



CREaTE

Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

<http://create.canterbury.ac.uk>

Please cite this publication as follows:

Williams, E., Norman, J. and Sondhi, A. (2017) Understanding risks: practitioner's perceptions of the lottery of mental health care available for detainees in custody. *Policing: A Journal of Policy and Practice*. ISSN 1752-4512.

Link to official URL (if available):

<https://doi.org/10.1093/police/pax067>

This version is made available in accordance with publishers' policies. All material made available by CReaTE is protected by intellectual property law, including copyright law. Any use made of the contents should comply with the relevant law.

Contact: create.library@canterbury.ac.uk



Understanding risks: Practitioner's perceptions of the lottery of mental health care available for detainees in custody

Abstract

The range of and growing number of health care requirements being presented within custody environments has been widely debated (Rekrut-Lapa and Lapa, 2014). Despite a number of reforms following the recommendations of the Bradley Review (2009) and the amendments made to the ACPO guidance on safe detention in 2012, research continues to highlight a lack of consistency to services available to effectively identify the needs of individuals in these arenas. This paper is based on part of a wider research project conducted in the Metropolitan Police Service and portrays the voice of the police practitioners working in custody suites. The research found that various notions of risk are central within this setting and that current practices are not sufficient for ensuring the safety of both detainees and officer safety. The research concludes by offering a proposal for capturing good practice and learning in order to create a more reflective and learning environment in custody suites.

Introduction

The multiplicity of health care needs amongst detainees who enter custody suites in England and Wales has been widely noted. These complex factors can result in a number of challenging issues for the practitioners operating within these environments (Rekrut-Lapa and Lapa, 2014). Conditions can range from detainees suffering from psychiatric conditions, drug and alcohol misuse, Autistic Spectrum Disorder and physical injuries that may require urgent medical intervention. Studies have consistently shown that the prevalence of mental health issues among detainees are over-represented in police custody compared to the general population (Chariot *et al.*, 2014; Rekrut-Lapa and Lapa, 2014) and is intrinsically linked to comorbid substance misuse conditions (Gerardin *et al.*, 2017; Clement *et al.*, 2013). Such factors may require both initial management and therefore, the correct identification of needs and subsequently, the appropriate response and support. MacKinnon and Grubin (2013) highlight systematic underreporting of mental health conditions and state that when a screening is completed incorrectly it can create extra work for the professionals and individuals with real and sometimes urgent needs are subsequently placed at considerable risk. Mackinnon *et al.* (2016) argue that such issues have become particularly pertinent recently. This relates to both the professional standards in custody and concerns about what has been defined as 'avoidable' deaths in custody.

Having access to trained health professionals in this field is vital to improving this position, particularly as people with mental health issues are becoming an increasingly prominent part of police work. It is therefore important that custody staff are supported in the complex decision making process in this area (Wooff and Elvins, 2017). The Police Federation of England and Wales reported in 2013 that custody Sergeants can experience difficulties when attempting to engage with partner agencies. Furthermore, Adebowale (2013) concluded that the police need to accept that mental health is core police business and subsequently commit to the change in processes required to deal with it more effectively. He recommended that the police need to implement a more systematic approach to partnership working, further training for all officers, stronger leadership through partnerships and a long term change strategy around mental health.

Healthcare within a police custody setting has traditionally been under the purview of a Forensic Medical Examiner (FME) or Police Surgeon who would traditionally focus on forensic sampling as well as treating a detainee's health needs (Payne-James et al, 2009). Over time a mixed model has developed to allow for a move towards allowing a Healthcare Professional (HCP) to provide routine care in police custody with arguably a greater focus on providing a health-check to police to minimise risk of death or injury. This model incorporates use of FMEs and nurses or paramedics either onsite or on call. At the time of this study, the majority of sites employed an on-call model utilising either FMEs or nurses/paramedics.

Given the critical and multifaceted role that custody sergeants have in relation to all aspects of a detainees' welfare needs, at all stages of their custody experience, the lack of research exploring the perceptions of police officers working in this volatile arena and their consideration of the risks within this environment seems surprising. This paper aims to present the voices of police practitioners involved in custody suites and to provide an overview of their perceptions about the current methods used in London to deal with mental health care needs.

Methodology

This research formed part of a wider Health Needs Assessment commissioned by NHS (England) in partnership with the Metropolitan Police Service (MPS). This section of the research focused on the collection of primary data obtained from qualitative semi-structured interviews and observations in five research sites out of London's thirty-two boroughs. These study sites were chosen to be representative of London by geography including inner and outer London and operational models (in-house compared to on-call approaches). Observations were undertaken in two of the custody suites within the study site sample. A total number of 82 semi-

structured interviews were undertaken with key practitioners who work within the custody environment to support detainees. Whilst these included a number of different practitioners¹, this paper is based on the interviews with police personnel including PACE inspectors, custody sergeants and dedicated detention officers (n=37).

