Paper F: Results - stakeholder interviews

We interviewed a total of 13 stakeholders during the course of the study. Interviewees were selected for their knowledge of one or more of the following areas: custody procedures, mental health issues, and/or appropriate adult service provision. Stakeholders were from a variety of professions, including: policing, health, legal services, service commissioners and providers and a mental health/criminal justice expert.

The interview schedule was thematic; structuring our schedule in this way allowed us to gather information about a key set of themes from all interviewees whilst also allowing interviewees to bring their own experience and expertise to the interview. Themes covered in the interview included:

- views of the Police and Criminal Evidence Act (1984);
- the difficulties encountered by the police when identifying vulnerabilities in adult suspects;
- the barriers which exist to appropriate adult call out;
- the availability of appropriate adults;
- commissioning appropriate adult services;
- diverting vulnerable adults from the criminal justice process;
- gaps and/or shortcomings in current provision of appropriate adults for vulnerable adults; and
- ensuring the rights of vulnerable adults are fully protected whilst in custody

A couple of the early interviews served to orientate the research team to the issues, while those towards the end of the study served to test out themes and ideas which were emerging.

The Police and Criminal Evidence Act (1984)

The Police and Criminal Evidence Act 1984 (PACE) sets out the powers at the disposal of the police to tackle crime In addition to the Act are the accompanying Codes of Practice (Codes), which police officers must take into consideration and refer to when carrying out various procedures associated with their work. The aim of PACE and its Codes is to strike the right balance between the powers of the police and the rights and freedoms of the public, maintaining that balance is a central element of PACE. As part of the interview we asked stakeholders for their views on the adequacy of PACE and the associated Codes in safeguarding the rights of vulnerable adults whilst in custody. Interviewees were fairly divided in their opinions; some believed the Act was comprehensive despite it being over 30 years old, while others believed it needed to be reviewed and updated. Difficulties highlighted by interviewees included the Codes of Practice not being a statutory requirement, the inaccessibility (e.g. the availability in custody of copies of the Codes in formats which are accessible to detainees with impaired vision, learning disabilities and in languages other than English) and lack of clarity of both the Act and the accompanying Codes, as highlighted by the interviewees below:

> *PACE is adequate, it's how it's adhered to - its application - that needs to be looked at. How do officers interpret the guidelines and codes, what is their understanding of Code G, who is monitoring whether the codes are being adhered to? That is what we need to look at.*

> *PACE is very comprehensive, although I think at times it's quite inaccessible. Given detainees have the right to consult PACE and to read the Code of Practice I think that's pretty much a token gesture because it's written in legal speak, it's full of language that's not particularly familiar... PACE could be much clearer about when an appropriate adult is required at different stages because when I meet people nationally appropriate adults seem to be going in at different stages* [in the custody process] *across the country.*

> *PACE was written over 26 years ago: it's completely inadequate. Mental Capacity Act has arrived, alongside other new legislation but PACE stays the same. In essence where you have Liaison and Diversion PACE will be adequate because the additional experts will be on hand to assist. Where there is no Liaison and Diversion, PACE will remain inadequate*

Views about whether and how to revise the existing Codes were varied. A number of interviewees suggested that the provision of appropriate adults for vulnerable adults should be a statutory requirement; others believed the Codes needed greater clarity, others suggested that there needed to be an information leaflet available to AAs which spelt out in a 'clear unambiguous' way the AA role in relation to other professionals in the custody area; whilst others suggested that officers should receive additional training to assist them in carrying out their responsibilities, as illustrated below:

> *I think at the moment some bits of the* [PACE] *guidance are open to interpretation ...The guidance needs to be clear....It shouldn't be that different forces in the country interpret the guidance in their own way.*

> *It's about applying the Codes in the way they were intended. Changing legislation always takes time. [We] should look to change the way AA provision is provided rather than changing the Codes.*

