

# The briefing

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## Policing mentally disordered offenders

This Police Foundation Briefing looks at the policing of mentally disordered offenders and identifies some of the key issues surrounding this aspect of policing.

### Introduction

It is estimated that up to 15% of incidents dealt with by the police include a mental health concern<sup>(1)</sup>, however mentally disordered offenders are difficult to define: are they offenders who happen to have a mental disorder, or are they people with a mental disorder which has led them to commit an offence? Should they come under the jurisdiction of the police or mental health

services? Specifically, a mentally disordered offender is someone who meets the diagnostic criteria set out in the Mental Health Act 1983 and who has also been convicted of a criminal offence. In practice, the term has a broader definition and there are generally considered to be three types of mentally disordered offender<sup>(2)</sup>:

1. People who have an existing mental disorder, and who have committed an offence (but not necessarily been convicted).

2. People who have been convicted of an offence or are on remand and subsequently develop a mental disorder<sup>(3)</sup>.
3. People with a mental disorder serious enough to prevent them from making a valid plea when brought to trial, or who may be found 'not guilty' for the same reason.

An individual who has committed a minor offence is most likely to fall into the first category and a proportion of these offenders will never be charged. The second type of offender might be someone who has been diverted from prison to hospital following a diagnosis of a mental disorder. A much smaller number of offenders will have committed an offence serious enough for the police to consider prosecution and a minority will fall into the final category. This Briefing, however, is primarily concerned with those who fall into the first category.

## Why is mental health an important issue for the police?

Since the large-scale closure of psychiatric hospitals and the implementation of 'care in the community' in the early 1990s, the police are often the first professionals to respond when the mentally ill are in crisis. The police are charged with protecting the safety of the individual and the community, so it falls upon them to control and contain an individual who presents a risk to himself and/or others, particularly if they are at large in the community or live alone. While being mentally ill is certainly not a criminal offence,

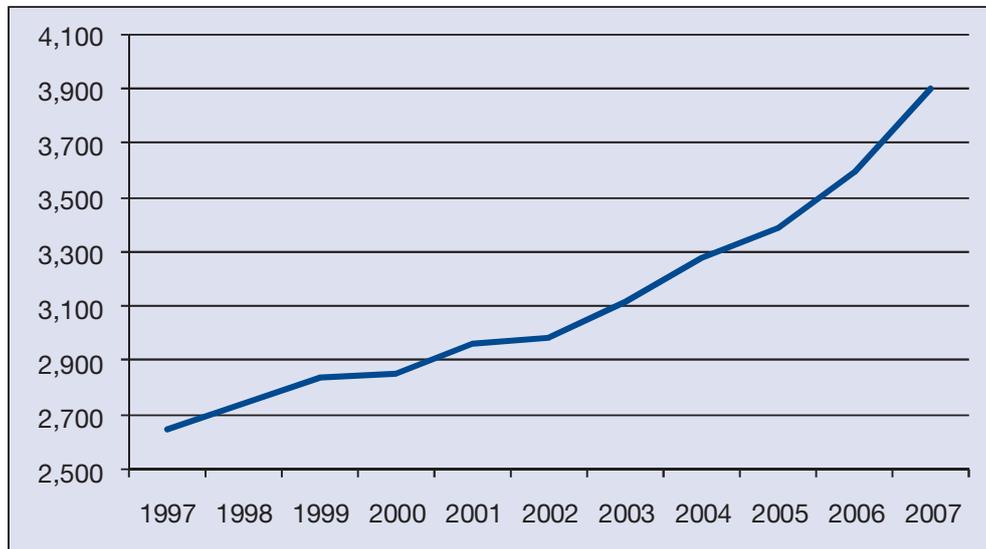
a mentally ill person in crisis might easily be deemed to have broken the law, for example by threatening members of the public or behaving in a disorderly manner.

Mental health is an increasing concern for the police service. Fig. 1 (overleaf) shows that the number of mentally disordered offenders convicted of a crime is rising. In 2007 over 3900 mentally disordered offenders were detained in hospital, the largest increase in 10 years.

