

Mental Illness, Learning Difficulties and Justice

What happens if someone who appears to be suffering from a mental disorder is arrested, or simply found, by a police officer? The legal definition of mental disorder was simplified by the Mental Health Act, 2007, to "any disorder or disability of the mind". So the answer is that the person should be taken as soon as possible "to a place of safety", normally a hospital but "in exceptional circumstances" to a police station. The likelihood is that, in many places, the person will be taken to the nearest police station with custody facilities.

In the Police Station

Every arrested person arriving at the police station must be presented to a custody sergeant who becomes responsible for that person's safety throughout the time he or she is there. The custody sergeant must open the written "custody record" and make an assessment of that person's health and condition. Where there are physical injuries, they must be treated usually by a doctor. Where there is suspected mental disorder or disability, the custody sergeant will ask the doctor if the detained person is "fit to be detained and fit to be interviewed". If in doubt or satisfied that the detained person requires immediate care elsewhere than in the police station, the doctor may be able to call upon the help of an "approved mental health professional", usually a specialist social worker.

This outline sets out very simply what is now found in the Code of Guidance C of the Police and Criminal Evidence Act, 1984. Code C arose following several cases of misjustice and wrongful conviction involving persons with mental disorder or learning difficulties and usually involving false confessions. From the time of Home Office Circular 66 of 1990, there has been a national policy for the diversion of persons "with disorder or disability of mind" out of the criminal justice system. Diversion wherever possible is the policy of the present government. Is the policy working?

Several government pilot schemes since the 1990s have pointed strongly to the efficacy of diversion in terms of the saving of police, court and prison costs even when these are offset by the costs in the health and social work services of care and treatment for diverted offenders. In 1992, a community psychiatric nurse was stationed in a busy custody suite of an urban police station. Over three months, several hundred detained persons were diverted into support, care and treatment and only one was prosecuted for the offence which had led to the original arrest. The financial savings were obvious.

A general policy of diversion creates a problem for the police and the Crown Prosecution Service, who decide whether to prosecute. Their role is to protect the public and, where they have evidence, bring before the courts those persons they

consider have committed crimes. This is a difficult balance and subject to strict criteria.

The reality is that, notwithstanding the policy to divert person with mental disorder or disability, many detained persons go through the police stations without the disorders and disabilities being recognised. This is particularly in the case of detained persons with learning difficulties. Such persons may even pass through the courts to arrive in prisons where, had the conditions been recognised at an earlier stage, diversion to care and treatment might have been possible with large costs savings. Where a condition is recognised, it is merely one of many factors for the criminal justice system.

It has been reported by custody sergeants that the arrival of a mentally disordered detainee is "the worst scenario". Whereas the custody sergeant is advised to deal with detained persons suspected of mental disorder or disability as quickly as possible, examinations of custody records show such persons spend much longer in police stations than others. The problems begin with the diagnosis. A large number of arrested persons show alcohol or drug misuse, conditions which are excluded from the definition of "mental disorder". But in 2005, £155,000 was spent on mental health training for police officers, just £1 for each police officer in England and Wales.

The custody sergeant is helped by Code C of PACE which refers to "vulnerable persons" as requiring special help. The custody sergeant who has called a doctor is likely to ask whether any interview will require an "appropriate adult". All persons under 17 require an appropriate adult and, where a parent or guardian is not available, the youth offender team of the local authority will provide an appropriate adult, either a social worker or volunteer. It would be unusual for any detainee suspected of mental disorder or disability to be interviewed without one. Most custody sergeants examine medications very closely when they are surrendered by the detained person at the opening of the custody record. The role of appropriate adult can be taken by a parent or guardian or other person who knows the detained person, as with detained juveniles. Clearly, an appropriate adult who knows the detained person is likely to be more helpful in many ways. But where such an appropriate adult has no training in mental health and disability and no training in performance of the role, this advantage is often outweighed by the problems. The police station is a daunting place for every newcomer.

An appropriate adult is required to "advise and assist" the detained person, help with understanding and "facilitate communication with the police". Like the detained person, the appropriate adult has a right to require the assistance of a legal advisor, often a Duty Solicitor. How legal advice to remain silent can be reconciled with the duty on the appropriate adult to facilitate communication is one of many problems. Unlike a solicitor, the appropriate adult has no privilege to prevent questioning by the police of what the detained person has said.

Following 1990, many schemes for the provision of volunteer appropriate adults in police stations were created. By 1992, 190 such schemes were recorded. Difficulties for appropriate adults became evident and enthusiasm for such schemes faded. MENCAP declined to cooperate in providing appropriate adults. In most police stations, social workers usually act as appropriate adults for juvenile detainees, where a parent or close relative is not immediately available. By 2009, the number of volunteer schemes had dwindled to 100.

