National Policing Improvement Agency

Review of the Literature on Mentally Disordered Offenders

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1. Introduction

The aim of this document is to review the literature in order to prepare a project brief for ACPO sponsored doctrine on mentally disordered offenders. The literature is reviewed under key themes. The review does not provide definitive answers to the questions raised, but highlights potential areas for consideration.

The original focus of the literature review was on mentally disordered offenders and suspects. As the work progressed, however, it became clear that, for the literature review, the focus on offenders and suspects was too narrow. The literature discussed important areas where the police and people with mental health needs (who were neither offenders nor suspects) came into contact with each other. In light of this, the terminology used in the review will vary according to whether the literature refers to offenders, suspects, mentally disordered people or people with mental health needs.

The number of people with mental health needs within the criminal justice system has been identified as a problem which all agencies within the system have sought to address. People with mental health needs are a complex and multi-sector problem; this requires agencies to work together. The police is one of these agencies, and in most cases, contact with the police is the first interaction that a person with mental health needs may have with the criminal justice system. The police are often called to incidents involving people with mental health needs. These incidents vary in their nature, and may involve anything from a call reporting inappropriate behaviour in public to the reporting of a serious criminal offence. A number of changes in the provision of health and social services for people with mental health needs, as well as the changing role of the police, have led to an increase in the contact between the police and people with mental health needs. Experts predict that contact will continue to increase in the future.

Incidents involving people with mental health needs pose significant challenges and risks for the police. The role which the police are expected to
play is discussed in the literature. The police are not, and cannot be, expected to act as ‘street corner psychiatrists’ (Treplin and Pruett 1992) and yet their contact with people with mental health needs requires them to have some understanding of mental health issues.

A crucial challenge is posed by the decision regarding whether the police should pursue a criminal justice outcome for a mentally disordered offender or whether they should be diverted to receive help from health and social services. Various Home Office Circulars have sought to provide guidance regarding when prosecution should occur, or when an offender should be diverted. As a result of these Circulars, so-called ‘diversion schemes’ have been created. Issues of diversion and prosecution, as well as the human rights issues involved in these decisions, are discussed in this document.

One of the main considerations to be made regarding the diversion or prosecution of a mentally disordered offender is around issues of public protection (Ritchie 1994). Once a person has been identified as suffering from a mental disorder, it is important to assess the risk they may pose. The assessment of risk is not a straightforward task and requires cooperation between different agencies which may hold information on an individual. The process is complicated further by the fact that mentally disordered offenders may have had previous contacts with the police but these contacts, if they have not received a criminal justice outcome, have not been registered anywhere. Clearly, a risk assessment based on incomplete information will not be accurate and could lead to tragic consequences.

Some of the greatest risks are linked to custody issues in general, and deaths in custody in particular. General custody issues involve the use of police cells as ‘places of safety’. Section 136 of the Mental Health Act 1983 allows the police to remove someone who appears to be suffering from a mental disorder to a place of safety. It has long been acknowledged that police cells are not appropriate ‘places of safety’, and yet it appears that in many areas there is no alternative place where the police can take a person detained
under Section 136. Other custody issues include the assessment of needs and the application of procedures required under the Police and Criminal Evidence Act 1984. Many PACE procedures involve other agencies (health and social services) and require the police to liaise closely with these agencies.

Without a doubt, the greatest risk in the custody setting is a death. The IPCC report (Independent Police Complaints Commission 2006) on deaths during or following police contact stated that one of their major concerns was the high number of deaths of people who died in or following police custody who had mental health needs. Figures from 2005/06 showed that of the 28 individuals who died in or following police contact, 2 were detained under Section 136 of the Mental Health Act 1983 and 4 had some form of mental health needs.

Many of the issues identified in this literature review are not particular to the policing of people with mental health needs but pose challenges to other areas of policing. For example, issues such as information sharing, risk assessment and the creation of, and adherence to, policies and procedures have been identified as key to other areas of policing. This review, however, will focus on their importance in relation to people with mental health needs.

1.1 Methodology for Literature Search

Literature was found through various databases and libraries. Key-term searches were run in the following databases:

- National Police Library
- Home Office
- Department of Health
- Department of Constitutional Affairs
- Home Office Research, Development and Statistics (RDS)
- Psych-Info
- Ingenta
- Criminal Justice Abstracts
- National Criminal Justice Research Service
Other literature was found through websites of relevant organisations. These included: NACRO, MIND, IPCC, Rethink and the Revolving Doors Agency. These websites were also used to gain other information which was not available in published report format.

This is not a systematic review of the literature. It is believed that a lot of ‘grey literature’ and research results can be found locally within relevant organisations. However, for the purposes of this document it was considered that the main issues were covered by literature accessed through the above sources. In the future, further research may be carried out in order to identify literature from other organisations and service providers.

The review covers literature from 1995 onwards, however earlier studies are included if they were deemed particularly important and influential. Only literature found in English was reviewed. The focus was on studies from the United Kingdom, however studies from other countries were included if relevant.

This literature review does not cover issues to do with training. The literature stresses that the police have training needs regarding mental health issues. However, it was decided at an early stage that the doctrine would not to cover training, this would be covered by a separately commissioned piece of work.
2. General Issues

2.1 What is a ‘mentally disordered offender’?

The Reed Review (1992) defined mentally disordered offenders (MDOs) as ‘a mentally disordered person who has broken the law.’ A slightly broader definition, and perhaps one which is more relevant to policing purposes, is used in the Home Office Circular 66/90 which refers to mentally disordered offenders as ‘mentally disordered persons who commit, or are suspected of committing, criminal offences’. These appear to be relatively straightforward definitions, however there are tensions within both the medical and legal aspects of the definition, and how they relate to one another. For example, there is no widely accepted definition of what a mental disorder constitutes: professional judgement and expertise are vital factors in diagnosis. Furthermore, some experts argue that, in order to classify someone as a mentally disordered offender, there has to be a demonstrable link showing that the disorder contributed to the offending behaviour (Winstone and Pakes 2005).

The Mental Health Act 1983 (MHA) provides a definition for the generic term ‘mental disorder’ and provides four specific categories of mental disorder: mental impairment, severe mental impairment, psychopathic disorder and mental illness. The first three are defined, while ‘mental illness’ remains undefined.

Mental disorder

“Mental Disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind and ‘mentally disordered’ shall be construed accordingly.” (MHA 1983, Section 1(2))

Arrested or incomplete development of the mind

This seems to cover any failure to meet the normal milestones of mental development, whether this is caused by genetic or environmental factors in
childhood, or by damage to, or disease of, the brain. It excludes those whose handicap derives from accident, injury or illness occurring after the mind has reached full development.

**Mental impairment**

“Mental Impairment means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and ‘mentally impaired’ shall be construed accordingly.” (MHA 1983, Section 1(2))

**Severe mental impairment**

“Severe Mental Impairment means a state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part if the person concerned, and ‘severely mentally impaired’ shall be construed accordingly.” (MHA 1983, Section1 (2)).

**Psychopathic disorder**

“Psychopathic Disorder: means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.” (MHA 1983, Section1(2))

The term ‘psychopathic disorder’ is an example of the problematic nature of different definitions in the fields of medicine and the law. In 1975, the Butler Committee concluded that the term ‘psychopathic disorder’ “is no longer a useful or meaningful concept.” Whilst the “Report of the Department of Health and Home Office Working Group on Psychopathic Disorder” (1994) states:
“What constitutes psychopathic disorder and how it should be managed and treated has, over the years, been the subject of intensive debate without any general agreement being reached. It is now generally accepted that the term ‘psychopathic disorder’ does not represent a single clinical disorder but is a legal category describing a number of severe personality disorders, which contribute to the person committing anti-social acts, usually of a recurring or episodic type. One important feature may be an inability to relate to others, and to take account of their feelings and safety. It has often proved difficult to influence this behaviour by means of social, penal and medical interventions.”

The above definitions are legal definitions that are used specifically for the purposes of the Mental Health Act and will generally not be used by psychiatrists except in the context of action under the MHA. Medical reports will usually include a psychiatrist’s diagnosis of the patient’s mental illness or disorder.

Any other disorder or disability of the mind
This could include ‘neurosis, personality disorders, behaviour disorders, disability resulting from head injuries and transient mental disturbances’.

Mental Illness
Mental illness is not defined by the MHA 1983, nor is any attempt made in the MHA Code of Practice to provide guidance on this term. Its “operational definition and usage is a matter for clinical judgment in each case.” The following attempt by the DHSS to define mental illness provides a guide to the symptoms that are associated with the legal category of ‘mental illness’:

‘Mental illness means an illness having one or more of the following characteristics:
- more than a temporary impairment of intellectual functions shown by a failure of memory, orientation, comprehension and learning capacity
- more than a temporary alteration of mood of such a degree as to give rise to the patient having a delusional appraisal of his situation, his past or his future, or that of others or to the lack of any appraisal
- delusional beliefs, persecutory, jealous or grandiose
- abnormal perceptions associated with delusional misinterpretations of events
- thinking so disordered as to prevent the patient making a reasonable appraisal of this situation or having reasonable communication with others
- the mental illness should be of a nature or degree to warrant the detention of the patient in the interest of his health or safety or for the protection of others’

(points to consider:
1. The current Bill has proposed a change to the definition of ‘mental disorder’ (see Appendix One). The changes will need to be monitored during the writing of doctrine.

2.2 How many MDOs are there?
It is not possible to provide exact figures of people in the general population affected by mental disorders. Many will not come to the attention of their GPs and/or hospitals (Prins 2005). Likewise, figures for MDOs are not readily available; there is no national requirement for the police, or any other criminal justice agency, to keep statistics on MDOs.

The Home Office provides yearly statistics on mentally disordered offenders. These statistics, however, only focus on restricted patients admitted to, detained in or discharged from hospital. In 2004, there were 3,282 MDOs on restriction orders. This was the highest figure for the last decade (Ly and

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More recent data from 2005 states that the number of MDOs on restriction orders increased by 3% to 3,395.

No national figures were found regarding the number of mentally disordered offenders who come into contact with the police. There is no national requirement for such data to be collected (Winstone and Pakes 2005). Some indications are provided below, but the quality of the data is far from satisfactory, and this remains an issue when planning for MDOs. Some small scale studies have attempted to estimate the number of MDOs which go undetected. Any attempt to estimate the numbers of MDOs is likely to be an underestimate – studies tend to focus on the more severe or ‘obvious’ mental disorders (such as schizophrenia) and more minor disorders will be missed (Winstone and Pakes 2005). Likewise, no data was found regarding the type of mental disorders people suffered and their disposal by the police.

Studies estimating the number of mentally disordered offenders have come to various conclusions. Two studies reported that the estimated number of mentally disordered suspects passing through police stations varied between 2% and 20% (Burney and Pearson 1995; Winstone and Pakes 2005).

2.3 What are the main interactions between the police and people with mental health needs?

It is widely acknowledged that the police receive very little specific training in mental health awareness and recognition, yet they spend a significant amount of time interacting with people with mental health problems (Office of the Deputy Prime Minister 2004). The police come into increasing contact with people who have mental health needs. These may include a variety of situations (many of which do not include offending).

First, the police may come into contact with people with mental health needs because they have committed, or are suspected of committing, a criminal offence. Research suggests that most contacts are for minor offences rather than serious crime (Bradley Taylor 1996; Wells and Schafer 2006). However no research was found which detailed the number of contacts related to which
offence, or indeed whether an offence was committed at all. The crime-related calls may also include psychiatric inpatient violence. However the research states that there is widespread under-reporting of potentially criminal behaviour in psychiatric settings (Brown 2006). Police officers interviewed during the study suggested that, among other things, the creation of mutually agreed guidelines and clear roles and responsibilities would increase the number of incidents reported.

Second, a person might call the police when they feel suicidal. No data was found regarding the number of calls of this nature to the police. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) states that ‘approximately one quarter of suicides in England and Wales, Scotland and Northern Ireland had been in contact with mental health services in the year before death, this represents around 1,500 cases a year’ (2001: 3).

Third, the police may be involved in an incident of a missing person who has mental health needs. According to data collected by Grampian Police from 3000 missing persons files, ‘approximately eighty percent of all missing people, over the age of 16 years, suffer from some form of mental condition’ (Association of Chief Police Officers 2006).

Fourth, the police may be called to deal with inappropriate or unusual public behaviour, where a member of the public feels threatened. The severity of the threat may vary from bizarre or abnormal behaviour to more serious threats (Stone 1995).

Fifth, a person with mental needs may call the police because they have been a (real or imagined) victim of a crime or abuse.

Sixth, a person may be in need of special care. For example, they may need to be transported to/from hospital or an assessment.
Seventh, the police may receive a call from a relative or concerned person during a psychiatric emergency.

Finally, the police may be asked to accompany a doctor or approved social worker to carry out a home-based assessment under Section 135 of the Mental Health Act (Roberston, Pearson et al. 1996).

Considerations:

1. What types of contacts will the guidance cover? Will it cover all types of incidents where the police and people with mental health needs come into contact?

2. There is little research on some key interactions between the police and people with mental health needs. Further research of the police and key agencies would provide very useful information for the writing of doctrine.

Various factors have contributed to the increase in contact between the police and people with mental health needs. These include various historic factors such as the increasing deinstitutionalisation of the mentally ill. As more people with mental health needs are living in the community, there has been an increase of ‘calls to the police about crimes and disorder involving people with mental illness’ (Bradley Taylor 1996; Cordner 2006).

