hudson et al, 1995).

- ***Other issues:*** This could be a very long list. In brief, other issues that have been raised in the research include: Overuse of police stations as a place of safety rather than hospitals (Revolving Doors Agency, 1993, 1994); evidence of confusion in the execution of legislative procedures (Keyes et al, 1995; Nemitz and Bean, 1994); underuse of Section 136 (Mokhtar and Hogbin, 1993); marginalisation of Section 136 patients within hospitals (Mokhtar and Hogbin, 1993); international comparisons showing higher rates of police referral in US studies than UK studies (Fahy, 1989); the use of appropriate adults (Nemitz and Bean, 1994; Hudson et al, 1995; Robertson et al, 1995).

Moving on through the courts

Once before the courts, there are a number of different directions MDOs might be sent in. These include:

- ***Psychiatric court disposal schemes:*** Overall, a very small proportion of all offenders appearing before magistrates' courts are referred to and assessed by psychiatric court liaison schemes. James and Hamilton (1991) noted that around 1.9 per cent of offenders appearing at court received a psychiatric assessment.

Treatment recommendations are generally made in two-thirds to three-quarters of cases assessed by psychiatric court liaison schemes. A study of outpatient referrals for court reports to a regional forensic service by Hosty and Cope (1996) noted that three-quarters of court reports contained a treatment recommendation. However, Mendelson (1992) noted a much lower proportion of treatment recommendations in court reports, only a third overall.

- ***Hospital admission*****:** one of the most common recommendations made in court reports is for hospital inpatient treatment. Studies of court liaison schemes indicate that hospital admission is recommended in around a third to a half of cases assessed (Joseph, 1990; Joseph and Potter, 1993a and b). Detention in hospital may be informal or compulsory under Part II (civil section) of the MHA, but detention under Part III orders (criminal sections) is an increasingly favoured disposal option at this level (Hudson et al,

1995). The literature also noted a high degree of agreement between psychiatrists and the judiciary in relation to recommendations for inpatient treatment (Joseph, 1990; James and Hamilton, 1991; Mendelson, 1992; Joseph and Potter, 1993; Hosty and Cope, 1996). Earlier studies of court liaison schemes spoke of difficulties in admitting patients under criminal sections of the MHA, and securing hospital admission often depended on getting the CPS to discontinue proceedings under section 23 of the Prosecution of Offences Act, or withdrawing the case in court (Joseph and Potter, 1990, 1993a,b; James and Hamilton, 1991, 1992).

The literature reviewed suggests that admissions from the courts to medium and high security care are much less common than admissions to the lowest levels of secure care (Joseph and Potter, 1993; Rowlands et al 1996). The impact of court assessment schemes and diversion at the point of arrest projects on local catchment area psychiatric teams can be dramatic, particularly if the majority of patients admitted to hospital are directed into local psychiatric provision. James and Hamilton (1991) reported a four-fold increase in hospital admissions since the introduction of the scheme. Exworthy and Parrott (1993, 1997) have argued that receiving hospitals do not necessarily become overburdened because of the availability of alternative disposal options. However, they still reported an increase of hospital admissions by more than a third.

- ***Other non-custodial disposals*****:** disposal options including probation orders (with or without a condition of treatment), conditional discharge or a nominal penalty are amongst the most common non-custodial options noted in studies of court liaison schemes. However, a wide degree of variation in the use of non-custodial disposal options exists across different court liaison schemes. Some schemes quoted utilisation rates of a third to half of cases assessed (Joseph and Potter, 1993; Exworthy and Parrott, 1993; Rowlands, 1996). In contrast, a study of outpatient referrals for court reports in relation to a criminal offence noted that the overwhelming majority of psychiatric recommendations related to probation orders (81 per cent), but only two-thirds of these recommendations were accepted by the court (Hosty and Cope, 1996). On the other hand, hospital orders were recommended in only 7 per cent of cases but had an acceptance rate of 97 per cent by the court. The authors highlighted a pattern of rejecting disposal recommendations that could not offer sufficient control over an offender's future behaviour, particularly recommendations for voluntary psychiatric treatment alone and probation orders with an agreement for voluntary treatment.

- ***Custodial disposals and discontinuance*****:** the literature indicates that penal disposals are relatively uncommon, usually not more than 10 per cent of cases assessed by court liaison schemes are disposed of in this manner. The influence of the policy to divert MDOs from the CJS can be seen in the fact that court-based liaison schemes have a much higher rate of discontinuance than is usual for offenders appearing at court. For instance, discontinuance rates ranging from a fifth to a third were noted in some studies (Joseph, 1990; James and Hamilton, 1991; Rowlands, 1996). However, other studies noted much

lower discontinuance rates of around 10 per cent or less (Exworthy and Parrott, 1993; Exworthy and Parrott, 1997).

Factors affecting the ways that MDOs are treated by the criminal justice system: What do we already know?

The literature indicates that police and court response and disposal outcomes may differ for the sexes, across ethnic groups, different diagnostic groups, for the homeless and for different types of offenders. Of course, some groups have received more attention than others in this respect. While evidence of group-specific trajectories at the point of entry into care exists, the exact reasons for such differences are much less clear. Furthermore, the literature rarely examines what happens after police-referred admission to psychiatric care and there has been little or no discussion or examination of throughput and aftercare.

Factors affecting police decision making

Again, a substantial body of work exists in this area. In his review, Fahy (1989) identified a range of factors thought to influence the type of referral procedure used by the police, including the frequency of encounters with the client group, the availability of local psychiatric services and the assessment arrangements in place between the police and local agencies, a reluctance to become involved simply on the basis of possible illness, officers' perceptions of their own skills, their views on the role of the police, etc. We have selected a series of factors where a quantity of research has been done, to highlight some of the issues that have been of interest:

- ***Gender***: comprehensive gender comparisons on important variables such as demographic data, psychiatric diagnosis, offending behaviour and offending history have seldom been presented in the literature, but limited comparisons have been made in some studies. Rather predictably, the literature shows an over representation of men in police detainee populations, a finding consistent with the gender breakdown of offender populations in general. Men are also over represented in mentally disordered police detainee populations, and predominate in police referrals and subsequent admissions to psychiatric care (Dunn and Fahy, 1990; Robertson, 1995; Hudson et al, 1995; Spence and McPhillips, 1995). However, there is also evidence that women are over represented in section 136 cases when compared with female mentally disordered police detainee populations (Revolving Doors Agency, 1994; Keyes et al, 1995; Robertson, 1995). We have already seen from official Department of Health statistics that women account for just under half of all section 136 admissions (Department of Health, 1998). Furthermore, women have been found to be three times more likely than men to have had a previous arrest under section 136 (Keyes et al, 1995). Police response to homeless men and women also differs. For instance, a study by Hertzberg (1987) showed that women of no fixed abode were more likely to be referred under section 136 for hospital admission by the police, whereas men were more likely to be processed into the CJS and receive a penal disposal.

