Introduction

Adults with mental ill health, learning disabilities and other mental vulnerabilities, face significant disadvantage in the criminal justice system (CJS). They are at increased risk of providing information which is inaccurate, unreliable or misleading (Gudjonsson, 2010). When asked about their experience of the CJS, they typically report they did not understand what was happening to them or why, that they felt alone, they did not know whom to turn to for support and that they were uncertain about what to say or do (Hyun et al., 2014). Further, more than a third of people who died in police custody in 2013/14, and two-thirds of people who took their lives within two days of being released, were reported to have had mental health concerns (Home Affairs Committee, 2015).

This review of the literature provides an overview of the prevalence and identification of mental disorders[1] and mental vulnerabilities[2] in police custody; the factors that influence custody sergeant decision-making on whether to call-out an AA; the commissioning of AA services and considers longstanding debates about who is best fit to serve as an AA. The review concludes drawing on the views of people with mental vulnerabilities who have recently experienced detention in police custody, as laid out in the recent HMIC thematic inspection on the welfare of vulnerable people in custody (HMIC, 2015).

Prevalence of mental disorders and mental vulnerability in police custody

Research evidence suggests that the prevalence of mental disorders and mental vulnerability is significantly higher within the criminal justice system than within the general population (see Tables 1 and 2).

Table 1: Prevalence of mental ill health and other mental vulnerability in the general population

Prevalence of mental ill health and other mental vulnerability in the general population		
Research	**Finding**	**%**
ONS (2001)	At any one time, British adults experiencing at least one diagnosable mental health problem.	17%
O'Brien (2006)	Learning disabilities (UK)	2–3%
Emerson et al. (2010)	Learning disabilities (England) *Equates to 1.2 million of which 75% are adults*	2.3%
British Dyslexia Association	Severe dyslexia (UK)	4%
Brugha et al (2009; 2012)	Autistic spectrum disorders in men/women (UK)	2%/0.3%

[1] Mental disorder means any disorder or disability of the mind (Mental Health Act 1983)
[2] A detained person is mentally vulnerable if, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies (PACE Code C 1G)

Table 2: Prevalence of mental ill health and other mental vulnerabilities in the criminal justice system

Prevalence of mental ill health and other mental vulnerabilities in the criminal justice system		
Research	**Finding**	**%**
Brooker et al. (2012)	People under probation supervision who have a current mental illness	39%
Singleton et al. (1998)	Remand prisoners who have a diagnosis of personality disorder	78%
Loucks (2007)	People who offend who have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.	20-30%
McBrien et al.(2003)	People diagnosed with learning disabilities who have experienced some contact with the criminal justice system	10%
Brugha et al (2012)	Prevalence of autism in prisons.	5-40%

Further, they are more likely to be drawn into the system, more likely to be arrested for minor offences, less likely to be granted bail and spend longer periods in police custody (Cummins, 2007; Hartford et al., 2005). The Bradley Report (2009) found that the estimated number of mentally disordered suspects passing through police stations varied widely between 2% and 20%. Other studies (see Table 3) looking at mental health and learning disabilities in police custody have found prevalence rates between 12% and 39%, with an average of 27% (Gudjonsson et al., 1993; Scott et al., 2006; McKinnon & Grubin, 2013; 2014). These figures coincide with the recent evidence submitted to the Home Affairs Committee, in which the police estimated that 20[3]-40%[4] of people passing through police custody have a mental health issue, whilst noting that the multiple definitions available left police unclear as to what to count.

A number of studies have suggested that the rate of AA need is slightly lower than the overall prevalence of mental health and learning disabilities at between 11% and 22% (Rapley et al 2011; McKinnon & Grubin 2013; Brown et al., 1992; Gudjonsson et al., 1993). However, the Police and Criminal Evidence Act 1984 Code of Practice C (PACE Code C) requires an AA for all adults for whom there is *suspicion* that they may be mentally disordered or mentally vulnerable and therefore demand for AAs may be higher than the need assessed by clinicians and academics (Home Office 2014).