Field notes were collated as a result of the observations undertaken in custody suites. Interviews with participants were recorded and transcribed. MAXQDA software² was used to organise and manage the data and the analytical team conducted a thematic analysis using a grounded approach (Glaser and Strauss, 1967; Glaser, 1978). The following themes were identified: Mental health care operating models were perceived as inconsistent; There is no effective infrastructure to reliably identify mental health needs in custody; Partnership working in this environment is complex; Effective risk assessment is compromised (relating to the current booking in process and the assessment tool itself); Currently there is a lack of bespoke and ‘evidence based’ training for custody staff. Plus the perception is that austerity measures have impacted on the number of individuals entering the custody environment which enhances the risks resulting from the previous themes.

Some limitations should be noted. The study reflected operational practice at the time of the fieldwork in 2015 and changes in service delivery will have occurred since then. Although there was an attempt to ensure that the study sites were representative of London, the findings may not be generalisable to areas out of London.

Findings

Haide *et al.* (2016) recently reported on a Europe wide survey about health care needs in custody. The survey found large variations with the systems in place to deal with health needs and this was mirrored in this study in just one police service in the UK. This section outlines the key findings from the research. Whilst they are presented as separate themes they are not mutually exclusive of each other and wider issues such as austerity, reduced resources and a

¹ This included custody Sergeants, PACE inspectors, Dedicated Detention Officers, Forensic Medical Examiners, Community Psychiatric Nurses, Custody Nurses, Mental Health Works (adult and young people) and Drug Intervention Workers

² MAXQDA is qualitative data analysis software version 2007

core holistic definition of what is meant by ‘health care’ between and within the different agencies is vital to keep in mind whilst reading this section of the report.

1: Mental health care operating models were perceived as inconsistent

Whilst this research was conducted in one force area it is worth noting that the models of healthcare delivery varied between the boroughs visited. The MPS employed HCP’s available twenty-four hours a day, either on-call or onsite as part of the Forensic Healthcare Model pilot in 2014. The aim being to undertake the assessments on site and standardise the process. This system was viewed positively by officers working in this environment for a number of reasons detailed below. However, the MPS have been struggling to both recruit the numbers required and to retain staff. Therefore, where this system is in place the standard of service remains inconsistent.

1.1: *Evidence of ‘good’ liaison but not consistent across London*

The mental health care provision was delivered differently depending on the individual process operating within the suite. This mirrors the research of Noga *et al.*, (2016), who found that identification processes for detainees’ health was often developed in an ad-hoc and localised format leading to a non-standardised approach. Within the new pilot sites visited, custody nurses were generally employed by a Trust commissioned by the National Health Service (NHS) and undertook their duties directly in the police custody suite. However, in larger boroughs this resource is spread across multiple suites. Generally, in these locations there is also a community psychiatric nurse (CPN) present and there are structures to facilitate access to other services such as community support workers and court diversion schemes.

The process variation resulted in a non-standardised approach to identifying and dealing with health needs in custody. This quote sums up the police perceptions of having access to that expertise:

‘... We recently had the Mental Health Team attached to the Custody Suite ... and he’s brilliant. ... He works 9 to 5 and in that period anyone that comes in with any mental health, we can just refer him straight away and they can speak to him and that’s brilliant because obviously he knows, he’s the expert on the mental health side of things ... whether in his opinion someone needs a mental health assessment and if not he’s got all the agencies that he

can refer them to and he can speak to other experts in certain areas. So having him here, he's an absolute Godsend...' (Custody Sergeant - B3).

Not having access to health care professionals can result in the reliance of local knowledge rather than a formalised process. This exacerbated by fragmented communication, access to relevant databases, internet and network access and the local knowledge held by mental health workers. The next section will attempt to explore the issues arising from the differing models of practice observed.

1.2: Deployment of mental healthcare resources were inconsistent and fragmented

The majority of sites were still operating the FME model. Indeed, analysis from the Police Custody Inspection Reports in all of the research sites identified some serious delays with FMEs responding to calls made to custody suites. This was related to FMEs covering large geographical areas often without an on-call rota system. The following quote illustrates the concerns custody staff have in relation to access they have to doctors:

'...There's only one [doctor] at a time. ... He may well be covering two areas, which will mean he could be working at six stations. ... It will be here but it could go over as far as four other boroughs. The travelling time between [two custody sites] it's probably an hour – and that's an hour out of his time. So, if he's cross-covering sections, then he's got a problem. ... you won't see him because he's too busy in the other section, so he can't get to your section, so you're there for six hours without a doctor. And that happens on a more regular basis than I think anybody cares to realise, to be honest...' (Custody Sergeant, C1)

The delays in FME response times leads to detainees needs not being assessed by a medical expert promptly and as a result medication was not always prescribed and administered on time.

