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Boats against the current: vulnerable adults in police custody

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abstract

One effect of the policy of deinstitutionalisation has been to increase police contact with people, who are experiencing the effects of acute mental illness. Policy documents such as Home Office circular 66/90 recognise that adults with mental health problems are especially vulnerable within the criminal justice system. The overall aim of policy is that vulnerable adults should be diverted to mental health services at the earliest opportunity unless the offence is so serious that this would not be in the public interest. However, there is little concrete evidence of the success of this policy. The result is that police officers have an increasing role to play in working with individuals experiencing acute mental health problems. In this process, custody officers have a key role to play as decision-makers as to whether the protections that PACE (1984) offers to vulnerable adults should apply. This article is based on a small-scale indicative research study, which examined how officers make these decisions and the training that they receive relating to mental health issues.

key words

offenders
mental illness
custody officers
protection

Introduction

The Police and Criminal Evidence Act (1984) provided key safeguards for the protection of vulnerable adults – that is, adults with mental health problems or learning disabilities – while in police custody. Along with the standard procedures and rights such as the provision of legal advice and the taping of interviews, such individuals have to be interviewed with an appropriate adult present. Custody sergeants have a key role to play in this process as they, in effect, carry out a risk assessment of every individual who comes into custody. Advice on ensuring the safety of those with mental health problems forms part of *Guidance on the Safer Detention and Handling of Persons in Police Custody* (ACPO, 2006). However, the guidance itself is not comprehensive. In any event, for it to be followed successfully, it is dependent on police officers making appropriate assessments of individuals' mental states. As outlined in this paper there are a number of obstacles here including: the lack of training police officers receive in relation to mental health issues, and a police culture, which, at times appears to be dismissive.

This article is based on a small-scale indicative study carried out in 2006 with an urban police force. The project was concerned with the process, by which custody officers decide that the PACE (1984) safeguards should apply. Custody officers have a central role to play, as the decision that an appropriate adult should be involved is one that they have, in effect, to make. All individuals coming into police custody are assessed as to whether they are fit to be detained. Custody officers will carry out an initial screening exercise seeking medical or other support as required. This is a fluid process, but the initial decisions that are made are very influential. The additional protections of PACE (1984) will not be applied if the individual is not assessed as being vulnerable.

Overview

People with mental health problems, who enter the criminal justice system (CJS), face a number of difficulties. The most obvious one is that the CJS does not exist to provide health care to vulnerable members of society. It might be argued that this is a *de facto* outcome of the failings of community care. However, this does not alter the fact that the role of the police is the reduction and prevention of crime, as well as detection and the subsequent prosecution of offenders. This problem seems to have been a consistent feature of modern industrial societies. As long ago as 1780, John Howard (1780) highlighted the fact that more 'idiots and lunatics' were being imprisoned.

Arboleda-Florez and Holley (1998) argue that one unforeseen consequence of the policy of the closure of long-stay hospitals is a shift in the position of the criminal justice system. As the system has to deal with increased numbers of people experiencing mental health problems, it has taken on a fundamental role in the provision of care in the community. This is occurring despite policy initiatives set for assertive outreach teams to engage those most at risk, in diversion from custody schemes. This phenomenon appears to support the hypothesis that Penrose (1939) put forward nearly 70 years ago. He argued that the way that a society decides to deal with those who behave in ways that challenge accepted norms, is decided by a range of factors. These will include the prevailing social and political climate, changes in what society considers to be normative behaviour and the resources that are available.

As a result of the policy changes and historically, police officers increasingly have a key role in the mental health field. Specific powers exist within the Mental Health Act (MHA) (1983), for example, to remove a person who appears mentally disordered and

in need of care or control to a place of safety (section 136 MHA). In addition, police officers are involved on a day to day basis in a number of areas, for example, supporting other professionals during MHA assessments, executing warrants under section 135 MHA or dealing with violent or aggressive incidents at psychiatric units. It is important to remember that people with mental health problems are citizens living in a range of circumstances. Therefore, like all citizens there are a variety of ways that individuals may have contact with the police.

This article is based on a pilot study, which took place with an urban police force to examine the skills officers require and the training that they receive in order to be able to work effectively with people with mental health problems. Among the issues that this study considered, were the training needs of officers who take on the role of custody sergeant. These officers have a key role under the PACE Act (1984) in terms of ensuring that all those in custody are safe. This will include arranging for medical assessments if required. PACE (1984) affords specific protections to vulnerable adults with mental health problems and therefore, the custody officers are central in the process of identifying cases where these protections should be applied. Police officers cannot be expected to take on the role of community psychiatric nurses or social workers. However, it is apparent that they need specific mental health awareness training that is more than merely a consideration of legal police powers or the Police and Criminal Evidence Act (1984).

