Mental Health, Vulnerability and Risk in Police Custody

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Abstract

Purpose
The issue of mental health and policing is a subject that has been debated from a number of different perspectives. The purpose of this paper is to report on the findings of a case study that explored mental health difficulties and vulnerability within police custody.

Design/methodology/approach
The design of the study was qualitative, and it utilised telephone, semi-structured interviews with all levels of the custody staff. This approach was taken because the aim of the study was to explore how people in different roles within the organisation, worked to safeguard vulnerable people in custody.

Findings

The findings from this study identified a number of interesting themes that could be explored further in later studies. Overall the respondents expressed frustration that vulnerable people find themselves in police custody for low-level crime, when it could have been avoided with improved mental health services in the community. Additionally, the findings demonstrated that despite the processes that are designed to safeguard the detainee, tensions still exist including, timely access to mental health assessments, appropriate training and support for staff, and the use of appropriate adults.

Research limitations/implications
Although the study was small in scale, the custody facility delivered detainee facilities for about 5000 individuals per year. The research and information obtained supported the police lead for mental health to identify opportunities for improving the customer journey, as well as recognising the need for further research to identify how officers and staff relate to vulnerable individuals in contact with the police service.

Originality/value
Despite the limitations of the study, the findings have captured interesting data from a range of professionals working in one police custody suite, and therefore it presents a holistic overview of some key issues around mental health, vulnerability and safeguarding within the context of police custody.

Keywords

Mental Health, Police Custody, Safeguarding, Vulnerability, Risk.

Introduction

As a consequence of the changes to mental health services the police are increasingly expected to take a role in supporting people with mental illness, and previous research suggests that they can feel unprepared for this role (Chappell & O'Brien, 2014; Maclean & Marshal, 2010). The Home Affairs Select Committee (2015) also noted that police officers are increasingly working with people who are experiencing a mental health crisis, and it called upon the health service to improve access to appropriate mental health support. In addition, the Crisis Care Concordant promotes partnerships between the police, health and social care to improve the experience of people in mental health crisis (Department of Health, 2014a). This has led to the provision of 'street triage' teams in some police authorities, that can divert people to appropriate services, and in other areas there has been a move to have mental health nurses based in custody suites (Department of Health, 2014b). Despite these positive changes, it is estimated that more than a third of people who find themselves in police custody have some form of mental health difficulty. In recognising this, it is therefore necessary to have systems in place where appropriate referrals to mental health services can be made (Ogloff *et. al.,* 2013), but there can be tensions between the two agencies (Maclean & Marshal, 2010).

Limitations of custody assessment

When a person is admitted to custody the Custody Sergeant carries out an Integrated Custody Risk assessment tool which creates a risk factor and care plan for staff. This consists of 32 questions which the Custody staff complete by information obtained from the arresting officer and detainee. The questions focus on a holistic physical and mental wellbeing approach including, suicidal ideation, self-harm or depression. The approach is completed on entry and reviewed at every step of the custody journey. This assessment is informed by any prior knowledge the police have about the person, but it also relies on the detainee's self-reporting, which can impact on the accuracy of the assessment (Bradley, 2009), particularly if

the detainee is reluctant to disclose information about their mental illness (Cummins, 2012). The identification of mental health concerns is crucial to ensure that, where appropriate, the person is diverted to mental health services or a mental health assessment is requested to ensure the safety of the person while in custody, and on release (Senior *et al.,* 2014; Ogloff *et al.,* 2013). Recognising mental illness can be difficult and a lack of training can lead to a degree of under-reporting when dealing with people in a highly-charged custody environment (Cummins, 2012). Adding to the complexity, there can be confusion when distinguishing between detainees who are under the influence of drugs or alcohol, and the detainees that are experiencing a mental health crisis (Clayfield *et al.,* 2011; Bradley, 2009). Where appropriate, the custody sergeant can ask for a mental health assessment to be carried out (Brooker *et al.,* 2015), however if the detainee is under the influence of drugs or alcohol the assessment will be delayed (Burns, 2013).