- ***Ethnic groups*:** before discussing police contact with mentally disordered individuals of particular ethnic groups, we will set out some more general research findings on psychiatric morbidity and ethnicity, and on police contact with non-mentally disordered people of different ethnic groups. Firstly, previous studies have noted a higher incidence of psychosis in British ethnic groups and a higher proportion of black Caribbean people admitted to hospital with a diagnosis of schizophrenia (Cochrain and Bal, 1987; McGovern and Cope, 1987; Harrison et al, 1988; Bebbington et al, 1994). We cannot explore the reasons for the excess of general psychiatric admissions for schizophrenia among black Caribbeans because such a task is outside the scope and remit of our review. However, we can briefly note some of the explanations provided such as, differential patterns of psychiatric illness; the propensity to misdiagnose illnesses in the absence of standardised diagnostic procedures and differences in cultural attitudes to mental illness (further in-depth discussion is provided by Hitch and Clegg, 1990; Littlewood and Lipsedge, 1981; Hickling, 1993). Secondly, studies of police contact with different ethnic groups have consistently shown that black people are over represented in police arrest figures within London and in other regions (Jefferson et al, 1992). This trend continues in relation to black people with mental health problems. For instance, Afro-Caribbean people are considerably more likely than their white counterparts to be detained by police and taken to a place of safety under section 136 of the MHA (Rogers and Faulkner, 1987, Victor, 1992). Studies have also shown an over representation of the population of New Commonwealth or Pakistani origin (NCWP) in section 136 admissions (Fahy et al, 1987; Dunn and Fahy 1990). Furthermore, the higher admission rates to acute hospital beds, particularly under compulsion, among people of black Caribbean affiliation concurs with findings of a higher rate of admission for black people where there has been some form of police involvement. Browne et al (1993) noted that black patients were three to four times more likely to be admitted with the involvement of the police across all admissions.

Dunn and Fahy (1990) found that black people were more likely than whites to receive psychotropic medication following police admission, to be kept in hospital longer and to be placed on a further compulsory order, but suggested that the increased rate of psychosis among black patients might account for these differences. However, the question of whether the diagnosis of psychotic illness was correct in the first instance remains unanswered. The authors concluded that the issue of ethnic group becomes important in cases where a policeman's lack of expertise in diagnosing mental health problems is compounded by the additional difficulty of dealing with subjects of a different ethnic group. When these factors coexist the disposal is more likely to be through the criminal justice system than through the psychiatric services. Robertson et al (1995) made a similar observation in relation to cases where section 136 was deemed appropriate by the authors, but not used by the police for non-English speaking detainees who merited some form of psychiatric assessment but did not receive it. Mokhtar and Hogbin (1993) also suggested that there might be a police bias against the use of section 136 for non-Caucasians. While the evidence indicates that police involvement is more likely to have preceded referral and admission to psychiatric care for black people than their white counterparts, there is little real consensus on any likely single, or even multiple reasons for this trend.

- ***Homeless mentally disordered offenders*:** the plight of homeless mentally disordered offenders has been increasingly recognised in recent years. There are no clear data on the rates of mental illness in homeless people and figures vary considerably across studies (Bhugra, 1992). It is generally accepted that the rates of mental illness are higher for the homeless and that homelessness and mental illness are related to an initial failure to develop adequate coping skills that is further compounded by a continuing downward drift as part of the secondary handicaps of illness (Craig et al, 1995). Accessing appropriate care can be more problematic for the homeless because they are less likely to be registered with a GP thus closing off traditional routes into care (Victor, 1992; Bhugra, 1997). Bhugra (1997) also noted that in the greater scheme of things, meeting first order needs for shelter, food and housing may take precedence over mental health needs, resulting in a rejection of psychiatric intervention. NACRO (1993) also point out that contact with the police as a result of repeated petty offending may be one way of having basic needs met on an intermittent basis.

- ***Diagnostic groups*:** we have already seen in chapter 4 that police-referred admissions to psychiatric care often suffer from chronic serious mental illnesses (Rogers and Faulkner, 1987; Fahy, 1989; Mokhtar and Hogbin, 1993; Hudson et al, 1995; Spence and McPhillips, 1995). In addition, police contact studies show that many individuals are socially isolated, of no fixed abode, known to the police because of previous criminal convictions, and known to psychiatric services, but no longer in contact with them. The vagrant lifestyle and absence of personal and professional support networks increases the likelihood of coming into contact with the police. Spence and McPhillips (1995) noted that people with personality disorder were more likely than other diagnostic groups to be detained repeatedly by the police. However, personality disordered individuals were less likely than those with a diagnosis of schizophrenia to be admitted to hospital following police referral, as might be expected (personality disordered people are rarely sent to hospital anyway). The authors concluded that the circumstances of acute assessment procedures were inappropriate to the care of this diagnostic group, and offered little hope of definitive intervention.

- ***Behaviour and offending*:** for individuals detained under section 136, the type of behaviour leading to police intervention is particularly important. Bizarre or threatening behaviour mainly triggered police detention under section 136, but threats of self-harm or attacks on others were much less common (Spence and McPhillips, 1995). Earlier studies have suggested that violent presentations were more common in young black men which in turn led to police involvement (Hitch and Clegg, 1990; Rwegellera, 1980; Harrison et al, 1994). However, a later study identified in our review noted that violent presentations were more common in white and black male police admissions, whereas non-violent presentations were more common in white and black women (Dunn and Fahy, 1990). Suicidal presentations were more common in white people of both sexes. Robertson et al (1995) examined the entry of mentally disordered offenders into the criminal justice system and found that the mentally ill were much more likely to be arrested for breach of the peace or public order act offences than the general detainee population. When the pattern of police disposal was examined for mentally ill and general

police detainee groups the authors noted that the former were less likely to be charged with notifiable offences. The opposite pattern emerged for non-notifiable offences, as mentally ill detainees who offended persistently were more likely to be charged than other police detainees. The presence of violence (violent offending or violent behaviour at arrest) was the most important variable in determining whether mentally ill people were processed into the CJS. Mentally disordered offenders that were processed into the CJS were significantly more likely than mentally disordered police custody detainees to have been rated 'violent on arrest', and thus unlikely to be diverted out of the CJS. This finding concurs with Hudson et al (1995) who noted that although violence or the threat of violence was linked to cases diverted to psychiatric care at the point of arrest, the offenders were unlikely to have committed serious acts of violence, and few of the offences resulted in charges.

In conclusion, our review indicates that the majority of police referred admissions to psychiatric care are seriously mentally ill. However, the police repeatedly come into contact with other diagnostic groups who exhibit mental health problems but fail to reach a threshold for hospital admission (Spence and McPhillips, 1995), or whose mental health problems do not trigger a referral for psychiatric assessment at all (Keyes et al, 1995). The presence of violence in offending behaviour or at arrest is a key factor in influencing whether mentally disordered offenders are processed further into the CJS. However, mentally disordered persistent petty offenders are more likely to be charged for their offending behaviour than non-mentally disordered offenders. The needs of the few who require inpatient psychiatric care have taken precedence over the needs of the many, who fail to meet the narrow eligibility criteria for inpatient care. However, these individuals would undoubtedly benefit from outpatient forensic or general services; other specialist intervention; social housing and other social and welfare services.

