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Troublesome Offenders, Undeserving Patients? The Precarious Rights of Mentally Disordered Offenders

Rob Canton

Introduction

This chapter affirms the importance of trying to establish an ethical basis for working with ‘mentally disordered offenders’ in the context of academic and policy debate that is often centred around ideas of effective treatment and system management. It is argued that a respect for human rights constitutes the most secure foundation not only for ethical policy and practice, but also for an approach that can contribute to solutions and to positive outcomes – both in terms of meeting the needs of mentally disordered offenders and in reducing reoffending. Rights are here understood as ethical entitlements and, although law is essential in defending and promoting these rights, it is also necessary to find a perspective from which to critique the law. The initial account suggests that human rights include both *liberties* (freedom from oppression and cruelty, for example) and *claims* (demands on government to foster circumstances in which people may thrive). The daunting question of what are the rights of mentally disordered offenders is explored by considering each of a paradoxical set of rights that have been attributed to them. It is argued that examination of these putative rights exposes some assumptions about (and ambivalent attitudes towards) mental disorder. It is likely that cultural influences and stereotypes influence reactions towards people believed to be mentally unwell and that these reactions may subvert or distort policy objectives (see Arrigo and Bersot, this volume). An understanding of the social origins of mental distress, including the effects of social disadvantage and exclusion, is set against the dominance of medical conceptions which have dominated policy debate. The chapter concludes by asserting claim rights, as well as the safeguards of liberty rights, and making connections between the entitlements of mentally disordered offenders and the ‘Good Lives Model’ (see Göbbels, Thakker and Ward,

this volume) which is now influential in desistance research. In the context of contemporary economic difficulties and the volatile politics of crime and punishment, the fundamental importance of establishing a secure ethical foundation for policy and practice must be asserted.

The problem of how to manage offenders with mental health needs seems intractable, and has puzzled and frustrated policy makers and practitioners for a very long time. This chapter tries to distinguish and perhaps to clarify some of the complex and contested questions to which these problems give rise. How, then, are these matters to be approached and discussed? While policymakers, practitioners and researchers have often set the question 'What works?' as their priority (see McGuire, this volume), it can be argued that a better initial question is 'What's right?' Both questions are complex and irresolvably contested, but there is much to be gained from beginning criminal justice debates by foregrounding ethical considerations, especially when considering offenders with a mental disorder. It has been properly insisted that 'the mentally disordered offender [should] be treated as a person first, as an offender second, and as mentally disordered third' (Peay, 1994; p. 1123). Yet a great deal of policy discussion inverts these priorities, considering, first, the individual's needs for diagnosis and treatment; second, the contribution of the agencies of criminal justice; and, third (if indeed at all), the ethical entitlements and safeguards that derive from being a person (see Mathews, this volume).

There is a real risk that ethical considerations are obscured or lost in debates about effective treatment or about the efficient management of the notoriously complex interfaces between systems of health care and criminal justice. Discussing the institutions of punishment – but making a point that is no less well-taken when considering those who are mentally disordered – David Garland writes that '...values such as justice, tolerance, decency, humanity and civility should be part of any penal institution's self-consciousness – an intrinsic and constitutive aspect of its role – rather than a diversion from its "real" goals or an inhibition on its capacity to be "effective"' (Garland, 1990: p. 292).

History too demonstrates the imperative value of keeping sight of the ethical status of patients with mental health needs. Histories of psychiatry are replete with examples of pain and humiliation inflicted on patients, sometimes with good intention, but also arising from more complex and perhaps questionable motives (Porter, 2002; Scull, 2005). Nor should it be assumed that these cruelties and abuses have been consigned to the past. Implicating the psychiatric profession and its symbiotic relationship with 'a massively profitable psychopharmaceutical industry', Scull suggests that 'we once more live in an era where simplistic and biologically reductionist accounts of mental disorder enjoy wide currency ... [and have adopted] a concept of mental illnesses as specific, identifiably different diseases, each allegedly amenable to treatment with particular

drugs or “magic bullets”’ (Scull, 2005: p. xii; see Mathews, this volume). It will be argued later that contemporary approaches to mentally disordered offenders tend to rest precisely on the assumptions that Scull calls into question, that policy discourse is ‘over-medicalised’ and that there are other ways of understanding and responding to mental distress – ways that may better respect the rights of those concerned. The history of the prison too includes any number of examples of gratuitous cruelty and degradation (Morris and Rothman, 1995; Wilson, 2014). Across the world, countless prisoners are still held in the most appalling conditions. In the USA alone – although for sure not only there – tens of thousands of inmates are held in conditions that can be argued to amount to torture, many of whom have a clinically diagnosable mental health need and/or learning need (Gawande, 2009; see also Council of Europe, 2014).