A significant number of people with mental health difficulties will come into contact with the police on a daily basis and the Police and Criminal Evidence Act (1984) PACE, provides the basis for the protection of vulnerable children and adults while they are detained in custody. Where a detainee is viewed to be vulnerable, there is a requirement that they will be provided with an 'appropriate adult' under the 'Safer Detention' guidance notes (Association of Chief Police Officers, 2012). In addition, the Mental Capacity Act (2005) requires that when a person is assessed as 'lacking capacity', all decisions should be made in their 'best interest' (Payne-James, 2009). However in a recent article, Dehaghani (2016) noted that the 'appropriate adult' safeguard may not be implemented for a number of reasons, including the attitude of custody staff, internal pressures and reliance on 'gut feelings'.

Identification of mental health concerns on detention is important because a person who finds them self in police custody might not be known to mental health services, therefore the arrest can be the first opportunity to screen for mental health concerns (Cummins, 2012) and could prevent self-harm and suicide in the future (Dorn *et al.,* 2014). To achieve this, there needs to be a partnership and information sharing between the police and mental health services

(Chappell & O'Brien, 2014; Hollander *et al.,* 2012). This partnership is particularly important at the point of release, because the police play a valuable role in ensuring that vulnerable people are referred to appropriate mental health services for ongoing support (Van den Brink *et al.,* 2012). Research has suggested that this can be difficult, especially when they meet resistance from crisis services because the person had previously not engaged with support offered (Pearsall, 2013). Despite this, there needs to be clear communication and planning for release from custody and where appropriate, this could include formulating a crisis care plans (Martin & Thomas, 2015).

Although deaths in custody have decreased they still occur, and suicides within 48 hours of release from custody have increased (Home Affairs Select Committee, 2015), therefore having robust systems to identify vulnerability is critical. In a recent study, Aasebø *et al.* (2016) found that the majority of deaths in custody can be attributed to the effects of intoxication with drugs, alcohol, and suicide. Forrester *et al.* (2016) found that over 16 percent of people who were referred to mental health services while detained in police custody, reported suicide ideation. It is the responsibility of the custody sergeant and the custody staff to take steps to reduce any risk that has been identified (Payne-James *et al.,* 2010). While acknowledging that all deaths in custody cannot be prevented, the provision of appropriate safeguards will prevent some deaths (Heide & Chan, 2016). This article is based on the findings of a small-scale study carried out in a large city centre custody suite and draws on data from interviews with custody staff including, inspectors, custody sergeants, detention and custody officers, triage staff and custody support officers. The aim of the study was to explore how custody staff at all levels assess and manage risk and vulnerability both within police custody, and prior to release.

Methodology

The research was carried out in 2015 by an experienced qualitative researcher with expertise in the area of mental health within the criminal justice system, supported by the police lead for mental health. This study utilised telephone, semi-structured interviews as a data

collection tool, as it allowed for some flexibility within a busy custody suite that can detain up to 17 people at any time. Originally the plan was to carry out the interviews face-to-face, however this became difficult because participants had to return to custody at busy times. In order to provide more flexibility, it was agreed to do telephone interviews, where the participant could contact the researcher at a convenient point within an allocated time slot. Participants were aware of the focus of the study and they had the option to see the questions before agreeing to be interviewed. The participants were provided with an information sheet and they then indicated if they were interested in participating in the study. Each participant (n=10) gave their consent to be interviewed and were given the opportunity to withdraw from the study at any point by emailing or telephoning the researcher prior to data analysis. The interviews were recorded (with the permission of the participant) and then transcribed verbatim. The data was then coded using NVIVO software to perform a thematic analysis as a method to identify and then analysing patterns within, and across the interview data (Braun & Clarke, 2006). The coding process included both deductive and inductive coding, with the initial codes drawn from the literature. The inclusion of inductive coding enabled the formation of new codes that were data driven, in an effort to represent the broad range of participant views.

In order to maintain confidentiality, the participant's names and roles will not be identified.