Factors affecting court decision making

- ***Gender:*** The literature on mentally disordered offenders presents little comprehensive discussion or analysis of gender differences relating to the passage of cases through the CJS, or to any judicial outcome. We will address two main questions here: Firstly, are women more likely than men to be processed into the CJS to the point of a court appearance? Secondly, is there evidence of gender differences in relation to court recommendations or subsequent judicial outcome? While women predominate in samples of cases presenting to general psychiatrists, the reverse is true of presentations to forensic psychiatric practice (Mendelson, 1991). In general, men predominate in cases appearing before the courts, in keeping with the fact that men strongly outnumber women in criminal statistics, and men predominate in cases referred for psychiatric assessment by court-liaison schemes. Robertson et al (1995) presented evidence suggesting that women are more likely than men to be diverted from the CJS at the point of arrest. Gender differences, court recommendations and judicial outcomes have not been explored in any of the literature relating to court liaison schemes, possible due to the small female samples available over the limited study periods. However, studies of forensic psychiatric practice have examined gender differences in forensic patients. Hosty and Cope (1996) found no significant relationship between

the risk of rejection of court recommendations and the age, sex and ethnicity of the defendant. Mendelson (1991) also found no sexual difference in relation to the proportion of court cases receiving a treatment recommendation, but the type of disposal outcome differed across the sexes, with men twice as likely as women to have an element of compulsory treatment imposed via the addition of a treatment condition to a probation order. Other studies have noted a gender bias that favoured psychiatric disposals for female offenders. Allen (1987) found a greater reluctance to use a psychiatric disposal for male offenders, even when they exhibited more severe symptomatology than female cases who had received such a disposal. While some commentators have spoken of the tendency to 'psychiatrize' women, Allen (1987) suggested that the trend may be attributed to a greater emphasis on moral and retributive factors in male cases that culminates in punishment rather than treatment. Some evidence of gender differences in relation to the imposition of custodial sentences also exists in studies of non-mentally disordered offenders. For instance, previous studies have expressed a concern that women are more likely than men to receive a custodial sentence earlier in their criminal careers (Seear and Player, 1986) and that women tend to be sentenced to prison for less serious offences than men (Carlen, 1988). A study of race and sentencing in the Crown Court by Hood (1992) found that for black and white women, the proportion of actual custodial sentences was considerably lower than would have been predicted if women and men had been responded to by the courts in the same way. Hood concluded that there was no evidence to suggest than women are more severely treated by the courts than men, or that black women are doubly discriminated against. Overall, the odds of a woman being sentenced to custody were very significantly less than the odds for a man. Thus the evidence supports the 'chivalry' or paternalistic' hypothesis that judges give more weight to mitigating features of the case in sentencing women offenders, whether black or white.

- ***Ethnic group***: similar questions will be addressed here: Firstly, are different ethnic groups more likely to be processed into the CJS to the point of a court appearance? Secondly, is there evidence of ethnic differences in relation to court recommendations or subsequent judicial outcome? We have already seen above that black people within and outside London are over-represented in arrest figures (Jefferson et al, 1992). A study of black, white and Asian males involved in the CJS in Leeds conducted by the same authors noted a higher proportion of black defendants were tried in the Crown Court, where the chances of a custodial sentence are higher, but found no uniform explanation for this trend. In a comparison of mentally disordered offenders assessed by psychiatrists at court with a general police detainee population, Robertson et al (1995) found that almost half the court group were black, nearly twice the proportion found in the general population of police detainees. Even when the relationship between seriousness of offence and entry into the CJS was taken into account the over-representation of black people in the court group remained highly significant. Hudson et al (1995) compared referrals to a DAPA scheme with referrals to a court liaison scheme and noted that there was a significantly greater proportion of black referrals in the court group. Browne et al (1992) examined the role of the criminal justice system as a factor in the psychiatric treatment of Afro-Caribbean people. All cases heard at an Inner London Magistrates' Court over a 12-month period were examined, and only 0.2 per cent were

identified as having been remanded for psychiatric assessment,. Although the sample of medical remands was small, there was still evidence of an over-representation of Afro-Caribbeans in particular. Black remandees were almost twice as likely to be assessed as suffering from some form of serious mental illness such as schizophrenia, and a higher proportion had had previous contact with psychiatric services, concurring with the findings elsewhere which show higher admission rates of black people (see Cochrain and Bal, 1987; McGovern and Cope, 1987; Harrison et al, 1988 above). Black defendants were more likely than whites to be remanded to custody and far less likely to be granted bail. In addition, the authors suggested that the treatment of black people in the CJS was consistently associated with coercion and containment. This was illustrated in an under-representation of black people in non-psychiatric probation orders and an over-representation in psychiatric probation orders. Comprehensive data of psychiatric recommendation and judicial outcome for different ethnic groups has not been provided in any of the studies of court liaison schemes. However, there is some evidence of an over-representation of black defendants in admissions to hospital following assessment by court liaison schemes. Hudson et al (1995) compared admissions to hospital between a DAPA scheme and HRM CLS and found that black people were twice as likely to be admitted from the court referral group than the DAPA group.

- ***Homeless mentally disordered offenders:*** here there is ample evidence to support the view that homeless mentally ill petty offenders are less likely to receive bail and be remanded to custody because of their lack of community ties and residential instability (Joseph, 1990; James and Hamilton 1991; Joseph and Potter, 1993). Earlier reports have noted that remand prisons served many different functions, including that of bail hostel for defendants of no fixed address. Taylor and Gunn (1984) noted that the inability to give a permanent address is a known factor in determining custodial remand and found that the men in their sample with active psychiatric symptoms and with a diagnosis of schizophrenia in particular were more likely to be of no fixed abode than the healthier men.

- ***Diagnostic groups*:** Schizophrenia is the most common psychiatric disorder attributed to defendants in studies of court liaison schemes and studies of defendants for whom court reports have been requested (Joseph and Potter, 1991; Joseph and Potter, 1993; Exworthy and Parrott, 1993; Exworthy and Parrott, 1997. Another characteristic feature of defendant samples is their previous experience of psychiatric services and previous inpatient admissions. The overwhelming majority of referrals typically have at least one psychiatric disorder diagnosed but women, in particular are more likely to be assigned a psychiatric diagnosis than men (Mendelson, 1991). Although, it is generally thought that those diverted to psychiatric care at arrest and at the point of court appearance have a similar clinical profile (schizophrenia and allied states predominating), Hudson et al (1995) have indicated that the degree of symptomatology is probably far less in police referrals, and this is reflected in the proportion of cases admitted to hospital from the courts.