That the most fundamental rights of suspects and offenders and of people believed to be mentally disordered have been grossly violated, so often and in so many places, should be a reminder of the need to determine the ethical parameters within which debates about effectiveness may take place. Before attempting to identify these parameters, it will be important to look briefly at the ethical concepts that are to be deployed in the discussion.

Human rights

One approach to an understanding of the constraints and obligations that set the ethical boundaries of responses to mentally disordered offenders is through an inquiry into human rights. There is no suggestion that *human rights* represents the only way to think about moral issues or that all ethical considerations can be framed as rights. *What is the right thing to do* can as well be explored through reflections on welfare, duties and virtues (see Sandel, 2009, for an excellent introduction to these topics). Yet the discourse of human rights has become the best established way of asserting liberties and claims, a familiar and international ‘language’ in which to conduct policy debate and one that is of particular value to oppressed and vulnerable groups (Clapham, 2007).

Rights encompass both liberties and claims (Gearty, 2006). *Liberties* include an insistence on restraints on inhuman and degrading treatment, on cruel or unusual punishment, against injustice; *claims* articulate a demand for the state to meet needs for human flourishing and well-being, for example, rights to education, employment, healthcare and to an adequate standard of living. These are claims that require more than forbearance and call for positive action by the state.

Human rights are everybody’s: they do not have to be earned and the sole and sufficient credentials to qualify for them are to be human. This insight is an essential reminder that, in the present context, it is not only the rights of those believed to be mentally disordered offenders that are at issue, but the

rights of everyone else as well – in particular, perhaps, of actual or potential victims of their crimes. This should not, however, be discussed as a question of *balance*. As Ashworth has argued, that metaphor often leads to a utilitarian calculation that the rights of victims ‘outweigh’ the rights of offenders (Ashworth, 1996; see also Canton, 2009). The implication would then be that majority rights should prevail. But rights can and should function as constraints on what the state may legitimately do. As Nozick powerfully asserted: ‘Individuals have rights, and there are things that no person or group may do to them (without violating their rights)’ (Nozick, 1974: p. ix).

The European Convention on Human Rights distinguishes between *absolute rights* (which may never be taken or given away), *limited rights* (which may only be compromised in explicitly identified specific circumstances) and *qualified rights* (where individual rights must be considered alongside broader social and community interests) (Ministry of Justice, 2006). Notoriously, too, rights may *conflict*. To assert a right, then, even persuasively, does not by itself settle the question, but it does mean that there is a need for a principled judgement. A human right may not be ignored or merely set aside as inconvenient: if it must be infringed (because other moral considerations turn out to be more compelling), this requires an ethical justification and the infringement should take place with a sense of regret, an attempt to mitigate the consequences for the right-bearer and a stimulus to look for solutions to future similar cases which better respect the right.

In the modern era, the authority of law has been fundamental to the framing and development of human rights, as statutes and international treaties have proliferated. In the UK, the most important such statute was the Human Rights Act 1998, which incorporated the European Convention for the Protection of Human Rights and Fundamental Freedoms into national law. The government’s professed intention at that time (Home Office, 1999) was that human rights should not merely be seen as a constraint on policy:

‘Though it is clearly right that all public authorities should not act incompatibly with the Convention rights, the Act was intended to do more than merely avoid direct violations of human rights....this is a constitutional measure, *legislating for basic values which can be shared by all people throughout the United Kingdom. It offers a framework for policy-making...*’ (Joint Committee on Human Rights 2003 – emphasis added).

It is indeed doubtful, however, that the Act has been embraced in this way. There has certainly been progress – many cases have come to court where the Act and the Convention on which it is based have been cited. In the area of criminal justice, attempts have been made in this way to clarify, defend and promote the rights of prisoners (van Zyl Smit, 2007) and those subject to community penalties (Gelsthorpe, 2007). But this often seems to have been wrung from a grudging and reluctant administration, which has reacted with just the

kind of litigious defensiveness that the government itself had originally warned against. There is little sign that the Convention has inspired penal policy. On the contrary, the Act – and indeed the very idea of human rights – now often attracts suspicion and hostility in politics and in the mass media (Gies, forthcoming).