'...we have an on-call FME so if there is anyone that needs medical stuff, if it's not urgent. ... Yes and you can ring up the FME and get advice or they'll come in. ... Sometimes it can take a long time because they might be in xxxx and xxxx have phoned them before we have and ... sometimes you'll be waiting hours for an FME and it's frustrating and obviously we've got people that need to be seen, whereas with the nurse here, away you go. He or she is there. Even sometimes just give them a shout and they'll watch you booking in and they can almost

start their assessment while you're doing the booking in procedure. FME can be 3 hours, 4 hours. Obviously that is a stress for us because that person is our responsibility to make sure that they're safe and well while they're here and we're constantly in the back of our mind thinking we've got 4 hours until an expert can say what is wrong...' (Custody Sergeant, B3).

This issue has a number of wider implications on the care of the detainees and indeed the potential risk to them and police practitioners whilst they are being held in custody. Whilst officers may have experience in identifying healthcare issues when they know the detainee or have familiarity with those particular issues, officers discussed the complexities with identifying needs correctly. Custody Sergeants are not clinically qualified to identify health care needs amongst detainees (MacKinnon and Grubin, 2012) and there can be an over reliance on experiential knowledge to complete this screening. Rubinstein (Cited in Braga, 2016: 312) argued that officers' perceptions of their common working field can improve as police mature and gain experience. However, the application of this local knowledge and expertise is rarely systematically analysed or considered next to other community or academic sources (Braga, 2016). In such a volatile environment which features a plethora of needs, having professionals to check this knowledge against is vital.

When long delays are experienced by the police to assist them with this recognition of need the impact on detainees who are experiencing specific withdrawal issues can be risky and dangerous. This can impact on officers resorting to calling an ambulance to deal with the issues. For example:

'... depending on how many areas they [the FME] can cover because sometimes they cover up two to four areas, but normally if it's something that is important they will do their best to get here. It can be between half an hour to four hours, it varies. ...Depending on the seriousness of it and how long the doctor advises us they may be then we would call an ambulance if we needed to...' (Custody Sergeant, Cam 1)

Where there is no dedicated custody nurse, on call staff are notified of a request for their assistance via a phone call from the custody sergeant. Police custody staff perceived both custody nurses and CPNs to be an extremely valuable and essential 'custody resource'. They described how having standardised access to a dedicated nurse in each custody area would be beneficial for providing more accurate risk assessments and relevant care provision for

detainees. Additionally, this would mean that critical advice and support could be delivered in cases where the detainee is not necessarily in need of 'urgent' medical support but still requires a more thorough and ongoing review to assess other social and health needs.

The implications of the time delays experienced when requesting both custody nurses and CPNs led to different 'healthcare pathways' being chosen in order for the police themselves to consider the most appropriate healthcare. This again highlights the level of inconsistency for detainees and officers voiced their positivity about having this resource available.

'...The introduction of nurses was one of the best things ever. And the Mental Health nurses. We've got two mental health nurses now and that's brilliant because they can take such pressure off your shoulders. Previously to get a mental health team out we had to call a doctor, there might not be a doctor available and you would have to wait another eight hours...'
(Custody Sergeant, E3)

As a result of the fragmented mental healthcare provision in custody, the ability to undertake immediate and sufficient risk assessments to identify mental health issues presents a range of challenges for police custody staff. The next section focuses on the perceived lack of infrastructure to support the effective identification of healthcare needs (particularly mental health) in custody and the ramifications of this absence.

2: There is no effective infrastructure to reliably identify mental health needs in custody

Despite having dedicated custody nurses in some boroughs they are not able to make recommendations concerning a detainee who may need to be formally sectioned. Custody staff rely on a team of two social workers and a doctor to attend the suite and make this decision. This has significant consequences for the detainees and practitioners as time delays result.

2.1: Delays, risks and what to do?

The issue of delays to accessing specialists has already been discussed in relation to the variation of operating models. However, delays to locating resources do not simply relate to the custody nurses or FMEs, custody staff often experienced delays and long waiting times for mental health teams to arrive and deal with particularly complex detainees. This was frustrating

both for custody staff (due to their experiences of dealing with the detainee whilst waiting) and for the detainee themselves. For example:

'... if they're like a violent prisoner or they're a bit volatile it's a bit frustrating in your head because you want to do the best thing for them and if they're saying they're going to take four hours to turn up and do this assessment and do whatever they need to do it can get a bit worrying because they could be kicking off in the cell or all sorts could be going on. Sometimes it's not worth waiting that long, you need quick action, like you need it quick and you need them to come quicker than they do...' (Designated Detention Officer, H1).