While symptomatology clearly influences disposal outcome, there is also evidence to suggest that different diagnostic groups experience different disposal outcomes. Hosty and Cope (1996) presented findings that clearly indicate a relationship between psychiatric diagnosis and rejection of court recommendations. For instance, they found evidence of higher rates of medical recommendation and low rates of rejection in cases of organic psychoses; schizophrenia and related psychoses; and affective disorder. The opposite picture emerged in cases of neurotic disorder, sexual deviation and dependency disorders. The most striking finding, however, was that cases of personality disorder were more likely than those with no diagnosis to have no recommendation made, perhaps reflecting a perception of therapeutic nihilism in these cases. The authors highlighted a persistent divide between medical and legal opinions in cases of psychotic and non-psychotic disorders. The latter clearly yielded a less receptive response to psychiatric recommendations by the courts in favour of more punitive outcomes. Taylor and Gunn (1984) examined the effect of psychiatric diagnosis on the conviction and sentencing of offenders and noted that there was no evidence that the mentally ill were more vulnerable to detention without subsequent conviction than their normal peers. But a psychiatric disposal was not an automatic consequence of remand in custody for assessment. Offenders diagnosed with schizophrenia were more likely than not to receive a hospital order but those who had additional substance disorder and schizophrenia were far less likely to receive a hospital order. Overall, only around a third of schizophrenic offenders became compulsory inpatients, another 10 per cent were engaged in formal treatment or supervised contacts, but over a third were given unsupervised or non-custodial sentences, and it was thought unlikely that these received any form of treatment.

- ***Offending behaviour*:** there is ample evidence that defendants assessed by psychiatric court liaison schemes are more often charged with serious offences, often involving violence than mentally disordered police custody detainees. This is to be expected as diversion at the point of arrest schemes (DAPA) are generally intended to deal with individuals who have committed less serious offences and might benefit from psychiatric assessment and intervention. Hudson et al (1995) found that cases referred to psychiatric court liaison schemes were significantly more likely to involve violence than mentally disordered offenders referred to police station liaison schemes. The findings of a recent study conducted by Robertson et al (1995) adds further support to the view that gravity of offence and violent behaviour increases as cases move further into the CJS. In a comparison of mentally ill police custody detainees and mentally ill defendants at court the authors found that only a third of ill police detainees had a rating of violence at arrest compared with 80 per cent of mentally disordered defendants seen at court. The differences were even stronger when mentally disordered defendants were compared with the general police detainee population, of whom as few as 8 per cent had allegedly committed acts of violence against the person. The type of alleged offence also has an impact on the judicial outcome, and particularly the acceptance or rejection of treatment recommendations by the court. Hosty and Cope (1996) found that the rate of rejection was higher for more serious offences such as arson, assault and sexual offences than for acquisitive offences which was thought to reflect the increased likelihood of a

custodial disposal for serious offences, particularly where hospital admission was not presented as an alternative.

What happens once people are taken into prison?

For a proportion of MDOs, the end result of their contact with the police and the courts will be that they spend a period in prison, either before or after sentence. As we have discussed in previous chapters, there is general agreement in the literature that prison is not a good environment for MDOs except in situations of extremis, where public safety is a major concern and alternative arrangements are not possible. However questions of equity in sentence and treatment have been raised which indicate that the situation is not completely straightforward. There are also questions relating to the shortcomings in the initial screening process on reception into prison, when many mentally ill prisoners are missed.

In this section we look first at the particular case of people remanded to prison, and then at the case of people sentenced to prison, including the pathways between hospital and prison *after* sentence.

The particular case of remands

Some people are remanded to prison, rather than being sentenced to it, and thus still have the status of `alleged' rather than `known' offenders. The literature reflects well rehearsed concerns about the suitability of the prison as a place of remand for mentally disturbed prisoners. Main issues that have been researched include:

(i) *The unsuitability of prison if the primary reason for a custodial remand was to obtain a psychiatric report* (Butler 1975; Reed, 1992). Prisoners remanded for medical reports are a heterogeneous group, with a broad range of needs (Faulk, 1975; Gibbens, 1977 - these are taken from James and Hamilton, 1991) and some have questioned whether remand for psychiatric assessment may be too high a price to pay for individuals who spend lengthy periods in prison but still fail to receive any psychiatric help (Taylor and Gunn, 1984; Coid, 1988; Dell et al, 1991). Some MDOs remanded in custody are charged with non-imprisonable offences, while others are detained for longer on remand than the period covered by their likely sentence. There are still cases where custodial remands occurred for reasons not associated with obtaining a psychiatric report, such as no fixed abode; where the detainee was on bail at the time of arrest or where there was a previous criminal record, all of which are cases that could fulfill the exceptions to the right of unconditional bail (James et al, 1997).

(ii) *The length of the remand period.* The remand period can be longer for ill prisoners remanded to prison awaiting assessment, initially because of problems getting assessed, and then secondarily because of delays in securing admission and beds (eg, Dell et al, 1991). Indeed, one of the recommendations of the Prison Advisory Group (Reed Committee, Final Report, 1992) was that the powers to remand in custody for the sole purpose of obtaining a psychiatric report should be repealed or amended, perhaps where the charge is less serious or not imprisonable (James et al 1997). However, it is clear that remand

to prison is inevitable for certain groups of offenders or alleged offenders, such as those charged with serious offences, who tend to be remanded to prison in the interest of public safety (Dell et al 1991; Smith et al 1991; Robertson et al 1994).

However, on the positive side, the literature clearly indicates that psychiatric court liaison schemes have brought about shorter remand times and quicker inception into psychiatric care. The typical waiting period between arrest and admission described by studies was on average, little over a week (James and Hamilton, 1991; Joseph and Potter, 1993; Pierzchniak et al 1997. Joseph and Potter (1993) suggested that the dual role of assessor and admitting psychiatrist meant that patients could be admitted directly from court, although 'fast track' admissions are not always feasible in practice.

James et al (1997) concluded that the possibilities of amending the law are limited by considerations of structure in court psychiatric services. For instance, most services operate only on certain days of the week and may be based on a system of cross-remand, so that remand in custody until the next available day always remains necessary. Furthermore, the total abolition of the power to remand would necessitate a complete reorganisation of magistrates' courts in England and Wales. However, the authors suggested that when court liaison schemes operate on a weekly basis, remand for more than 6 nights should never be necessary. Consequently, the widespread availability of court assessment should permit a change in legislation to limit remand in custody for reports for a maximum of a week.

Pathways of remand prisoners

In theory, remand prisoners may be urgently transferred to hospital if necessary, under certain sections of the MHA 1983. This power is widely supported (Dell et al, 1991; Exworthy and Parrott, 1993; Robertson et al, 1994; Akinkunmi and Murray, 1997; Reed Committee, Final Report, 1992). However, the increase in uptake of this section of the Act is by no means uniform, and studies show wide variations in the use of the provision within and between regions, attributed to differences in the availability of beds in medium secure and local psychiatric provision (Anderson and Parrot, 1995).

Why are people on remand urgently transferred to hospital? Those who are transferred seem to have a certain diagnostic and offending profile, consisting of much psychosis, some violence, and a previous history of psychiatric illness (eg, Smith et al, 1991; Anderson and Parrott, 1995; Bannerjee et al, 1995). Where do they go? Either to open or locked wards in general psychiatric hospitals, to RSUs or to Special Hospitals. Banerjee et al (1995) reported that only a third of those urgently transferred were still in contact with community or hospital-based services at the time of arrest - the authors postulate that this suggests a failure of community care for people with a serious mental illness, who subsequently offend. The suggest that it is likely that for some, intervention and treatment at an earlier stage would have prevented offending and removed the need for remand to begin with.