*While the rising number of mentally disordered offenders is clearly a concern, it should be recognised that the mentally ill are far more likely to be the victims rather than the perpetrators of crime<sup>(4)</sup>.*

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system notes that there is no national requirement for the police to keep statistics on the mentally ill who come into contact with the police<sup>(5)</sup>. The IPCC has however published some information on the different reasons for detaining suspects under Section 136 of the Mental Health Act 1983, based on police records. It shows that the most common reason for detention is 'breach of the peace' (29%), followed by 'threats to harm self' (16%). More serious offences, such as 'actual bodily harm' (5%) or 'sexual offences' (2%) were found to be quite rare<sup>(6)</sup>, which suggests that the criminal behaviour of mentally disordered offenders is usually relatively minor.

Fig. 1. Restricted patients detained in hospital



Statistics of mentally disordered offenders 2007, England & Wales (Ministry of Justice)

## Legislation and guidance

The Mental Health Act (MHA) 1983 (updated by the Mental Health Act 2007) and the Police and Criminal Evidence Act (PACE) govern the policing of people with mental health problems. Section 26 of PACE allows the police to arrest, and Section 32 permits them to search, an individual considered to be in need of police intervention. An officer may remove an individual deemed in need of 'care or control' from a 'public place' to a 'place of safety' for up to 72 hours, under Section 136 of the Mental Health Act 1983, or secure a warrant to remove an individual from their home or other property, if necessary by force, under Section 135 of the Act. Detention under Section 135 or 136 does not however amount to arrest under criminal law even though the individual concerned may have committed an offence which brought them to the attention of the police.

The Mental Health Act 2007 brings mental health law into line with the modernisation of mental health services, current human rights legislation and the European Convention. Significant amendments in relation to policing include the power to transfer a detainee between places of safety (e.g. From a police station to a hospital) and the power to recall and arrest psychiatric patients subject to community treatment orders. The Act also broadens the definition of a 'mental disorder' to 'any disorder or disability of the mind' and so includes, for example, sexual deviances. While this should help to ensure that all mentally ill offenders are treated equitably, it also widens the net (i.e. brings more people into the category of mentally disordered), including those whose symptoms might just be temporary<sup>(7)</sup>. It does not however include those who are temporarily disordered because of the influence of drugs or alcohol.

Once a detainee is in a place of safety under Section 136 of the Mental Health Act they

should be assessed by an ‘approved clinician’ (a doctor) and an Approved Mental Health Professional (AMHP) who could be a social worker, nurse, occupational therapist or psychologist. The approved clinician and AMHP will decide whether the individual has a mental disorder serious enough for them to be admitted to hospital (voluntarily or otherwise). Changes to the 1983 Act now allow for the individual to be moved from one place of safety to another (during their maximum 72 hour detention) by a police officer, an AMHP or other authorised professional.

### Rights of the individual

Under Code C of PACE 1984, the police must take responsibility for safeguarding the welfare of a mentally disordered person. This includes the right to have an Appropriate Adult (AA) present. The AA can act as an advocate for the detainee during a police interview and can assist with practical and legal matters, such as obtaining a solicitor. If the detainee is experiencing severe distress and is at risk of self-harm, the police must ensure that they receive appropriate care, which may include access to a doctor or admission to hospital. A Forensic Physician or Appropriate Health Care Professional must assess the detainee to determine whether they are fit for questioning and well enough to remain at a police station. This is not the same as a full Mental Health Act assessment and the assessor can be a GP, although a detainee has the right to request a psychiatrist<sup>(8)</sup>.

### Guidance

The revised Code of Practice to the Mental Health Act 1983 states that the use of police custody should only happen on an ‘exceptional’ basis, with psychiatric hospitals or Section 136 units, rather than emergency departments, being the recommended option<sup>(9)</sup>.

The Code also states that officers should make contact with the approved clinician and AMHP prior to the detainee’s arrival at a place of safety. Recent guidance from the Royal College of Psychiatrists recommends that detainees should be transported to a place of safety by ambulance to avoid causing embarrassment or unnecessary distress and that the wait for an assessment should not be longer than three hours<sup>(10)</sup>, far shorter than the maximum 72 hours permitted under the current legislation.