As evidenced in the quote above, custody staff felt that such delays could lead to further violence from the detainee. Given the recent criticism concerning individuals with severe mental health needs being held in custody rather than in an appropriate place of safety (de Viggiani, 2014) this is concerning for officers, particularly if they have to resort to restraining detainees. In the context of individuals with mental health needs this raises both moral and ethical issues for the police. Indeed, as Kleinig (1996: 53) argues those that work in public roles are “vulnerable to impossible choices – in which, no matter what they do, some egregious wrong will be done”. Klockars (1980) refers to this as using dirty hands and this quote highlights the dilemma that officers face:

'...If they're kicking off there's nothing more you can do than take them straight down to a cell and that means getting leg restraints out and handcuffs so be it. At the end of the day it's for their own safety. If they're trying to get booked in and they're hitting their head on the counter or something like that, for their own safety that is the best way to tackle it. We're not going to stand there and let them do that and make it worse...' (Designated Detention Officer, H1)

The provision of healthcare in a custody environment can result in conflicts in priorities amongst the different partners involved. Indeed, as de Viggiani (2013) argues different professional values can create conflict when deciding whether the priority is a detainees' health care needs or the need to detain or question them. Furthermore, the consequences of not holding them in custody is also risky for officers in terms of the actions they may take on being released without a sufficient diagnosis.

'...You can't hold someone indefinitely in Custody while you wait for a mental health assessment because... we have PACE to abide by and it's not the right environment to keep someone in if they need help.... If you've got someone who needs a mental health assessment and your clock's running, it's like what can I do? I don't want to release him because if his clock runs out obviously we've got to release him but ... if I release him and we feel he needs a mental health assessment, what happens if he goes out of here and runs in front of a lorry or something on the busy road...' (Custody Sergeant, B3)

Interviewees also described their concerns with the process for detainees leaving custody and the risk assessment this involves. This quote highlights the clear concerns officers have when involved in this process:

'We have a risk assessment form which we fill in when they leave the station. If someone's depressed or suicidal then we're supposed to write on this risk assessment form pre their release what we've done to try and avoid him leaving the station and maybe harming himself, throw himself off a bridge or under a train.... I think personally, it's a corporate get out clause, blame it on the sergeant if anything goes wrong when he leaves. What can I really do to stop this man going to kill himself? They've told us you have to go the extra mile, you have to do, the pressure's on to book in another five prisoners that are in the back yard freezing to death and they're telling me I've got to do everything I can to stop this man going out of here and self-harming. What can I do? I'm armed with a bit of paper, a piece of paper' (Custody Sergeant, Ac 1)

There were also clear variations in officer experience of being able to identify mental health problems initially. Those who had been working in custody for a longer period of time were more likely to know regular detainees and this advanced their local knowledge but this method is arguably not reliable enough. Young et al (2013) discuss a number of the limitations in the reforms resulting from the 2009 Bradley report focused on improving the identification of vulnerable factors amongst detainees in custody. This quote indicates that these issues remain pertinent.

'I think a lot of the time it is simply gut feeling' (Custody Sergeant, Cam 2)

4: Inadequate bespoke mental health training for police custody staff

The complexity of the health care issues that the detainees can present on arrival means that a one size fits all approach is not appropriate. Understanding the nuances around the different issues was mentioned by officers at all sites. For example:

'...Mental health; it's such a big thing now. Over a year, we're talking thousands of mental health assessments in police stations at the Metropolitan Police Service. But nobody who works in the custody suite has had any training in how to deal with mental health issues – which strikes me as just a little strange and slightly lax really...' (Custody sergeant, Cam1)

Custody staff, namely Dedicated Detection Officers (DDOs) and Sergeants had mixed perceptions in relation to the training they had received. DDOs felt their role was simpler than that of officers and predominantly involved complying with a straight forward and thorough process of supporting detainees and other custody staff. Therefore, the adequacy of the training was considered less of an issue for these officers.

However, custody sergeants felt that training and the amount of time ring-fenced for formal training sessions was inadequate particularly given the complexity of needs. Therefore, they perceived their own personal experience gained whilst in custody to be the best training available.

'...When we do our Custody course, which is two weeks, I found that a really good course out of a lot of courses I've been on. I learned quite a lot but this job is one of those jobs where it is just experience. I think there is only so much you can be taught. I've done nowhere near as much Custody as (my colleague) so I've been learning a lot from them while I've been in here over the last five months. ... That's the best sort of training. I think we get adequate training to start with and the things that are in place at the moment are enough, it's just that extra bit that you learn by doing it. There's no better training than doing it...' (Custody Sergeant, B3),

Therefore, it is clear that the as a result of a lack of training, officers followed their own experiential knowledge when dealing with assessing and supporting risk. The issue of staff knowledge and the 'experience' individual officers have in this field is also inconsistent and further exacerbates the lottery approach to the identification of health care needs initially.