Findings

Barriers to accessing mental health services

The findings of this study support the supposition that although dealing with mental illness had always been part of the police role, over time this had increased. Participants suggested that the recession had resulted in a decrease in health and social care services, leaving people uncertain where to get support when they are in crisis. All the participants were committed to improving the care of people experiencing mental health crisis, but they noted that they can often feel ill-equipped for the role.

"...it's a massive challenge for the police...because we are seen as a jack of all trades."

The participants also suggested that people are increasingly calling the police when they are feeling low and suicidal because they know they will get a response.

"We are finding that we are becoming more and more responsible for doing everyone's job really, you have to be a social worker, a counselor."

Custody was described by one participant as a *'safety net'* for people who have not been able to get the support that they need elsewhere and participants noted the importance of having appropriate liaison and diversion arrangements in place to refer people to mental health services. All participants noted the high levels of vulnerable people who are detained in custody and they expressed frustration that even when there are clear signs of mental illness and suicide ideation, there can be difficulties accessing a mental health assessment. The initial mental health screening can be done by a nurse or a forensic medical examiner (Doctor) in the first instance. If a formal assessment under the Mental Health Act (1983) is required, this would be requested through the local authority and local mental health trust. Any delay in accessing this assessment has an impact.

"She'd always end up staying with us and we'd have to restrain her every time she was here, not because she wanted to hurt us, but [because] she really wanted to hurt herself."

"... it is quite distressing if you've got someone with severe mental health problems who obviously can't cope with being in a cell."

Several of the participants suggested that some people who come in to custody have reached a *'crisis point'* in their life and this can be the root of their offending behaviour.

"She came into custody regularly but [was] never ever subject to any mental health assessment, she always went through the system and went to court…she wasn't somebody who needed criminalising…it was obviously her cry for help."

They suggested that in some cases the *'crisis'* was the result of the person stopping their medication and then drinking or using drugs to self-medicate. The participants suggested that

if someone had been able to intervene at an earlier point, the person could have been treated appropriately and spared from repeated visits to custody.

Identifying Vulnerability and Managing Risk

During the interviews, some participants suggested that there can be up to nine out of ten people that come into custody who have some sort of mental health difficulty, ranging from mild depression and anxiety, through to severe psychiatric illness. There was an awareness at all levels that there are safeguarding processes including, appointing of an appropriate adult and making a referral for a mental health assessment but they suggested that the main challenge is identifying when a person is suffering from a mental illness, understanding how this illness relates to the offence and having robust processes that reliably assess the level of risk.

"The biggest part of my role is doing that risk assessment we have to do when they come into custody."

Participants raised concern that although everyone who is booked into custody are asked the same set of questions to assess risk, the process relies heavily on the person being honest when answering. They noted that despite asking the same set of questions, the person's willingness to give comprehensive answers varies and this impacts on the reliability of any risk assessment. Assessing the level of risk can be complex and participants noted that where a person has previously been in custody, there could be some information on the police system that would suggest mental illness, self-harm or issues with drugs and alcohol problems. Despite this, the participants were concerned about the possibility of 'missing something' because while alcohol intoxication is easy to identify, the signs of mental illness or distress are not always as obvious.

"What's really scary about that is, sometimes you have people in custody with no background information on them and they'll say no [when asked about their mental health], not at all, nothing….then you get a doctor in and the doctor does a little digging with their GP and

actually they could have an extensive mental health background, they're not necessarily going to disclose that to you when standing in front of you at the custody block.”

Participants at all levels discussed the need for continuous assessment of risk and acknowledged that it is an important role for all custody staff. Each person is placed on a risk level, ranging from one to four and has to be updated as and when things changed. Participants described their concern that these levels of risk can quickly escalate within custody, especially where a person is in mental distress.

“When she first came we didn't realise how severe she was, so we just were on a camera watch on a level three. But we quickly learned that if she was in custody she had to be on a one-to-one…on a level four.”