## Policing mentally disordered offenders

### Arrest and detention

A mentally disordered offender may come to the attention of the police through a referral from a member of the public, friend or relative; in the process of the police responding to an incident; as a result of their investigations or through a formal referral from a specialist agency.

The police should consider each individual on a case by case basis, weighing up the seriousness of the offence against the severity of their mental disorder and their perceived culpability. There may be a number of different outcomes following first contact with a suspected mentally disordered offender:

- No offence has been committed; there is no concern about the individual’s mental health and no further action is required.
- A minor offence has been committed and the individual is released with a caution (provided that the detainee understands that they have committed an offence).

- An offence may or may not have been committed, but the person is mentally unwell and it is not in the public interest either to arrest the individual or detain them. They can safely be returned to their home or carer.
- An offence has been committed which is serious enough to warrant immediate arrest prior to any other action (e.g. subsequent detention).
- The individual may or may not have committed an offence but is judged to be seriously mentally disordered and is detained under the Mental Health Act 1983.

The arresting officer is required to make a rapid assessment of the individual and this requires basic mental health awareness, knowledge of local mental health services and an awareness of their legal powers. The police have considerable discretion when dealing with a suspected mentally disordered person and need to decide what the overriding concern is at that point – whether the law has been broken and/or whether the individual is in need of care and control.

### In custody

The custody sergeant is responsible for the detainee from the time they arrive at the police station, and will make decisions about them on the advice of other professionals. If the detention has been brought about under Section 136, the first course of action will be to arrange a mental health act assessment. If the detainee is suspected of having committed an offence, the police will seek the advice of the Crown Prosecution Service (in the usual manner) to decide whether the detainee should be prosecuted<sup>(11)</sup>. Before an interview can proceed the police must be confident that the individual is fit for questioning and ensure an appropriate adult (AA) is present if the detainee is ‘mentally vulnerable’<sup>(12)</sup>.

The police essentially perform a gate keeping role in relation to mentally disordered offenders, which means that the advice given to custody sergeants from health and social services is critical, both in terms of whether the criminal justice or mental health route is appropriate, but also with regard to options within the mental health system, such as compulsory admission to hospital or a referral to a Community Mental Health Team. Coordinating a number of different professionals is complex and time consuming and various multi-agency schemes (e.g. the Criminal Justice Mental Health Liaison Scheme or the Police Station Assessment Scheme) have been developed to facilitate this process. Such partnerships bring together mental health professionals, such as Community Psychiatric Nurses or approved Social Workers, to help the police identify people with mental health problems, offer advice on the best course of action, or facilitate the gathering of information. Their main aims are usually to ensure that, where appropriate, offenders are diverted away from the criminal justice system at the earliest opportunity and/or that relevant information is gathered and made available to the courts in the event of a prosecution. However these schemes are by no means universal: there are approximately 120 in England and Wales of which 79 operate from police stations<sup>(13)</sup>.

Following detention, there are a number of different outcomes, all of which need to secure the right balance between the seriousness of the offence and the culpability of the offender. The three main outcomes are:

1. There is insufficient evidence to justify detention, or it is not in the public interest to charge the individual. In this case the custody sergeant will have no concerns about the individual’s mental health, or the individual does not meet the criteria for detention under Section 136 of the Mental Health Act 1983.

2. The individual is released on bail (under Section 47/3B of PACE) and asked to return to the police station at a later date, or released on bail but with certain conditions imposed under section 37/7a, while police gather further evidence.
3. The individual is found to be seriously mentally disordered and detained under the Mental Health Act 1983. In this instance, either no prosecution will be pursued or the person will be charged and a hospital order sought under Section 37 of the Mental Health Act 1983 <sup>(14)</sup>.

As before, detention and assessment under the Mental Health Act 1983 can be instigated at any point after an individual has been arrested or charged.

## Some key issues

Mentally disordered offenders can be difficult to police because of the time, resources and knowledge required to deal with them fairly and effectively. They straddle the mental health and criminal justice systems, creating problems for the individual, the police and the criminal justice system as a whole. Ideally the police should act as efficient and well informed gate-keepers to appropriate services; at worst they may be left to 'pick up the pieces' in the absence of appropriate or timely assistance from other professionals.