However that may be, one of the principal advantages of framing ethical debate in the language of human rights is that their legal basis makes them *justiciable* – capable of being put to test and determined in a court of law. Political decisions can be challenged in court – domestically, through the Human Rights Act 1998, and internationally through the Convention in the European Court of Human Rights. Invoking human rights in this way has been employed to good effect in recent years. For example, the Howard League has used the processes of judicial review to clarify and promote recognition of the rights of young people in custody and the duties that are owed to them, establishing the key principle that the state is not absolved of its duties to young people because they are designated ‘young offenders’ (Howard League, 2008).

Yet while the legal standing of human rights affords these progressive possibilities, enabling challenge and insistence on the enforcements of rights through due process of law, the topic should not be explored solely through an analysis of statute and case law. It is important, after all, not to lose sight of a conception of human rights that can appraise, challenge and limit the powers of the state, including its legislative and judicial authority. In this paper, then, discussion about rights will not be confined to those rights that have been established by law, but will include ethical arguments about what it would be to deal with mentally disordered offenders fairly and well. (For the legal aspects of the Convention’s impact on the rights of people who are mentally disordered, see especially Richardson, 2005; Prior, 2007; Hale, 2004.) Moreover, in general, a dependence on the law here will be slow to progress. Legislation takes time and courts can only have regard to cases that are brought before them.

It has been argued, then, that the discourse of human rights represents the most instructive way of exploring ethical issues in relation to mentally disordered offenders; that regard should be had to both liberties and claims; and that the foundation of rights in law is both a strength (making ethical assertions justiciable) and a limitation (because not all rights are – or perhaps even could be – articulated in statute or case law). In particular, it has been asserted that human rights are those rights that all people possess in virtue of our common humanity. The corollary of this is that to fail to take account of someone’s rights may be to treat them as less than human (see Arrigo and Bersot, this volume).

Mentally disordered offenders and rights

Definitions of the term *mentally disordered offender* are discussed by others in this volume (see for example Göbbels, Thakker and Ward). Here it is enough

to note that there can be no uncontroversial definition of this term, not least because any definition is 'partly dependent on the incentives for its construction' (Peay, 1994: p.1123; see Arrigo and Bersot, this volume); that there are legal, medical and lay understandings that are different, even if they sometimes overlap; that attempts to apply or to reject the application of the term to an individual is in practice strongly influenced by professional and resource interests; and that, without a sufficient definitional consensus, attempts to frame policy will founder and estimates of the numbers of people concerned should always be regarded with caution if not scepticism. It can even be argued that it is impossible to identify a 'group' of mentally disordered offenders whose members have as much in common with one another, or are sufficiently different from many offenders excluded by definition, to constitute any kind of group or category (Canton, 2002). The term mental disorder encompasses a very wide range of conditions, yet policy commonly fails to respond to this diversity.

As for ethical inquiry, the expression *mentally disordered offenders* is an unpromising start. It is a reductive term that understands people in complex and troubled circumstances in terms of their worst behaviour (as *offenders*) and assimilates people with a wide range of mental health difficulties. It 'groups' people with any number of dimensions of difference – gender, age, ethnicity, sexuality (see for example Petrillo, this volume; Chitsabesan and Hughes, this volume) – as well as widely differing offending careers. It smuggles in, at least by implication, assumptions about the connections between mental health and offending. With these cautions duly noted, discussion moves on to consider how the rights of mentally disordered offenders might be explored.

A brief historical and international review of forensic psychiatry some years ago ended by identifying a number of central themes, including:

the right to be punished; the right not to be punished; the right to be treated; the right not to be treated; the justice of indeterminate sentences especially when associated with treatments of debatable efficacy; and the poor predictability of dangerousness. (Higgins, 1984; p. 13)

It seems to me that this paradoxical set of claims and problems offers a framework in which many of the most complex ethical concerns may be explored. Reflection on these questions illuminates some of the philosophical and legal ambivalence and confusion that are regularly acted out in practice, contributing to an explanation of why policy is so difficult to frame and so often frustrated in implementation. It may also expose certain assumptions – about the nature of mental disorder, about punishment and treatment, about the capacity of mentally disordered people to be (or to be held) responsible, about their supposed irrationality and consequent unpredictability – which

are all the more influential in policy debate and in practice because they are insufficiently articulated or inspected.