A second factor stated in the literature is the ‘revolving door phenomenon’ whereby people are discharged from hospital before they are ready and, after a short period in the community, are returned to hospital. One study states that the way in which decisions on release are made exacerbate the problem: the person with mental health needs is often not consulted. In addition, the decision of where a person will be released to is often made a few days prior to release, thus leaving very little time for any plans to be made (Rethink, Sane et al. n/d).
Research also suggests that, as supervision is relaxed, other factors compound the person’s mental health needs. These include the tendency to self medicate, the abuse of illegal drugs and alcohol and a greater risk of homelessness.

The factors that contribute to the increased contact between the police and people with mental health needs will continue to exist in the foreseeable future. In addition, the Mental Health Bill’s 2006-2007 proposal (see Appendix One for details) to introduce supervised community treatment orders may lead to an even greater increase in contact: the police may, for example, become involved in returning mentally ill people from the community to hospital if they break the conditions of their treatment order.

Consideration
1. There is literature (mostly from the US) on crisis intervention and negotiation which covers how the police should deal with people who may have a mental illness. This can be summarized for the doctrine if it is decided that this information should be included.

2.4 What is the diversity of MDOs?
The diversity of mentally disordered offenders and their needs must be considered. Diversity, in this context, refers to an individual’s ethnicity or race, gender, age, religion/belief, sexual orientation and disability. Most of the literature found, however, focused on age (mainly young people), race and gender.

‘A disproportionate number of women and black people enter the mental health system and secure units in particular. Though the factors of race, culture and gender remain insufficiently analysed, there is a real basis of concern that black people are misdiagnosed and that women are over-exposed to forensic psychiatric intervention (Allen, 1987) and, in particular, are selected for maximum security far too readily.’ (Stone 1995)
2.4.1 Black and Minority Ethnic Groups

The prevalence of common mental health problems is fairly similar across different ethnic groups, although rates are higher for Irish men and Pakistani women and lower for Bangladeshi women (Office of the Deputy Prime Minister 2004).

Various reports have highlighted the over-representation of black people at every level of the criminal justice system (Browne 1990; Office of the Deputy Prime Minister 2004; Criminal Justice System Race Unit 2006). The section below highlights some of the explanations why this may be the case, although all studies stress the need for further research. Although little research was found specifically on Black Minority Ethnic (BME) MDOs and the police, the points raised below are also relevant to the service that the police provides.

The Mental Health Alliance (2007) highlights that:

‘Disproportionately high numbers of people from black and minority ethnic backgrounds continue to be detained and forcibly treated under the [1983 Mental Health] Act.’(2007:6)

The Ritchie Report (1994) stated that, based on evidence they had received during the Inquiry, a high number of black people (in relation to other ethnic groups) were detained under the MHA 1983. One report cited an increase in the admissions under the MHA 1983. The section rate varied according to different studies. ‘Some reports claim the section rate of black people to be twice as high as for white people, while others have found it to be as much as six times higher’ (Rethink, Sane et al. n/d). The report claims that possible reasons for this are: over-diagnosis of severe mental illness (in particular schizophrenia), mistrust of services (leading to delay in seeking help) and a greater disinclination to persist with taking medication.
Other studies have also confirmed that people from BME communities are likely to turn to services at a later stage of their illness, when their problems may have become more serious (Office of the Deputy Prime Minister 2004). Various cultural explanations are given for this – mistrust of services (as mentioned above), stigma, services which are not culturally or religiously sensitive and the lack of BME mental health staff (Rethink n/d). Likewise, the MPA Joint Review (Metropolitan Police Authority 2005) identified ways in which the needs of BME communities were badly served by the current provision of mental health services.

Research also found that:

- black and minority ethnic mentally ill offenders were more likely to be arrested and detained (Robertson, Pearson et al. 1996; Rethinking Crime and Punishment 2004); and
- black people with schizophrenia were more likely to be convicted of offences than white people with schizophrenia (Centre for Public Innovation 2005).

2.4.2 Gender

A NACRO report looked at the key issues facing women offenders with mental health issues in the criminal justice system. The report highlighted the need for mental health services specifically designed to meet women’s needs. Female MDOs were very disadvantaged because there were few tailor-made programmes. The study also found that there was a gender bias in court disposals whereby women were more likely to receive a psychiatric disposal than men (NACRO 2002).

The same study found that minority ethnic women were disproportionately represented in prison; they accounted for 25% of the female prison population, 19% of whom were black and 15% were foreign nationals (who were mostly held for drugs offences) (NACRO 2002).
A study carried out on three diversion schemes in Scotland concluded that the profile of a typical person who was diverted was someone who was older, less criminal and more likely to be female. However, the study was unable to conclude why more women were diverted. Four suggestions were made:

- women were more likely to have a psychological disturbance;
- women were more likely to seek help;
- the medical profession were more likely to categorise certain types of person as suffering from a psychological illness; and
- the police were more likely to inquire about the possibility of certain mental illnesses or notice it in certain groups (Duff 1997).

2.4.3 Age

Only one study was found which looked at psychiatric disorders in suspected offenders over the age of 60. From a screening of 153 offenders, 50 were identified and interviewed. The study concluded that:

‘The prevalence of psychiatric disorder in older people apprehended by the police is higher than in other community samples, particularly in those accused of shoplifting, but no clear evidence was obtained to support the idea that first offenders in old age are more likely to suffer from psychiatric disorder than recidivists who have offended prior to age 60...With a growing elderly population and an increased use of cautioning as an alternative to prosecution it seems likely that many elderly offenders with mental health problems will go unnoticed, despite court diversion and similar schemes. Closer links between community psychiatry teams for the elderly and the police seem indicated to identify elderly offenders with unmet mental health needs early on in the judicial process.’ (Needham-Bennett, Parrott et al. 1996)

Several studies looked at the mental health needs of young people. Most of the literature focused on the mental health needs of young people in custodial settings. The fact that most studies have focused on custodial settings, makes it difficult to know how mental health needs change as the young person
comes into contact with different aspects of the criminal justice system (Hagell 2002).

The age of young offenders in the studies varied from 10 years of age to 18 years. It is therefore difficult to make comparisons due to the different needs of the populations discussed (Douglas and Plugge 2006). The studies agreed that the risk factors for having mental health needs were the same as for offending. These may include factors such as inconsistent parenting, over-harsh discipline, economic stress on the family, under-resourced neighbourhoods, exclusion from schooling and employment (Hagell 2002; Dimond, Floyd et al. 2004).

Young offenders are at a higher risk of mental health problems than the general population of adolescents. Studies examining the mental health problems in the general adolescent population (defined in this case between the ages of 11-15) estimate that 13% of girls and 10% of boys have some mental health problems (Dimond, Floyd et al. 2004). Estimates for young people in contact with the criminal justice system who have mental health problems range between 25% to 81%.

Only one study (from the US) was found on the police interaction with young people with mental health needs (Healey and Hirschhorn 2002). This study focused mainly on providing practical guidance for officers involved with young people with mental health needs.

Three further studies reported findings, or made recommendations, which were relevant to the police. Firstly, the research highlights the fact that young offenders have multiple needs, and that the provisions for these are not currently met (Hagell 2002; Douglas and Plugge 2006). Secondly, Farrant (Farrant 2001) claimed that diversion schemes should include young persons. However, no data is provided on the number of diversion schemes which currently provide for young people. Finally, Hagell’s study made a recommendation for police stations:
‘All police stations should have a checklist of factors that may indicate a young person’s predisposition toward mental health problems. If a young person meets the criteria then an initial mental health assessment should be undertaken in accordance with agreed procedures.’ (Hagell 2002:32).

Consideration:
1. During early talks about the doctrine, it was agreed that the findings of the literature review would help inform a decision on whether to include young people in the doctrine or not.

2.4.4 Learning disabilities
Many of the issues discussed in the literature on people with learning disabilities are similar to those discussed above for other MDOs. This is especially true around the police’s ability to identify learning disabilities and the provisions under PACE when a person is taken into custody (Rhead 1997; Howard and Tyrer 1998; Scott, McGilloway et al. 2006).

People with a learning disability are likely to come into contact with the police due to their behaviour which can sometimes be interpreted as aggressive and violent (Rowe and Lopes 2003). Estimates of the number of people with learning disabilities vary between 1% and 11.5% (Howard and Tyrer 1998). Given that the prevalence of intellectual disability among the general population is estimated to be between 1-3% (Hayes 2006), it can be concluded (if the average estimate is taken) that they are over-represented in the criminal justice system.

There is a high tolerance of aggressive and violent behaviour in settings where people with learning difficulties are cared for. Many of these incidents are not reported to the police (Rowe and Lopes 2003; Scott, McGilloway et al. 2006).
People with learning disabilities are more vulnerable in a number of areas. Various studies highlight the fact that people with learning disabilities may fail to understand their legal rights, have poorer memory and are more suggestible and acquiescent than people with normal intelligence (Howard and Tyrer 1998; Gudjonsson and Henry 2003). Their vulnerability is increased by their poor literacy skills and their lack of willingness to discuss their learning disability because it is too personal (Rowe and Lopes 2003). In addition they are more likely to suffer mental illness, be depressive and have a personality disorder (Rowe and Lopes 2003).

There is some debate over the extent to which people with milder forms of learning disabilities are aware of the long-term implications of their actions (Howard and Tyrer 1998).

Finally, people with borderline learning disabilities are more vulnerable because they cannot draw on the support systems that people with moderate, severe or profound learning disabilities can. Likewise their condition is less likely to be identified (Rowe and Lopes 2003).

Consideration
1. As with young people, it was agreed that a decision would be made on whether to include people with learning disabilities or not.

2.4.5 How can services be improved for a diverse population?
Regarding the improvement of services, the above paragraphs summarise the areas which are seen as problematic. There is wide consensus that improvements need to be made and services need to be more sensitive to race, culture and gender (Prins 2004). This statement should be extended to include all other member of a diverse population. The Office of the Deputy Prime Minister's (2004) report stated it was necessary to promote social inclusion by:
- including people from a range of backgrounds in design and delivery;
- delivering services in appropriate locations;
- having access to translators and interpreters;
• taking into account community and family and carers; and  
• recognising and respecting people's different cultural and religious.

A study into inquiries of homicides carried out by mentally ill people concluded that few inquiries had looked at the effect of ethnicity on the type of care and treatment people had received. The Woodley Inquiry (1995) suggested ways to make the provision of mental health services for ethnic minorities more effective. They suggested that ethnic minority voluntary organisations should be involved; that mental health service users forums should be created and a policy for working with ethnic minorities should be developed through consultation (Parker and McCulloch 1999).

The MPA Joint Review (2005) highlighted that there were few examples of appropriate interventions. The Rethink Factsheet on Black and minority ethnic (BME) communities and severe mental illness (n/d. http://www.rethink.org/how_we_can_help/advice_service_and_information/factsheet_az.html. Accessed on 17 January 2007) provides a list of projects and services specifically designed to meet the needs of different BME communities. Rethink aims to campaign for changes which will make this support part of the mainstream provision.

Consideration
1. This is an area where there is likely to be a lot of unpublished information. Information may also be held by service user groups or providers. If needed further work would identify this.
3. What are the key issues for the police when they interact with people with possible mental health needs?

3.1 How good are the police at identifying mental health needs?
The police’s ability to identify mental health needs affects the way MDOs get treated. This is especially relevant regarding any further action the police decide to take. The high numbers of prisoners with mental health needs demonstrates that the identification of mental health needs is a problem throughout the criminal justice system. However, it may be the case that some mental disorders manifest themselves during the judicial process and may not have been present prior to, or at, arrest. Furthermore, a distinction has to be drawn between identification when an officer first encounters a person with possible mental health needs and identification at a later stage, where the support of mental health professionals can be called on.

The following section is not intended to be a toolkit for diagnosis for police officers. It aims to highlight areas of confusion that have been identified by the research. Most studies on the police’s ability to identify mental health needs were small scale studies – their conclusions must therefore be treated with due caution.

Various studies have examined the custody records of people detained by the police in order to check whether, in some cases, their mental health needs had not been detected. The percentage of cases where mental health needs had not been identified varied significantly between the studies. In a study carried out in Hampshire it was found that, on average, about 7% of the sample were suitable for diversion to an existing scheme but had not been detected by the police (Vaughan, Kelly et al. 2001). Three factors made it less likely for the police to be able to identify mental needs. Firstly, the wording of the screening interview; general questions like ‘are you fit and well?’ were less likely (than more detailed questions) to elicit mental health needs. Secondly, mental health needs were often masked by alcohol and drug misuse (op cit 2001: 13). Thirdly, the settings in which the screening was done was often not
appropriate when gathering sensitive information. As a result of these three factors the information gathered varied greatly from case to case.

A second study concluded that a much higher number of people (30%) with mental health needs had not been initially identified as having mental health needs by the custody sergeant or the Forensic Medical Officer (Scott, McGilloway et al. 2006).

A third study by Roberts et al (2006) found that of the 2764 consultations (of FMEs whilst persons were detained in custody) they examined, in 25.4% of cases, custody staff did not identify the presence of mental illness.

As can be easily predicted, several studies found that the police were able to identify some mental health needs and mental disorders more easily than others. A study carried out in 1996 found that the police were ‘perfectly well able to identify the most obvious signs and symptoms of mental illness and mental handicap’ (Robertson, Pearson et al. 1996). Similar results were reported by earlier studies stating that the police could recognise schizophrenia but were not so good at identifying depression or mild mental handicaps (Burney and Pearson 1995; Stone 1995; Burke and Hart 2000).

Two studies looked at the way in which the identification of a mental disorder affected the way the police dealt with a mentally disordered person. A study by Phillips and Brown (Truelove 2004) concluded that those who the police had arrested for an offence and identified as mentally disordered were, on average, less likely to be charged. A second study found that ‘MDOs were also more likely to have cases against them discontinued or proceedings against them dropped than non-mentally disordered offenders’. In 40% of the cases, no further action was taken, while 29% were not proceeded with in court (Truelove 2004).