Studies have shown that the time spent on remand and the step in the pathway may be affected by the initial route into care (via court liaison or the traditional prison system) and the level of secure care required (Piezchniak 1997). However, the literature on pathways for people sent to prison on remand rarely goes beyond the point of admission to psychiatric care. Data on the length of time spent in psychiatric care or the outcome of that care are seldom provided but data on final court disposal in the above studies indicates that therapeutic and non-custodial disposals are far more common than custodial disposals. It appears that once prisoners *are* remanded to hospital for psychiatric assessment or transferred under section 48, they are at least likely to receive a therapeutic disposal.

Alternative models for remand?

Weaver et al (1997) commented that despite the policy to promptly transfer mentally ill prisoners to NHS care, arrangements have been slow and ineffective. They described a dedicated regional service for male mentally disordered remand prisoners provided by the Bentham Unit, a 14-bedded locked ward, providing a remand bed facility to which patients may be admitted before court disposal and determination of final placement. Admission to a remand bed was associated with a shorter length of stay in prison (median interval 35 days for both units) but also a significantly longer total interval between remand and final relocation to NHS psychiatric care (median interval 85 days v 55 days, p=0.015). However, combining outreach services with an NHS remand bed facility enabled faster transfer of mentally disordered remandees out of prison than catchment area services. Cripps, Duffield and James (1995) described the services provided by the Henry Rollin Unit, a 40-bedded local 'hybrid' mixed forensic and intensive locked unit, including a remand facility offering rapid access to beds for assessment, including cases where disposal was likely to be to a higher level of security. In the first 15 months of operation there were 255 admissions (average 17 per month). 22 per cent of which were on remand orders arising from the courts and prisons compared with only 2 per of similar admissions at another comparable locked unit in London. Most remand admissions were section 35 court orders or section 48 Home Office warrants. A major function of the unit was the provision of effective diversion in the form of remand assessments, accepting 6 per cent of all section 48 transfers for England and Wales in 1993. The diversionary function was evidenced by the fact that that 68 per cent of those on Part III orders were subsequently discharged either to the community or an open ward.

Experiences once sentenced

There are two possibilities here. The first is that sentenced prisoners remain in prison, the other is that they are moved to hospital. The first noticeable thing about the research is that, once in, this is the end of the pathway for many, at least until they are reach the end of their sentence. Thus, two major cross-sectional studies of the prevalence of psychiatric morbidity and treatment needs of sentenced and remand prison populations showed that despite high prevalence rates of psychiatric disorder, only a small minority of prisoners were thought to require transfer from prison to hospital psychiatric care (Gunn et al, 1991; Maden et al, 1995). Other small-scale studies that have concentrated on individual prisons have

found that between 3 and 4 per cent of prisoners require transfer to psychiatric care under the MHA (Banerjee et al 1995; Resnick, 1995; Birmingham, 1996).

Some - the minority - do leave prison to go to hospital, in the same way that remand prisoners do. For sentenced prisoners, the Home Secretary has discretion to attach a restriction direction if it is thought that would be necessary to protect the public from harm. The restriction ends at the earliest date of release, when an application for discharge to a mental health review tribunal can be submitted. However, a prisoner can be remitted to prison before this if their mental disorder has responded to treatment and they can complete their sentence in prison.

Some studies of sentenced prisoners transferred to hospital for urgent psychiatric treatment have drawn the following conclusions and have raised some issues:

- ***Types of people transferred.*** In a study of transfers over a three-year period, Huckle (1997) found that the most common psychiatric diagnosis was schizophrenia, and over half had a history of previous in-patient or out-patient psychiatric treatment. All transfers were of male prisoners and the most common offences included burglary and robbery. However murder and arson featured in a significant minority of cases.

- ***Place of transfer*:** Huckle (1997) reported that transfers were predominately to lower levels of secure care, with only a third going to medium secure beds and 6 per cent to maximum security.

- ***How long do they stay away?*** In the Huckle (1997) study, just under half of prisoners returned to prison to complete their sentence following treatment, a quarter remained in hospital care for the duration of the study while the rest were either transferred to lower levels of secure care or discharged into the community. A follow-up study of the group showed that a quarter were readmitted to hospital care.

- ***How does the prison know when transfer should be an issue?*** Hargreaves (1997) drew attention to a number of critical limitations in detecting and responding to severely mentally ill prisoners. In a descriptive study of the transfer of severely mentally ill prisoners from one prison he noted continuing delays in responding to severe mental illness before transfer from prison happens. Factors thought to hamper transfer included the chronicity of illness and multiple handicaps experienced by prisoners. The long-term needs of such patients were a potent factor in the decision to withhold hospital care. Hargreaves also found a reluctance to accept prisoners whose previous morbidity had been attributed to personality disorder, even after significant changes in presentation had occurred. However, in contrast to the findings of a study by Grounds (1991), prisoners serving determinate sentences appeared at an advantage compared with life-sentenced prisoners. It was thought that the need to expedite treatment in advance of the earliest date of release may afford greater priority to prisoners serving fixed terms.. It was felt that wing officers were not sufficiently aware of the need for a low index of suspicion for mental

disorder and required further education in this respect. (See comments from Taylor and Gunn, 1984; Mitchison et al, 1994; Resnick, 1995; and Birmingham, 1996 about the failure to detect mental disorder in prisons - mainly outlined in the epidemiology chapter). The author also recommended continued expansion of secure provision to meet long-tern psychiatric needs. He also called for a the re-examination of the existing section 47 transfer provisions and suggested that transfer for a period of assessment in cases where disputes occurred regarding diagnosis, as recommended by Reed (Reed Committee, Final Report, 1992) would increase both the flexibility and usefulness of the section.

- ***Release from hospital after transfer***: The MHA 1983 introduced two main changes to the provisions of transferring prisoners. After the prisoner's earliest possible release date has been passed, the patient may apply for discharge to a Mental Health Review Tribunal. In addition, the criteria for recommending a return to prison were widened so that a patient could be remitted to prison if they could not be treated effectively in hospital.

- ***Length of stay under a transfer versus the original sentence:*** Grounds (1991) examined the transfer of sentenced prisoners to a maximum security hospital over a 23-year period and noted their length of stay in relation to the sentence imposed. Grounds found that patients admitted from 1961 - 1970 were transferred on average, 23 months before the earliest date of release while those admitted during 1971-80 were transferred on average 10 months before the earliest date of release. Grounds examined in detail the first and last forty transfers to Broadmoor during the course of determinate sentence and examined the time intervals in each stage of the admission process. In summary, Grounds found that in the earlier years of the study period transfers tended to occur relatively quickly and at an earlier stage of the sentence. In later years however, the situation changed for the worst, as medical recommendation were made later in the sentence, decision-making took longer, and the waiting list led to considerable delays between acceptance for admission and the achievement of transfer. He also noted that it seemed possible to transfer prisoners on the basis of reports made some time before transfer. The study highlights the importance of detecting mental disorder and effecting transfer from prison to hospital at the earliest possible stage of sentence. In looking at the departure time in relation to the latest date of release for determinate sentence patients, Grounds found that patients were more likely to leave hospital after their latest date of release (62 per cent) than before it (38 per cent) and sex offenders left Broadmoor for the community significantly later in relation to their LDR compared with other categories of offender (Grounds also refers to life-sentenced prisoners). (See also Huws et al, 1997.)