Given the clear benefits for the offenders, the police, the courts and the prisons, why have the difficulties for appropriate adults not been eased and the volunteer schemes expanded into a national scheme covering all police stations with custody facilities? With small grants from the Home Office and Department of Health, the National Appropriate Adult Network was set up in 2004 as a charity. It offers advice and training to the voluntary schemes and the youth offender teams of local authorities which have joined it. But the Network's Annual Review for 2011 (See www.appropriateadult.org.uk) states the main problem – "...in spite of the efforts of NAAN and others, there is still no statutory body with the responsibility to ensure the provision of an effective appropriate adult service for vulnerable adults... and as NAAN has argued and demonstrated over a number of years, this situation needs to change."

In the Court

Where the custody sergeant is satisfied that the evidence is inadequate of an offence by any detained person, that person will be de-arrested and discharged from the police station. In the case of a detained person with mental health problems or learning difficulties where evidence for a prosecution exists, the custody sergeant may decide that diversion is the best option. Many custody sergeants may grant the detained person bail to return to the police station at a later date while ensuring he or she has an appointment to see a mental health or disability professional in the meantime. If the bailed person keeps the appointment and, where necessary, enters into care and treatment, the custody sergeant may lift the bail without further action.

There are other options amounting to diversion. Where evidence exists, the custody sergeant, in consultation with the Crown Prosecuting Solicitor, may offer the detained person a formal, recorded caution or conditional caution in return for an admission of culpability by the detained person and the approval of the appropriate adult. This system of "instant justice" has expanded greatly in recent years and has come under considerable criticism, not least because it draws the prosecution into the judicial punishment process. The detained person comes under great temptation to admit guilt simply to avoid appearing in the court.

Should the detained person with mental disorder or disability be charged and bailed to appear at the court in respect of an alleged offence, it is likely the court and others concerned in the court process will be forewarned by the police or the Crown Prosecuting Solicitor.

The USA now has some 150 "Mental Health Courts" which specialise in dealing with offenders with mental health or disability problems. These courts are usually backed by "diversion and liaison" teams with health and social welfare professionals. The evidence of the Mental Health Courts and teams has been very positive both in terms of the engagement with care and treatment by defendants and reduction of offending.

In England and Wales, almost all court cases start in the Magistrates Court. In 2009, Lord Bradley reviewed people with mental health or learning difficulties in the criminal justice system (See www.dh.gov.uk<Home<Publications) and the Home Office established pilot mental health courts at Brighton and Stratford in East London which ran for 12 months until January, 2010. The pilots were limited and did not address the problems of many defendants such as those with "dual diagnosis", for example, both mental disorder or learning disability and drug or alcohol mis-use problems. Although the pilots suggested mental health courts had a considerable positive effect on reoffending and "revolving door" offenders, the experiments were too limited to demonstrate clearly benefits in the long-term health of the defendants or cost savings. They did demonstrate the gaps in communication between all the services in the criminal justice system and the community health services.

'Diversion and liaison' schemes aimed at defendants with mental health or learning difficulties started in the 1990s after Circular 66 of 1990 and the special provisions for vulnerable persons in the police station. The coverage of England and Wales court is very patchy. There are about 100 schemes of different types covering about 190 Magistrates Courts, some founded by police authorities and others by primary care health trusts. Most are staffed by mental health or social work professionals. Some schemes are as little as the provision of a mental health nurse who may attend the police station for the assessment by the custody sergeant and may follow a defendant with mental health or learning difficulties into the court. Most diversion and liaison schemes are based at courts to deal with defendants identified to them by the police, the Crown Prosecuting Solicitor, the court itself or court workers such as probation officers or defence solicitors. Their usual role is to provide such defendants with support and advise the court on the disorder, disability or difficulties of the defendant in hearings and on the disposal of the case. The court may ask the mental health team to contribute to a probation report about the defendant or ask for a medical report.

A request by the court for a report about the defendant from a psychiatrist or psychologist can create difficulties. Most schemes include health service professionals able to communicate and liaise with others within the primary health care services and hospitals. But any adjournment may need to be up to 6 weeks while the report is obtained. The issue of bail arises. In many cases, issues of possible further offending or lack of cooperation by the defendant arise. Although all courts are strongly advised against the practice of remanding a disordered defendant in custody, that is, to prison, for preparation of the reports,

this often happens. Out of 101 “approved” premises for bail in England and Wales, only three deal with mentally disordered defendants. Places in hospitals are very difficult to obtain. When sentencing with the advice of a medical report, the court has powers to impose a community sentence with requirements for mental health treatment. But out of more than 200,000 community sentences imposed in 2006, only 725 had such treatment requirements. A Crown Court may make community sentences, including Guardianship Orders and Supervision Orders. It may also make Hospital Orders with or without restrictions. The numbers of such orders have grown each year as long-stay hospitals have closed and the “secure estate”, hospital prisons, has grown in response. The number of “restricted patients” grew from 2500 in 1998 to 4000 in 2008.