Mental health issues and the criminal justice system

Penrose's (1939) hypothesis suggests that the level of need for institutional mental health care will remain fairly constant. Therefore, in

a society that has well-resourced mental health systems, an individual who behaves in a bizarre or challenging way will be more likely to be admitted to hospital. If such services do not exist to meet the level of need, such individuals will be drawn into the criminal justice system. Penrose's original hypothesis chimes with the experiences of community care policies in the 1980s and 1990s. Gunn (2000) highlights the fact that the previous 20 years have seen a reduction in the number of psychiatric beds but a continued increase in the numbers of mentally ill prisoners. This has occurred in other countries that have followed deinstitutionalisation policies (Wolff, 2005). For some commentators the overall effect of the shifts and changes outlined above has been the '*criminalisation of the mentally ill*' (Borzecki & Wormith 1985).

In the literature, the increased risks that people with mental health problems face in the criminal justice system have been identified. The first is that they are much more likely to be drawn into the system in the first place (Hartford *et al*, 2005). Further studies highlight that this group is more likely to be arrested for minor offences and less likely to be granted bail (Teplin, 1984; Robertson *et al*, 1996; Robertson, 1988). In this context, mental illness itself is seen as a risk factor. In addition, these individuals are much more likely to have the sort of chaotic lifestyle that will make them appear a less attractive option for bail. (Taylor & Gunn, 1984). The result is that people with mental health problems are likely to spend longer not shorter periods in custody (Hiday & Wales, 2003).

The above studies are largely based on the North American experience of deinstitutionalisation. However, as inquiries in the UK (see for example, Ritchie, 1994) and the analysis presented in *Modernising Mental Health Services* (DoH, 1998) outline, there is an increasing overlap between the

criminal justice system and community-based mental health services. The overall picture as painted by Wolff (2005) is a very depressing one. The vision of the original architects of community care has not materialised. Instead, fragmented, under-funded services struggle to meet the needs of the most marginalised members of the community.

The Office of the Deputy Prime Minister (ODPM) report on social exclusion (2004) highlights the barriers that people with severe mental health problems face in playing a full role as a citizen. These include access to housing, employment and training, stigma and social isolation. A history of offending is a barrier in itself, the effects of which can be multiplied by mental health problems. There is interplay between economic and social factors and the risks of severe mental illness. Eaton (1980) highlighted '*the downward social drift of schizophrenia*', and Kelly (2005) uses the term '*structural violence*' (adapted from liberation theology) to analyse the way that economic and health factors combine to restrict the life opportunities of people with severe mental health problems. It is within this policy and service context that the police roles considered below are acted out.

Policing and mental health issues

Despite the studies above which have established that people with mental health problems are more likely to come into contact with the police, Bittner (1967) suggests that the police are reluctant to become involved in dealing with situations where the person has a mental health problem. He suggests that it is not seen as proper police work as it is concerned with welfare rather than the apprehension of offenders. The increased contact, as a result of deinstitutionalisation outlined above, has exacerbated some of these difficulties. Robertson *et al* (1995) argue that there is a clash here between two

police functions: the detection of crime and bringing the offender before the courts and the wider welfare role that police officers perform. This process becomes more complex in this area as the police role may be to access mental health services, including formal assessments under the Mental Health Act (1983). Dunn and Fahy (1987) suggest that the sorts of community interventions in psychiatric emergencies such as the use of section 136 MHA powers or the execution of a warrant under section 135 MHA are not seen in the 'canteen culture' as real police work. Officers can be called upon to perform the role of assessing mental health needs with little or no training. Furthermore, individuals presenting with mental distress are often masked by alcohol or drugs. In addition, one has to consider the inherent effect of the stresses of being held in custody.

In the cases of people who are experiencing some form of mental distress section 136 of the Mental Health Act (1983) allows for the officer to take that person to a place of safety if they appear to have a mental disorder and be in '*immediate need of care or control*'. As noted above, the main thrust of policy in this area is the diversion of people with mental health problems from the criminal justice system. If a person is arrested under section 136, they must be assessed by a psychiatrist and approved social worker. It is hardly surprising that the use of this power varies; however, it is worrying that the variations are so great (Bartlett & Sandland, 2004). The Mental Health Act Commission (MHAC) 2005 outlined a number of concerns including poor recording of the use of the power and significant regional variations. In addition, the report highlighted the ongoing concern that police stations were being used as the designated place of safety for those detained using the section 136 MHA powers.