It was clear when talking to officers that there are some key differences in the definition of what is meant by healthcare. Officers appeared to be more concerned with the immediacy of the risk being presented to them whilst nurses and MH workers had additional concerns about longer term social issues which potentially impact on the 'health' care needs which are visibly

presented. Whilst officers felt reassured by an ability to ask the specialists about the risks and a diagnosis, assessments by the other agencies were described as being more in depth and involved questions which might facilitate some longer term plan about the individuals needs and potential referrals.

'If he (Mental health nurse) says to someone, I'm actually a mental health trained assessor ... then they might tell him more ... and he can pass on. ...If the person's not in need of an assessment but possibly needs further checking or help, then he can pass that on to the necessary agencies' (Custody Sergeant, B3)

The inspector interviewed here had previous experience of dealing with MH issues and recognised the need to ensure that relevant agencies were aware when someone was being released from custody whereas other officers interviewed saw their role and involvement as finishing when the detainee leaves the suite.

'In the bad old days we would just leave someone and that would be it really we didn't have much input, but working with the medical people we've got here we have to set up a risk assessment to make sure... just explain to them they'll see this person, and go to this person, make sure that they get home safely and they've at least been put in the right direction as far as they were suicidal or things like that. We flag it up to social services, even though a lot of the time maybe they're not sectioned from the police station we still do that to make sure obviously they're not just going into the big bad world and there's no support mechanism there for them' (Custody Inspector, Br1).

There was a sense of a 'sticking plaster' approach from some officers we interviewed but this was often related to their realistic sense that long term solutions are depleting in the current climate of austerity and budget cuts to all agencies. Whether risk assessments should cover the complexity of the needs both socially and health wise is for a wider debate. De Viggiani (2013) presents some strong arguments about developing a broader public health approach to assessments which capture an individual's social factors as well as health needs. He argues that the 'conventional epidemiological approaches used to measure prisoners' health are essentially individualistic and healthcare focused' (pp: 764) and yet the factors are linked for the consideration of longer term needs. Other agency workers are more likely to see the physical visible health needs as symptomatic of other longer term issues as found by Noga *et al.*, (2016).

Custody sergeants stated that the majority of their time was dedicated to detainees that posed risk to others or themselves in the shorter term. There is limited use of the assessment as a method to signpost individuals to appropriate services (Noga *et al.*, 2016). Alongside this, custody sergeants could feel vulnerable as a result of their limited training, not simply in relation to the identification of health needs but also the potential risks that these needs may present to them. Indeed, they welcomed the idea of more formal training, particularly in relation to mental health, identifying risk and dealing with the potential risks posed.

There are opportunities arising from these perceptions of staff that may essentially help with learning about these issues. Sharing this more informal knowledge in a more systematic way with other colleagues and staff from other agencies may facilitate a more learning and reflective environment. Given the drive from the College of Policing to support a more reflective and critical thinking work force where employees can reflect on their own and the organisations actions and behaviours (Norman and Williams, forthcoming), the positive of consequences of this should be considered where training formally is limited. Indeed, a mix of shared learning forums and more formal training would give officers the ability to reflect on their own practices following an experience with a detainee with specific health needs.

This should also be considered next to the thorough epidemiology available on the type of issues presented in custody (Rekrut-Lapa and Lapa (2014). Sharing information about local need and conducting time analysis and profiles from the data available may facilitate more evidence based learning for custody staff about the issues presented to them at a local level.

Initially, Custody Sergeants' feel under pressure to accurately assess risk with limited or no training and secondly they can feel vulnerable to sanctions and even job loss if they complete the risk assessment incorrectly. Consequently, Custody Sergeants tend to view the 'risk assessment' as a 'tick-box' exercise to ensure there is a catch-all approach to risk, even when there is doubt. Utilising a 'tick-box' or what was described as a 'blanket' approach to assessing risk may result in ignorance concerning the complexities of the health problems experienced by the detainee – this is vital in getting the correct support in place. For example, when asked about the screening process, one respondent reported that:

'...Well we go through the risk assessment questions, and if they tick the right boxes we will request a nurse or doctor to come and check them over. If they don't tick the box verbally, if we think when we look at him and think this guy's a bit strange then we will do it ourselves off our own back. We don't have to rely on the risk assessment' (Custody Sergeant, Ac 2).

Such issues have also been raised in research exploring risk assessments at domestic abuse (Myhill et al, 2016).