In conclusion, as Hoggett (1996) has noted, the normal processes of the law are affected at several junctures in cases where the alleged offender is mentally disordered. The authorities may decide not to prosecute, but if they decide to do so, the defendant may be remanded in custody or transferred to hospital before being dealt with. At the point of trial, mental disorder may occasionally provide a defence to the charge or enable the courts to choose a therapeutic disposal. However, the fact remains that, for one reason or another, mentally disordered offenders do end up in the prison system, or experience

mental health problems after their imprisonment. It is noted in other contexts how psychiatric problems ebb and flow, and offenders who have no apparent symptoms at the time of the offence may require psychiatric intervention at a later stage while in prison, posing challenges of constant vigilance and awareness for prison staff. The diverse nature of both the presentation and response to psychiatric disorder was illustrated in the cross-sectional study of the sentenced prison population by Gunn et al (1991).

Responding to mental disorder in prison

This is not a `pathway' in the strict definition of the term, in that we are not talking about people being processed from one situation to care to another. However, it might be useful at this point to briefly consider what happens to those who remain in prison and receive their treatment there rather than in hospital. In this respect, as in respect to transfers and other transition points, the literature provides evidence that the process of gaining access to assessment and care for mentally disturbed prisoners is hampered by persistent delays and difficulties. This has not been a major area of research, but there are a few good studies (Dell and Robertson, 1988; Coid, 1988).

Treatment is given in prison rather than hospital for a variety of reasons. For example, some patients might not be suitable for transfer because they are too disturbed or potentially dangerous. Coid (1988) reported that of 362 prisoners remanded to one prison for psychiatric reports, 88 per cent were thought to require hospital admission, but over a fifth of those were rejected for transfer to hospital. These people seem to be chronically disordered, in need of long-term management and care. However, Coid concluded that they posed little real threat to the community in terms of criminal behaviour. He suggested that they were rejected for treatment because of a selection bias operating in favour of prisoners with responsive conditions. This is part of the general issue of `treatability' and what to do with the long-term untreatable. A similar picture emerged in a study by Dell et al (1989) which examined the way in which prisoners were selected for hospital orders.

Issues arising from the pathways research

- Given the levels of complexity & the inherent difficulty of dealing with mental illness which comes and goes, how well does the current system work? How good are the police at gate-keeping? There is an increasing recognition of the burden that falls on the police in particular, but it is a matter of some concern that vulnerable people may not be channelled into care. This may be partly because there are few alternative sources of help and support for the less serious offender who was catered for in the early days of diversion, but who now appears to fall outside changing eligibility criteria. Court-based diversion schemes now deal with the more serious offenders, so that minor offenders may be returned to the streets without psychiatric input, perhaps until they become violent.

- The issue of vulnerable people being held in custody before a psychiatric assessment is obviously still a serious one. For example, homelessness should not be an imprisonable offence, and there should be access to a range of accommodation for those in need.

- In the wrong place? "There is little point in 'diverting' someone if he or she has nowhere to go or if the placement is unsuitable or inadequate". (Reed, 1992). "Information on the extent of unsuitable placements is not routinely available" (Reed, 1992, p10). But, it is clear that people *are* in the wrong place, including in prison when they should be in a secure hospital ward, in a higher level of security than is necessary, in hospital when they should be in the community. To start with, diversion should occur at the earliest possible point, but it is important that those in need are not diverted out of the whole care system entirely.

- Time is of the essence. Prisoners requiring transfer to hospital should be dealt with quickly; when hospital orders are made, prisoners should be admitted immediately. Hospitals accepting patients should be able to do so without lengthy court procedures.

- It seems possible that the chronic nature of psychiatric disorders, associated long-term care requirements, tenacious resistance to treatment, and challenging or disruptive behaviour, often become the justification for refusing access to care facilities and treatment programmes rather than the eligibility criteria which trigger psychiatric intervention. Thus some mentally disordered offenders persistently find themselves in care 'cul de sacs' without any chance of ongoing help or support.

- There is only limited information on throughput and outcome in general. Overall, few studies follow offenders through their psychiatric or CJS experience. Most of the studies provide a snap-shot of groups who are inpatients in a particular secure setting or who are remanded in custody or serving determinate or indeterminate prison sentences but their journeys leading to that particular point in care or custody may have been different. There is a striking lack of follow-up data on diversion at any point in the system. The only police studies that have attempted to build up a picture of patterns in police contacts is the recent study by Revolving Doors.

Summary Box: Pathways into and out of care

- This is potentially one of the most interesting areas covered in this review, but there is a lack of longitudinal data in the field. We can piece together various specific and cross-sectional studies but funding longer-term follow-up studies of patients (beyond one simple move withing the system) is critical. Very few studies have addressed pathways through the range of provision, most just take a small section.
- Given the complexity, it is difficult to assess whether or not the system works. There is certainly a level of bias inherent in interactions between MDOs and various parts of the system based on a range of factors (which vary) but the overall effect of this is unclear.
- How many people are in the wrong place? This is also a critical are for some systematic research, looking both at how people got to the wrong place and how they could be helped to move on.
- Further attention needs to be given to the issue of outcomes. What are appropriate and achievable outcomes at different stages in the system?

11 EFFECTIVENESS RESEARCH

Background

There are two main issues raised by the title of this section. The first is the question of whether provision is effectively targeted and delivered. This has been covered to a large extent in the preceding chapters. The second is the effectiveness of specific interventions targeted at known MDOs.

Like many in this review, this is an area of research challenged by methodological pitfalls. These include:

- Problems designing evaluations because of the nature of the sample and the legal restrictions (eg, limitations on the use of random allocation techniques).

- Difficulties in choosing appropriate outcomes. This is further complicated by the wide range of illnesses and crimes that might be covered by the title MDO.

- Problems of enforcing treatment on people, including those who simply refuse, and others who are thought not to understand what they are agreeing to (eg, Ladd, 1995, discussion of involuntary electro-convulsive therapy).

Is intervention going to work?

There have been a number of reviews in the last decade on the evaluation of interventions for a range of different social problems, including mental health and crime. With respect to crime, the tone of these reviews is now relatively optimistic after a period of considerable pessimism in the 1970s. There are a number of initiatives that have been shown to be effective, if the outcomes are sensible. A key point here is the extent to which antisocial behaviour is open to change, and the extent to which behaviour has to be changed in order to claim success. It may be more realistic, for example, to aim for a reduction in the level of offending with persistent offenders, rather than to aim to achieve complete cessation of offending.

How far are mental health problems treatable? Should this be related to whether people are provided with interventions or not? Reviews on the treatability of mental health problems draw different conclusions for different types of problem. The main concern of people working with MDOs has been the treatability of personality disorders. Treatment of psychopathy has a low rate of success in general (Roth, 1990) compared to other disorders, and indeed the psychiatric literature is split in terms of what can be achieved particularly with people with personality disorder in the community. Recent policy developments have begun to emphasis a responsibility for this group which is leading to some reexamination of what is possible. In particular, cognitive behavioural therapy has been claimed to be at

least partly successful (Young, 1990). A more intense form of treatment has been developed in recent years, entitled `schema-focused behavioural therapy' (eg, Layden, 1998). As part of this current series of reviews, a systematic review on therapeutic communities was also commissioned. We have not seen the results of this at the time of writing.