A consideration of Goldberg and Huxley's (1980) model, which identified a series of filters that operate to influence in psychiatric

services, reveals the existence of a similar process for diversion from the criminal justice system. An individual officer may have received more in-depth training on mental health issues, be more experienced, know an individual or have had previous contact with them, and would draw on these factors as part of the decision-making process. In addition, one would have to consider the nature and severity of the incident that the officer is attending.

As noted above, police officers actually receive little training that relates to wider mental health issues. The training that they do receive is focused on procedural or legal issues such as their powers under section 136 MHA. In addition to this lack of training, police officers appear to have limited confidence in wider health and social care systems (Dunn & Fahy, 1987; Home Office, 2002). These studies highlight a number of frustrations that officers felt including delays, bureaucracy and ineffective interventions by health or social care systems. This final point emphasises the different organisational perspectives or a clash of organisational values. One can understand the frustration of officers called to a situation that they thought had been resolved earlier. It is probably a feeling shared by the other professionals involved. However, it is in most cases, a reflection of the complexity of the issues involved rather than a failing on the part of health or social care professionals involved. Despite this, studies of police attitudes and practice indicate that arrest can be seen by officers as a way of ensuring that a psychiatric assessment is carried out (Hartford *et al*, 2005).

The term 'vulnerable adult' is very difficult to define. PACE (1984) relies on the terms mentally disordered and mentally handicapped when it seeks to identify those who might be in need of additional protection in custody. The reality of the experience of arrest and detention is that it is likely to put any one of us at some risk. There are a

number of factors that would need to be considered here including the nature of the offence. However, it is possible that there are particular increased risks that adults with mental health problems may be more likely to face. The first is the impact on their mental health of being in custody. In addition to the stress of being arrested, there is the bleak nature of the environment, in which one is held. To try to ensure the safety of those in custody, cells are very basic. There may also be additional stresses, for example, if an individual is deemed at risk of self-harm or suicide, they will have their clothes removed and are given a paper suit to wear. Such moves, designed to protect individuals are in themselves distressing. The work of Gudjonsson and Mackeith (2002) demonstrates that those who are psychologically vulnerable or suffering from mental illness can give unreliable testimony including false confessions. It is therefore very important that steps are taken to protect such individuals in custody.

Training needs

All of the above, results in an identified need for greater training of police officers to develop the awareness and recognition of mental health problems. Carey (2001) and Dew and Badger (1999) identified that few officers felt that they had been given sufficient training in this area and that most of the training took place 'on the beat'. It is also apparent that a lack of confidence in mental health services means that the police become disillusioned and cynical about the efficacy of involving their mental health colleagues. This may be part of a cultural or value clash about what is seen as a realistic intervention with the police emphasising hospitalisation and medication. It is also a reflection of professional frustration as officers can be called back, either by mental health

professionals, carers or family members, to intervene in a situation they thought had been dealt with.

Police attitudes to people with mental health problems certainly need to be examined in more depth. The Pinfold *et al* study (2003) demonstrated that short training courses can tackle some of the deeply engrained stereotypes about mental illness with the benefits including improved communication between officers and subjects. The officers also felt more confident in their own dealings with these individuals. However, it is interesting to note that the view that people with mental health problems are violent was the most difficult to tackle. A greater confidence in community mental health services will only come from an improvement in services that tackles the long-standing issues of under-funding, poor organisation and lack of a commitment to inter-professional working that have dogged mental health services for far too long. Steps are being taken to improve the training of police officers. In the financial year 2004/05, the Home Office and NIMHE made £155,000 available to improve training. However, as the MHAC report suggests (2005:271), this amounts to about £1 for each officer in England and Wales. The historical neglect of this area means that it will need investment over a sustained period to redress the deficit.

The research literature has focused on identifying the extent of mental health problems among the specific populations in the criminal justice system (Singleton *et al*, 1998) and examining the possible links between mental illness and offending (Taylor & Gunn, 1984). There have also been wider studies exploring the effects of the policy of deinstitutionalisation (Wolff, 2005). Studies of the role of the appropriate adult, report on the low numbers of police interviews where an appropriate adult attends (Nemetz & Bean, 1994), the limited role that appropriate adults play in the interview and the range of

individuals who take on the role (Medford *et al*, 2003). The other area that has been examined is the provision of service. Bucke and Brown (1997) found that in 60% of these cases a social worker took on the role of the appropriate adult. Evans and Rawstone (1994) found that there were increased difficulties for social services departments in providing staff to take on this role out of standard office hours. However, the literature has not considered in significant depth the process by which police officers decide that an adult is vulnerable within the meaning of PACE (1984).