The Community Oriented Policing Services (COPS) guide on mental illness (Cordner 2006) spells out the possible tragic consequences if police are unable to make a quick identification of mental health needs. If the police are
not trained to identify the signs, they will not use the skills needed to deal with such a person. In some cases, the person with mental health needs may not cooperate and this may lead to an escalation of tension, and perhaps violence (Cordner 2006). To support this statement, the COPS Guide quotes the following research results. First, research carried out in the UK concluded that almost half (11) of the 24 shootings by the police between 1998 to 2001 involved someone with mental health needs (Cordner 2006). Second, ‘It is estimated that people with severe mental illnesses are four times more likely to be killed by police’ (Cordner 2006).

The identification of mental disorders or more mild mental health needs is not an easy task for police officers. Police officers are often required to make a quick judgement call in fast-moving and tense situation. In addition, symptoms of mental illness may be masked by alcohol and substance misuse (see section below) or by other medical conditions.

Only one study was found which provided guidance on symptoms which may signal the presence of a mental health need. The possible symptoms listed included the following:

- ‘history of mental health problems, and/or possession of psychiatric medications
- a plain, emotionless facial expression and body language
- incoherent thoughts or speech
- inability to focus or concentrate
- bizarre appearance, movements or behaviors
- delusions of personal importance or identity; unrealistic over-confidence
- hallucinations or perceptions unrelated to reality
- agitation, often without clear reason
- pronounce feelings of hopelessness, sadness or guilt’ (Healey and Hirschhorn 2002; Cordner 2006).
Throughout the UK procedures have been developed in order to provide early identification and assessment of people who are suspected of having a mental disorder. Some of these procedures include the so-called ‘diversion schemes’ which were set up as a result of Home Office Circular 66/90. These procedures are discussed in more detail below.

3.2 How does the stigma attached to mental illness affect the way police deal with people with mental health needs?

There are many stigmas attached to mental illness. Studies mention, in general terms, the existence of such prejudice in society at large. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) stated that the stigma faced by people with mental illness should be addressed, and that the findings of the Confidential Inquiry Report could be used to dispel the myths. The Office for the Deputy Prime Minister (Office of the Deputy Prime Minister 2004) points to the long term effects of the stigma associated with mental illness:

‘Stigma and discrimination can affect people long after the symptoms of mental health problems have been resolved. Discrimination can lead to relapses in mental health problems and can intensify existing symptoms’.

Although it can be assumed that the police are no exception in holding such views (Ritchie 1994), the literature review only found one study dealing with the police’s attitude to people with mental illness. This is a study from the US, and looked at the ways in which the knowledge that a person had a mental illness influenced the police officers perceptions, attitudes and responses. The participants (n=382) were asked to respond to eight vignettes describing situations involving minor infractions and disturbances. In half of the cases, the person was labelled as schizophrenic, in the other four cases no information was provided regarding the mental health of the individual. The study concluded that:
'Police officers viewed persons with schizophrenia as less responsible for their situation, more worthy of help, and more dangerous than persons for whom no mental health information was provided' (Watson, Corrigan et al. 2004).

While the findings of this study are interesting, there are limitations in so far as it was a small study; the officers were asked to respond to written vignettes - in real-life situations their reactions may be different. In addition, there is always the fear that they were responding in a way that is socially desirable rather than their response being a reflection of their real attitudes.

The study also highlighted the link between mental illness and dangerousness in the minds of the police. It is feared that, because of this association, the police may respond to an incident with a heightened sense of risk; they may approach people with mental illness more aggressively and this may lead to an escalation in the situation and cause unnecessary violence (Watson, Corrigan et al. 2004).

3.3 What are the issues around ‘places of safety’?

Once a police officer has identified a potential mentally disordered person, one option available to the officer is to remove the mentally disordered person from a public place and take them to a place of safety (under Section 136 of the MHA 1983). An IPCC study (Independent Police Complaints Commission 2007) estimated that around 11,500 people were detained under this power in 2005/6, though it states that this is likely to be an underestimate. A ‘place of safety’ (as defined by Section 135) may include a hospital, a police station, a specialist residential or nursing home for people with mental health needs, residential accommodation provided by a local social services authority or any other suitable place, the occupier of which is willing temporarily to receive the patient.

A person can be detained for a maximum of 72 hours (from the time of arrival at the place of safety) ‘for the purpose of enabling him to be examined by a
registered medical practitioner and to be interviewed by an approved social worker and of making any necessary arrangements for his treatment or care’. The IPCC study (2007) found that the average amount of time that people detained under section 136 MHA spent in custody was 10 hours.

The Code of Practice to the MHA 1983 (revised in 1999) states:

**The place of safety**

10.5 The identification of preferred places of safety is a matter for local agreement. However, as a general rule it is preferable for a person thought to be suffering from mental disorder to be detained in a hospital rather than a police station. Regard should be had to any impact different types of place of safety may have on the person held and hence on the outcome of an assessment. Once the person has been removed to a particular place of safety, they cannot be transferred to a different place of safety.

**Good practice points**

10.6 Where an individual is removed to a place of safety by the police under section 136 it is recommended that:

a. where he or she is to be taken to a hospital as a place of safety immediate contact is made by the police with both the hospital and the local social services department;

b. where the police station is to be used as a place of safety immediate contact is made with the local social services authority and the appropriate doctor.

The local policy for the implementation of section 136 should ensure that police officers know whom to contact.

In 1992 the Reed Committee supported this Code by recommending:

‘that effective local agreement between police and mental health services should seek to ensure that, wherever possible, mentally
disordered people can receive supportive care without first being taken to the police station’ (Stone 1995).

Likewise the Home Office and Department of Health document stressed the importance of agreement between the police and health and social services regarding suitable arrangements for the assessment of mentally disordered offenders (1995: 13).

However, it appears that, in many areas police stations are still used as places of safety. A NACRO survey of court diversion and criminal justice mental health liaison schemes (carried out in 2005) found that in 34% of cases police stations were the only designated places of safety. An MPA Joint Review (Metropolitan Police Authority 2005) established that, in spite of some existing protocols, current arrangements were not working and recommended that Section 136 arrangements should be reviewed and agencies work together to improve the current situation. In addition, an IPCC nationwide study on the use of police stations as places of safety is due to be completed by the summer of 2007. (http://www.ipcc.gov.uk/index/resources/research/mh_polcustody.htm. Accessed on 12 January 2007).

During the search for literature, only three studies were found which provided some indication of alternative places of safety to police cells. First, NACRO’s survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes (2005) asked about designated places of safety. Alternative places of safety included: psychiatric hospital (in 14% of cases); psychiatric hospital and police station (13%); Accident and Emergency (8%); Accident and Emergency and police station (6%). Other places of safety included acute wards and high dependency unit/psychiatric intensive care.

Second, the MPA Joint Review (2005) found that where protocols had been drawn up, the designated places of safety depended on local circumstances. In most cases it was located within an acute mental health unit. The Report
highlighted areas of London where good practice existed. This included the Chase Farm Hospital in Enfield. There was a very detailed protocol in use which outlined all roles and responsibilities involved.

The MPA makes recommendations for ‘ideal assessment centres’ which would include the ability to deal with mental health assessments, restraint and violence including the capacity to resuscitate, medical triage, capacity to address the needs of people whose crisis could be caused by either mental illness or substance (including alcohol) abuse (2005: 8).

Finally, the Royal College of Psychiatrists (Royal College of Psychiatrists 1997) formed a working group to identify the standards expected of any place used as a ‘place of safety’. It looked at the physical facilities, the staffing levels and policies in relation its use.

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<td>1. Winstone and Pakes identify the need for further research in this area, in particular regarding which current arrangements are the most effective in improving service delivery (Winstone and Pakes 2006)</td>
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3.4 What factors should the police consider when interviewing MDOs?

Much of the research on interviewing mentally disordered offenders is covered in other sections, for example those sections regarding PACE in Appendix One and the section on Appropriate Adults found below. This section focuses on the decisions made regarding fitness to be interviewed, the reliability of accounts provided by people suffering from a mental disorder, and mentally disordered offenders’ understanding of legal information provided to them by the police.

Regarding the fitness to be interviewed, Gudjonsson et al (2000) explored the psychological factors considered important by consultant psychiatrists, Forensic Medical Examiners (FMEs), lawyers and police officers in relation to determining fitness for interview. The factors most commonly identified were confusion and disorientation, withdrawing from heroin, communication
problems, a paranoid belief, and not seeming to understand simple questions. In contrast, claiming amnesia, depression and appearing suggestible and eager to please were not factors that respondents thought rendered the detainees unfit for interview. Overall, 37 of the 314 participants (12%) found persons with communication problems unfit for interview, irrespective of the protection offered by an appropriate adult. Interviewees with a history of mental illness, but not currently ill were most commonly considered fit without the use of an Appropriate Adult or legal advice, particularly among FMEs and consultant psychiatrists (55% & 63% respectively). The corresponding figure for lawyers and police officers was 22% and 33% respectively.

Studies have also looked at the reliability of accounts provided by mentally disordered people. A study by Gudjonsson and MacKeith (1994) found a case where a false confession made to a double murder and rape was obtained under the legal framework of PACE 1984. The false confession occurred when a solicitor and an appropriate adult were present, the interview was taped and video recorded, and the offender was not placed under any extreme pressure by the police. In spite of some inconsistencies the confession made by the offender was convincing and would probably have been compelling evidence against him in court if the real murderer had not been apprehended. Pearse, Gudjonsson, et al (1998) found there was no evidence to support the hypothesis that those suspects considered vulnerable were more likely to confess than the non-mentally ill.

Several studies have looked at mentally disordered people’s understanding of cautions and ‘Notice to Detained Persons’. With regards to cautions, Shepherd et al (Shepherd, Mortimer et al. 1995) also found that only about half of the new caution was understood by their research sample, and that only one in eight understood the middle sentence which is arguably the most crucial. There is evidence that suspects frequently claimed to have understood the caution even though they have not. Whilst apparently understanding that they did not have to answer questions, they may in fact have believed that they must say something. A second factor is whether
suspects understood the nature of the allegation and what factors may be relevant to their defence. The suspects understanding might be aided by the provision of legal advice, but there still remained a danger that a court may draw adverse inferences where the lawyer, satisfied that his client did not have a proper understanding, advised him not to answer questions (Cape 1996).

A further study (Pearse and Gudjonsson 1997) looked at the safeguards of the PACE Codes Of Practice that specify that a suspect must be informed of their rights by the custody officer when brought to the police station. They must also be provided with a ‘Notice to Detained Persons’. Research has consistently shown that both the Notice to Detained Persons and the Codes of Practice are difficult to understand because they contain lengthy sentences composed of considerable technical jargon. At one stage it was estimated that the Notice was understood in its entirety by fewer than one in four of the general population. The research also found that not all suspects took advantage of the right to free legal advice. Some declined in the belief that it would not assist their case (63%), others, that it would delay their release (12%) or felt it unnecessary (5%). The researchers concluded that this refusal to have legal advisors may be because the suspects did not understand their legal entitlements. This is particularly worrying because another study (Gudjonsson and Henry 2003) found that suspects were more likely to make admissions when no legal representative was present. The study stated that officers interviewing adult suspects without an appropriate adult were significantly more likely to challenge the suspect’s account and they also interrupted the suspect more often when giving their version of events.

3.5 What is the role of an ‘appropriate adult’?
When a vulnerable suspect is detained or interviewed, PACE Code C must be adhered to. The custody officer must inform an appropriate adult (AA) about the grounds under which a MDO is detained and the whereabouts of the MDO. An appropriate adult can be:
• a relative, guardian or other person responsible for their care or custody;
• someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police;
• failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police (PACE 1984, Section 1.7b).

Although this is the general provision, Note 1D states that, in the case of mentally disordered offenders, it is preferable if the appropriate adult is someone trained or experienced in caring for mentally disordered people rather than a relative with no such qualifications. However ‘if the detainee prefers a relative to a better qualified stranger or objects to a particular person their wishes should, if practicable, be respected’.

The appropriate adult has a number of roles:
• to ensure that the interests and rights of the detainees are protected. They are not expected to act simply as an observer (PACE CODE C Section 11.17) during the interview;
• to give advice and assistance to the detainee (this can include private consultations); and
• to facilitate communication between the police and the person being interviewed.

Several studies have highlighted the fact that appropriate adults are used in a disproportionately low number of cases. Bean and Nemitz’s (Bean and Nemitz 1998) study of 20,805 custody records in four police stations found that an AA was used for only 38 mentally disordered adult suspects. Further examination of the custody records showed that an additional 448 mentally vulnerable suspects should have had an AA called. In the 38 cases where an AA was used it was invariably because the suspect was recognised as being mentally handicapped or having other disabilities such as being blind or ‘deaf and dumb’. Usually the custody officer did not call a police surgeon for these
suspects which suggests that the custody officers had a certain level of confidence in their ability to identify such disabilities. For those suspects where the police surgeon was called they were invariably almost always declared ‘fit to be interviewed’.

The literature points to several difficulties to do with appropriate adults. First, who is best equipped to be an appropriate adult? Research suggests that, in many cases, the person called upon to fulfil the role of the AA is unlikely to have any experience, little or no knowledge of the law and is unlikely to be familiar or comfortable with the dynamics of the police station or interview procedure (Robertson, Pearson et al. 1995). Some commentators have stated that an untrained appropriate adult can do more harm than good (Bartlett and Sandland 2003).