Participants explained that levels one and two identified the frequency of the custody checks, level three requires constant surveillance using CCTV and level four requires the position of officers at the door of the cell. There was clear evidence that the custody support workers and the detention and escort officers review the level of risk continuously. They described how they did this by engaging the person in conversation while they were providing them with food and drink, and when carrying out their scheduled checks. The custody support workers and the detention and escort officers reported that if their interactions with the person in custody (PIC) raised concern about the person's state of mind, this would be fed back to the custody sergeant immediately. The level of risk is calculated individually and as a collective, and the participants noted that when a number of PIC's require level three and four care, this can result in the closure of custody to ensure the safety of all.

“… if you got someone who potentially wants to kill themselves or self-harm and you're the sergeant trying to keep the lid on that as well as the other prisoners, then you can't be compliant with PACE and keep [them] safe.”

The participants explained that when someone is viewed as the highest level of risk, staff will sit in the doorway of the cell to support the person, but at times it is necessary to use restraint.

All of the participants discussed the requirement to provide someone with an 'appropriate adult' if they were deemed to be vulnerable, but there was a lack of clarity about who has the responsibility for identifying the need, and some confusion about the role of an 'appropriate adult' within custody. One participant suggested that it was the role of healthcare professionals and others suggested that the person just needs reassurance that custody staff are fulfilling their role.

"...the appropriate adult is treated as a parent or a social worker, so if they want some time to explain something to them in the cell, then we do it."

During the interviews some participants raised the concern that it is not always possible to locate an 'appropriate adult' because although they have a list of contacts, this does not guarantee that someone is available, and willing to come in.

"...they quite often live in some sort of supported accommodation and they have got protocols and pathways to deal with that person."

There was a shared view amongst most of the participants that, where possible, when a vulnerable adult arrives in custody, attempts should be made to find someone who knows the person to act as their 'appropriate adult'. They suggested that this is not always possible unless someone is living in supported housing, or is known to other services.

"...we had a detainee with schizophrenia who had assaulted someone in his supported housing...because he was mentally vulnerable, he needed an appropriate adult to make sure he understood what's going on...we could not access an appropriate adult so we had to bail him without having an appropriate adult with him."

The frustration expressed above was mirrored in the interviews with other participants, who suggested that waiting for an appropriate adult can increase concern about the person's emotional needs while in custody. The participants also noted that there can be a tension when dealing with a serious crime, because although they understand the need for an appropriate adult, they also need to collect evidence and samples as soon as possible.

The issue of vulnerability was also discussed in relation to release from custody with participants noting that the police have a duty of care for the 24 hours after release.

"...although they might say that they are not suicidal – the people that are quiet and don't cause you any problem [are] probably the most likely to go out and do it."

Vulnerability on release was an increased concern when it had not been possible to identify mental health support services or when the person has been charged with a crime that will impact negatively on their life such as drink driving because it could mean the loss of their job.

"We do what we call pre-release care plan. At an extreme, someone who has downloaded pornography or charged with some sort of sexual offence with a child and hasn't been remanded in custody, our care plan would involve some sort of safeguarding for them so they don't take their own life or self-harm. That's one extreme."

A pre-release plan could also be used where the person has a mental illness and potentially still pose a risk of suicide on release.

Challenges

There was agreement from most of the participants that custody is not the right place for somebody who is vulnerable, as the environment can have high noise levels, with people banging on their cell door and shouting for hours. They explained how this type of environment can lead to increased anxiety and a worsening of a mental health crisis, with the result that the person's mental state is likely to deteriorate.

"I think that they need to go to somewhere that is more like a homely environment. They should not be in the same place as is typical criminals that have shoplifted in order to finance a drug habit"

Although there was the suggestion that custody was not the right place for someone with a mental illness, there was also the recognition that the offence needed to be dealt with. The participants noted the importance of considering the seriousness of the offence that has been committed, alongside any assessment of the level of learning difficulty or mental illness.

Where a person in mental health crisis is detained, the participants all noted the importance of getting a detailed mental health assessment.