[3] Home Affairs Committee, Oral evidence: Policing and mental health, HC 202, Tuesday 2 September 2014
[4] Home Affairs Committee, Oral evidence: Policing and mental health, HC 202 Tuesday 28 October 2014

Table 3: Mental health & mental vulnerability in police custody

Studies considering prevalence of mental disorders and mental vulnerabilities		
Research	**Finding**	**%**
Gudjonsson et al. (1993)	Problems which might interfere with their functioning or coping ability during police interviewing	35%
Scott et al. (2006)	Custody records containing evidence of possible mental illness or learning disability as judged by mental health nurses	12%
(Rapley et al. 2011).	Custody records with some medical need (either physical or mental, including learning disability) / excluding general medical needs and substance misuse	47%/ 23.8%
McKinnon & Grubin (2013)	Adults in police custody having mental disorders including intellectual disability according to clinical interviews	38.7%
McKinnon & Grubin (2014)	Adults in police custody with psychosis, major depression, intellectual disabilities and people who lacked capacity to consent.	25.6%
Studies considering prevalence of mental disorders / mental health only		
Robertson et al. (1996)	'Obvious' serious mental illness in police custody including cases of schizophrenia, affective disorders, brain damage and solvent abuse induced psychosis	1.4%
Shaw et al (1999)	Serious psychiatric disorder among those held in custody overnight appearing at Magistrates Court.	6·57%
Payne-James, (2010)	Those found to have an active mental health diagnosis amongst a cohort who had been referred by custody officers to an FME	18%
Young et al. (2013)	Current symptoms of Attention Deficit Hyperactivity Disorder (ADHD) / Conduct Disorder	23.5% / 76.3%
Studies considering prevalence of learning disabilities and difficulties in custody		
Holland et al. (2002)	Learning disabilities (study of existing research)	0.5% to 9%
Scott et al. (2006)	Definite or possible learning disability	1%[5]
Gudjonsson et al. (1993)	Intellectual disabilities / below the reading age of 9 / mental handicap.	8.6% / 6% / 3%
Young et al. (2013)	Intellectual disabilities	6.7%

[5] Community Mental Health Nurses screened 9014 custody records for evidence of mental ill health of learning disability. 1089 records (12%) screened positive. Of these 95 were judge on interview to have a possible or definite learning disability. This is 8.7% of those screened or 1.05% of the total records screened.

Police identification of mental disorders and mental vulnerability

When vulnerable adults arrive at custody, they often do so with multiple and complex needs. It has been found that of the adults identified with either mental health, substance misuse or alcohol misuse issues, the majority, have more than one of these issues (Home Affairs Committee, 2015; Brooker et al., 2011).

Research suggests that current risk assessment processes regularly lead to an inaccurate picture of people's mental health needs and, in turn, failure to engage with AAs and mental health professionals (Adebowale, 2013; Shaw et al., 1999). It has been found that police risk assessments identify between 52% to 63% of those with mental health and learning disabilities (McKinnon & Grubin, 2013; 2014; Rapley et al, 2011); highlighting potential gaps in the identification of vulnerabilities picked up by the police. Research shows that the some conditions have lower identification rates. For example, psychosis was identified by police around 40% of the time (McKinnon & Grubin, 2013), and the identification of learning disabilities in police custody was around one sixth of the prevalence in the general population (Rapley et al., 2011). It has been reported that indicators such as poor reading and writing skills and attendance at specialist education services are not consistently recognised as potential indicators of learning disability (CJJI, 2013).

Studies (Hodgson, 1997; Jacobson, 2008; Young et al., 2013; CJJI, 2013) suggest that low identification rates are the result of:

- A lack of effective and systematic screening
- A lack of training for police
- Mentally vulnerable individuals often showing no visual or behaviour clues or greater signs of anxiety and stress than other people who are detained by police
- The influence of alcohol or drugs complicating assessment
- A disregard of self-reporting
- The failure to use historical information from police records to identify learning disabilities to the same extent as they are used for mental health
- Some people seeking to disguise it (while others may be happy to alert police to their condition or it may be apparent from other information provided)
- Computerised risk assessments based on standardised questions which may be less likely to identify intellectual disability than mental health, drugs and alcohol use and self-harm (McKinnon & Grubin, 2010).

Most BME communities are disproportionately represented in the criminal justice system, mental health care and learning disability inpatient care (ONS, 2011; Ministry of Justice, 2011, Centre for Mental Health, 2014) though they do not necessarily have a higher prevalence if mental ill health or learning disabilities (Nazroo and King, 2002). Cultural factors can reduce access to services such as the fear of stigma, the imperative to 'save face', maintain social status and moral reputation (Centre for Mental Health 2014).