Gudjonsson (Gudjonsson 1995) also raised concerns about the use of relatives as appropriate adults because their objectivity may be overridden by emotions and sometimes they may suffer from their own mental problems which are not immediately obvious to the police. It seems preferable that, given the complexity of the role, a trained professional should carry out this role.

Second, it appears that police stations do not always have access to trained professionals (Robertson, Pearson et al. 1996). A variety of schemes, run in different ways by various agencies, seem to be in existence. This problem arises because no agency has statutory responsibility for the provision of appropriate adults to the adult population. (YOTS are responsible for the provision for appropriate adults for juveniles). The National Appropriate Adult Network (NAAN) aims to lobby parliament, set standards and provide training (http://www.appropriateadult.org.uk/Home/home/Home. Accessed on 25 January 2007).

Third, there is some confusion over the details of the role of AAs, especially in interviews and regarding their role as a ‘facilitator of communication’. The example given included a situation where a solicitor might advise a ‘no
comment’ interview. In this situation, it was not clear how far the appropriate adult should intervene in order to facilitate communication (Bartlett and Sandland 2003).

Considerations
1. Carry out research into the difficulties for police in accessing and dealing with appropriate adults.
2. Conduct research on the existence of appropriate adult schemes. The NAAN carried out a survey in 2005, but any future survey carried out should be more focused to the needs of the doctrine.

3.6 What factors should be taken into account when deciding between the prosecution or diversion of mentally disordered offenders?

In recent years there have been various government initiatives to promote the diversion of mentally disordered offenders away from the criminal justice system and into the care of mental and social services. The police, in its role as the first point of contact between MDOs and the criminal justice system, play a crucial role in decisions on diverting offenders. In many cases, the police will make a decision at the scene of an incident (Wells and Schafer 2006). In these cases the police may decide not to take any further action. In cases where the person is brought into the police station, the Crown Prosecution Service plays a key role in deciding whether or not to prosecute an offender.

There is limited data available on the diversion of MDOs and numbers diverted at the different stages. The data is not gathered in a systematic way. Laing states that, according to available statistics, the number of diversions are very low (Laing 1999). A study carried out in London (Burney and Pearson 1995) stated that it was difficult to estimate how many diversions take place at the level of the police station.

The various governmental initiatives have created some confusion regarding the diversion or prosecution of mentally disordered offenders. The older initiatives, in particular the Home Office Circular 66/90 (Home Office 1990)
stressed the importance of alternatives to prosecution. A more recent Circular (Home Office and Department of Health 1995) pointed to other factors which should be taken into account when considering prosecution. These other factors included the gravity of the offence and the safety of the public. In addition to this more recent Circular, moves within the wider criminal justice system have emphasised the role of victims and public protection. The paragraphs below discuss the different issues the police need to consider when deciding to prosecute a case or not. Much of the information presented below will be familiar to any reader involved in the criminal justice system, however, it is felt necessary to bring it together in one section in order to discuss its applicability to the case of mentally disordered offenders. It must be stressed that it is not possible to provide a straightforward answer to the question of prosecution versus diversion. The decision will be based on the individual case and the issues discussed below should be taken into consideration.

Home Office Circular 66/90 on the provision for mentally disordered offenders stressed that MDOs should receive care and treatment from health and social services. It stated that once the CPS had established that there was sufficient evidence, ‘careful consideration should be given to whether prosecution should be required by the public interest’, and that alternatives to prosecution should be considered first before deciding that prosecution is necessary (Paragraph 4 (iii)). However, as pointed out in the Ritchie Report (Ritchie 1994) the circular provides no guidance on the range of issues which should be considered when deciding on prosecution.

As a result of this Circular, so-called ‘diversion schemes’ were set up around the country. NACRO’s latest survey concluded there were 135 such schemes in operation in 2005 (NACRO 2005). Some of these schemes operated in police stations, others operated in the courts. The composition of the teams also varied. For example, in the case of a scheme operating from a police station, it could be a single community psychiatric nurse based at the station to aid with the identification of a mental disorder (the Bourneville Lane police
station scheme is given as an example of this type of scheme (Home Office and Department of Health 1995)). In court-based schemes, there could be a community mental health team linked to a court.

The schemes operating out of police stations allowed the police to direct a mentally disordered offender or suspect to them; the police would take no further action. The action of diverting a MDO meant that, in many cases, no record of their contact with the police was formally registered.

However, in 1992, the stabbing of Jonathan Zito and the subsequent Inquiry into the Care and Treatment of Christopher Clunis (Ritchie 1994) led to some changes in attitudes towards diversion. The Ritchie Report stated that serious offences should be prosecuted:

‘It seems to us a matter of real concern that a mental patient’s serious crimes are overlooked, often because the victim is not willing to prosecute, probably he knows the assailant is mentally ill. We agree that it is right to keep the mentally ill away from the criminal justice system for minor offences. But it seems wrong to us that a person who is mentally ill should not be prosecuted for a serious offence and should thereby be deprived of the real help they might otherwise receive under a Hospital Order or the Probation Service. We consider that the police should encourage the victim to prosecute in such cases’. (1994:38).

In addition, the Ritchie Report made the following recommendation to the Home Office:

‘We consider that the Home Office should publish a Guide to help the Police with the interpretation of the Circular, so that, a medical opinion from the Forensic Medical Examiner is always obtained by the Police if it appears to them that an offender is suffering from mental illness, and so that the potential seriousness of the offence and the public interest
is always taken into account in deciding whether to charge’ (1994: section 53.0.4 page 124).

As a result of this, the Home Office published Circular 12/95. However, if its intention was to address the recommendation from the Ritchie Report and provide guidance regarding Circular 66/90, it failed. The Circular emphasised the fact that the decision to prosecute should be guided by what was in the public interest. The Circular stated that existence of a mental disorder should never be the only factor considered and that ‘the police must not feel inhibited from charging where other factors indicated that prosecution is necessary in the public interest’ (paragraph 12). The circular asserted that other factors should be taken into account. These include:

- the gravity and circumstances of the offence; and
- history of previous contacts with the criminal justice system, psychiatric and social care services.

Furthermore, the Circular stated that the CPS decision must be made in context and ‘the needs of the defendant must be balanced against the needs of society; if the offence is serious, it remains likely that a prosecution will be needed in the public interest’ (paragraph 14).

In summary, Circular 12/95 provided further factors for the police and CPS to consider, but provided little specific guidance. Once again, the circular referred to the Code of Practice for CPS regarding the public interest test.

The Code for Crown Prosecutors (Crown Prosecution Service 2004), provides the general principles which the CPS uses when deciding whether to prosecute a case. However, it does stress each case is unique and should be considered on its own facts and merits. There are various aspects which are worth highlighting with regards to mentally disordered offenders.
In order for the CPS to decide to prosecute, there has to be enough evidence to provide a ‘realistic prospect of conviction’. The reliability of the evidence is important. The code asks ‘Is there evidence which might support or detract from the reliability of a confession? Is the reliability affected by factors such as the defendant’s age, intelligence or level of understanding?’ (2004 at 5.4.b). The reliability of evidence is important in the context of MDOs. A MDO’s level of intelligence or understanding may mean that their evidence is deemed unreliable. Furthermore, the Ritchie Report (1994) highlighted that very often victims were not willing to proceed with a prosecution because they know that an offender was mentally ill. Research has also shown this is particularly true for members of staff of mental or social care settings who suffer assaults (Brown 2006). If a victim is not willing to provide evidence, the CPS may decide there is no further action required on a case. The Ritchie Report (1994) called for the police to encourage victims to continue with a prosecution.

Once it has been decided that there is enough evidence to charge a person, the next question is whether it is in the public interest to bring the case to court. The Code (2004) states that the public interest factors will change from case to case but ‘[b]roadly speaking, the more serious the alleged offence, the more likely it will be that a prosecution will be needed in the public interest’. The Code goes on to provide (at section 5.9) that a prosecution is more likely to be needed if, amongst other things:

- the offence was committed against a person serving the public (for example, a police or prison officer, or a nurse);
- ‘the defendant’s previous convictions or cautions are relevant to the present offence’; and
- ‘there are other grounds for believing that the offence is likely to be continued or repeated, for example, by a history of recurring conduct’.

Beyond these general principles there is no further guidance available for the police regarding what types of offences should be considered for diversion.
One particular area where more guidance would be useful is regarding the different points at which diversion from the criminal justice system can occur.

Diversion may take place at various stages within the criminal justice system. There are a number of points where it is possible that certain offenders will not be prosecuted, or not imprisoned or not punished (Laing 1999). These include:

- Informal diversion by the police;
- By statute – implementation of section 136 Mental Health Act 1983;
- Referral for psychiatric examination before court hearing and subsequent discontinuation of prosecution proceedings;
- Disposal via the mental health services either at court or after sentence; and
- Disposal by mental health services during the course of the sentence (e.g. transfer from a prison to a hospital) (Prins 2006).

There are no rules governing the point at which diversion from the criminal justice system will occur. This will depend on what is judged to be appropriate in each case, given the background to, and type of, offence. The fact that diversion remains open to interpretation has been criticised by some commentators (Laing 1999).

There have been recent developments within the criminal justice system which need to be considered in the debate over diversion. First, the increased focus on the rights of victims (Laing 1999). The decision to divert someone away from the criminal justice system should strike a balance between the rights of the offenders and the rights of the victim. Second, there has been an increase in emphasis on public protection and risk management (Bean 2001; Bartlett and Sandland 2003). Third, the human rights of the offenders and what is in their best interest should also be considered. The question has been raised as to whether diversion is always in the offenders’ best interest. Prins (Bean 2001) observed that it was often assumed that the offender will
want to be diverted, and this may not always be the case. Prins suggested that the offender may be placed under pressure to admit an offence in order to participate in treatment. Fourth, recent measures to address anti-social behaviour have been applied to people with mental health needs. These measures include Penalty Notices for Disorder and Anti-Social Behaviour Orders. (More details on how these work are provided in Appendix One). There has been opposition regarding the use of these measures on people with mental health needs (Mason 2005; Revolving Doors Agency 2006). It would be interesting to carry out further research on the way in which these have been used, and whether their use in the context of mental illness has been legally challenged. Finally, the increased emphasis in ‘citizen focused policing’ (Home Office 2006) will lead, amongst other things, to the establishment of Neighbourhood Policing in every community by 2008. The MPA Joint Review (2005) and the Revolving Doors Agency Report (2006) highlighted the important role that Neighbourhood Policing Officers, with their sound knowledge of a community, can play in supporting people with mental health needs.

One central question in the debate over diversion has been the success (or effectiveness) of the different diversion schemes. There is no agreed definition of what success might look like and different schemes have adapted this accordingly. Definitions of success will depend on the stage of the criminal justice system at which the schemes intervene. They include: the numbers being taken out of the criminal justice system; the reduction in the length of remand or, in some cases, the ability to provide a more multi-agency treatment to offenders.

Studies have come to conflicting conclusions on the success of diversion. Some claim that there is simply not enough data to answer the question:

‘A key aim of diversion is to reduce criminality, but again few data are available, so that we do not know whether diversion schemes reduce offending, delay it or have no impact at all’ (Bean 2001).
Other studies, however, have stated that there is sufficient empirical evidence to conclude that the schemes are efficient (Laing 1999; Riordan, Wix et al. 2003).

The importance of local conditions is highlighted by various studies (Laing 1999; Winstone and Pakes 2006). The success of the diversion scheme will depend on the availability and standard of the services (in particular mental health services) which the offender is diverted to (Bean 2001). A study carried out on schemes in Hampshire concluded that the availability of alternative accommodation and funding were key issues for the success of the scheme. Likewise, the relationship between the different agencies was seen as a key factor in the success of scheme. It was important to have good working relationships between the different agencies (Vaughan, Kelly et al. 2001).

Considerations:

1. Further research into the way in which decisions are made in practice would be very useful for the writing of doctrine. What are the main issues of concern for police officers? (For example, are there issues with trying to get the necessary evidence together?) What is the relationship between CPS and the police regarding the charging of mentally disordered offenders? Are there any examples of good practice where these issues have been effectively managed?

2. One study found that the police could influence future decisions by the information they put on the file regarding the incident and any observations regarding the person (Duff 1997). Further research into this would provide important information for the writing of doctrine.

3. Do Inquiries (other than the Clunis Inquiry) provide further recommendations regarding diversion?

4. The doctrine is clearly not going to be able to provide a straightforward answer to such a complex issue. However findings from the literature and from further research may provide a list of important considerations to be made when deciding to divert (and what form that diversion should
5. Interesting to get a picture of diversion schemes operating at the police station level. How is success defined for the police? What are the strengths and weaknesses of the different schemes?

3.7 *In what ways do the police have to work with other agencies?*

Multi-agency working is seen as crucial to the successful management of MDOs. Many of the issues discussed in the literature focus on aspects that are relevant to all kinds of multi-agency working. The section below, therefore, focuses on the issues that are particular to mentally disordered offenders and suspects.

The police must work with other agencies and professionals when managing MDOs. In the early stages of involvement with the MDO the relationship between the police and local health and social services is key. All police officers who might come into contact with mentally disordered suspects or offenders should be aware of the provisions for the mentally disordered in the local area. This awareness may aid their decision-making regarding how to treat a MDO and where to take them. If an officer is aware that support is available locally in terms of health, housing and social services they might consider referring the person to such services (Burney and Pearson 1995). Likewise, contact with other agencies may help the officer to determine whether the present incident is a one-off event or one in a series of incidents (Home Office and Department of Health 1995).

The police need to call on the help of other agencies on arrival at the police station. The police may require that a mental health professional carry out an assessment of the person being held. As discussed above, various arrangements have been set up for this to be possible. However in other areas such arrangements either do not exist or do not work well.