The right to be punished

Among the arguments to be found in the extensive philosophical literature on the justifications of punishment is the claim that offenders have a *right to be punished*. While the origins of this claim could be traced to Kant or to Hegel, the case has been more recently developed by Bennett (2008), building on an influential paper by Strawson (1960 [1982]). Our 'reactive attitudes' to the behaviour of others, which include resentment, gratitude, forgiveness and anger, contribute to the very fabric of human society, exchange and reciprocity. Reactions to wrong-doing can only be withheld by assuming towards someone an 'objective attitude', regarding their behaviour as 'caused', rather than autonomous and done for *reasons* (which is the way in which we usually understand human conduct). While there are circumstances where this objective attitude is appropriate, it is at odds with our usual expectations of one another and 'a sustained objectivity of interpersonal attitude, and the human isolation which that would entail, does not seem to be something of which human beings would be capable' (Strawson, 1960 [1982]; p. 81). Since the capacity to be a moral agent is definitively human, to deny this capacity to someone is, in a literal sense, to dehumanise them and part of what it means to respect moral agency is to impose punishment when this is deserved.

For the present discussion, however, the issue is not whether there is a right to be punished, but rather whether, if there is such a right, there are any general grounds for supposing this right to be inapplicable to mentally disordered offenders. Instructively, when looking for examples of where the objective attitude might be appropriate, Strawson mostly refers to people who are in some way or another mentally disordered. But why does mental disorder lead to a withdrawal of our usual reactive attitudes? One likely explanation is that irrationality has often been regarded as a defining characteristic of madness (Porter, 2002). Reasons for behaviour do not apply to people with a mental disorder: it is the mental disorder that controls their conduct and their behaviour is viewed through that lens. As Nathan Filer puts it, 'If people think you're MAD, then everything you do, everything you think, will have MAD stamped across it' (Filer, 2013: p. 216). Yet as Moore insists, in more prosaic terms, '...most of the actions of a mentally ill person are a result of non-illness factors' (Moore, 1996: p. 41). Peay notes that 'Mental disorder may correlate with certain kinds of offending, but is rarely causative...' (Peay, 2012: p. 432).

In truth, mentally disordered people offend for the same broad range of reasons as everybody else – for example, through fear, greed, poverty, abuse, anger, drunkenness, arrogance and despair. The problem then becomes one of trying to understand what contribution the mental disorder made to the

offence. It may, for instance, have affected motivation or perhaps been a disinhibiting factor. It should also be noted that mentally disordered offenders are at least as likely as (probably more likely than) others to use alcohol and / or illegal drugs (Watkins, et al., 2001; see Pycroft and Green, this volume). In most cases, drug use or drunkenness will not be accepted as a substantially mitigating factor, but the problem of disentangling the (legally culpable) influence of substance misuse from the mental disorder (for which they are held not to blame) is intractable. There will be cases in which these influences are more readily discernible, but there can be no general assumption that diagnosed mental ill health was 'the cause' of the offence and takes away the right to be punished.

In law, the number of cases in which mental disorder leads to acquittal are extremely few – much more commonly, it is adduced in mitigation (see De Lacy, this volume). But in that case, the Court should have regard to all the statutory purposes of sentencing (Criminal Justice Act, 2003, s. 142) and it is not at all clear why reform or rehabilitation (perhaps through treatment) should be given priority over punishment, deterrence, incapacitation or reparation. A mindset that assumes that mental disorder conclusively explains an offence will sometimes redound to the offender's advantage, but (as will be argued later) this is by no means always the case. At the same time, that mindset has profoundly disadvantaged people with mental illness and learning disabilities by setting them outside ordinary understandings of human interaction and invoking the objective attitude which Strawson (1960 [1982]) shows to be typically dehumanising. Punishment, it can be argued, is one component of respect for persons.

Finally, mention must be made of the procedural safeguards associated with punishment that may be withheld for interventions characterised as 'treatment' (see McGuire, this volume). In particular, retributive punishment insists on *proportionality* and sets principled limits determined by the seriousness of the offence. Yet if an offence is 'caused' by some impairment, then proportion can be suppressed in the name of treatment and public protection. Indeterminacy is a natural consequence, for at the time of sentence it is not at all clear when treatment may be expected to have had its effect. Such might be the basis of the right to be punished.

The right not to be punished

If there is a general right to be punished, then, the reasons for denying this right to mentally disordered offenders must be made out. The right *not* to be punished, as has been seen, might rest upon assumptions that mentally disordered offenders are somehow less culpable – an assumption made by many people, although one which can also be viewed with suspicion as the fabrication of excuses. Perhaps it is feared that the imputation of mental

disorder might confuse less complicated reactions to wrongdoing and enable defendants to 'get away with' something less than their deserts (see also Webb, 1999). In this chapter, our concern is more with a moral understanding of responsibility than the legal concept (for an excellent introduction to the relevant legal debate, see Johnstone and Ward 2010, especially Chapters 4 and 5). And in these terms it is natural to think of *degrees of responsibility*, which would vary not only with the characteristics of the crime, but also with the characteristics of the offender. From a moral point of view, as well as with regard to a focus on solutions, this individualisation is an essential aspect of an appropriate response to offending by people believed to have a mental disorder.