Identifying vulnerability

The recently published HMIC report 'The welfare of vulnerable people in custody'[1] highlighted the detrimental impact custody can have on vulnerable adults and how quite often it is the wrong approach to take. Custody staff (both police and civilian) were, however, reported as demonstrating "an understanding of the needs of vulnerable people and tried to respond appropriately (pg 18)". In addition the report found that:

> *It was noticeable that police officers and staff were highly dependent on their own experiences and personal judgements when identifying and responding to vulnerable people, rather than being able to refer to official training or guidance.*
>
> (HMIC 2015: 18)

[1] HM Inspectorate of Constabulary (2015) The welfare of vulnerable people in custody. London: HMIC

A number of our interviewees reported similar views to those reported by HMIC; many highlighted the difficulties custody staff face in identifying vulnerability, a difficulty which is sometimes exacerbated by the frenetic nature of a custody suite and the time pressures that are placed on police officers to adhere to the requirements of PACE. Other interviewees suggested that whilst there is no statutory requirement for vulnerable adults to be supported by an AA this can sometimes lead to custody staff overlooking a vulnerable suspect's need for an AA. Interviewees' thoughts on the difficulties of identifying vulnerability are highlighted below:

> *The decision as to whether somebody needs an AA lies with the custody officer. So the custody officer presumably is expected to have a good knowledge of psychiatry, of learning disabilities, of vulnerability generally, and of course...what the role of the AA is there to legislate against and the simple fact is, they don't have either of those*

> *Many vulnerabilities are difficult to appreciate straight away; many are hidden from the police. Where there are other professionals in custody this can be overcome but it is still difficult & no amount of training will improve some of the identification.*

> *The police do not have the skills to identify vulnerability at all. ... Coupled with this is the unwillingness to identify vulnerability. Why would you add a five hour delay to your enquiry just to help a prisoner, that's what you are asking a police officer to do. You take them off the street for five hours, they are late home because someone is just borderline, do they or don't they need an AA? If they get the chance they will say: no, they're fine. That is why the statistics are so low. As a police officer I've done interviews without an AA when the person has not wanted one but has needed one*

> *The concept of who is and isn't vulnerable is a big issue for custody sergeants... There is always an area of doubt: who should or shouldn't have an AA? It's complicated; mental capacity can vary, today I need one tomorrow I don't. It is completely unrealistic to ask custody sergeants to be mental health experts…. Some vulnerabilities are subtle and difficult to spot. There's also a lack of information for officers on the street, if you call through on the radio, you will never be told a suspect needs an AA: this isn't seen as essential information. People are judged on their last visit to custody: it's assumed they don't need an AA if they didn't have one when last in custody*

Improving the identification of vulnerability as early in the police process as possible and providing the support needed were seen as important elements of improving the custodial processes for vulnerable adults. Interviewees were unanimous in their view that the current police response is inconsistent and very much a 'postcode lottery' for detainees. The introduction of liaison and diversion services was welcomed and viewed as a positive step forward to achieving a better police response for vulnerable adults. Providing the police with additional experts to work with was also viewed as one of the benefits of liaison and diversion. In areas where custody staff and operational officers work alongside mental health nurses, interviewees were positive about the benefits of this arrangement, in particular the opportunity for both to actively engage in a knowledge transfer process. Other suggestions put forward by interviewees included: providing the police with a standardised assessment tool, greater information-sharing between agencies (both in terms of shared *systems* and *willingness* to share) targeted training for custody staff (both civilian staff and police officers) and joint training with triage nurses.

To improve identification we need experts in custody as well as out with officers; in [area] there are mental health nurses in custody and a triage car. Liaison and diversion staff providing a level of expertise will also improve identification. Officers see the same people come through time & time again ... They want someone else there (in custody or on the street) who can give them a view.

There needs to be an exploration of the influences on custody staff decision making. How do custody staff/arresting officers identify vulnerabilities through the risk assessment process and thereby the need for AA services? There needs to be greater use of mental health nurses and other professionals in custody. Use health risk assessment tools or a vulnerability assessment framework developed.