Police officers interviewed in a Hampshire diversion scheme were frustrated at the lack of availability of approved social workers and consultant
psychiatrists. The officers felt it was difficult to get them to carry out prompt assessments, and they felt that social workers and psychiatrists did not think it was urgent for them to attend police stations to carry out assessments (Vaughan, Kelly et al. 2001).

Another study found considerable variation in the relationship between police officers and doctors carrying out assessments. In some cases, the doctors spent time with the police officer to discuss the person before going on to do the actual assessment (Robertson, Pearson et al. 1996). In other cases, this exchange of information did not take place.

Problems have also been identified regarding instances when the police take MDOs to accident and emergency departments. The Ritchie Report (1994) highlighted the fact that when police took a person to hospital for an assessment, it often meant a long wait, and the person was often discharged without any explanation to the police (Ritchie 1994: 127). The research found that, in those areas where specific protocols and policies were established regarding the treatment of MDOs by accident and emergency, it made things a lot easier for the police officer taking them to hospital (Wells and Schafer 2006). The existence of protocols meant that police and hospital staff knew of the procedure to follow, as well as being aware of their roles and responsibilities within the process. These protocols often meant that officers spent less time at A and E.

The importance of formal protocols and policies is highlighted by studies. It is important that these protocols aid co-ordination both at the strategic and frontline level. The Home Office and Department of Health document (1995) states it might be helpful if a senior police officer develops force policies to ensure effective co-ordination. Other studies have focused on the importance of co-ordinated working at the grass roots level – on how important it is for those who interact directly to be aware of each other’s roles and responsibilities and to know who to call with a particular issue.
Information sharing between the different agencies is often crucial in the successful management of MDOs. A protocol should integrate the legal framework. In many cases effective information sharing can be achieved through close and effective cooperation between individuals from different agencies (Centre for Public Innovation 2005).

Two studies into the inquiries of homicides carried out by mentally ill people stated that communication problems between agencies were very common. That is the ‘failure to pass on key information in the right form, at the right time, to the right person’ (Parker and McCulloch 1999). For example, the Clunis Inquiry (1994) highlighted the failure to communicate between the agencies, including the police and probation. As a result of this failure to pass on vital information (for example regarding attacks while in hospital) it became impossible for any agency to accurately assess the risk which Christopher Clunis posed.
4. What are the risk issues for the police when they encounter people with mental health needs?

4.1 *How do the police assess risk? Are there any risk assessment models?*

The literature review found various risk assessment and management tools to assess people with mental disorders used by clinicians and wider professionals within the criminal justice system. However, no study looked at specific risk assessment models used by the police in relation to mentally disordered offenders. The only reference to police screening is made in Winstone and Pakes who quote a study by Langley which states that ‘police stations need to be given a checklist of factors to aid mental health screening’ (2005 in Winstone and Pakes 2006: 34).

A study by the Revolving Doors Agency (2006) did not discuss specific risk assessment tools but listed the barriers the police face when carrying out an assessment of the needs of a person arriving in custody. First, the lack of standardisation and definition. There is no standard risk assessment, and each force has developed its own risk assessment. Some assessments are more sensitive to the possible needs of mentally ill people. The fact that there is no standard definition of mental health and mental disorder, and the fact that these terms are not widely used within the mental health sectors, places an additional burden on police officers to understand these terms and to treat sufferers in an appropriate, non-stigmatising way. Second, there is the issue of self-reporting. An accurate assessment of needs requires the person being assessed to be able, and willing, to provide information. For some people, this may not be possible due to their mental illness. Other people may not wish to provide such sensitive information in custody. This is especially true if the assessment is done in an open custody suite where there is no privacy, or if the person has had previous negative experiences of the police. Third, there is the issue of dual diagnosis, that is, the fact that a person may be under the influence of drugs and/or alcohol when they arrive in custody. In such cases it may be difficult for a custody officer to differentiate symptoms caused by mental illness and those caused by intoxication. The fourth and final issue
relates to the assistance which custody officers may have available. The study identified that ‘custody officers often have little recourse to advice or guidance on mental health issues from within their force, or external agencies’(2006: 24).

There are different types of risk assessment tools in use within the criminal justice system. The literature looks at those which are used as screening tools, and more detailed tools which either aim to identify certain conditions or to provide an indication of the risk posed by the individual. The section below is a summary of risk assessment tools which are available to professionals other than the police who come into contact with mentally disordered offenders.

The literature review carried out by Winstone and Pakes (2006) gathered evidence of screening tools used by prisons and within youth justice. The youth justice board’s screening tool is SQIFA (Screening Questionnaire Interview for Adolescents) which can screen for depression, self harm, anxiety, reaction to experiences such as trauma, substance misuse, Attention Deficit Hyperactivity Disorder and Psychotic disorder (Winstone and Pakes 2006: 32).

Prisons use a simple screening tool designed to capture severe mental health problems. It is based on the following four questions:

- ‘Is the inmate charged with homicide?'
- Has the inmate ever received treatment from a psychiatrist for any form of mental health problem (not including treatment only in prison or one-off assessments?)
- Has the inmate ever received antidepressant or antipsychotic medication (outside prison only)?
- Has the inmate ever deliberately harmed himself?’ (Winstone and Pakes 2006: 33)
Three risk assessments, used by clinicians, were found to have ‘relatively strong predictive powers of risk of violent re-offending’ (Quinsey, Harris et al. 1998).

- **Violence Risk Assessment Guide (VRAG)** (Quinsey et al, 1998). The VRAG is an actuarial instrument with a twelve-item scale including factors such as psychopathy, schizophrenia, personality disorder, separation from parents in childhood, age at time of index offence, failure on prior conditional release, victim injury in index offence, female victim in index offence, never married, primary school maladjustment, history of alcohol abuse.

- **Violence Prediction Scheme** (Webster et al, 1994). This instrument combines actuarial and clinical factors... This covers antecedent history, self-presentation, social and psychosocial adjustment and treatment progress.

- **HCR-20** (Webster et al, 1997). The HCR-20 consists of ten historical items, five clinical items and five risk-management items. The historical variables include previous violence, age of first violent offence, relationship stability, employment stability, alcohol or drug abuse, mental disorder, psychopathy, personality disorder, early home and school maladjustment and prior release or detention failure. Clinical variables include insight, attitude, symptomatology, stability and treatability. The risk variables include plan feasibility, access, support and supervision, compliance and stress (in Powis 2002).

In addition to the instruments listed above, the *Psychopathy Check-List Revised PCL-R* (Hare, 1990) is commonly used to identify psychopathy\(^1\) in offenders, which is consistently associated with increased risk of violent recidivism (Powis 2002).

The literature also discusses general issues to do with risk assessment and management; these apply to all types of risk assessment. First, accurate risk

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\(^1\) In spite of the fact that the usefulness of the concept of ‘psychopathy’ is subject to intense debate (see earlier section on definitions) this identification instrument is used by clinicians.
assessment requires timely information from many sources, and it is often
difficult to acquire this (Hodgins and Isberner 2000; Nash 2006). The Ritchie
Report (1994) provides a good case study in the way in which information was
simply not available to the different agencies assessing the risk posed by
Christopher Clunis. Examples include the omission of vital information (such
as attacks made on fellow patients and members of staff) or documents going
missing. The Inquiry also identified a misunderstanding of confidentiality and a
lack of communication between agencies which meant they were not fully
aware of the information that was held on a person.

Second, once a risk has been identified decisions regarding its management
have to be taken. A risk assessment tool will not provide detailed information
on what is to be done (Taylor 2004); this will depend largely on professional
judgement and local circumstances. The professional will rely on their
knowledge of interventions which are available locally and which may benefit
this particular case. In some cases it will not be possible to eliminate a risk
completely, the best that can be done is to manage the risk effectively. A
study carried out into homicides by mentally ill people highlighted the poor risk
management of clients (Parker and McCulloch 1999). A further study
concluded that general lessons about risk management could not be learnt if
inquiries continued to focus on individual cases (Taylor and Gunn 1999).

Third, risk assessment should be seen as a dynamic process, rather than a
static one. Different factors, such as a change in circumstances, could trigger
a change in the level of risk a person poses. Ideally, this change in
circumstances should lead to a re-assessment of the risk. In reality, this may
not be as straightforward – the person may not be in touch with an agency or
may simply not share relevant information with the agency. Once again, the
Ritchie Report (1994) showed the ways in which Christopher Clunis relapsed
in unpredictable ways, and how it was near impossible to predict the timing
and nature of these relapses.
Considerations

1. The police will carry out risk assessment at various stages of their contact with mentally disordered people – at the scene where initial contact takes place, on arrival to the custody suite, after the interview and/or medical examination. Any further primary research to be carried out for the NPIA doctrine would aim to gather information on risk assessment tools used by the police at these various stages.

2. Will the doctrine cover all the above different types of risk assessments? A further discussion on this would be useful at this stage.

4.2 Is there a link between mental health and offending?
There is a widespread perception that people with mental illness are disproportionately involved in offending. However, as discussed below, research has found that there is no simple link between mental health and offending. The general conclusion is that there is a link between certain types of mental disorders and some types of offending. When the link has been established, the nature of the link is unclear; it cannot be assumed that the link is causal, there may be no more than an association between the two (NACRO 2002). Furthermore the link between mental disorders and offending is a weak one.

Studies show that most mentally ill people are not a threat (Taylor 2004; Centre for Public Innovation 2005; Prins 2005). Studies looking at specific types of mental illness have come to the same conclusion. In the case of schizophrenia, Taylor (2004) concluded that the majority of people are not violent and estimated that only about 3-4% of society's antisocial behaviour will be caused by people suffering from schizophrenia. Mouzas (Mouzos 1999) concluded that the probability of someone with schizophrenia committing a crime is relatively small. In fact, a meta-analysis carried out by Bonta et al found that schizophrenia (along with psychosis) was related to lower levels of violent recidivism (Powis 2002). In the case of personality
disorders, ‘there is some evidence that non-psychopathic personality disorder is associated with crime and violence. The evidence is limited and weak however, and the nature of that association is unclear’ (Burke and Hart 2000).

Most recent studies have concluded that diagnosis of a mental disorder is not enough to establish a link between the mental disorder and offending; the focus must be on whether the person was experiencing psychotic symptoms at the time of the offence (Prins 2005; Cordner 2006; Nash 2006). It is clearly difficult to prove that the offender was suffering from symptoms which made them lose control over their actions at the time of the offence (Ainsworth 2000). In addition, and as highlighted below, alcohol and substance misuse often complicates symptoms.

There is limited data available on the types of offences which people with mental illness are involved in. Claims are made that most people are involved in minor offences (Cordner 2006). An IPCC research project (2007) examined the additional reasons for detention for people who were detained under Section 136 of the MHA. The study allowed for up to 2 additional reasons for detention to be recorded. It found that the most common additional reasons were breach of the peace offences, followed by threats to self harm. Homicide is, perhaps, the most studied offence. The National Inquiry into Suicide and Homicide by People with Mental Illness has provided detailed data on the previous convictions of people with mental illness who had subsequently been convicted for homicide. It found that, 37% had a history of violence against the person, 31% of criminal damage, 16% of threats of violence, 16% of possession of offensive weapons and 4% of sexual offences (National Confidential Inquiry Team 2001).

Regarding the rate of recidivism of mentally disordered offenders, there is not much data available. The Home Office Statistical Bulletin on mentally disordered offenders (Ly and Foster 2005) states that 8% of MDOs
discharged from hospital were reconvicted of a standard list offence\(^2\) within 2 years of discharge and 1% were reconvicted for a grave offence (Ly and Foster 2005). Winstone and Pakes highlight the fact that some studies have found:

‘significantly lower reconviction rates for offenders who are mentally disordered compared to those with no mental disorder, matched for demographic factors and offence gravity…This is convincing evidence that people categorized as mentally disordered offenders are significantly less likely to engage in repeat offending even where their conviction is for a serious offence; the rates of recidivism are significantly less than for their matched group without a mental health complication. Mentally disordered offenders can therefore be argued to pose less risk to the public than other offender, which begs the question of how this group have become so stigmatised’ (Winstone and Pakes 2005b).

Regarding the predictors for recidivism, Bonta et al (1998) concluded that ‘the predictors of recidivism among mentally disordered offenders were almost identical to the predictors found among non-disordered offenders. The main predictors were criminal history, antisocial personality, substance abuse and family dysfunction. This conclusion was found to hold for both general and violent recidivism’ (Winstone and Pakes 2005). Chricton (1999:660) came to a similar conclusion: ‘…violence has been found to be more strongly influenced by gender, age, past violence history and substance misuse’.

To summarise, the results from studies looking at the links between mental disorders and offending are inconclusive. There are no simple links, it depends on the mental disorder and the type of offending, and whether a person is suffering active symptoms at the time of the offence. Even where links are established, they are believed to be weak. Some studies have even

\(^2\) ‘Standard list offences’ is a Home Office classification of offences. They refer to all indictable (i.e. triable by a judge and jury at crown court) or triable either way offences (i.e. may be tried either at a crown or magistrate court) plus a few of the more serious summary offences (i.e. triable only at a magistrate court or where fixed penalties are given). These include some offences of violence against the person, sexual offences, burglary, robbery, theft of/from vehicle, other theft and handling stolen goods, fraud and forgery, criminal damage, drug offences and motoring offences.
concluded that mentally disordered people have lower rates of recidivism. However, from the perspective of the police, it is important to remember the minority of people who may pose a great risk to the public and who need to be effectively managed in order to prevent an escalation of risk or a tragic outcome. The general academic literature discussing the relationship between mental health and offending does not address this issue in sufficient detail.