Many excusing or mitigating conditions – duress, provocation, mistake – depend on ideas of what people of sound mind might do in the circumstances; but another set of conditions may arise from deficiencies associated with mental disorder. These might be cognitive defects or volitional deficiencies. Hallucination or delusion are paradigm examples of cognitive impairments, while compulsion, obsessions and impulsivity might all influence volition. As has been argued, however, the diversity of mental disorder makes generalisations impossible here and a 'right' of (all? most?) mentally disordered offenders not to be punished on the basis of their (limited or lack of) culpability is hard to establish.

The right not to be punished, however, might be grounded not so much on assumptions or speculations about culpability (at the time of the offence), but on the possibility that prosecution and punishment might aggravate mental ill health, as assessed at the time of sentence (see Rogers and Ormston, this volume). The right not to be treated in ways that aggravate any mental condition seems unassailable: even the most punitive-minded people reject (or should reject) any form of punishment which leads to a deterioration in someone's physical or mental health. The European Court of Human Rights has ruled that, under Article 3 of the Convention, 'the authorities are under an obligation to protect the health of persons deprived of liberty ... [and] in the case of mentally ill persons, to take into consideration their vulnerability...' (*Keenan v United Kingdom* [2001] 33 EHRR 38: 111).

Yet this is a right that should be enjoyed by all defendants. The deleterious effects of punishment – especially imprisonment and, still more, solitary confinement or detention in dehumanising conditions – are well known (Shalev, 2008). It has been said that:

Many studies assume that mental health difficulties are imported, failing to consider that the pains of imprisonment can distort the prevalence of mental health problems. ... Mental health problems and confinement may then go hand in hand' (Scott and Codd, 2010: p. 24).

The regular inspections of the Committee for the Prevention of Torture (Council of Europe, 2014) often uncover evidence of psychologically damaging forms of incarceration, while in the USA even the most psychologically robust inmates are likely to be traumatised by the isolation of the regime in 'Supermax' prisons (Shalev, 2009).

There is no reason to doubt that psychiatric assessment can help courts to distinguish those who are most vulnerable in these respects (see De Lacy, this volume) but the categories of *mentally disordered offenders* and *the vulnerable* do not coincide. For example, people assessed with *personality disorder* make up a large proportion of the prison population (62% of male and 57% of female sentenced prisoners – Stewart, 2008), but it is by no means clear that this condition of itself makes them vulnerable to psychological deterioration in custody. Equally, there is no doubt that there are a number of defendants with no known psychiatric history or whose mental health has not been assessed whose psychological well-being will deteriorate in a prison.

It is possible to argue that punishment is unjustifiable and that accordingly *all* defendants have a right not to be punished (Zimmerman, 2011). Discussion here has tried to determine if there are particular considerations that apply to mentally disordered offenders. The overlooking of diversity immanent in the term *mentally disordered offenders* has complicated discussion throughout. As well as exposing assumptions that are commonly made about the capacity of people with mental disorder to reason and to act purposefully, these reflections point to possible explanations of the limited success of policy in this area. Sentencers are not persuaded that mental disorder should always constitute grounds for diversion (from the criminal justice system, from custody or other sanctions) or that imprisonment is never appropriate and generalised policies about mentally disordered offenders that guide them in that direction are likely to be limited in their effect. In the next part of this chapter, the right to be treated and the right not to be treated will be explored.

The right to be treated

The right to be treated for mental disorder seems fundamental and is affirmed prominently in the UN statement *The protection of persons with mental illness and the improvement of mental health care* (United Nations, 1991). Yet while this appears to stand as a decent aspiration of any civilised society, it is a right that, in practice, is not enjoyed by many people in mental distress in the UK. Although it has been estimated that one in four adults experience some kind of mental health difficulty in the course of a year (Mental Health Foundation, 2007), mental disorder has never been included in the time-parameters for treatment and management by the health services (for example, reduced waiting times). With the whole health system under pressure, it has been said

by authoritative observers that 'The mental health service in England is in crisis and unsafe' (BBC 2013c, 2014; see also Laurance, 2003).

If there were accessible services, it might be possible for many people to gain the treatment or support that they need before their distress and bewilderment find expression in criminal offences. In that case, fewer people with mental disorders need come to the attention of criminal justice in the first place. As it is, some people unable to obtain services through community access on a voluntary basis will instead be treated compulsorily at the order of the Court and the criminal justice system is at risk of replacing primary health services as the way of accessing mental health treatment.