The Bradley Report<sup>(15)</sup> highlights the importance of partnership working and the implementation of agreements between various agencies involved with a mentally disordered offender. However, the review discovered that there could be significant delays in the assessment and treatment of mentally disordered offenders, including delays in securing transport to a place of

safety. The average length of time from entering to leaving detention is 10 hours <sup>(16)</sup>.

From the mentally disordered person's perspective, arrest and detention at a police station may be stressful and frightening. Custody suites can be chaotic and police cells isolating; they may actually worsen a detainee's condition, particularly if they have not committed a serious offence and are only being held for their own safety. While the police may be aware that a detainee is in distress, suicide attempts, for example, can be unpredictable. ACPO guidelines <sup>(17)</sup> state that Section 136 detainees should receive more frequent checks than others in custody. If the detainee is judged to be very high risk, 'constant supervision' may be appropriate, even if this means that an officer must be diverted from other duties. A national training pack for custody officers has been recently published with the aim of preventing or minimising harm to those who come into police contact <sup>(18)</sup>.

In practice, there is no rapid and reliable method for identifying a mentally disordered offender. Custody officers face difficult decisions and in some cases may lack the time and resources to make a proper assessment. If the custody sergeant is not alert to the individual's condition and fails to call an AA, a police interview could be very challenging for a mentally ill person. In turn, the evidence gathered could be unreliable and a confession could be called into question. The normal investigative technique, which is aimed at overcoming the resistance of a non-vulnerable adult, may be wholly counterproductive when the suspect is mentally ill. The Bradley Report <sup>(19)</sup> recommends that all police custody suites should have access to liaison and diversion schemes which could perform a number of

roles, including screening for vulnerable people, advising on their needs and providing appropriate information to enable diversion away from the criminal justice system and into health and social care services.

Non-compliance with police instructions can also present difficulties for the police, particularly when they are called to respond to an incident in the community. Police officers might also confuse a genuine mental health problem with drug and alcohol intoxication. The IPCC has noted instances where Section 136 has been used unlawfully to detain individuals who were intoxicated with drugs or alcohol<sup>(20)</sup>.

### Appropriate ‘place of safety’

Each year it is estimated that only 6,400 people are detained in hospitals as places of safety, compared with almost double the number held in police stations<sup>(21)</sup>. In some cases detainees are as young as 12 or on one occasion, 89 years old<sup>(22)</sup>. A lack of appropriate facilities appears to be the main reason<sup>(23)</sup> – in reality the choice is often between an accident and emergency department or a police station. An emergency department, in effect a public place, is not well equipped to deal with a violent detainee and the Royal College of Psychiatrists<sup>(24)</sup> has suggested that they should only be used “where medical problems require urgent assessment and management”. A police station, on the other hand, may adequately contain a detainee but it cannot provide the psychiatric care they might need.

The quality of facilities and the availability of personnel may vary significantly between police stations and the wait for an AA takes on average 6 hours, but can take long as 20 hours in some instances<sup>(25)</sup>. In terms of

police time this places a burden on officers, and for the detainee prolongs the distress of being held in custody. Fortunately the Mental Health Act 2007 now permits a detainee to be transported from one place of safety to another during the 72 hour detention, which helps the police and other professionals meet the varying needs of the detainee. However guidance on the appropriate place of safety can sometimes be complicated; for example following the death of Roger Sylvester in 1999, the Police Complaints Authority<sup>(26)</sup> called for detainees suffering from ‘acute behavioural disorder’ to be taken to A&E.

Dedicated places of safety, such as Section 136 suites in psychiatric hospitals or hospital emergency departments, present a viable alternative to the police station or the normal A&E routes. Funding from the Department of Health in 2006 aimed to increase these facilities<sup>(27)</sup>, however it did not cover the provision of full-time, multi-disciplinary staff. Even when Section 136 units are operating successfully many will refuse to take detainees who are violent or intoxicated as an assessment cannot be conducted unless a detainee is relatively calm and sober<sup>(28)</sup>.