Consideration

1. It is not easy to find data on the mentally disordered offenders who have previous history of violence and who are high risk. Some information on this can probably be extracted from Inquiries, if required for the doctrine.

4.3 What is the relationship between mental illness and substance abuse?

The relationship between psychiatric disorders, substance misuse and dependence has been the subject of a number of studies in both the UK and the US.

A UK based study which analysed the ONS Survey of Psychiatric Morbidity (Coulthard, Farrwell et al. 2002), specifically looked at tobacco, alcohol and other drug use and dependence, and their relationship to psychiatric morbidity. Alcohol problems were assessed through the Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organisation. The Severity of Alcohol Dependence Questionnaire (SAD-Q) was completed by those scoring above 10 on the AUDIT scale to provide a standardised measure of dependence. Degree of drug dependence was assessed by a set of five questions; if someone answered ‘yes’ to at least one question they were defined as dependant. The prevalence of substance use and dependence in groups with psychiatric disorders were compared with rates in the general population.

The results of this survey showed that women with significant levels of neurotic symptoms were more likely than those without to have an AUDIT score of 8 or more (hazardous drinking), or of 16 or more (harmful drinking).
7% of men with a significant level of neurotic symptom scored above 16 on the AUDIT scale, compared with 3% of men without significant levels of neurotic symptom. The likelihood of having an AUDIT score of 16 or more (harmful drinkers) was greater for people presenting with multiple disorders rather than a single disorder. This was true for both sexes. Both men and women with significant levels of neurotic symptoms were more likely to have used drugs, or be dependant on them. For example people who had neurotic symptoms were more than twice as likely to have used any drug in the last month. Having multiple disorders rather than only one disorder did not increase the prevalence of drug use and dependency.

From the ONS survey less than 1% of the general population were classified as being moderately, or severely dependant on alcohol, but this figure rose to 2% for people with any neurotic disorder, and 6% among individuals with two or more neurotic disorders. These relatively small finding contrasts with those reported from clinical studies but this may relate to the small sample size or to the fact it was a household survey rather than an institutional survey. For example a study by Weaver et al (Weaver, Madden et al. 2003) showed much greater rates of co-morbidity in those being treated by community mental health teams. In this study 85% of respondents were considered to be alcohol dependant, and 75% drug dependant.

A study by the Mental Health Foundation (Mental Health Foundation 2006) on alcohol and mental health found that the prevalence of alcohol dependence among people with psychiatric disorders is almost twice as high as in the general population. And people with severe mental illness such as schizophrenia, are at least three times as likely to be alcohol dependant as the general population. The report also states that the number of UK hospital admissions with a primary or secondary diagnosis of 'mental and behaviour disorders due to alcohol' rose from 71,900 in 1995/96 to over 90,000 in 2002/03.
A UK study by Powell and Peveler (Powell and Peveler 1996) also looked at the relationship between alcohol and mental health by studying two populations of alcoholics; one being treated in a short term hospital treatment unit, and one in a six week residential programmes. In both groups approximately 25% of individuals had features of at least one personality disorder, with borderline personality disorder being the most common in females, and anti-social disorder being prevalent in males. People with severe and enduring mental illness, such as schizophrenia, were again at least three times as likely to be alcohol dependant as the general population, and individuals with alcohol problems were at increased risk of having schizophrenia.

A study by Barnaby et al (2003) examined data to investigate the prevalence of alcohol and drug misuse in inpatients admitted to psychiatric wards, and the extent and accuracy of detection by the psychiatrists doing assessments on admission. Of the 200 patients who took part, 49% scored greater than 8 on the AUDIT scale, 44% scored 15 or above. More than half of the patients (58%) reported lifetime substance misuse, and 27% reported taking illicit drugs in the 30 days before admission. However the study also found that staff in mainstream mental health services urgently needed training in detecting and managing co-morbid substance misuse. A separate study (Virgo, Bennett et al. 1999) interviewed key workers of all NHS inpatient day patient and outpatient Adult Mental Health and Addictions services in a rural population. Of those with serious mental illness under the care of AMH services, 12% had problems with alcohol, compared with over 40% of those using the Addictions services. However, only half of those with co-occurring disorders in either group recognised the dual nature of their illness.

The largest of these surveys in the US on co-morbidity was the National Psychiatric Co-Morbidity Survey (Kessler 1994) which found that approximately 14.1% of adults met criteria for alcohol dependence at some point in their lives. Within the 12 months prior to the survey interview 2.5% met criteria for alcohol abuse, and 4.4% for dependence. Approximately 7.5%
met criteria for drug dependence, and 4.4% for drug abuse. Cannabis was the most common illicit drug of dependence followed by cocaine. Another US study, the Epidemiological Catchment Area (ECA) study, carried out by Reiger (Reiger, Farmer et al. 1990) found similar results. 29% of persons with a mental health disorder had also experienced a substance use disorder, while half of those with drug disorders had experienced mental health disorders. Amongst those with any drug disorder, the most prevalent co-morbid disorders were anxiety (28%); affective disorders (26%); antisocial personality disorders (18%) and schizophrenia (7%).

In contrast, a study conducted by Roberts et al (2006) found lower rates of mental illness in alcohol and drug dependant people (13% and 6% respectively) who were examined by forensic medical examiners whilst detained in police custody. The large discrepancy between the results of this study and others (Reiger, Farmer et al. 1990; Weaver, Madden et al. 2003) is likely explained by the difference in target population. The number of patients examined by the FME whilst intoxicated rendered mental health assessments impossible in many cases. But even allowing for the difference in examined populations, it is conceivable that under reporting of mental illness occurs routinely in the custody suite and that co-existing mental illness may be being under diagnosed. Another interesting point raised by this study was that out of the 2764 consultations recorded, 386 were identified as suffering from mental illness, but in 25.4% of these cases custody staff did not identify the presence of mental illness.

A study of drug deaths in police custody by (Best, Havis et al. 2004) examined cases for possible mental health issues based on 43 deaths in custody that had been supervised by the Police Complaints Authority. In 18 of the 43 cases there was evidence of one of three groups of mental health symptoms; in five cases there was evidence of psychosis, in another five there was evidence of self harm or suicidal attempts, and in a further eight there were indications of anxiety or depression. This constitutes a total of 42% of the drug death cases studied having co-occurring mental health issues. The data
suggests a link between those who had histories of self-harm with increased likelihood of alcohol consumption. While there was no difference in the likelihood that those identified as having mental health problems had been using either cannabis or alcohol, those with mental health problems were less likely to have used cocaine or heroin, but more likely to have used diazepam, and more likely to have used other prescribed drugs. They were also more likely to have swallowed the drugs used prior to death. The data also showed that those with mental health problems were disproportionately more likely to be thought to be faking illness by the officer involved in the case.

Empirical evidence strongly supports the adverse effects of substance abuse on the course of severe mental illness as dual diagnosis persons frequently have complex needs with profound problems in other health related aspects of their lives. These include higher rates of relapse, incarceration and criminal involvement, medical non-compliance, symptom exacerbation, increased hospitalisation, disruptive behaviours, and decreased social functioning (Owen, Fischer et al. 1996). In addition some drug use may induce a psychotic disorder. The mental health charity MIND states that stimulant drugs, such as amphetamine and cocaine, are most commonly associated with causing psychotic illness, if used over a long period. It also states that some mental health workers believe that too much or very changeable levels of the brain chemical dopamine plays a role in causing the symptoms linked to schizophrenia. The link between cannabis and psychosis is well established, and recent studies have found a link between marijuana use and depression. The explanation most accepted is that cannabis triggers the onset or relapses of schizophrenia in predisposed people and generally exacerbates the symptoms. The study often quoted in support of this casual hypothesis examined the incidence of schizophrenia in more than 50,000 Swedish conscripts followed for 15 years (Zammit, Allebeck et al. 2002). It showed that use of marijuana during adolescents increased the risk of schizophrenia.

Research also supports the correlation of increased violence and substance abuse among persons with mental illness (Boles and Johnson 2001). Corbett
et al (1998) found that drug abusing male inpatients with a personality disorder were significantly more likely to have consumed alcohol at the time of committing a violent offence. And patients with a history of substance misuse were significantly more likely to take illegal drugs at the time of their violent offence compared with violent offenders with the same diagnosis but without a history of drug abuse. In the comparison between those with and without a history of substance misuse; they found that the former were five times (for those with schizophrenia) and seven times (for those with a personality disorder) more likely to have taken drugs as the time of the violent offence.

According to a study by Hartwell (2004) offenders with dual diagnosis are more likely to be serving sentences related to their substance use, to be homeless and violate probation after release, and return to correctional custody. The study identified that 344 of the 501 mentally ill offenders involved with the correctional system in Massachusetts screened positive for substance abuse problems. The analysis also showed that the dually diagnosed are more likely to be involved with the criminal justice system due to public order offences (25%), property offences (13%), and drug charges (11%), than their non substance abusing counterparts. And 90% of all recidivists returning to correctional custody are dually diagnosed. Offenders with dual diagnosis are also more likely to be female and to have a history of being on probation and of using mental health services.

A study by Alemagno et al (2004) found that those with co-existing disorders are reported to be at higher risk for arrest and are arrested for less serious offence. In a sample of 311 adult arrestees 35% scored at risk of both mental disorder and substance disorder. Those in the dual risk groups were more likely to lack stable housing, to have a history of substance abuse treatment and to test positive for cocaine. The US National GAINS centre reports that persons with co-existing mental illness and substance abuse are disproportionately represented in local jails. (Jails are locally operated facilities that hold persons awaiting trial or sentencing, serving a sentence of generally 1 year or less.) With regard to the prevalence of substance use
disorders among those with severe mental disorders, the GAINS centre also indicates that both male and female detainees have a 72% rate of co-occurring substance use disorders.

The overwhelming majority of evidence seems to suggest that those suffering from a mental disorder are disproportionately more likely to abuse, or be dependant on, substances. However detecting co-occurring mental illness and substance abuse has proved problematic even by medical professionals within a mental health facility, and even those suffering from substance abuse and mental illness may not recognise the dual nature of their condition. The evidence also seems to suggest that those who are suffering from co-morbidity have even greater problems than those who are either just suffering mental ill health, or are just substance abusers. Such problems include higher rates of criminal justice involvement, relapse, and medical non compliance, as well as an increased risk of violence.
5. What other issues were discussed by the literature?

5.1 Should the police have a media strategy for dealing with cases involving people with mental health needs?

The MPA Joint Review (2005) recommended that the MPS and NHS ‘apply a joint media strategy that will minimise the extent to which the press report on the mental health status of people accused of serious violent crimes including murder. Such strategy should also aim to minimise the negative reporting on mental illness and the occurrence of violent crimes and murder’ (Metropolitan Police Authority 2005).

The role of the media in shaping the debate and perception of mentally disordered offenders was discussed in various studies (Ainsworth 2000; Cordner 2006). The literature search did not come up with any instances which specifically discussed media strategies of the police. In order to gain an understanding of existing practices and issues, primary research would have to be carried out.

Consideration
1. Carry out research into existing media strategies on mental health issues.

5.2 How do MDOs perceive the way they have been treated by the police?

The literature review found limited research regarding the ways MDOs felt they had been treated by the police. The most specific study was carried out by Jones and Mason (2002). They found that MDOs (detained under Section 136 of MHA 1983) were generally dissatisfied with the way they had been cared for and treated by the police. The study’s main result includes:

‘For a person with mental health problems who anticipates negative responses from the police: (i) when police show positive attitude then person raises positive expectations of hospital experience, (ii) when police show negative attitude then there is an increase in feelings of worthlessness’ (Jones and Mason 2002).
The MDOs identified that, at the initial point of contact, the police were more concerned with maintaining law and order than their mental health. However, there was an interesting difference between the MDOs who were taken to Accident and Emergency and those taken to a police cell for assessment. The former felt that, at A and E the police took on a more caring role. The latter felt increasingly dehumanized by the surroundings and their treatment there.

Other studies were more general. Two studies mentioned the fact that police stations were frightening places for people with mental illnesses (Bean 2001; Metropolitan Police Authority 2005). A third reported on surveys of persons with mental illness where respondents indicated ‘that police officers were a significant source of stigmatization and discrimination against persons with mental illness’ (Watson, Corrigan et al. 2004).

5.3 How do people access professional help for their mental health needs?
No studies were found that addressed the different ways in which people came to receive help for their mental health needs. Some indication, however has been given by studies discussed above. For example, regarding BMEs it is well established that they are likely to come into contact with care providers at a later stage of their illness. The study from the Social Exclusion Unit states that

‘People from minority ethnic backgrounds are more likely to enter mental health services after initial contact with the police or other forensic services (those that have links to the criminal justice and health systems), although they are no more likely to be aggressive before admission’. (Office of the Deputy Prime Minister 2004)

Consideration
1. More information on this is probably available from service providers and organisations providing care to particular groups.
6. Conclusions
The literature on mentally disordered offenders covered a wide variety of themes. Rather than draw conclusions from the review, this section (1) highlights the gaps identified in the research and (2) details the next steps to be taken regarding the possible doctrine on mentally disordered offenders.

6.1 Summary of gaps identified in the research
6.1.2 General Issues
- Pathways to care. The review of the literature has suggested that different groups of mentally disordered people will access mental health services through different routes. However, not a lot of detailed information was found on this. This information is probably held by service providers and other agencies such as NACRO. Further research into this issue could be carried out through primary research with relevant groups.

6.1.3 Issues specific to the police
The review of the literature highlighted some areas where more research could be carried out on the relationship between mentally disordered people and the police.