Primary mental health care support also seems less available to some groups. For example, there is evidence that 'there are significant and sustained differences between the white majority and minority ethnic groups in experience of mental health services and the outcome of such service interventions' (National Institute for Mental Health, 2003: p. 10). That report went on to express concerns about the adequacy of primary mental health support to people from minority ethnic groups and noted that often their access to psychiatric services is through arrest and prosecution.

Policy, especially when reasserting the value of diversion (see Rogers and Ormston, this volume), is at risk of assuming a well-resourced capacious mental health care system. But this does not exist. Nor is it clear that hard-pressed psychiatric services should give priority to defendants and offenders. Medical practitioners should presumably make judgements about resource allocation on clinical grounds, but Peay (2012) cites evidence to suggest that people sent to hospital from court tend to be (clinically) *less* needy than those referred from the community.

Treatment can mean many different things – from medication to regime management, from counselling to cognitive behavioural programmes. For that matter, as Peay notes, 'There may be a mismatch between health and criminal justice personnel in respect of the objectives of treatment' (Peay, 2012: p. 441). For health professionals the priority may be to treat the disorder believed to underlie the offending, while for criminal justice personnel the principal objective may be to avert the problem of managing difficult people safely in penal custody or in the community. Again, given the uncertain relationship between crime and mental disorder, treatment – even (clinically) successful treatment – may make little or no difference to future offending. So while from one point of view a right to treatment ought to be affirmed, it is much harder to work out what this amounts to in practice. These issues will become clearer as the right *not* to be treated is discussed.

The right not to be treated

These are ethical dilemmas in determining robust and lasting solutions to managing mental disorder. Baroness Hale (2004) makes the critical distinction

between *enabling* access to treatment as of right and *enforcing* treatment, which, without due safeguard, amounts to the violation of a right. There are, to be sure, hard questions about the capacity to consent, but the (defensible) presumption should be that, as with physical ill health, people ought not to be treated against their will and their view may be overridden only after careful assessment, legal scrutiny and due process (Hale, 2004). While resistance to treatment is often construed by the psychiatric profession as an irrational refusal – the inability of an ill patient to comprehend the benefits of treatment – the outcomes (and side effects) of treatment often remain so uncertain that it is by no means clear that refusal must be ‘irrational’ (see Mathews, this volume). For that matter, mental health professionals themselves dispute the efficacy of certain treatments for certain conditions (for discussion see, for example, Bentall, 2003).

Discussions about treatment for mentally disordered offenders are often predicated on particular understandings of the nature of mental disorder, as well as assumptions about its relationship with offending. Drug therapies and ‘talking cures’ are felt to be the appropriate treatment. Yet there are other ways of understanding and responding to mental distress. Attention to the *social* influences on mental disorder – ‘bad things happen and can drive you crazy’ (Read and Haslam 2004) – is a reminder that social factors make a significant difference to the onset, development and treatment of a range of mental disorders and to prospects of recovery. Leff (2003) is among those who have argued convincingly that a significant improvement of the environment, especially in the quality of personal relationships, is at least as effective as medication in guarding against relapse in depression and schizophrenia. We should take more seriously the possibility that, as well as mental disorder ‘causing’ crime, offending and its consequences contribute to and aggravate mental distress. Offenders’ lifestyles often bring them considerable anxiety and stress. The offences themselves, as well as the fears and realities of detection and punishment, can bring enormous stress as well as undermining those factors that stabilise and nurture mental health – not least (though not only) supportive relationships. Offending and its consequences – especially imprisonment – result in social exclusion, stigma, closing down of opportunities and relationships (Uggen et al., 2004). These are all factors associated with mental ill health (Canton, 2008).

It is well established that many people with a mental disorder lead lives marked by enormous social disadvantage. People with schizophrenia commonly experience stigma and discrimination in many countries, leading to their impoverishment, social exclusion and a low general quality of life (Thornicroft et al., 2009). There have been similar findings for people with major depressive disorders (Lasalvia et al., 2013). Mentally ill people are vulnerable to hate crime on the basis of their mental ill health or disability (Clement et al., 2011; see Tyson and Hall, this volume), are believed to be three

times more likely to be victims of crime (BBC, 2013b) and five times more likely to be murdered than the general population (*The Independent*, 2013). Already often in poverty, they are especially vulnerable to the impact of economic recession (BBC, 2013a).