"We go straight to the medical health professional services that we have to use in custody… we will go straight to them, and be guided by them really"

"…all we can do is rely on other medical professionals for support to say if they need to be sectioned or go through the criminal justice system"

Where a person is assessed as needing a mental health assessment the participants noted that they would not be interviewed until they were deemed to be fit.

Participants noted that where there is a low-level crime, attempts are made to look for a community resolution, but when the crime committed is of a serious nature, decisions need to be made about how to proceed.

"If the offence is a serious one, then I would use custody to both deal with the criminal but also mental health aspect"

"Depending on how unwell a person is, we did try to deal with the crime first"

Where there are concerns about a mental illness the participants were all aware of the process that they would go through in order to get a mental health assessment as a basis for the care of the person in custody. Participants noted tensions between the police and the healthcare professional because people can wait a number of hours to be seen initially and then they are referred for another service.

"…we would call healthcare professionals and we would be waiting however long for a nurse who says they need a mental health assessment, so you're waiting for a doctor to come out and for him to say yes I do believe they're suffering with a mental health illness [so] we will then need to turn the crisis team out"

The participants noted that any delay in getting a mental health assessment impacts on the criminal justice process by reducing the time they have to conduct their enquiries. They explained how they are only able to detain someone for 24 hours, and by the time they get

confirmation that the person can be interviewed, they might only have 4 hours left on the PACE 'clock'. During the interviews a number of participants explained that there was even greater difficulty getting a mental health assessment if the person has been drinking or taking drugs. They understood the reason for this, but they noted that this increases the time the person would remain in custody. One participant discussed projects within the policing custody landscape where psychiatric nurses were placed in custody, and they suggested that this could have a positive impact because they could access mental health assessments in a timelier fashion.

"...quite often the doctors who are in custody might not be as well versed in mental health as the CPN...psychiatric nurses deal with mentally ill people all day every day, and again they have access to all the records, the systems, they are familiar with all the treatments and pathways"

Other participants referred to the projects where nurses were permanently placed in custody and suggested that their role could go beyond the remit of providing mental health assessments. They suggested that the nurse could provide the detainees with someone to talk to and the nurse could make referrals to drug and alcohol services. The issue of drugs and alcohol was another tension for the participants because it is difficult to get an assessment until the person is no longer under the influence.

"...it's frustrating if someone has dual diagnosis, they are actually an alcoholic but as well as that they are mentally unwell. Mental health services generally won't go near them so then it's like 'who picks that up'...what happens with that person then?"

"...it seems like, almost an excuse to avoid dealing with somebody, to avoid treating somebody's symptoms because they are intoxicated, so it is frustrating and it does provide barriers."

The participants were all committed to improving the experience of people who are having a mental health crisis and some suggested that in the past there had been a lack of knowledge and understanding in this area of policing. Some of the participants discussed the tension that

can exist when someone needs to be taken to hospital, because it is not appropriate to take them to an accident and emergency department, especially if the person is violent and could put others at risk.

Conclusions

This study demonstrates how the participants understood their role in supporting people that were experiencing some type of mental distress and identified some concern about the increase of risk and vulnerability within police custody. The findings support Chappell & O'Brien (2014) suggestion that police can frequently feel ill-prepared for the role and there was evidence of the tension between the police and health services, as identified by Maclean & Marshal (2010). The increased level of mental illness within society and the decrease in mental health services appeared to result in custody staff frequently being required to care for detainees who are experiencing mental distress. In addition, it appears that changes to mental health services, and the reduction in community support, could be linked to low-level crime that could have been prevented with early intervention from health and social care services. This is an area that would warrant further investigation to understand if this is the case.

Clearly, the needs of detainees in police custody are complex and participants in this study expressed concern about managing the levels of risk and vulnerability within the custody environment. Most of the participants felt that they were not knowledgeable enough to deal with the needs of detainees and there was a consensus that having a mental health nurse working in custody would be beneficial, enabling the early identification of mental health concerns as advocated by Cummins (2012). Picking up on Dehaghani's (2016) discussion on the use of appropriate adults, the findings suggest that this is not always carried out. Reasons for this included, the participants' lack of knowledge about their purpose and the lack of availability, especially out of hours.