- Officer’s decision making at an incident and regarding diversion. No research was found on the way in which officers at the scene of an incident make decisions regarding what they do with a person who may have mental health needs. For the purpose of the doctrine, it would be useful to have a picture of the type of factors which influence a decision. Likewise, the literature did provide a detailed discussion of the factors faced by the custody officer (and others) regarding diversion. The legislation and policy regarding diversion has led to some confusion. It would be interesting to get a sense of why this confusion has occurred in order to address it in the doctrine.
• Diversion schemes at the police station level. Diversion schemes at police stations vary. It would be interesting to build up a picture on how they are structured, and the strengths and weaknesses of the different models.

• The MPA Joint Review (2005) identified that the management of violent behaviour of offenders needed more careful consideration. This is clearly an important issue, however, no specific studies were found which specifically considered the management of violent behaviour in mentally disordered offenders; references were made to the general guidelines regarding the management of violent behaviour.

• Places of Safety. Police cells continue to be used as places of safety, even though they are seen as inadequate. The IPCC research study is due to report by the summer of 2007 and this may answer many of the questions left unanswered by the literature reviewed above (for example, what are the issues in rural location? And what works best in order to improve services for offenders?).

• Types of contact between the police and mentally disordered. The literature review has outlined some of the types of contact between the police and mentally disordered offenders or suspects. No data was available regarding which was the most common type of encounter and how much police time was spent on the different types of contacts.

• Risk assessment on mentally disordered offenders. The literature review did not come up with any studies regarding risk assessments in use across police forces.

• Diversity. There is not much research on the issue of the police and mentally disordered offenders from diverse backgrounds. The research available has tended to concentrate on black and minority ethnic groups and women.
• Police policies and procedures. No research study was found which examined the policies and procedures in place to deal with mentally disordered offenders.

• Relationship between the police and the media regarding mental health issues. The MPA Joint Review (2005) highlighted the need to have a joint police and NHS policy regarding relations with the media. It is unclear whether forces have a specific media policy which deals with incidents regarding mentally disordered offenders.

• Recent developments in the criminal justice system. Various reports have pointed out that Neighbourhood Policing and Community Justice Centres could, in the future, make an important contribution in the way that the criminal justice system deals with mentally disordered people at a local level. In addition, a study on Multi-Agency Public Protection Arrangements (Kemshall, Mackenzie et al. 2005) recommended that mental teams be integrated into the management of offenders with mental health needs. It appears that since this study, most MAPPA meetings have some representation from mental health staff.

6.2 Next Steps

• Agree and draw up the Project Initiation Document detailing the scope of the doctrine.

• Establish links with key stakeholders and users. At an initial stage this will be used to refine the scope of the document. At later stages, the stakeholders will be involved in more detailed consultation.
Appendix One. Legal and Policy Issues

Mentally disordered offenders are dealt with by statute, case law and administrative devices. This section aims to cover legislation and policy surrounding MDOs. (This appendix does not provide an in-depth discussion of the relevant cases – this can be done once the scope of the doctrine is agreed).

1. Current Legislation
1.1 At arrest
1.1.1 Mental Health Act 1983

The key legislation covering the detention, care and treatment of persons suffering mental disorder is the Mental Health Act 1983, which must be read in conjunction with the Codes of Practice to the Act. Key sections which are relevant to the police include:

- Section 1 on definitions (as discussed above).
- Section 2 on compulsory admission to hospital and guardianship.
- Section 3 on admission for treatment.
- Section 4 on admission for assessment in cases of emergency.
- Section 135(1) gives the police the power to enter premises and to remove a person believed to be suffering from a mental disorder (who has been or is being ill treated or neglected or is unable to care for himself) to a place of safety.
- Section 135(2) provides the power to enter premises and remove a patient in respect of whom there is authority to take to any place/retake into custody, where admission to such premises has been refused.
- Section 136. If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above. A place of safety may
be a police station, hospital, mental nursing home, residential accommodation or any suitable place where the owner is willing to receive the patient. The purpose of this section is to enable the person to be examined by a doctor and for the arrangement of treatment or care, if required.

- Section 137(2) “A constable or any other person required or authorised by or by virtue of this Act to take any person into custody, or to convey or detain any person shall, for the purposes of taking him into custody or conveying or detaining him, have all the powers, authorities, protection and privileges which a constable has within the area for which he acts as constable.”

- Section 38(7) A constable can arrest an offender who absconds from hospital or during conveyance to the hospital where he is to be detained in terms of an interim hospital order. After the arrest, the absconder is to be taken before the court which made the said order – the latter may terminate the order and deal with the absconder as if no order had been made.

- Section 18(3) Power to take into custody and return a patient who is absent without leave from a place at which he is required to reside.

1.1.2 Police and Criminal Evidence Act 1984 and Codes of Practice

PACE and the Codes of Practice govern the arrest, detention and treatment of all suspects, including those who are mentally disordered or mentally vulnerable.

PACE Code C covers the detention, treatment and questioning of persons. It deals with the assessment of a person and the role of 'appropriate adult'.

- Section 3.16. It is imperative that a mentally disordered or otherwise mentally vulnerable person, detained under the Mental Health Act 1983, section 136, be assessed as soon as possible. If that assessment is to take place at the police station, an approved social worker and a registered medical practitioner shall be called to the station as soon as possible in order to interview and examine the
detainee. Once the detainee has been interviewed, examined and suitable arrangements made for their treatment or care, they can no longer be detained under section 136. A detainee must be immediately discharged from detention under section 136 if a registered medical practitioner, having examined them, concludes they are not mentally disordered within the meaning of the Act.

- Section 10.12 stipulates that the caution must be repeated in the presence of an appropriate adult.
- Section 11.15 states that a person who is mentally disordered should not be interviewed, asked to provide or sign a written statement under caution in the absence of an appropriate adult.
- Section 11.17 spells out the role of the appropriate adult. (See Section 16 below for details)

PACE Code D focuses on issues of identification of persons by the police.

- Paragraph 2.12 “If any procedure in this Code requires a person’s consent, the consent of a: mentally disordered or otherwise mentally vulnerable person is only valid if given in the presence of the appropriate adult”.
- Paragraph 2.14 “If any procedure in this Code requires information to be given to or sought from a suspect, it must be given or sought in the appropriate adult’s presence if the suspect is mentally disordered, otherwise mentally vulnerable or a juvenile. If the appropriate adult is not present when the information is first given or sought, the procedure must be repeated in the presence of the appropriate adult when they arrive.”
- Paragraph 2.15 “Any procedure in this Code involving the participation of a suspect who is mentally disordered, otherwise mentally vulnerable or a juvenile must take place in the presence of the appropriate adult. See Code C paragraph 1.4.”
- See also paragraph 6.9 regarding the presence of an appropriate adult during the removal of clothing for purposes of taking an intimate or non intimate sample.
1.1.3 Human Rights Issues
There are a number of cases dealing with the detention of a person suffering from a mental disorders and Article 5 of ECHR (the right to liberty and security). It is now trite law that indefinite detention is compatible with Article 5(1) (e) as long as the guarantees found in subsection 4 are complied with.

“The ECHR has decreed that for detention under the MHA 1983 to comply with the convention and therefore be legal it must be compatible with Article 5 and protect against arbitrary detention. The disorder, therefore, must be established by medical evidence, be persistent and be of a ‘nature or degree warranting compulsory confinement.’ Moreover, the detained individual must have access to a speedy review of their detention by an independent body.”(Littlechild and Fears 2005)

As regards Article 6, the right to a fair trial

- R v H [2003] 2 Cr App R2 (Section 4A Criminal Procedure (Insanity) Act 1964 found to be compatible with Article 6 ECHR by House of Lords)

There are many other cases on the rights of mentally disordered offenders and the legislation used to treat and detain them, which can be provided if required.

1.2 At trial
Sections regarding MDOs at court include Sections 35-38 of the Mental Health Act 1983. Section 35 sets out the provisions for the Magistrates’ and Crown Court to remand a defendant to hospital in order for a report on their mental condition to be prepared. This is appropriate where it would not be practicable to remand the person on bail, especially when the accused is likely to break the condition of bail. Section 36 provides for an accused to be

3 Article 5 (1) (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants

4 Subsection 4 reads as follows: Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful
remanded to hospital for treatment, instead of being remanded in custody, pending trial or sentence. This applies only to defendants appearing in the Crown Court. This power may be used in cases where the defendant might otherwise be found unfit to plead, to enable a defendant to receive treatment prior to trial, which may proceed at a later date when the condition of the defendant has improved.

As an alternative to a penal disposal, the court may employ section 37 and issue a hospital or guardianship order. Section 38 contains the provisions enabling a Crown Court and the Magistrates Court to make an interim hospital order after conviction. To do this the Court must be satisfied, on written or oral evidence of two registered medical practitioners, that the defendant is suffering from one of the stipulated forms of mental disorder and that there is reason to suppose that it may be appropriate to make a hospital order.

1.1.2 ‘Fitness to plead’ (now known as “Under a disability in relation to the trial”)

It may be asserted by the defendant, his legal representative, the prosecution or it appears to the judge that the defendant/ suspect is ‘unfit to plead’ due to some form of mental disability, i.e. the suspect cannot be properly tried because of a mental disability. The procedure for determining whether someone is fit to plead is set out in the Criminal Procedure (Insanity) Act 1964, as amended. Sections 4 (finding of a fitness to plead) and 4A (finding that the accused did the act or made the omission charged against him) apply.

The issue used to be decided by the jury; however the Domestic Violence, Crime and Victims Act 2004 amended section 4(5) so that now the court alone decides on the fitness of the suspect to plead. (See Home Office Circular 24 / 2005).

Section 35 Mental Health Act 1983 makes provision for a person to be remanded at a hospital in order that an assessment is done on his mental state. A report is then prepared for the court. The purpose of this section is for a diagnosis of a mental disorder to be made, if appropriate. The remand is for 28 days; however this can be renewed by further periods of 28 days to a maximum of 12 weeks.
In contrast section 36 relates to circumstances where there is a previously diagnosed mental disorder – the section enables the court after hearing two medical practitioners, to remand the defendant to a hospital for treatment.

Once a court finds the suspect is not fit to plead, then the jury will decide whether he did the act or made the omission charged against him, see section 4A.

If the provisions of sections 4 and 4A are satisfied, then the court must act in terms of section 5 and 5A of the Criminal Procedure (Insanity) Act 1964, which includes the options of:

- a ‘hospital order’ as found in section 37 of the Mental Health Act 1983,
- a ‘supervision order’;
- an absolute discharge.

However, if the person was found fit to plead then the trial will continue as normal.

See:

- R v Antoine [2000] 2 All ER 208, HL
- R v H [2003] 2 Cr App R2 (Section 4A Criminal Procedure (Insanity) Act 1964 found to be compatible with Article 6 ECHR by House of Lords)
- R v M [2003] EWCA Crim 3452 (court sets out the 6 factors which the defendant must have the ability to do for the trial to proceed)

1.1.3 Defence of Insanity

This is an allegation that at the time of the offence the suspect was not able to understand the consequences of his/ her actions or was incapable of forming the necessary intent (mens rea) for the offence. The law here is governed by the decision in the M’Naghten case (1843) 10 Cl & Fin 200:
“...the jurors ought to be told in all cases that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.”

If the defence succeeds the defendant will be found not guilty by reason of insanity - section 1 Criminal Procedure (Insanity) Act 1964.

“The special verdict required by section 2 of the Trial of Lunatics Act 1883 (hereinafter referred to as a “special verdict”) shall be that the accused is not guilty by reason of insanity; and accordingly in subsection (1) of that section for the words from “a special verdict” to the end there shall be substituted the words “a special verdict that the accused is not guilty by reason of insanity”.

The Trial of Lunatics Act 1883, section 2 states:

“Where in any indictment or information any act or omission is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane, so as not to be responsible, according to law, for his actions at the time when the act was done or omission made, then, if it appears to the jury before whom such person is tried that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict that the accused is not guilty by reason of insanity.”

In reaching a decision of a ‘special verdict’ the jury must have heard the oral evidence or had the benefit of the written evidence, on the mental state of the suspect, of two or more registered medical practitioners, of which at least one is duly approved [Section 1 Criminal Procedure (Insanity and fitness to plead) Act 1991].
Should such a verdict have been reached, then the court will have a range of options which are set out in section 5 Criminal Procedure (Insanity) Act 1964, as amended.

1.1.4 Diminished Responsibility

If the suspect was charged with murder and he/she would have normally been found guilty (all the elements of the offence are either admitted by the suspect or are proved by the Crown); but is found to be suffering from a mental abnormality, he will then be found guilty of manslaughter and not murder on the basis of diminished responsibility. See Homicide Act 1957, section 2.

See:

- R V Clarke [1972] 1 All ER 219
- R V Byrne [1960] 3 All ER 1
- R v Martin (2001), The Times 1/11/2001 – here a Norfolk farmer was convicted, after the failure of a plea of self defence, of murdering an intruder. This verdict was subsequently altered to one of diminished responsibility when evidence that the defendant had a paranoid personality disorder emerged. The Court of Appeal reduced the original sentence imposed (mandatory life imprisonment) to one of five years imprisonment.

It is worth noting that Section 77 PACE makes specific reference to ‘confessions by mentally handicapped persons’ and the caution and procedure to be followed when admitting such as evidence.

“(1) Without prejudice to the general duty of the court at a trial on indictment with a jury to direct the jury on any matter on which it appears to the court appropriate to do so, where at such a trial—
(a) the case against the accused depends wholly or substantially on a confession by him; and
(b) the court is satisfied—
(i) that he is mentally handicapped; and
(ii) that the confession was not made in the presence of an independent person, the court shall warn the jury that there is special need for caution before convicting the accused in reliance on the confession, and shall explain that the need arises because of the circumstances mentioned in paragraphs (a) and (b) above.”