Police requirement for AAs

Police and Criminal Evidence Act 1984 Code of Practice C (Home Office, 2014) states that if a custody officer has any doubt about the mental state or capacity of a detainee, that detainee should be treated as mentally vulnerable and this should prompt an Appropriate Adult (AA) call-out (see Paper I).

However, research suggests that despite police identification of mental vulnerabilities among suspects, AAs are only called in 54-63% of cases; highlighting a disjuncture between the identification of need and AA call-outs for adults with needs around mental health and learning disabilities (Medford et al, 2000; McKinnon & Grubin, 2014; CJJI, 2013). Studies have shown that whilst the police often recognise the extent of the mismatch, the use of AAs remains generally low (Leggett et al., 2007; Cummins, 2007). Consequently, the proportion of adults in custody for whom the police require an AA is very low. Findings range from 0.18% to 14% (Bean & Nemitz, 1994; Rapley & Sandberg 2011). However, it is interesting to note that the most recent studies found rates of 4.8% (McKinnon & Grubin, 2013) and 4.2% (Young et al., 2013) respectively, mirroring the 4.3% found by the Royal Commission on Criminal Justice more than 20 years ago (Gudjonsson et al., 1993).

Decision-making by custody officers

There are a wide range of factors that influence a custody sergeant's decision to call an AA. This includes the nature of the offence; the circumstances of the arrest, the presentation of the suspect; and wider pressures in the custody suite; in addition to a custody sergeant's continued reliance on their own interpersonal skills and experience (Cummins, 2007). Whilst screening questionnaires have been developed to help police identify vulnerabilities, this has not necessarily translated into commensurate AA call-outs (McKinnon & Grubin, 2014). In an evaluation of a volunteer scheme, Nemitz and Bean (1998) found that as trust between the AAs and police grew, the demand for the service increased. Other factors that enter the custody sergeant's decision-making equation on whether to call-out an AA are discussed below.

Training

Described as 'woefully inadequate' (The chair of the Police Federation cited in Dodds, 2014), the lack of training provided to custody sergeants on mental health, learning disabilities and other mental vulnerabilities is consistently reported to be inadequate and correlated with the under-use of AAs (Palmer, 1996; Cummins, 2007; Williams, 2000; CJJI, 2013).

Delegation of decision-making to healthcare professionals

PACE Code C states that 'Health care professionals should advise on the need for an appropriate adult to be present' (para. 5, Annex G of Code C) but that, 'Once the health care professional has provided that information, it is a matter for the custody officer to decide whether or not to allow the interview to go ahead and if the interview is to proceed, to determine what safeguards are needed' (para. 8, Annex G of Code C).

However, there is evidence to suggest that, rather than consulting with healthcare professionals (HCPs) regarding the need for an AA, custody officers often delegate their legal responsibility to HCPs to make the decision on whether an AA is required (Phillip and Brown, 1998; Medford et al, 2000; Williams, 2000; McKinnon et al, 2010). This is perhaps unsurprising given custody officer's likely perception of their relative levels of training. Indeed, there is some evidence to suggest that forensic physicians (commonly referred to as forensic medical examiners or FMEs) or healthcare professionals (HCPs) are more likely suggest an AA call-out (Rapley et al., 2011). However, recently, the current training, management and capability of forensic physicians to recognise when an AA is required have come under scrutiny (Adebowale, 2013; CJJI, 2013). Typically GPs, there is no requirement for them to have psychiatric or learning disability training. Previous research has found them: to be poorly informed on PACE Code C the thresholds and requirements; to ignore suggestibility and the differing contexts of a doctor's examination and a police interview (Norfolk, 1996); and to confuse and conflate decisions over fitness to interview with the requirement for an AA (Robertson, 1993; Williams, 2000).

Assessments have been increasingly undertaken by specialist nurses. Some have little or no training in relation to learning difficulties, such as access to AAs (CJJI, 2013). It was found that in one force visited by inspectors, none of the ten detainees with identified learning disabilities received an AA, even though, many had been medically assessed (CJJI, 2013).