***The Memphis Model of mobile crisis teams is an example of good practice. The aim is to quickly resolve a crisis while avoiding the criminalisation of mentally disordered offenders. The team will either deal with the mental health crisis on site or act as advisors to officers at the scene. For the scheme to operate effectively the psychiatric emergency services must agree not turn away violent or intoxicated offenders. Evaluation has shown that these schemes reduce the average arrest rate from 21% to 7%<sup>(29)</sup>.***

## Mental health and cultural awareness

Currently police officers receive only brief training in mental health awareness, usually between two and four hours of probationer training, however there are a few exceptions to this, for example Dyfed Powys Police requires its probationary officers to participate in ward activities at a psychiatric unit for several days, followed by two days training in 'mental health first aid' <sup>(30)</sup>. Mental health awareness is clearly crucial and the Home Office <sup>(31)</sup> has called for improved training so that mentally disordered offenders can be recognised and managed effectively. But it can also be argued that it is inappropriate and potentially dangerous for the police to be placed in a position where they might feel under pressure to act as if they were mental health professionals.

The Care Services Partnership provides a programme of Mental Health First Aid (MHFA) training aimed at professionals who may come into contact with the mentally ill in the course of their duties. It defines MHFA as: 'the help given to someone experiencing a mental health problem before professional help can be obtained'. The aim is to preserve life, prevent mental health problems from becoming more serious, promote recovery and provide comfort to the person in crisis <sup>(32)</sup>. MHFA is currently being used in the criminal justice system, although the Sainsbury Centre <sup>(33)</sup> advocates its wider use by the police service. MHFA might be useful at several points when the police come into contact with the mentally ill, for example to de-escalate a worsening situation, in many cases avoiding the need for arrest. The Metropolitan Police Authority has identified that de-escalation techniques should be part of police training <sup>(34)</sup>.

The Sainsbury Centre highlights the importance of having a 'proportionate' response to people with mental health problems <sup>(35)</sup>. Unfortunately it is all too easy to overlook the vulnerability of the mentally ill, viewing them instead as threatening and potentially dangerous, particularly when they have a serious mental illness such as schizophrenia. Conversely, officers anxious to avoid the risk of suicide may be over zealous in removing or exchanging clothing. In some cases detainees have reported being left naked in their cells <sup>(36)</sup>.

***Although the homicide rate amongst the mentally ill has risen in recent years it still remains relatively low. In 2004 and 2005, 70 homicides were committed by the mentally ill <sup>(37)</sup>.***

It is well recognised that people from some black and minority ethnic backgrounds are over-represented in all parts of the criminal justice system <sup>(38)</sup>. Black people are almost twice as likely as white people to be held in police custody under Section 136 of the Mental Health Act 1983 <sup>(39)</sup> and some black communities are also over-represented in mental health forensic services <sup>(40)</sup>, however the influence of stressors that play a role in mental illness, such as poverty or racism, is difficult to quantify. The Sainsbury Centre also suggests that some cultures may not readily acknowledge mental illness leading to untreated disorders occurring more frequently in these sections of the population <sup>(41)</sup>, although this does not explain why there is little difference in Section 136 detention rates for white and Asian people <sup>(42)</sup>.

## Conclusion

The dual nature of mentally disordered offenders means that they may need to be both 'treated' and 'policed'. In practice however, this is not widely reflected in joined up criminal justice and mental health services. Efforts to introduce, for example, multi-agency Section 136 suites or primary care services within police stations have been limited. There is however increasing recognition that this kind of policing requires a multi-agency approach (see, for example, 'Cutting Crime: A new Partnership 2008-2011')<sup>(43)</sup>. However, more could be done within the police service itself. The Bradley Report<sup>(44)</sup>, for example, recommends that Safer Neighbourhood teams should 'play a key role in identifying and supporting people in the community with mental health problems...who may be involved in low-level offending or anti-social behaviour, by establishing local contacts and partnerships'.

The lack of reliable data on police contact with the mentally ill is a major obstacle: it is very difficult to provide adequate services for mentally disordered offenders unless the scale and nature of the problem is fully understood both locally and nationally. The wider definition of mental disorder, introduced by the Mental Health Act 2007, will mean that a larger number of offenders will have a recognised mental disorder that needs to be addressed via mental health services. The absence of effective monitoring may, for example, lead to a failure to identify disproportionate detentions among say the black community, which in turn hinders the development of measures to combat such disproportionality.