The assessment process that custody officers carry out is a complex one. It requires a range of skills not the least of which is the ability to work in a highly pressurised environment. There appear to be a number of variables that may be affecting the decision-making process. These will include the skills, training, experience and attitudes towards mental illness of the arresting officers and the custody sergeant, the local systems that have been established, the nature of the offence, the circumstances of the arrest and the presentation of the individual, who has been arrested. To this, one might add environmental factors such as the other pressures in the custody suite and on the officer at the time.

Mokhtar and Hogbin's (1993) research on section 136 MHA indicates that police officers use the powers appropriately in cases where an individual's behaviour is extremely disturbed. However, mental health problems exist on a continuum with such cases at one end of it. As outlined above, there are a number of variables that might influence decision-making. Establishing clear causal links between them is problematic. For example, length of service is one variable, but it is difficult to establish the exact nature of its impact. One would expect more experienced officers to be more aware of mental health issues and thus be more skilled

in this area. However, it is also possible that length of service has a negative effect as it may make officers more distrustful of community mental health services.

The pilot study

The research was carried out in the spring of 2006. An initial approach was made to one police force in an urban area of England, which agreed to take part in the project and it formed part of a general review of custody management issues. As seen above, custody officers have a key role to play under PACE (1984) in that they have to ensure that vulnerable adults are properly protected while in custody. This group of officers have overall responsibility for the process. Their experiences should therefore provide an insight into a range of issues in this area. As an initial scoping exercise, a series of 10 semi-structured interviews was carried out with custody officers. The force covers a large urban area, as it moves to more centralised systems, not all stations actually hold people in custody. Interviews were arranged at the 10 stations where individuals were held in custody. This meant that the interviews covered a range of settings with a variety of practice arrangements with local SSDs, PCTs and voluntary agencies. The police stations were also based in areas that were culturally, ethnically and demographically diverse. My initial discussions were held with an inspector with responsibility for the development of policies to ensure the safety of those in custody. Gaining access is always likely to be an issue in such settings. The inspector and I agreed a provisional timetable for the interviews. It was agreed that I should carry out the interviews during a handover period as this meant that two sergeants would be on duty. This would hopefully ensure that an officer could be interviewed. All stations were emailed details of the project and a

proforma outlining the very broad areas of interest that would form the basis of the interview.

On one occasion, it was not possible to carry out the interview because of operational demands placed on the officers. The nature of this research project raises a number of ethical issues. Although I had obtained ethical approval for the study via the usual university channels and all the interviewees gave their written consent to take part, there is always, in a hierarchical organisation such as a police force, a concern that pressures may have been placed on individuals to take part. At the beginning of each interview, it was emphasised that those involved could refuse to answer any question or withdraw from the study at any stage. No officers chose to do this.

Given the nature of the project and the setting, confidentiality also had to be considered. Any case examples discussed were anonymous. I did not have or seek access to any individual custody records. This study is part of a wider examination of the operation of PACE (1984) within the area. The focus of these interviews was to gather information about the training needs of custody sergeants with regard to mental health issues but also to explore the operational pressures that exist. The advantage of the approach here is that a qualitative method allows the researcher to look at individual cases in some depth. The issue that was of most concern was the way that individual officers make a decision that the specific provisions of PACE (1984) should be applied.

Following the interviews, a short questionnaire was developed in the hope that a wider range of views could be captured quickly. As a method, the questionnaire lacks the subtlety of the interview. This is particularly true in this setting as the complexities of the issues do not lend themselves to the sorts of responses

questionnaires generate. The questionnaire was sent out via police HQ to all custody officers. Unfortunately, the number of responses was low (20 replies) at less than 10%. There are a number of explanations for this. The turn around time was relatively short – but it should be noted that usually the response rate tends to tail off rather than increase. As in any organisation, there will be a number of absences because of sickness, annual leave or the shift system. However, the combination of such factors would not account for such a poor response rate. The most likely explanation is, hardly surprisingly, that the questionnaire did not count as a working priority for the officers involved.

Findings

All 10 officers interviewed emphasised the difficulties in making the assessments that PACE (1984) requires. The environment and pressures to ensure that delays in the booking in system are kept to a minimum meant that the assessment was carried out very quickly often with a lack of privacy. The public nature of the environment made it difficult for individuals to disclose any mental health history. The problems in assessment are exacerbated by the fact that mental health problems can be masked or exacerbated by alcohol and drugs. Obviously, significant numbers of those arrested are intoxicated. This means that it is difficult to identify the cause of disturbed behaviour. There might be clear indications that somebody is drunk, but this is not always the case. The situation with other substance misuse can be even more complicated as intoxication might mirror the symptoms of mental illness. The increased availability and use of street drugs along with the failures of community care has meant that the problems of mental illness and substance misuse overlap. In all the interviews, officers highlighted that large numbers of those

coming into custody state that they have been prescribed medication for specific mental health problems, depression/anxiety being the most common. Despite the recognition of the extent of these problems, the number of cases where an appropriate adult was involved was generally very low.