The training currently offered to staff is considered to be inadequate by police officers and agency staff. A DDO reported who had responsibilities for ‘booking in’ individuals into the custody suite said he received one course to inform him how to undertake a risk assessment, after he had been in post for a significant amount of time, ‘...usually about six months after joining we go on an inputter’s course and learn how to book people in and do a risk assessment and go through their rights and stuff...’ (Designated Detention Officer, Br). This respondent continued by referring to his professional judgement and experience and how he uses this when considering risks. For example: ‘I’ve done it for two years now and you do start to see what certain people are like and the way they are acting and their mannerisms and stuff and you look at them and you think, I think there is, so you do sort of go off your own back a bit...’ (Designated Detention Officer, Br). Therefore, officers perceived themselves to rely more on their past professional experience and knowledge to make assessments. Given in 2015 there were seventeen deaths in custody in England and Wales, hearing the risks of this articulated by interviewees in the research is significant.

Training is complicated as if training options are not interactive and perceived of as role relevant they are less motivating for officers to utilise at a practical level. Cummings and Jones (2010) research tested two training initiatives introduced for police officers dealing with mental health issues in custody. These were 1) class room based training and e-learning, and, 2) a collaborative approach with the police and National Health Service (NHS) to provide a training programme that allowed officers spending some time in a mental health unit that was connected to their Operational Command Unit. The latter was proved to be more successful at raising mental health awareness and changing attitudes towards mental health issues, as officers were involved in the learning experience. Some of the complexities presented by detainees in these research sites mean that a more reflective atmosphere for learning alongside more formal training would be more effective.

5: ‘Book-in’, assess risk and process

The research identified that risk is continually assessed as soon as the detainee comes into the custody suite, the ‘booking-in’ process initiates the first formal risk assessment. However, there were strong concerns from police custody officers regarding the honesty of detainees in this initial assessment when they were asked questions. The subsequent impact of this on the actual

accuracy of the risk assessment is critical if there was important information that detainees did not choose to disclose.

'...If they're not honest with you then that's it. So you might, for example, we have a marker if someone's suicidal and the question you ask is have you ever tried to harm yourself, do you have any mental health issues and they might say no and you say are you sure and they go yes. The next question is have you ever tried to harm yourself and they go no, but they might say on the markers, attempted suicide. So it'll only work if the person's honest and we do say to them don't be embarrassed by the questions, we ask everyone the same questions. I think they're a little bit outdated...' (Custody Sergeant, Br1)

This quote highlights a number of challenges. The perception that detainee honesty is the main information provider for an accurate risk assessment highlights the need and importance of proper training around how to effectively identify risk and look for these nuances. There are also wider issues here about how officers might build up trust with detainees to encourage them to disclose the information required more openly.

This is further compounded by the custody suite environment itself. The data from the custody suite observations and interviews with the non-custody officers indicated that the environment in which detainees are booked-in to the custody suite is open and lacks privacy. Skinns *et al.*, (2015) discuss the issue of privacy, claiming that it is an important part of the relationship between staff and detainees as without it, detainee distress may be reinforced by discussion of private issues in a public environment. This may impact on the delivery of the risk assessment. Therefore, a lack of a 'safe environment' or 'private place' to book-in may hinder the information assessed in the first instance to understand and identify risk. Consequently, needs may go undetected. For the purpose of effective medication, referral etc. this is vital and the ramifications are serious.

'...Well you're breaching codes of practice and PACE really. You're breaching codes of practice, in which case they sue the job. You're liable to complaints. As long as you, I tend to put everything down, as much information as you can so it covers me anyway and my staff while we're here. But again it boils down to as long as we get looked after ourselves, as in proper breaks and stuff. If you don't get looked after you make mistakes on the Custody record...' (Custody Inspector, Br1)

5.2 Capacity to constantly monitor risk and address need

Continuous monitoring of detainees is essential. Detainees' frustrations and subsequent problems can be exacerbated by being arrested and also by being transferred to custody which may not be the correct environment for them. Police custody staff were perceived by healthcare providers to be very efficient at monitoring detainees following the 'custody care plan' being put in place and they felt confident that Custody Sergeants would inform them if they felt there was a problem. However, police staff raised concerns about the numbers of DDOs and the cuts to budgets in relation to their deployment in custody areas.