It may be argued that, whatever the origin of their mental disorder, people have a right to treatment. The point here is that if a woman living in impoverished circumstances burdened by her responsibilities and perhaps enduring domestic violence from a partner visits her doctor and reports symptoms that lead to a diagnosis of depression, a decision to prescribe anti-depressant medication is not necessarily what she most needs – nor is it politically neutral. It is well known that many women offenders have precisely this kind of profile (see, notably, Corston, 2007; see Petrillo, this volume).

A right not to be treated, then, might rest on matters of consent, but also on concerns about the efficacy of medical treatment. Whether or not a condition is 'treatable' is not always the right question and effectiveness depends on any number of variables (Allen, 1987; see McGuire, this volume; Scally, this volume). Moreover, psychiatric or psychological treatment may be inappropriate. It is at least arguable that attention to the oppressive conditions that confront so many mentally disordered offenders would be quite as beneficial for mental health as 'treatment' and that treatment is unlikely to have its effect without regard to this context. It may be convenient for politicians to translate problems of socio-economic origin into personal pathologies (both for offenders and for people with a mental disorder), but these reflections expose the radical inability of social problems to be resolved by either criminal justice or psychiatry – even working in partnership (see Rogers and Ormston, this volume; Hean, Walsh and Hammick, this volume).

To summarise: following Higgins (1984: p. 13), the chapter has so far reviewed '...the right to be punished; the right not to be punished; the right to be treated; the right not to be treated'. These notional rights have been looked at separately, but it must be recognised that they are usually inter-related. A right to be treated, for example, is often connected in debate with a right not to be punished. It has been argued that none of these rights is as straightforward as might appear and that cases can be mounted both for and against them all. It may well be that these doubts about what is fitting when a mentally disordered offender is arrested or attends court may subvert any generalised policy like *diversion*. Police and courts may well – and reasonably – be unconvinced that this is always appropriate and, most fundamentally, a policy that is intended to apply to so heterogeneous a 'group' as mentally disordered offenders is always likely to founder. Discussion moves next to the other themes reviewed by Higgins – dangerousness, 'prediction' and indeterminacy.

Indeterminacy and treatment, dangerousness and prediction

Risk and public protection have become established as the over-riding shared objectives of the agencies of criminal justice (see Arrigo and Bersot, this volume). Garland sets this in the context of a *culture of control* where public protection 'has become the dominant theme of penal policy' (Garland, 2001: p. 17; Loader and Sparks, 2002). In mental health policy, too, risk has become a determining influence on the character of the psychiatric system (Laurance, 2003). The deeply embedded cultural belief that people who are mentally ill are volatile, irrational and unpredictable fuels these fears (Porter, 2002). If prediction and knowledge are needed to manage our risks, how are risks that seem inherently unknowable and unpredictable to be managed?

The harder it is to understand why an offence has taken place, the more likely it will be that a psycho-pathological explanation will be sought. Since so many crimes of violence are in this sense unintelligible, there is a discernible trend towards understanding such crimes in psychiatric terms (Canton, 2002). Other contributors to this volume (see for example, Chitsabesan and Hughes; Gatawa; de Lacy) explore aspects of the assessment and management of risk, its potential and limitations, uncertainties about 'prediction' and the especially vexed question of the inter-related but distinct assessments of dangerousness from people variously assessed with personality disorder, psychopathy or suitability for the *Dangerous and Severe Personality Disorder* programme (Peay, 2012; see Scally, this volume). Focus here is on the implications for human rights.

Of particular concern is that the prevalence of risk-thinking in criminal justice policy has the potential to subvert valued safeguards, especially proportionality (Hudson, 2001; see Arrigo and Bersot, this volume). Proportion sets limits (principled, if hard to specify) to punishment, but once the perceived imperative of public protection is allowed to supersede these safeguards, it is hard to limit intervention. While it has been an assumption of this chapter that human rights offer defences against oppression, it is to be noted here that the European Convention on Human Rights explicitly countenances detention for people with a mental disorder. Among the reasons why Mullen (1999) denounced the DSPD programme (see Scally, this volume) was precisely because this preventive / pre-emptive detention would have been unlawful unless it could be brought within the scope of Article 5 1. (e), which allows for the lawful detention of persons of 'unsound mind'.

Yet where treatment is required it may be thought impossible to say, at the time of sentence, how long it will take for it to have its effect; and where diagnosis and prognosis are uncertain, as so often with personality disorder (see, for example, Tyrer et al., 2007), it is especially difficult to know when treatment *has* had its effect. An inevitable consequence is that mentally disordered offenders will be more likely to receive indeterminate sentences, without the

safeguard of (retributive) proportionality. A study in 2008 confirmed that, as well as orders under mental health legislation, offenders with mental disorders were over-represented among those sentenced to Indeterminate Sentences for Public Protection (IPP), enacted in the Criminal Justice Act 2003. This study also found that the stresses and doubts of indeterminacy add to mental distress (Sainsbury Centre, 2008).