As with the ‘approved adult’ schemes in the police station, there are problems with the court-based diversion and liaison schemes, apart from covering only 190 magistrates courts out of total of 330. Diversion is, in theory, available at all the stages of the criminal justice process but it clearly becomes more difficult after the police station. The court schemes are recipients of referrals of defendants with mental health problems or learning difficulties rather than proactive in finding such people among all defendants. The evidence is clear that many such persons pass through the police station and the court without the problems being recognised and care and treatment started.

Information about mental health diversion and liaison schemes and what, if any, contribution they make in cost-benefit analysis terms is scanty. The schemes are very different in their aims and funding. There is no collective reporting or auditing process. Many schemes report their major problem as one of isolation. A study in 2009, “Diversion” by the Sainsbury Centre for Mental Health (See www.centreformentalhealth.org.uk) concluded that the possible financial savings to the criminal justice system could be very large even when off-set by extra costs to the health services. This conclusion is supported by the limited studies of the Mental Health Courts and diversion schemes in the USA.

In the Prison

Every prisoner is screened on reception to prison including for mental health problems although rarely, if at all, for learning difficulties. Notwithstanding the protections for persons with mental health problems or learning difficulties in the police station and the court, the number of such persons in prison is alarming. The Office of National Statistics reported in 2001 that, on averaged figures, 8% of prisoners had psychosis, 66% had personality disorders, 45% had depression or anxiety, 45% had drug dependency and 30% had alcohol dependency. Only one fifth of the 47 prisons in England and Wales that receive unsentenced prisoners have diversion schemes in all the courts they serve. With the closure of many long-stay hospitals since 2001, the situation must have worsened and there is evidence of increased numbers of prisoners with severe mental illness. It is estimated that learning difficulties among prisoners are at least three times more prevalent than in the community.

“Mental Health In-reach Teams” in prisons started in 2001 with the assumption by the National Health Service for health services in prisons and by 2007 covered 80% of prisons in England and Wales. The original aim of the teams was to deal with prisoners with severe mental illness but the Bradley review found that such are the mental health problems of prisoners the teams have usually developed much wider remits. Most teams are staffed by a small number of mental health nurses. Evaluation of the work of the teams shows the overwhelming extent of the problems, such that many mental health and learning difficulties, including severe mental illness, escape recognition. Many prisoners whose conditions are recognised, for example personality disorders, cannot be treated, notwithstanding treatments are available in the community. Psychiatric reports are now obtainable quickly but transfers to hospital often require long delays. In 2009, less than 20% of 84 teams thought they could meet the needs of the prisoners.

Women prisoners show the highest incidence of depressive illnesses and self-harm whereas male prisoners have more personality and addictive disorders. It is reported that more than 33% of all prisoners self-harm at some point. Suicides among prisoners now usually exceed 100 each year. There is evidence that imprisonment is likely to make mental illness worst, especially amongst unsentenced and newly sentenced prisoners. Surely no one can believe that imprisonment encourages the recovery of good mental health?

Conclusion

Very many people with mental health problems or learning difficulties now live quite unnoticed lives in the community. It is an irony that the closures from the 1990s of many long-stay hospitals coincided with major increases in crimes on the statute books and in penalties, led by policy catchphrases “prison works” and “zero tolerance”, just as persons with mental health problems and learning difficulties came again to be seen in public. The Press continues to highlight the very small number of incidents involving such persons and usually out of context. The results are reminiscent of the findings by the Unitarian prison reformer, John Howard, in the 1770s – “the criminalisation of the mentally ill”.

The problem starts in the community where mental health and learning difficulties services do not support people sufficiently and, in the case of mental illness, at an early stage of loss of mental wellbeing. This leads to contact with the criminal justice system and an even further reduction of appropriate support.

This is a moral issue. Surely persons with mental health problems or learning difficulties in prison deserve the same standard of care and treatment as those in the community? Moreover, when the UK prison population has doubled since the 1990s to an all-time high of 89,000 in 2012, diversion holds out the possibility of major savings throughout the criminal justice system even after deduction of health and social services costs.

The Bradley Report in 2009 pressed for a national scheme of "Criminal Justice Mental Health Teams" developing "a partnership of all services" for persons with mental health problems or learning difficulties in the police station, through the court, through a community sentence or through prison to settlement in the community after release. As yet, this national framework has not happened.

What can you do?

Lobby locally and nationally so that politicians and administrator can understand the need to get things right in the health services and the criminal justice system for men and women with mental health problems or learning difficulties and save money.

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