Most of the officers stated that they had received little or no specific training about mental health issues either as a constable or before they had taken on the role of custody sergeant. The training that was given in this area largely related to procedural issues under PACE (1984). Examples were given of training that had been organised on a local level. This involved inter-professional training and sessions with nursing and social work staff. This model of training was very positively regarded by those officers who had received it. There were no arrangements in place in this area for refresher training or continuous professional development.

As part of the interview, I asked the officers to take me through the procedure that is followed when someone is taken into custody, from the point of view of the custody sergeant. The custody record is now a computerised record. Part of this is a standardised risk assessment that is completed for all those in custody. This involved asking a series of questions about mental health history, use of drugs and alcohol, and self-harm. This was a starting point, as officers used a combination of their own interpersonal skills and experience in such situations to determine whether further specialist assistance was required. All the officers emphasised that risk assessment is a fluid process. A recurring theme in the interviews was that a duty of care is owed to those in custody. This was held to be ultimately the responsibility of the sergeant on duty, who it was felt would receive little support from management. The prospect of the devastating personal and professional effects of a death in custody loomed large in the working lives of the officers I interviewed.

There were no specialist facilities in any of the police stations. People with mental health problems had to be accommodated in the cells available. All the officers felt that this was a far from satisfactory situation. During the interviews, examples were given where the risk assessment had not succeeded in identifying an individual, who had later seriously harmed themselves. This included a young woman who had used a hidden razor blade to harm herself. The police station is not a therapeutic environment. It was widely acknowledged that the physical layout and conditions in the custody suites mean that officers or other professionals can do little more than ensure that a person is physically safe. There were concerns raised that if attempts were made to develop specialist services, that this would exacerbate the problems in this area as other agencies would seek to use such facilities inappropriately resulting in increased police involvement, not less.

Section 136 MHA (1983) can result in the police station being used as the place of safety. For the custody sergeants, this was seen as one of the worst custody scenarios that they might face on duty, and was to be prevented if at all possible. The individual was likely to remain in custody for a prolonged period while a MHA assessment was carried out, and if necessary a bed found. In three interviews, it was felt that once the person reached the police station, other agencies did not give the situation the proper priority. This was an echo of some of the wider frustrations expressed about community-based mental health services.

In both the initial interviews and the responses to the questionnaires, officers highlighted their concern about the lack of formal training that they had received. In the interview stage, examples were given of steps taken to tackle this, for example, input from a local approved social worker to examine the workings of section 136 MHA. However, there was a lack of a structured framework or

recognition for the need for continuous professional development in this field. This reflected the themes identified in the literature. The result was that officers relied on their professional experience or, on occasions, previous knowledge of individuals in custody in order to carry out assessments.

Discussion

PACE (1984) provides valuable safeguards for vulnerable suspects. However, current practice raises cause for concern. The policy of deinstitutionalisation has not been adequately supported by the range of community-based services and resources that its pioneers envisaged. This view was confirmed in *Modernising Mental Health Services: sound, safe and supportive* (DoH, 1998). One effect of this woeful provision has been an increased role for the police. The evidence so far from the prison estate (Singleton *et al*, 1998) is that diversion from custody is an aspiration rather than a successful policy.

In the environment outlined above, police officers and custody officers have an essential role to play. Diversion will be most effective if it can take place at as early a stage as possible. There is evidence (James, 2000; McGilloway & Donnelly, 2004) that this can be effective. In both of these studies, CPNs were attached to police stations to divert those involved in minor offences and attempt to engage a difficult to reach group with mental health services. Police stations cannot meet the needs of acutely unwell individuals. The physical environment and lack of nursing staff to support officers makes this impossible. Despite these difficulties, however, police stations are likely to remain the default 'place of safety'. Individuals who pose an immediate physical risk to themselves or others, or where a serious

offence has been committed, will continue to be placed in custody. The findings of this initial pilot study indicate that custody officers, on the whole, do not receive an appropriate level of mental health training to equip them with the skills to carry out this complex and demanding role. One effect is that the protective function, which the role of the appropriate adult provides, is enjoyed by relatively few adults in police custody. For this to be addressed successfully, not only will the training needs of police officers have to be revised, but the fractured and dislocated structure of community based mental health services will also have to be overhauled.

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