'...In a perfect world, we would have five DDOs and two custody sergeants, but we are understaffed at present. We've got to the point where we're at four DDOs, some teams operate with three and it's normally between two and three sergeants. There was a day where we had three constant watches on, just through self-harm or medical conditions and we had two of those constant watches where they were violent, so they required two DDOs to do each constant watch...' (Custody Sergeant – E1)

One of the main enablers of providing an efficient monitoring system for detainees in cells is via CCTV. This was viewed as invaluable by all respondents. However, one of the DDOs highlighted times when the cameras were not working and CCTV not being available in every cell. The use of CCTV has been key when identifying 'high risk' and managing crisis situations, as it enables an immediate response. Having access to this is vital and the complexity of this is highlighted in the quote below:

'...It's just having the staff to be able to deliver what's expected because it puts a huge amount of strain particularly when you've got people there who have got mental health problems are kicking, fighting or whatever, and they really need to resource places like this. For a long time historically in the police custody was just deemed to be put them in a box, feed them, interview them, then kick them out. It's trying to get that sort of excuse the pun, that mental state as far as officers are concerned to think... custody is incredibly risk centred, because you've got people here who are not very well for want of a better expression, haven't got much time left because of physical injuries or etc., we have to be able to pick up and know this could be life-threatening or whatever...' (Custody Inspector, Br1).

5.3 Meeting the needs of detainees are compromised due to a cut in resources

All interviewed respondents' expressed concern in relation to budget cuts and the implications of this in terms of the vulnerabilities being presented in custody being addressed sufficiently with a decreased ability to respond.

Research completed in Police Scotland (Wooff and Elvins, 2017) found that the use of staff backfill to deal with staffing issues exacerbated the risk issues particularly relating to the experience of officers working in such complex environments. These officers rely on the expertise of others and the authors note that the backfill process ‘was identified as a riskier way of managing the custody environment than resourcing custody from those officers that regularly work in that environment.... This is a key example of the way that a less efficient process may also be riskier to detainees and staff’ (pp:3).

There is currently a high turnover of DDOs and the numbers are also being cut. There was a sense amongst respondents that Police custody officers are not able to move around the organisation and they felt tied to a role. The impact of this was that they reported low levels of morale and felt despondent about their role and the support they were provided in it. Reduced resources was felt in all areas regardless of the different operating models or agency staff being interviewed. The need for the provision of a 24/7 model to support the growing number of detainees with mental health issues was clear and whilst increased numbers of healthcare staff would facilitate covering longer hours, it would also provide a larger bank of healthcare staff to be used and called on. As healthcare staff are also stretched, their caseload is spread over a number of sites. De Viggiani (2013) refers to this issue in his evaluation of health care facilities in custody particularly in relation to staff morale and the effective capability to perform their professional function.

Working to a regional model but having very local needs to address is complex. The reality is that custody staff find it difficult to get hold of healthcare staff. Consequently, the correct assessment of, support for and the actual needs of the detainees is compromised.

‘Now when I joined 29 years ago the FMEs... by and large it was a Rolls Royce service, you got people who were very experienced they came reasonably quickly, they had a rota everything was a lot slicker than it seems to be now. Since they’ve brought in nurses and a new system, rotas and stuff it is more noticeably now that you’ll gaps and you’ll get FMEs... I don’t know whether its teething problems, I don’t know whether it’s a problem with the rotas but it is not as slick as it used to be’ (Custody Inspector, Br1)

Concluding remarks

This research raises some alarming issues about the current approaches to identifying mental health care needs in custody. Whilst this work mirrors the observations made by other academics in this field, the research is distinct in that it depicts the voice of the practitioners

working in this environment and their own sense of risk. This relates to both organisational and individual accountability and risk, detainee risk and their own personal safety risks. The limited training, reduced resources, reliance on experiential knowledge and the non-standardised approach to the provision of health care professionals in this arena is generating a climate of extreme volatility and potential harm.

Despite the challenges presented by the differences in occupational cultures and perceived purpose of custody (Skinns *et al.*, 2015) there is certainly an argument to support a more joined up long-term partnership approach for dealing with the needs of custody detainees and the factors that might influence some of their health issues (De Viggiani, 2013). Furthermore, this may impact on what one police *respondent* termed the '*revolving door of custody*'. The issues with the join up between and differing priorities of health care and police agencies has also been explored by Anderson and Burris (2016).

With clear shortfalls and inconsistencies in current healthcare provision and given the complexities of some of the issues experienced by the detainees coming into custody, regular feedback meetings as a more informal method of sharing experiences and reflecting on practice may facilitate better understanding of these nuances and how things could be done if similar factors present themselves again. Without a structure to start collating this informal craft or experiential knowledge (Braga, 2016) as staff leave knowledge is lost. Simplistic tick box risk assessments can be perceived by officers as a way of avoiding personal and organisational risk in light of the growing concern about custody and health needs. However, this may deskill officers and impede the important capture of experience in custody setting. Having a more evidence based approach which includes officer knowledge, local epidemiology and academic research is potentially a way forward.