In reality, interventions specifically to `cure' mentally disordered offending as a whole do not exist. Programmes and initiatives are aimed at one or another aspect of the problem, not at its entirety. This is probably sensible. However, interventions aiming to address a part of the difficulty ought to be based on a causal model of how that might relate to other aspects of the problem and, as we have seen, causal models for the relationship between offending and mental health are not clearly delineated. In the main, the interventions are aimed at mental health problems, rather than at offending. An exception to this is treatment programmes for sex offenders (eg, Miner, 1997).

In a rare discussion of treatment at the interface of mental health and offending, Schultz-Ross discussed the theoretical difficulties of bringing together legal and psychiatric theory. The approaches offer a stark comparison. At the starkest, the legal aspects require punishment, the psychiatric aspects rehabilitation. The law is not based on a treatment model - psychiatry is. Schultz-Ross implies that the difficulties of acting at the interface often result in a concentration on the illness characteristics, ignoring the offending behaviour.

In terms of what is being delivered within the current systems, the emphasis within the prison service at least has been on assessment with a view to referring on to other services, rather than providing in-house treatment.

Problems delivering effective provision and interventions

Quite apart from the issue of treatability and causal models, the problems delivering effective provision to MDOs are those that are associated generally with multi-disciplinary issues. Those that have been highlighted have included:

- Communication between professionals. We have already discussed the challenge of multi-agency working. The main problem is the same for multi-agency teams in any topic, including the issue of information sharing and establishing responsibility (NE Thames Regional Health Authority, 1994).

- The problem of multiple diagnosis, particularly if one of the diagnoses is of substance or alcohol abuse.

- Forensic psychiatry may be developing, but it is still only on offer to a few patients. The reality in the general psychiatric service is that MDOs will remain the responsibility of the local psychiatrists. These may not be very experienced at dealing with offending behaviour. General psychiatric training

will not usually cover crime, although it will cover statutory obligations. It is often quite difficult to arrange for forensic assessments, and almost impossible if the offending behaviour is not particularly persistent or violent.

Treatment refusal

As we have already seen, compliance with medication is a major difficulty for an important minority of MDOs. Admission to hospital does not mean compliance with treatment, particularly if the admission was compulsory, and care in the community can pose significant problems for ensuring compliance. There are now specific therapeutic regimes specifically directed at improving medication-taking (sometimes called "compliance therapy").

Recent government encouraged initiatives

Just in recent weeks, there has been a widely publicised and well-funded government initiative on support for `assertive outreach' and `crisis management'. Assertive outreach indicates a 24 hour, 7 day-a-week service, offering constant availability of community mental health team workers to deal with difficult-to-engage clients. Assertive outreach workers are intended to have a restricted case load of approximately 10 clients, largely psychotic, with whom they will work in a `befriending' manner. The underlying rationale is that these workers will provide the central point of information that has been difficult to establish in multi-agency teams. The service will be the only point of contact for the patient - a `one-stop-shop', which will cover initial queries about the whole range of social and health welfare issues that might arise.

Resources have been allocated both to set up these services in a series of pilot areas, and also to evaluate them. It is intended that assertive outreach will be a completely separate service, backed up by a consultant psychiatrist & team manager. These developments are part of the progression to a `First Class Service' from the NHS (Department of Health, 1998), of which the National Institute of Clinical Excellence also plays a part.

Summary Box: Effectiveness research

- Two key questions were identified. The first, of whether intervention or provision is effectively targeted and delivered, has not been answered.
- Treatment of psychopathy and management of personality disorder have received patricular attention. There is some limited optimism (at least with psycopathy) that interventions can be therepeutic.
- There is a central problem that interventions are most likely to be successful if they are based on a clearly articulated theory, but theory development in th whole are of MDOs is lagging a considerable way behind.
- New policy initiatives in this are have included 'assertive outreach'.

12 CONCLUSIONS

In 1992, the Reed Committee wrote "The effective development and operation of services for mentally disordered offenders requires a sound academic and research base. This base is at present poorly developed..." (p29). This scoping review leads us to the conclusion that there is a wealth of information about various types of mentally disordered offenders in different settings, but that there is less in the way of clear overviews of the main issues. Some parts of the research literature are far more developed than other parts. This is usually because they fall clearly within one discipline and are a clear focus of interest for academics working in that area - for example, the studies of the interactions with the police is a major interest in criminology. Studies of the characteristics of MDOs in different settings are a major interest in mental health research. However, bringing together the research areas into a multidisiplinary whole presents more of a challenge.

Each chapter of the review ended with a Summary Box, and, in addition, the contents of these were brought together in the Overview in Chapter 1. At this point, we provide less detail than in those sections, but give a broad picture of the direction of the review. This chapter concludes with suggestions for a research agenda for the future.

Summary of key findings

The following is a very brief summary of some of the main conclusions we drew in each of the chapters of this scoping review.

- The ***approach taken*** was an inclusive and best-evidence approach. Where good reviews did not exist in an area, we looked for the best of the rest of the literature. In some cases, this resulted in a wealth of information, in others we were left with very little except commentary and discussion pieces.

- ***Definitional issues*** were posed by the interface between criminology and the psychiatric and psychological literatures. The terms `offender' and `mental disorder' are both open to cultural interpretation and changing interpretations. Definitions were found to be either legal or medical, and ranged between the very inclusive (people who might be ill and who are at-risk of offending) to the rigid (only those who meet specific psychiatric and legal criteria).

- There have been a number of ***developments in the field*** over the last two decades, and we outlined some of the recent policy and practice developments. The most noticeable of these were the development of care in the community, the emphasis on diversion from prosecution, the issue of defining need, and the challenges of multiagency working. We also noted the growth of forensic psychiatry as a discipline in its own right, and a revival of academic interest in dangerousness and risk assessment. Commentors on these developments had raised a number of issues such as the arbitrariness of the current system, the pros and cons of care near home or further away, and the problems of establishing effective outreach work.

- The rather complicated ***statutory framework*** was described in Chapter 4, to set the context for later sections. Legal definitions of mental disorder in England and Wales are laid down by the Mental Health Act 1983, and this was the starting point for discussion. The MHA is split into civil and criminal sections. Other relevant legislation includes the Police and Criminal Evidence Act, The Bail Act, the Criminal Procedure Act, the Criminal Justice Act, and the Mental Health (Patients in the Community Act) to name a few. Issues arising from the statutory framework included problems inherent in the MHA's emphasis on MDOs as the province of medicine rather than law, a divide between treatment in hospital and care in the community, and the issue of the `treatability' criteria.

- The situation with respect to ***existing provision*** was laid out in Chapter 5. MDOs can be treated in a number of settings with different philosophies of care and levels of security, including special hospitals, medium secure units, lower security psychiatric provision, patients in prison (both sentenced and remand) and those being supervised by probation.