While offending behaviour may often need to be followed up by the criminal justice system,

the majority of offences committed by the mentally ill are minor, and diversion at the earliest opportunity would avoid criminalising vulnerable people whose offending is often a symptom of their mental health and other needs rather than criminality *per se*. Originally developed to operate at court level, referral and diversion schemes have expanded to operate through some police stations, which is a positive development, but if all mentally disordered offenders are to receive equitable treatment, then this can only happen if all police stations have access to such schemes. Ultimately, policing mentally disordered offenders requires an integrated, multi-agency approach which is both timely and efficient and responsive to the needs of the individuals involved.

## Notes and references

1. Sainsbury Centre for Mental Health (2008) *The Police and Mental Health*
2. Tim Newburn T. and Neyroud P. (2008) *Dictionary of Policing*, Willan Publishing
3. A very high proportion of prisoners have a mental disorder but their mental illness is not serious enough to meet the criteria under the Mental Health Act 1983.
4. Mind (2007) *Another Assault*
5. Department of Health (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, Department of Health
6. Docking M., Grace, K. and Bucke T. (2008) *Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983*, IPCC
7. Discussion with Jill Peay
8. Mind (2008) *Mind Rights Guide 2: Mental health and the police*
9. Department of Health (2008) *Mental Health Act 1983 Code of Practice*, Department of Health, The Stationery Office
10. Royal College of Psychiatrists (2008) *Standards on the use of Section 136 of the Mental Health Act 1983 (2007)*
11. Schedule 2 of the Criminal Justice Act 2003
12. Code C, Paragraph 1.7 of PACE
13. NACRO (2009) *NACRO directory of criminal justice mental health liaison and diversion schemes in England and Wales*
14. The deciding factor in a prosecution is not solely the seriousness of the person's mental disorder but also the seriousness of the offence. Where the offence is very serious then prosecution will always follow regardless of the seriousness of the mental disorder
15. Department of Health (2009) *op. cit.*
16. Docking M. et al. *op. cit.*
17. ACPO (2006) *Guidance on the Safer Detention and handling of Persons in Police Custody*
18. Hansard, 15 October 2008
19. Department of Health (2009) *op. cit.*
20. Docking M. et al. *op. cit.*
21. Sainsbury Centre for Mental Health (2008) *op. cit.*
22. Docking M. et al. *op. cit.*
23. *Ibid.*
24. Royal College of Psychiatrists (2008) *op. cit.*
25. Jill Peay (ed.) (2008) *Criminal Justice and the Mentally Disordered*, Ashgate Publishing Ltd
26. The PCA no longer exists and its role is now undertaken by the IPCC and it has not revoked this guidance – cited in Metropolitan Police Authority (2005) *Joint Review: Policing and Mental Health*
27. Royal College of Psychiatrists (2008) *op. cit.*
28. *Ibid.*
29. Lamb H.R., Weinberger L.E. and DeCuir W. J. (2002) 'The Police and Mental Health' in *Psychiatric Services*, October 2002 vol. 53, No. 10.
30. Information courtesy of Stuart Jones (Hywel Dda NHS Trust)
31. Home Office (2007) *Cutting Crime: A new Partnership 2008-2011*
32. See [www.mentalhealthfirstaid.csip.org.uk](http://www.mentalhealthfirstaid.csip.org.uk)
33. Sainsbury Centre for Mental Health (2008) *op. cit.*
34. Metropolitan Police Authority (2005) *Joint Review: Policing and Mental Health*
35. Sainsbury Centre for Mental Health (2008) *op. cit.*
36. Mind (2007) *op. cit.*
37. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness press release. See <http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/>
38. Ministry of Justice (2008) *Statistics on Race and the Criminal Justice System – 2006/7*
39. Docking M. et al. *op. cit.*
40. Rutherford M. and Duggan S. (2007) *Forensic Mental Health Services: Facts and figures on current provision*, Sainsbury Centre for Mental Health
41. Sainsbury Centre for Mental Health (2008) *op. cit.*
42. Docking M. et al. *op. cit.*
43. Home Office (2007) *op. cit.*
44. Department of Health (2009) *op. cit.*



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