1.3 At sentence


Where the court is given a discretion in sentencing, then the presence of a mental abnormality will have a bearing on the court’s decision. Prior to imposing a custodial sentence (unless it is fixed by law) on a person who appears to be suffering from a mental disorder, the court is obliged to obtain a medical report – section 157 Criminal Justice Act 2003. The court also has the option of making use of Section 38 of the Mental Health Act 1983 to make an interim hospital order to evaluate the defendant’s response to hospital treatment, prior to a hospital order being made. If a Crown Court makes a hospital order on a convicted person, it has the power to make a ‘restriction order’ in terms of Section 41 Mental Health Act 1983. The effect of this order will be to restrict the discharge, transfer or leave of absence from hospital for a specified or an unlimited period without the consent of the Home Secretary.

See also section 166 of the Criminal Justice Act 2003, which contains ‘savings for powers to mitigate sentences and deal appropriately with mentally disordered offenders’.

The Criminal Justice Act 2003, section 207 makes provision for a ‘mental health treatment requirement’ in relation to a community order or a suspended sentence order.

The Sexual Offences Act 2003 makes provision in section 135 for the interpretation of the provisions of Part 2 in respect of mentally disordered offenders.
2. HO Circulars

2.1 Home Office Circular 66/90 Provision for Mentally Disordered offenders

The main purpose of the Circular was to draw attention to the legal powers in existence for all agencies dealing with mentally disordered persons who have committed, or are suspected of committing, a crime. The section below will only address the issues which are relevant to the police.

The Circular also outlined ‘the desirability of ensuring effective co-operation between agencies to ensure that the best use is made of resources and that mentally disordered persons are not prosecuted where this is not required by the public interest’.

The key issue in this circular is whether the prosecution of a mentally disordered person, who has committed a crime, is in the public interest, or whether an alternative can be applied.

‘It is government policy that, wherever possible, mentally disordered persons should receive care and treatment from the health and social services. Where there is sufficient evidence, in accordance with the principles of the Code for Crown Prosecutors, to show that a mentally disordered person has committed an offence, careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution, such as cautioning by the police, and/or admission to hospital, if the person’s mental condition requires hospital treatment, or support in the community, should be considered first before deciding that prosecution is necessary.’ (Paragraph2, Page 2)

‘where it is suspected that a mentally disordered person may have committed an offence, consideration should be given – in consultation with the Crown Prosecution Service, where appropriate – to whether
any formal action by the police is necessary, particularly where it appears that prosecution is not required in the public interest in view of the nature of the offence.' (paragraph 4.iii, page 3).

The Circular makes no reference to any specific issues which should be considered when decided on prosecution. The Circular simply refers to the Code for Crown Prosecutors regarding the sufficiency of evidence and whether or not a prosecution is in the public interest (paragraph 6, page 5).

A further key issue is the need for the police to work closely with other agencies. Other agencies include CPS (all relevant documentation should be made available to the CPS), local health, probation, and social services. The police will work with these agencies regarding mentally disordered people; it is important that they have good working relationships at a local level.

2.2 Home Office Circular 12/95 Mentally Disordered Offenders: Inter-Agency Working
Circular 12/95 supplements Circular 66/90. The circular focuses on various issues. Firstly, once again inter-agency working is promoted in a number of areas which include information-sharing between different agencies (paragraph 10).

Secondly, it details when mentally disordered persons should be charged and prosecuted (paragraphs 12-16):

‘Provided sufficient evidence exists, the decision whether to charge must be guided by what is in the public interest. The existence of mental disorder should never be the only factor considered and the police must not feel inhibited from charging where other factors indicate prosecution is necessary in the public interest. It is essential to take account of the circumstances and gravity of the offence and what it known of the person’s previous contacts with the criminal justice system and psychiatric and social care services’. (paragraph 12)
The decision to charge will be based on the CPS Code for Crown Prosecutors and will depend on the existence of sufficient evidence to secure a realistic prospect of conviction and whether the prosecution is in the public interest.

‘In cases of any seriousness, prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour. The existence of mental disorder at the time of the offence or the possible detrimental effect of prosecution on a person’s mental health are factors tending against prosecution. But it is important for the decision of the CPS to be taken in context. The needs of the defendant must be balanced against the needs of society; if the offences is serious, it remains likely that a prosecution will be needed in the public interest.’ (paragraph 14).

A summary is provided concerning the responsibilities of the different agencies of the criminal justice system. The one relevant to the police reads as follows:

‘19.1. Chief Officers of Police are asked:
(a) to develop arrangements for the examination by psychiatrists or other mental health professionals of detained persons, including cases under section 136 of the Mental Health Act 1983;
(b) to consider setting up mental health assessment schemes at selected police stations;
(c) to appoint a co-ordinator to develop force policy and practice, in relation to mentally disordered suspects and offenders, including provision of information and training for officers; and to develop effective contacts with other local services and agencies;
(d) to contribute to any strategic discussion of local arrangements for mentally disordered offenders and to co-operate with any local interagency schemes such as those based at court;
(e) to ensure that force policy on deciding when to charge reflects the need to safeguard the public as well as to meet the health and social care needs of individuals;

(f) to review record keeping arrangements and provision of information for the Crown Prosecution Service where prosecution is needed in the public interest; and

(g) to bring to the attention of police surgeons information about force policy and practice, in particular, arrangements for psychiatric assessment of detained persons and any mental health assessment schemes at police stations’.

3. Other Codes and Guidance

3.1 The Code for Crown Prosecutors 2004
General considerations regarding prosecution are dealt with in this Code. With regards to the mentally disordered, the Code states at Section 5 ‘that a prosecution is less likely to be needed if:

- the defendant is elderly or is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is real possibility that it may be repeated.

The Crown Prosecution Service, where necessary, applies Home Office guidelines about how to deal with mentally disordered offenders. Crown Prosecutors must balance the desirability of diverting a defendant who is suffering from significant mental or physical ill health with the need to safeguard the general public’

Accessed on 23 January 2007)

3.2 Crown Prosecution Service Mentally Disordered Offenders
This document brings together information from various sources which is relevant to the CPS. Much of the information has been discussed above. The full document can be found at: http://www.cps.gov.uk/legal/section3/chapter_a.html

4. Other relevant provisions

When the police are called to a scene involving a person with mental health needs, they can resort to various options. Some of these options have been outlined above – the section below outlines other options which the police have used against people with mental health needs.

The police may decide to take no further action against the person with mental health needs. This may be done for a number of reasons, including the fact that the person can be diverted to other services, such as health and social services, for assistance.

Cautions can be used in certain cases where the person meets the requirement for a caution to be issued. A caution can only be issued to an adult who has admitted guilt for an offence. Cautions are only given for minor or less serious offences, in cases where the person could have been charged or prosecuted for that offence. An alternative to this are Conditional Cautions where the imposition of conditions are considered to be an effective and appropriate way of addressing the offenders’ behaviour.

4.1 Measures to address anti-social behaviour

There is evidence to suggest that measures intended to reduce anti-social behaviour are being used for people with mental health needs (http://www.asboconcern.org.uk/; RDA, 2006, Mason 2005). These measures include Penalty Notices for Disorder and Anti-social Behaviour Orders (ASBOS).
Penalty Notices for Disorder (PND) can be issued by police officers) to anyone over 16 years old. It is a one-off penalty of either £50, £60 or £80 depending on the severity of the behaviour. Recipients have 21 days to pay the penalty or request a court hearing, and if it is not paid it will be reissued at one and a half times the amount. Failure to pay will result in a court fine or imprisonment. The Home Office website (http: www.homeoffice.gov.uk/anti-social-behaviour/penalties/penalty-notices) provides examples of where a PND may be issued. They include the following which could be applied to people with mental health needs: behaviour likely to cause harassment, alarm or distress to others, drunk and disorderly behaviour in a public place: destroying or damaging property up to the value of £500; using threatening words or behaviour.

Anti-social behaviour orders (ASBOs) were introduced by the Crime and Disorder Act 1998. The powers to impose ASBOs were strengthened and extended by the Police Reform Act 2002, which introduced orders made on conviction in criminal proceedings, orders in county court proceedings and interim orders. These orders are of civil law nature and have the effect of prohibiting a person from:

- engaging in specified acts of antisocial behaviour;
- entering specific areas; and
- associating with specific persons.

Breach of an ASBO is a criminal offences, which is arrestable and recordable. Penalties for breaching an order include imprisonment or payment of a fine.

Two studies, one carried out by the National Association of Probation Officers (Mason 2005) and another carried out by the Revolving Doors Agency (2006), opposed the use of ASBOs and Penalty Notices for Disorder to target those who are mentally ill:

'It seems likely that the behaviour of these people was not fuelled by anti-social intent, but mental illness that needed medical intervention. It
seems cruel to subject the mentally ill to an order that their mental state prevents them from obeying’ (Mason 2005).

The Revolving Doors Agency study feared that ASBOS and PNDs allowed for a quick and ‘easy’ enforcement option for the police. The process did not allow for the recognition of mental health needs (Revolving Doors Agency 2006:7). Furthermore,

‘Policies promoted within the Home Office guidance on the use of ASBOs, which encourage the subjects and conditions of orders to be widely publicised in local areas, may also exacerbate mental health problems for those subject to the orders, and in turn make breach more likely still.’ (Revolving Doors Agency 2006).

5. Future Legislation
5.1 Mental Capacity Act 2005

The Act will come into effect from April 2007 onwards. The Mental Capacity Act 2005 applies to everyone over the age of 16 years where a doubt exists over the mental capacity of the person. The Act has wide ranging provisions, as set out in paragraph 4 of the explanatory notes:

“The Act aims to clarify a number of legal uncertainties and to reform and update the current law where decisions need to be made on behalf of others. The Act will govern decision-making on behalf of adults, both where they lose mental capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth. It covers a wide range of decisions, on personal welfare as well as financial matters and substitute decision-making by attorneys or court-appointed "deputies", and clarifies the position where no such formal process has been adopted. The Act includes new rules to govern research involving people who lack capacity and provides for new independent mental capacity advocates to represent and provide support to such people in relation to certain decisions. The Act provides recourse, where necessary, and at the appropriate level, to a
court with power to deal with all personal welfare (including health care) and financial decisions on behalf of adults lacking capacity.”

5.2 Mental Health Bill 2006-2007

At the time of writing (January 2006) a Mental Health Bill is before the House of Lords. The Bill proposes a single, broader definition of mental disorder. Mental disorder is defined simply as ‘any disorder or disability of the mind’.

The MHA 1983 has a series of exclusions, a person cannot be treated under this act ‘by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.’ (Section 1(3)). The current Bill removes these exclusions, the only proposed exclusion relates to dependence on alcohol and/or drugs. If approved, this will mean that people can potentially be treated under mental health legislation on the grounds of promiscuity, immoral conduct or sexual deviancy.

Various organisations are opposed to the changes in definition and exclusions. The Mental Health Alliance has produced a briefing paper on the proposed Bill stating the problems with this definition. It draws on conclusions from the Richardson Committee from 1999 and the Joint Parliamentary Scrutiny Committee from 2005 to support its opposition (Mental Health Alliance 2007). The Mental Health Alliance is opposed on the grounds that the definition is too broad and the lack of specified exclusions may lead to the act being used in inappropriate ways.

In addition, the following proposals may have an indirect effect on the police’s dealings with MDOs. These include:

- Changes in Professional roles. The Bill introduces a broader range of clinicians and social care professionals who can carry out statutory functions. The existing ‘Responsible Medical Officer’ is replaced by a ‘Responsible Clinician’ and the ‘Approved Social Worker’ with an ‘Approved Mental Health Professional’. The Mental Health Alliance is concerned that appropriate training, regulation and professional support be provided for these new roles. It also believes that the role of
Approved Mental Health Professional should remain independent in order to safeguard the person’s human rights (Mental Health Alliance 2007). For the police, it would mean a change in the professionals they deal with.

- Introduction of supervised community treatment orders. The Bill proposes that these orders be imposed on people who are discharged from hospital, but who must continue to receive treatment in the community. The Bill proposes that, if a person fails to comply with their treatment, they can be forcibly returned to hospital and treated against their will (Mental Health Alliance 2007). A Cochrane systematic review (Mental Health Alliance 2007), which examined compulsory outpatient treatment for people with severe mental disorders, concluded there was little evidence that the introduction of compulsory treatment orders in other countries had an effect on the mental state of the individual, homelessness, or the likelihood of being arrested by the police. The research also found that 238 people would have to be made subject to compulsory community treatment in order to prevent one arrest.

Points to consider:

1. Keep up to date regarding developments in legal fields and any circulars which may appear regarding MDOs.
2. Case law relevant to MDOs has not been discussed in detail at this stage. This would be reviewed when writing doctrine.
3. Mental Capacity Act. Look into more detail to determine which aspects are relevant to the doctrine.
4. Human rights. May need more on this area, when focus of doctrine become clearer.
5. Public inquiries into homicides by people with mental illness. These would be useful in order to gain an understanding of wider issues raised.
Appendix Two. Flowchart of Mentally Disordered Offenders in Criminal Justice System (Stone 2003 page 3)

Consideration
1. It might be useful to amend this flowchart so that it concentrates on the police section only.
References


Coulthard, M., M. Farrwell, et al. (2002). Tobacco, alcohol and drug use and mental health, HMSO.


National Confidential Inquiry Team (2001). Safety First. Five-Year Reporst of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London.


Rethink (n/d). Black and minority ethnic communities and severe mental illness.