The introduction of schemes for vulnerable adults to carry cards identifying their vulnerabilities could help – such schemes have been successfully introduced for certain vulnerabilities in some parts of the country

Whilst appreciating the difficulties the police face in identifying vulnerabilities in adult suspects, several interviewees suggested that the situation is compounded by the non-confidential, open-plan layout of custody, which may prevent vulnerable adult suspects from disclosing their vulnerabilities in public. It was argued that, to improve identification the design of the custody environment should be re-thought or private spaces more readily available and offered.

Barriers to AA call-outs once vulnerabilities are identified

Once a detainee has been identified as vulnerable, one of the key difficulties is securing the services of an AA. An AA must be over the age of 18 and be able to support the detainee during/throughout the custodial process. The Home Office Guidance (2011)[2] states that the role of an AA is to:

- "support, advise and assist the detainee
- ensure that the police act fairly and respect the rights of the detainee
- help communication between the detainee, the police and others"

Procedures which should involve the presence of an AA include:

- the detainee being informed of his/her rights
- cautioning
- a recorded PACE interview
- charging and related actions

Other procedures which may require an AA include: being present for fingerprinting, DNA swabbing, ID parades and searches (strip and intimate). Current provision of AA schemes is patchy. Where there is no coverage the police rely on volunteer AAs, relatives or members of the public. All of our interviewees sympathised with the predicament many custody sergeants find themselves in; far too frequently a detainee will be identified as vulnerable and the police are unable to locate an AA. The problem of AA availability is further exacerbated by the

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117682/appropriate-adults-guide.pdf

timing requirements of the PACE clock[3], and the day and time of an arrest. It was mentioned to us on several occasions that finding an appropriate AA at 3am on a Sunday morning in many areas of the country is "a nightmare for custody sergeants". This situation either leads to detainees being bailed to another day and time, being kept in until an AA can be found or being processed without an AA present.

In addition to the lack of universal custody coverage by AA schemes, interviewees also raised concern about the appropriateness of some AAs. Interviewees were divided about whether family members should be AAs, whilst interviewees recognised the importance of the emotional support a relative can provide they also thought that remaining objective proved difficult for many family members. The lack of training provided to relatives, members of the public and some volunteers was viewed as problematic by our stakeholder interviewees:

> *Provision is patchy across the country, in some areas it's particularly good, especially those areas where there are dedicated AA schemes; in other areas the police have few resources to pull on, bar family members who may or may not be appropriate*
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> *There are very few people who are qualified or trained to deal with people with learning disabilities or autism around the criminal justice system.*
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> *There are not enough AAs. It's much better where there are* [dedicated] *AA services; otherwise the police have to rely on relatives, which can be problematic. Training is important, which is more difficult if it's a relative. AAs should be trained, equipped to provide the best service and have a degree of professionalisation, they can be volunteers, however, rather than professionals.*
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> [there is] *inconsistent commissioning of AA services across the country and therefore AAs are not always available. There is a difficulty with using members of the public as AAs because they are not trained. In* [particular area*] AAs receive training, are shadowed and properly accredited. In* [particular area] *there is a rota of volunteers provided to the police and they are contacted directly during working hours, but no out-of-hours provision*.

Interviewees were unequivocal in their view that AA provision needed to be provided by trained volunteers/professionals, some interviewees thought the current AA services should extend their coverage across England and Wales to all 43 forces and that there should be more than one service covering each force area. Others believed that AA provision should – in the future - be brought under the umbrella of liaison and Diversion schemes. Other interviewees suggested creating a comprehensive list of volunteers in each force area who can be called upon on specific days at specified times of the day.