Researchers have suggested that HCP staff do not focus sufficiently on psychological or mental health symptoms and recommended improved knowledge and awareness (Young et al., 2013; McKinnon & Grubin, 2014). It is also notable that the design of computerised risk assessments can actively discourage genuine consultation around the need for an AA, by forcing medical professionals to respond only 'yes' or 'no'. Jacobson (2008) recommended PACE Code C be amended to make explicit that an AA is mandatory whenever a custody officer has sufficient concerns about a suspect's mental state or capacity to request a health professional's assessment of fitness for detention and/or interview. This is logically consistent since an AA is already required whenever a custody officer has a suspicion.

Availability of AAs

Research consistently highlights the difficulties in some areas with the availability of AAs, with local social services emergency duty teams responding only if they had no higher priorities (Durcan et al 2014). This has a direct impact on operational decisions, causes delays in investigations and leads to mentally vulnerable people being detained for longer than is necessary, including overnight, and in an environment which is unhelpful to their mental state (Home Office, 2008; CJJI, 2013). In a survey of police forces, most commented that the poor level of service provision was due to a lack of statutory responsibility for vulnerable adults (Perks, 2010). Notably, Norfolk (1996) found a statistically significant association between those FMEs who said police put pressure on them not to recommend an AA and areas where the police have difficulty in finding AA.

Early research indicated difficulty finding AAs in around half of areas and problems securing timely attendance due to the lack of an equivalent of the custodial duty solicitor scheme (Royal Commission on Criminal Justice, 1993; Norfolk, 1996; Hodgson, 1997; Signy, 1997; Littlechild, 1998[i]). On average, it is reported that an vulnerable adult spends over 4.5 hours in custody prior to the AA's arrival, with some waiting more than 20 hours (Medford et al, 2000).

The 2002 PACE Review found that the chaotic and unstructured provision of AAs lead to avoidable delays in custody and recommended national policy and full national guidance. Further research led to recommendations for adequate funding, statutory provision of adult services, training for police and the overhaul of 'fractured and dislocated' community-based mental health services (Pritchard, 2006; Cummins, 2007). Although researchers noted that there are many AA schemes serving adults in existence that operate effectively, some long-established, providing extensive coverage and well-integrated with other local services (Jacobson, 2008) the subsequent PACE Review concluded that, "There are [still] difficulties in some areas around availability and attendance of appropriate adults at police stations" (Home Office, 2008 p.30). A recent HM Inspectorate report suggests there are still significant issues with the availability of AAs in some areas and that, "Custody sergeants said appropriate adults were not always available to assist with cases" with only two of six forces reporting AAs are available day or night (CJJI, 2013 p.5).

Commissioning AA services

It has been recommended that there should be a statutory provision for vulnerable adult suspects, equivalent to that for children, and that the necessary funding is ring-fenced whether the duty lies with local authorities or health (Pritchard 2006; Jacobson, 2008; Perks 2010; PRT, 2011). A PACE Review proposal to place the statutory duty on police forces was rejected in consultation responses, due to concerns over conflict of interest and perceived independence and suggesting it should lie with local authorities (Home Office, 2010).

While local approaches have been identified as a good model, concerns have been raised about the 'patchy and of variable quality' of development, the lack of evaluation of training courses and the ease with which they could be undermined by poor selection and training or dominated by ideologies that are more concerned with securing treatment than protecting rights (Bean & Nemitz 1997; 2001). In response to these risks, the PACE Review consultation showed broad support for local agreements with social services, voluntary schemes, and companies but also a national approach supporting recruitment and retention, communications, learning the lessons and monitoring and accountability (Home Office, 2007; 2010).

The recent report 'The Bradley Report five years on' provided an independent review of progress against the Bradley Report's recommendations. It noted the lack of statutory responsibility and recommended clarification of the funding arrangements and access to AA provision in any facility where a vulnerable person is likely to be interviewed (Durcan et al 2014). Sir Stephen Bubb's review of progress on the (post-Winterbourne View) Transforming Care agenda emphasised the need for a Government response to these recommendations,

explicitly recognising how 'fundamentally important' the issues were to its agenda - transforming care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services (Bubb 2014). In 2015, in response to the Bubb review, NHS England, the Department of Health, the Local Government Association, the Association of Directors of Adult Social Care, the Care Quality Commission and Health Education England published a commitment to strengthen the Transforming Care delivery programme by creating a new delivery board, as well as reinforcing the need to respond to those same recommendations[6].

Who makes an appropriate AA?