The findings identify that although each person brought into custody will be assessed by the custody sergeant, there was concern that people do not always acknowledge a history of mental illness, self-harm, drug or alcohol addictions when asked. This supports the literature

that suggests the initial assessment is limited by what the person decides or is able to disclose (Bradley, 2009). It was reassuring to note in the findings that although the first risk assessment is carried out by the custody sergeant, the custody staff continually assess risk and report any concerns that they have. It would appear from the findings that this continuous assessment is carried out by detention and escort officers and custody support officers, therefore processes and training need to be in place to support them.

Although this is a small-scale case study in one custody suite, it does offer some useful insight into the issue of mental health, vulnerability and risk within police custody. The results suggest that although there have been some initiatives where the health services and the police are working together, there continues to be some tensions that need to be explored further.

Discussion

This study demonstrates how the participants understood their role in supporting people that were experiencing some type of mental distress and identified some concern about the increase of risk and vulnerability within police custody. The findings support Chappell & O'Brien (2014) suggestion that police can frequently feel ill-prepared for the role and there was evidence of the tension between the police and health services as identified by Maclean & Marshal (2010). The findings identified how the participants perceived that an increased level of mental illness within society, and the decrease in mental health services, had resulted in them having to care for detainees who are experiencing mental distress in custody.

The findings highlight the difficult balance between dealing with the crime while also being aware of the detainees' mental health or learning disability. There is recognition that when there are concerns, requesting a mental health assessment can prolong the period in custody, but this is a necessary process before the person is interviewed.

Clearly, the needs of detainees in police custody are complex and participants in this study expressed concern about managing the levels of risk and vulnerability within the custody environment. Most of the participants felt that they were not knowledgeable enough to deal with the needs of detainees and there was a consensus that having a mental health nurse working in custody would be beneficial, enabling the early identification of mental health concerns as advocated by Cummins (2012). In 2014 a number of stations within the force area undertook a liaison and diversion programme where mental health nurses work in custody between 8am and 8pm to support information exchange and more rigorous assessment.

The findings identify that although each person brought into custody will be assessed by the custody sergeant, there was concern that people do not always acknowledge a history of mental illness, self-harm, drug or alcohol addictions when asked. This supports the literature that suggests the initial assessment is limited by what the person decides or is able to disclose (Bradley, 2009). It was reassuring to note in the findings that although the first risk assessment is carried out by the custody sergeant, the custody staff continually assess risk and report any concerns that they have. As part of the Safer Detention Policy the risk assessment is continuously reviewed. This occurs not only when the detainee is moved from the cell or interviewed but at Statutory review times as well as when there is a change of staff.

Picking up on Dehaghani's (2016) discussion on the use of appropriate adults, the findings suggest that participants also had some concerns about this process. These concerns included the ability to identify an appropriate adult, the impact of any delay on the investigation and the negative impact of extended custody on the detainees' emotional state. This was also linked to concerns about vulnerability and the need to consider the detainees state of mind during their detention and on release from custody.

Although this is a small-scale case study in one custody suite it does offer some useful insight into the issue of mental health, vulnerability and risk within police custody. Since 2015 the

number of liaison and diversion schemes have grown, providing coverage across the whole force area. The Force has also undergone a significant custody facility review, two purpose-built state of the art custody facilities have been developed creating a safer and more efficient/effective custody environment.

Mental health triage has become business as usual and provides staff with alternative options for crisis resolution as well as an enhanced information exchange process to inform risk assessments where it is felt necessary and proportionate to share.

Significant work has been undertaken within the force area to use an intervention and prevention approach at the front end of policing delivery. Officers on the street review all the available information and options for early intervention, within low-level offences. Based on a threat, risk and harm assessment if deemed applicable, an out of court disposal (e.g. fixed penalty notice, conditional caution) should be administered.

It is also important to recognise that the force has conducted significant work with local partners to reduce the detention in police cells under the Mental Health Act has become an exceptional event with less than 10 incidents over the last 3 years.

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