- A great deal of ***epidemiological and descriptive research*** exists, and in Chapter 6 we laid out some of the main topics that have been covered, and identified some of the key gaps. Little is known about the epidemiology of MDOs in the general population, except that it is clear that there is an interaction with gender (males more predominant, but different patterns of MDO for males and females). Within the sentenced and remand populations, levels of mental disorder have been found to be very high (up to three quarters) and the primary diagnoses have been of schizophrenia, with high rates of comorbidity, especially with substance abuse. MDOs commit a range of offence types, of which violence is only a part. The more secure the environment, the more serious the offences and consequently the higher the proportion of violent offences.

- The study of MDOs ***interactions with the police*** has been considerable, providing a wealth of information on the problems of the recognition, response and management of mentally disordered people across a vast spectrum of disturbance, and offending behaviour. The role of the police as gatekeepers to both the mental health and criminal justice systems has been examined in detail. On one hand they have been found to be relatively skilled at identifying people with clear mental health problems and referring them on to other services. They are perhaps less skilled (as would be expected) at the borderline and less serious cases. These are also the cases who are becoming less likely to be dealt with by court-liaison schemes, and may be falling through nets.

- Despite some large scale surveys in recent years, we concluded from the descriptive work that there was a clear need for a ***series of new reviews*** leading to a broader overview of the picture, looking at differences between levels of security as well as between MDOs and others within any one level.

- The chapter on ***pathways*** identified what happened to MDOs at different stages within different systems, and looked at the factors (such as ethnicity, offence type) that affected the ways in which they were dealt with. There was only limited information on throughput and outcome in general. Most of the studies provided snapshots of groups who were inpatients in particular settings at any time, but ignored the crucial issue of the ebb and flow of mental health problems.

The research agenda

At the beginning of the decade, the Reed Report provided a picture of the possible components of a strategic plan for research on mentally disordered offenders. This is presented in Figure 12.1. It is clear that the intervening years have filled in some of the gaps. For example, the work on the prevalence of mental disorder in the remand prison population was published in the middle of the decade, and this current series of reviews meets some of the other needs (eg, epidemiology).

On the basis of this scoping exercise, we would conclude that the future research agenda needs to include both (a) things that the research community needs to do for the sake of improving the general academic base, and also (b) things that need to be done to translate good data collection practices into strategies that agencies can use to improve the assessment of needs and services. Thus, development of theory is needed in its own right, but there is also a strong need for contributipms to evidence-based practice on the ground.

Improving the academic base

(i) There are a number of areas where more reviews are necessary. Part of the difficulty in this whole area has been the breadth of material and the difficulties of distilling the overall picture from the mass of empirical evidence, much of it very variable. We would suggest that there are several areas where further reviews could usefully be commissioned, following some of the chapter headings of this scoping review. The epidemiological work has already been done, but others include:

- a broader review of gender and offending and mental health, within which the Lart review would be set.
- a reader-friendly and terminology free description of the full range of the statutory framework and its implications.
- a specific review on the relationship between offending and mental health, in terms of risk factors, raising questions as well as summarising the limited existing research evidence. There is a need to look at the international literature in this respect, particularly the US and Scandinavia.
- A more detailed comparison of the pathways research with what is known about pathways in and out of other services for different groups of clients.
- A review of international models of provision (beyond the scope of this scoping review).

Figure 12.1 Reed 1992 - Possible components of a strategic plan for research on mentally disordered offenders

TOPIC	SOCIAL POLICY	BASIC RESEEARCH IN MEDICINE ETC.	SERVICE DELIVERY	LEGAL AND PENAL PRACTICE
Mentally Disordered Offenders	Relationships between prevalence of offending by mentally disordered and social deprivation	Epidemiological surveys by NHS Region. Longitudianal studies of MDOs. dev. Of drug treatments	Provision of services by general psychiatrists. Quality of aftercare in community	Use of hospital/gurardianship /probation orders or prison sentences
Personality Disorders	Environmental factors which influence personality disorder	• Literature review • Treatability issues • Diagnostic issues	• Evaluation of treatment	Use of hospital/prison disposals
Sexual Offenders		• Distintion between sexual disorders and sexual offending. Epidemiological survey in the UK	• Roles of penal health and social services	Effect of changes in the law
Violent Offenders	Effect on victims	Relation to mental disorder. Treatment programmes in prison and community	Evaluation of treatment programmes	
Police		Profiling offenders	• Services required to assist police to identify MDO's	• Use of section 136
Community Services		Effect of the reprovision of local services on mental health	• Effect of social supervision of restricted patients	
Prisoners		• Prevalence of mental disorder in rmand prison population	Arrangements for mental health services for prisoners	Measures to prevent suicide or self-harm
Adolescents	Effect of disturbed childhood on later incidence of mental disorder/offending	Indicators of future offending (especially sexual offending)	Evaluation of current interventions (especially sexual offending)	Pathways into custody of juveniles (effects of new child and CJ legislation)
Diversion	Attitudes of prison officers to MDOs. Public attitude to not prosecuting mentally disordered offenders		• Resources required for effective diversion schemes	MHA sections – suitability of, for diverting MDOs from CJ system. Power of judges/magistrates
Hospital Services	• Outocme indicators for hospital care		• Assessment of needs for different types of hospital provision	
Women		Prevalence of mental disorder	Availability/use of services	Differential use of hospital orders
Ethnic Minorities		• Evaluation of treatment approaches and responses	• Availability/use of services • Equitable treatment of Ethnic Minorities.	

• Recommended priority (RS 6.8)

(ii) A more detailed discussion of the definitions used in different studies (including international comparisons), the reasons for excluding or including different groups of disorder etc, resulting in guidelines for research in different areas.

(iii) There is an obvious and clear need, also articulated in the Reading epidemiological review, for an epidemiological study of the coincidence of mental health problems and offending.

(iv) Longitudinal research on pathways following patients and offenders though the system for a period of years rather than months is also critical. It would be valuable if this could be a combination of studies including qualitative and quantitative data, and tapping the perceptions of the patients and offenders as well as facts of their transitions.

Strengthening evidence-based practice

In addition to the studies listed above, these should also be considered as useful to the development of a more policy and practice relevant research agenda:

(i) There is a need for a programme of work and testing on the development of better information gathering tools which can be easily used in the various settings across the range of provision.. Indeed, this was commented on recently by the Social Services Inspectorate, who commented that there was a need for help from the research community in the development of effective and useful information systems, particularly joint information systems (eg, SSI, 1996). This work should be related to development of simple but clear models for evaluation of services.

(ii) This could be related to, or the building blocks for, a needs assessment exercise across different types of provisions (in addition to, for example, existing assessments of needs in some specific establishments such as Special Hospitals). Matching needs to the services being supplied should highlight shortcomings in the current system, and contribute to the development of more effective models of provision.

(iii) There is very little in the research literature on the successes or difficulties of contracted-in mental health services or dedicated forensic services in prisons, apart from small scale evaluations of individual schemes.

(iv) A national Local Authority survey of definitions in use (of MDOs) and their operationalision, the existence and success of local multi-agency working, and the range of services available, would provide a good context for many of the studies suggested in this section.

(v) We came across very little in the literature on costs and outcomes analyses but on the basis of evidence in other fields (eg health generally) this will be a particular focus over coming years. Methodologies are being developed that could be applied within several of the studies listed here.

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