While the psychiatric profession may be believed to possess the relevant expertise in determining risks, the claim to this authority becomes questionable once it is appreciated that criminal ‘predictors’ outperform diagnostic ones – that is, the risk factors of reoffending for mentally disordered offenders are much the same as for everyone else. A meta-analysis by Bonta and colleagues demonstrated that, both for general and violent forms of reoffending, ‘Clinical or psychopathological variables were either unrelated to recidivism or negatively related’ (Bonta et al., 1998: p. 139). In practice, it is often extremely important to distinguish psychiatric from criminogenic factors – otherwise, clinical stability or improvement could lead to overlooking the possibility that levels of risk are the same (or higher) or, on the other hand, that risks of reoffending have reduced, even though there has been no discernible clinical improvement. This is not to deny that mental disorder is sometimes associated with likelihood of recidivism, but the connection needs to be explored and understood person by person rather than resting on uncritical and over-generalised assumptions (Canton, 2005).

Reflection on risk demonstrates the ways in which a focus on public protection has the potential to infringe the rights of mentally disordered offenders. The ‘psychiatrisation’ of bad behaviour leads to indeterminacy and an exaggerated regard for the contribution of mental disorder to risk assessment and management. Treatment can be invoked to warrant interventions that might otherwise be unlawful (the DSPD programme), even where there is substantial doubt about the clinical efficacy of such treatment, supported by the claim that all this is taking place in the interests of the individual offenders themselves. In this way, the identification of someone as a mentally disordered offender, instead of becoming the basis for a meeting a special need, turns out to lead to special control (Peay, 2012).

Good lives and claim rights

Research in probation and rehabilitation has been refreshed in recent years by desistance scholarship (McNeill and Weaver, 2010; see Göbbels, Thakker and Ward, this volume). People desist from offending by coming to live *good lives* (Ward and Brown, 2004; Ward and Maruna, 2007), their criminogenic needs and risks transcended by ways of living in which crime increasingly has no place. These insights have encouraged a shift of attention towards the processes

of personal change in which rehabilitative intervention may well have a place, but often a subordinate and supportive role to wider developments in the individual's life. Desistance has tended to emphasise the importance of social capital: people need opportunities to acquire and sustain lives that will transcend their offending behaviour. The relationships and social bonds involved depend not only upon individuals' abilities and motivation, but also on the availability of opportunities – a function of the sociopolitical order beyond the reach of criminal justice practices.

This is a perspective that is much less apparent in academic and policy debate about mentally disordered offenders and indeed is marginalised by the over-medicalised conception of mental disorder that dominates contemporary psychiatry. Yet it has been argued that there are other ways of trying to understand mental distress with rather different implications for policy. A *good lives* perspective here would attend not only to liberty rights (safeguards against oppression and injustice), but also to claim rights – including a right to fair access to the resources of civil society which are effectively unavailable to many offenders and many people with mental disorder. Adequate access to accommodation, employment and (of course) healthcare are among the rights that call for positive action (not just forbearance) from the state. Desistance research would lead us to expect that a policy that ensured due respect for these rights would enhance mental health, reduce reoffending and increase public protection.

Conclusions

Among the rights most prominently affirmed in almost all human rights conventions is the right to equal treatment and the rejection of unfair discrimination. Discrimination often arises either from an exaggeration or from a denial of difference. Mentally disordered offenders are vulnerable to both such errors and much of the argument in this chapter has opposed the exaggeration of difference: the idea that there is a discrete group of offenders with mental disorders whose rights and needs are distinct from those of others and who should accordingly be managed or treated in quite different ways. The chapter has called these assumptions into question in many ways. At the same time, there is more that should be said about the hazards and injustice of a denial of difference. All agencies will inevitably encounter offenders with mental disorders and distress and must take proper account of their circumstances if they are to do them justice.

The foundations of a respect for human rights would consider mentally disordered offenders holistically rather than reductively, be cautious of any over-generalised policy for so diverse a 'group', be critical of assumptions that there is a straightforward causal relationship between mental disorder and

offending and recognise the contribution that social capital – including, but not just, ‘treatment’ – makes to desistance.

Looking to the future, to those initiatives that may shape the way in which offenders with mental disorder are managed and treated, it has been argued here that an approach that begins with human rights – rather than with treatment effectiveness or system management – could turn out not only to entail a better and fairer treatment for mentally disordered offenders but also to enhance the public’s fundamental right to be safe.

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