References

ACPO (2012) *Guidance on the Safer Detention and Handling of Persons in Police Custody (2nd Edition)*

Adebowale, V. (2013) *The independent commission on mental health and policing report*. London: The Independent Commission on Mental Health and Policing

Anderson, .and Burris. (2016) Policing and Public Health: Not quite the right analogy
Policing and Society Volume 27:3 pp: 300-313

Bradley (2009) *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. Department of Health and Ministry of Justice.

Braga, A. (2016) The Value of 'Pracademics' in Enhancing Crime Analysis in Police Departments.
Policing Vol 10 (3) pp:308-314

Chariot, P., Beaufrère, A., Denis, C., Dang, C., Vincent, R. & Boraud, C., 'Detainees in police custody in the Paris, France area: medical data and high-risk situations (a prospective study over 1 year)', *International Journal of Legal Medicine*, 2014, 128(5); pp853.

Clement, R., Gerardin, M., Victorri, C.V., Guigand, G., Wainstein, L. and Jolliet, P., 2013. Medical, social, and law characteristics of intoxicant's users medically examined in police custody. *Journal of forensic and legal medicine*, 20(8), pp.1083-1086.

Cummings, I. and Jones, S. (2010) Blue remembered skills: mental health awareness training for police officers. *The Journal of Adult Protection*. Vol. 12 (3).

De Viggiani, N. (2012) Adapting needs assessment methodologies to build integrated health pathways for people in the criminal justice system. *Public Health*. Volume 126 (9) pp:763-769

De Viggiani, N (2013) A clean bill of health? The efficacy of an NHS commissioned outsourced police custody healthcare service. *Journal of Forensic and Legal Medicine*. Vol 20 (6)pp: 610-617

Gerardin, M., Guigand, G., Wainstein, L., Jolliet, P., Victorri-Vigneau, C. and Clement, R. Evaluation of problematic psychoactive substances use in people placed in police custody. *Journal of Forensic and Legal Medicine*, 2017, 49, 24-32.

Heide, S., Chariot, P., Green, P., Fabian, J. and Payne-James, J. (2016) Healthcare and forensic medical aspects of police, detainees, suspects and complainants in Europe. *Journal of Forensic and Legal Medicine* (online)

HMIC (2013) *Police custody is regularly being used to detain people whose only 'crime' is that they are suffering from mental disorder, a joint inspection has found.* 016/2013 HMIC Inspectorate Report published 19 June 2013.

<https://www.justiceinspectors.gov.uk/hmic/news/releases/0162013-police-custody-is-regularly-being-used-to-detain-people-whose-only-crime-is-that-they-are-suffering-from-a-mental-disorder> , downloaded 19/02/2015.

Kleinig, J. (1996) *The Ethics of Policing*. Cambridge: Cambridge University Press

Klockars, C. (1979) 'Dirty Hands and Deviant Subjects' in Klockars, C. and O. Connor F. (Eds) *Deviance and Decency*. Sage: London

MacKinnon, I., Thomas, S., Noga, H. and Senior, J. (2016) Police custody health care: A review of health morbidity, models of care and innovations within police custody in the UK with international comparisons. *Risk, Management and Healthcare Policy*. Vol 9 pp: 213-226

Myhill., A. and Johnson, K. (2016) Police use of discretion in response to domestic violence. *Criminology and Criminal Justice* Vol 16 (1) pp:3-20

Noga, H., Foreman, A., Shaw, J. and Senior, J. (2016) Multi-agency action learning: Challenging institutional barriers in policing and mental health services *Action Research*. Vol 14(2) pp: 132-150

Norman, J & Williams, E (forthcoming) 'Putting Learning into Practice: Self reflections from Cops', *European Police Science and Research Bulletin*

Payne-James, J. J., Anderson, W. R., Green, P. G., and Johnston, A. (2009) 'Provision of forensic medical services to police custody suites in England and Wales: Current practice', *Journal of Forensic and Legal Medicine*, Vol. 16, pp. 189-195.

Rekrut-Lapa, T. and Lapa, A. (2014) Health needs of detainees in police custody in England and Wales: Literature Review. *Journal of Forensic and Legal Medicine* pp:69-75

Skinn, L., Wooff, A. and Sprawson, A. (2015) Preliminary findings on police custody delivery in the twenty-first century: Is it 'good' enough? *Policing and Society* pp.1-14

Wooff, A. and Elvin, M. (2017) Measuring risk and efficiency in police Scotland custody settings: a pilot study. *SIPR Research Summary* No 27

Young, S., Goodwin, E. and Gudjonsson G. (2013) The effectiveness of police custody assessments in identifying suspects with intellectual disabilities and attention deficit hyperactivity disorder. *BMC Medicine* Vol 1: 248