> *There should be a paid pool of individuals that are available across all police forces and targeted at particular times of day and night. Often we rely on call-outs and/or volunteers. I'm not saying we shouldn't have a voluntary network but I actually think we should have a core requirement and coverage in all police forces and all local authority areas.*
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> *AAs need to be individuals that are trained, understand what the role of an AA is, are on-call, available and able to refer to other services. Provision needs to be throughout the criminal justice system not just at the*

[3] Once a detainee has been booked into custody the PACE clock starts to tick. The police are legally allowed to hold an individual for 24 hours before a disposal decision has to be taken. If the police wish to detain a suspect for longer they must request an extension. In the first instance from a police officer of Superintendent rank and thereafter from a Magistrate. The longest period a person can be held in custody without being charged or bailed is 72 hours.

point of arrest. There needs to be an AA whilst a vulnerable adult is in the police station, court, probation etc. The service should probably be mental health led.

AA schemes should be brought under umbrella of liaison and diversion. There's a huge benefit to be had of having a coherent approach to people's vulnerabilities. Liaison and diversion is principally about mental health, but now it's accepted that all of someone's needs should be recognised: e.g. drugs and alcohol and other issues. It's a false economy to just deal with the first presenting issue rather than provide wrap-around services to support those who have found themselves in the criminal justice system.

Commissioning and governance of AA services

Stakeholder interviewees tended to view the commissioning and governance of AA services as a shared responsibility. There was general agreement amongst interviewees that delivering AA services should be through a partnership, comprising of health, police and social services. Most interviewees believed that AA provision should not be the responsibility of the police or the PCCs, as highlighted below:

The provision of AA services is essentially a safeguarding issue. Local Authorities need to understand and recognise this. It should be multi-agency led, with mental health as lead. Partners must include: health, police and voluntary/statutory mental health services. Adult safeguarding boards should widen their remit to inspect AAs and provide guidance on best practice.

The current commissioning of AA services was seen as inconsistent; in some areas AA services were paid for by the PCC in other areas the Local Authority, in a number of areas provision was provided by voluntary agencies and paid for by a partnership, which often consisted of health, police and social services. In some areas the commissioning teams are integrated and sit within the remit of health and social care. Most interviewees were of the view that Adult Safeguarding Boards should be the lead agency in reviewing and deciding upon the level of need and the governance arrangements. Clinical Commissioning Groups (CCGs) were generally viewed as the best agency to commission AA services at a local level. The following insights reflect our stakeholder views regarding the commissioning of AA services:

It's very complicated and messy at the moment because all issues are separately funded: there are several funding streams and haphazard provision because AA provision is not statutory

Personally, I don't think it sits just with adult social services. I think the safeguarding board should oversee AAs for vulnerable adults, I think that would be very helpful. It then positions it in people's everyday practice around safeguarding.

I think commissioning AA services sitting with the Local Authority has been a very positive thing ... Our funding is becoming more complicated. As well as adult social care contributing to our funding, CCG now have a big input. Our commissioning team is integrated and sits with health and social care, which seems to work really well. Our local safeguarding board has oversight of the service... I'm not overly confident about that sitting with the PCC, my kind of impressions of the PCC is very much responding to what local communities say ...and I am not convinced that the rights of vulnerable detainees is going to be high on people's agendas

> *Ideally AAs should become part of liaison and diversion, with Treasury funding liaison and diversion through mainstream funding.* [Till 2017 liaison and diversion will be funded as Department of Health project.] *With mainstream budgets you can start to provide wrap around services. Post 2017 the aim should be for AA services to 'piggy back' onto liaison and diversion because the money will come through NHS England, the National Commissioning Board should be the lead, with partnerships to include police, PCCs, Local Authorities, social care, housing and education. Commissioning at a local level should be through Health and Well-Being Boards with a strategic body that holds the money for CCGs. This way there will be less reliance on voluntary services having to provide services like AAs.*

Some interviewees acknowledged that historically the relationship between health professionals and police managers - at a strategic level - had lacked a partnership approach. In part this was due to the remit of the two organisations being diametrically opposed and in part due to the funding, oversight and accountability arrangements of the two organisations; as illustrated by the interviewee below:

> *The relationship between health and policing has always been problematic (mainly at a strategic level).There's been a lack of police presence on Health and Wellbeing Boards and the incredibly complicated accountability arrangements make it even more difficult. Who holds health services and their provision to account? It is really hard to unpick. They can say they have no mental health beds; if police say 'no' to a vulnerable adult in custody they then have to provide a guard at A and E, as if their mental health is a police problem.*

Stakeholder interviewees did, however, provide us with many examples which illustrated the benefits of the two services supporting one another both 'out on the street' and in custody. Many police forces now work alongside mental health nurses at an operational level, in custody and in the control room. One of the benefits of co-ordinating responses and maximizing capacity is the ability to provide detainees with the means to link with other (more appropriate) services for their needs. Ultimately our interviewees agreed that whilst vulnerable adults often found themselves in custody they also were known to the police as victims. There was unanimous agreement amongst our interviewees that custody for vulnerable adults was only really appropriate for a small number of cases. The shared view of interviewees was that the more the police work with and refer to other services the less likely vulnerable adults will be to keep returning to the custody suite.

> *There must be joined-up thinking between liaison and diversion, street triage, victim services (most offenders with mental health problems are also victims) and AA services. These four services need to be under the same umbrella and funded in the same way. Mental health agencies and the police do not link up and work well together; there is a huge tension. There is a real need for community advocates to help bridge that gap. There is a data disconnect and a professional disconnect.*

> *We've always worked with what is now the liaison and diversion service. For as long as I can remember we've had mental health workers based in custody suites and at court and I think AAs have a very positive role to play with them* [liaison and diversion]

> *AAs should be part of liaison and diversion services, and street triage should be rolled out nationally. The latter will assist police to identify vulnerable individuals and to make decisions based on a number of facts - the offence, vulnerability of the individual, services available, and the likely criminal justice outcome.*

> *How difficult would it be to make AA schemes part of liaison and diversion? Not a problem in terms of guidance, if there is a policy agreement. It is about piggy backing onto a current programme. If over time there needs to be a legislative change it becomes inevitable and not controversial because it is happening on the ground: you are merely tidying up what is current practice. The impact on the public of the police and health working together is phenomenal*.

Diverting vulnerable people away from the criminal justice system

> *During the course of our inspections it was clear that custody could have been avoided for a number of vulnerable adults and children, had other action been taken by police officers, or other services been available to support these individuals (HMIC, 2015 pg. 22)*[4]

The view expressed by HMIC was shared by our interviewees. One concern raised by a small number of respondents, however, related to the availability of appropriate service to refer people to. Local services must be available otherwise there is little point in attempting to break the custody cycle.

> *Diversion should be the aim, the one thing we know about the CJS is that it doesn't work. We lock up the same people, we put them through the same process, they go into prison they leave prison, they go back in. Land D, triage nurses etc. are all good news. We need early intervention, at the first point of contact.*

> *Diversion away from the CJS should be the goal. The police have options at the point of arrest and should explore these. They need to apply the necessity and proportionality test far more than they do. For me it's all about turning off the demand tap for AA services. We should not be at a place where there are more vulnerable people in custody with corresponding increased demand for the safeguard/support services that AAs are a part of. If Human Rights principles and policing priorities were aligned in practice there should be a corresponding reduction in vulnerable people being arrested for minor offences, that might be dealt with lawfully in other ways.*

> *We have too many vulnerable adults who end up in the custody suites when they should never be there at all. What we really should be doing is looking at preventing people from being in the custodial setting...we should be looking at strong alternatives*

One final comment made by a number of interviewees was the need for commissioners and service providers to view police custody as one part of a process. Concentrating on custody alone was viewed as short sighted and not in the best interests of vulnerable adults; vulnerable adults should be supported at every point in the criminal justice system. As highlighted below.

> *AAs should be part of the process and not seen in a silo. An AA should flow with the system to whichever part of the system a vulnerable person goes - be it prison, courts or into services. It's about individual case management. AAs should be provided wherever they are needed in the CJS; not just for the police element of the service.*

[4] HM Inspectorate of Constabulary (2015) The welfare of vulnerable people in custody. London: HMIC