Whilst PACE 1984 guidelines identify who should take on the role of AA for children, for adults, this is left to the Codes of Practice (see Paper B). The literature outlines the relative efficacy of different types of AA, including the use of family members, social workers and volunteers.

(i) Family members

The literature highlights that the use of family members as AAs for children is fraught with difficulty. Problems with the use of parents as AAs for children include; a misunderstanding of the AA role, the threat of physical violence towards their child, pressure on their child to confess, aggression towards police and their involvement in ongoing family conflicts (Dixon et al, 1990; Brown et al, 1992; Evans, 1993; Littlechild, 1995; Bean, 1997; Bucke and Brown, 1997; Pierpoint, 2006). However, it is not clear to what extent these issues are present for family members acting for vulnerable adults.

Studies suggest that the AA role is too complex for the short explanation that a busy custody officer can deliver to an untrained person and a small amount of information about the role can render a person less effective than if they had none (Williams, 2000; Nemitz & Bean, 2001; Dhami and Garcia-Retamero, 2014). The 2008 PACE review proposal to limit the role to trained individuals while encouraging parents and carers to attend was strongly supported in consultation responses subject to 'significant resource and capacity implications' (Home Office, 2008; 2010) and is supported by research (Littlechild 1995, Pierpoint 1999, 2000a, 2000b, 2006). The view of the Inspectorates is that, "If the Appropriate Adult system is to be fit for purpose, it must be staffed by workers/ volunteers who have received appropriate training" (CJJI, 2013 p.20).

(ii) Social workers

Issues with the use of social workers as AAs are well documented (Kay and Quao, 1987, Dixon, 1990; Brown, 1997; Hodgson, 1997; Williams, 2000; Pierpoint, 2001; White, 2002). These include the perception of them as 'instruments of control or punishment' by vulnerable suspects, their tendencies towards elements of crime control, and the fact that they are more co-operative towards the police than parents. It has been questioned whether social workers' training, experience and codes of ethics suits them to the role, with confidentiality being

[6] http://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf

a key area of conflict of interest (Thomas, 1995; Williams, 2000; Pierpoint, 2001). Case law has held that those in a position of authority over a client are inappropriate (Hodgson, 1997). Perhaps the most critical issue that the unit cost of a social worker outside London is £159 per hour of face-to-face contact or £226 of qualifications are included (Curtis, 2013)[ii] meaning that many individual custody episodes would cost over £1000.

(iii) Volunteers

Prior to the enactment of a statutory duty to ensure AA provision for children, the government proposed the use of volunteers as a response to limited availability (Home Office, 1995) and to save money by reducing the time spent by social workers (Audit Commission, 1996).

Though efficiency had been the only consideration, later evaluations proved positive at least on the basis that volunteers arrived more quickly than social workers, reducing the time spent in custody (Bean and Nemitz 1997; Nemitz and Bean, 1998; Revolving Doors Agency, 1996; Pierpoint, 2008). Volunteers were able to act without conflict of interest or emotional attachment. Whilst volunteers did not always contribute enough, the quality of contributions was superior to parents or social workers. However, effectiveness was found to be contingent on good selection and preparation, improved training and monitoring practices, and effective regulation and guidance (Pierpoint 2000a; Pierpoint, 2001). There is an absence in the literature considering the relative efficacy of people paid to be a dedicated AA, whether sessional or otherwise.

Insights from people who have used AA services

The thematic joint inspection on vulnerable people in custody (CJJI, 2015) commissioned research into views on AAs of people who had used their services. It found that:

- Children are always provided with an AA but vulnerable adults are not.
- People sometimes decline an AA to get out of custody faster, something that can be a matter of regret. This should be addressed to protect the rights and welfare of vulnerable detainees.
- Some people value having an AA whom they know and trust, while others felt inhibited talking openly and honestly with a parent/carer present.
- Some who had a parent/carer as their AA understood the role to be entirely passive. If a parent/carer acts, it is better if they have good knowledge of custody and criminal justice.
- No people who used an AA service recalled meeting their AA earlier than shortly before the interview.
- Where AAs take a long time to arrive it delays the custody process.
- AAs make a positive difference to the custody experience and outcome. They provide support during interviews (people feel more relaxed and can understand and communicate better), protect rights (more able to exercise their rights), and promote fairness (unprofessional conduct and inaccurate information is challenged)
- People who had used AAs said *all* detainees should have one to ensure welfare and rights in custody.

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