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A Path Not Taken? Mentally Disordered Offenders and the Criminal Justice System

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The long stated aim of UK Government policy has been to divert mentally disordered offenders from the Criminal Justice system to services where their mental health needs can be adequately addressed. An examination of the rates of mental disorder amongst those appearing before the Courts and in the prison population shows that this policy is not achieving its stated aims. This article considers two elements of possible police and social work involvement to examine the cultural shifts that are required to make this policy more effective.

Keywords: Mentally Disordered Offenders; Diversion; Appropriate Adult

Methodology

A wide range of literature is potentially relevant in this area, including literature from psychological, sociological, psychiatric and social work sources. My own search focused on three main sources. Firstly, bibliographic databases were chosen for their coverage of the fields of mental health and criminology. The search strategy included free text terms (e.g. offenders) and MESH headings (mental illness/offenders) and included law, psychological, sociological and health databases (e.g. JUSTIS, PsychINFO and Sciencedirect). Secondly, the internet is firmly established as a research tool. A series of searches was carried out using a variety of search engines (including Google scholar and Lycos). A range of specialist websites in the area of forensic psychiatry were also searched. The search term combinations were similar to those outlined earlier. Reference lists and bibliographies were collected from each text and, if relevant, were traced. Thirdly, contact was also established with other researchers, voluntary groups and policy makers in the field.

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Introduction

The issue of the people with mental health problems entering the criminal justice system and not receiving adequate health care is not a new one. As long ago as 1780, John Howard noted that prisons were housing more 'idiots and lunatics' (Howard, 1780) and highlighted the detrimental effects of this on the prison regime for both sets of prisoners. Similar observations and criticisms have been made at various times since. The period of de-institutionalisation saw an increase in these concerns. Arboleda-Florez and Holley (1998) argue that one unforeseen consequence of the policy of the closure of long-stay hospitals was a shift in the position of the criminal justice system to having to deal with increased numbers of people experiencing mental health problems. This is in spite of policy initiatives such as the use of assertive outreach teams to engage with those most at risk, diversion from custody and even, in certain United States jurisdictions, mental health courts. This phenomenon appears to support the hypothesis that Penrose (1939) put forward nearly 70 years ago; that the way in which a society decides to deal with those who behave in ways that challenge norms is decided by a range of factors, such as the prevailing social and political climate and changes in normative behaviour and available resources. According to Penrose, the level of need in terms of institutional care will remain fairly constant. Therefore, in a society with well-resourced mental health care, an individual who behaves in a bizarre or challenging way will be more likely to be admitted to hospital. If such services do not exist, such individuals will be drawn into the criminal justice system. Penrose's hypothesis chimes with the experience of the development of the policy of Community Care in the 1980s and 1990s. Gunn (2000) notes that this period saw a reduction in the number of psychiatric beds but a continued increase in the numbers of mentally-ill prisoners. This has occurred in other countries that have followed de-institutionlisation policies, such has the United States (Borum, 2000).

For some commentators, the combined effect of the shifts and changes outlined earlier has been the 'criminalisation of the mentally ill'. Borzecki and Wormith (1985), cited in Hartford *et al.* (2005), argue that for this thesis to hold two conditions need to apply. Firstly, there needs to be higher levels of contact between mentally ill people and the police than between the police and the wider population and secondly, the arrest rate for those experiencing mental health problems would have to be shown to be higher. Hartford *et al.* (2005), in a statistical analysis of police recording of contacts and responses to calls in Ontario, Canada, confirmed the greater risk that people with mental health problems face in contacts with the police. There are two elements to this: firstly, greater likelihood of contact with the police; secondly, following contact, a greater likelihood of custody. These findings have been supported in a range of studies, which also demonstrate that the mentally ill in the USA are more likely to have a higher arrest rate, are at a greater risk of entering custody rather being granted bail and are more likely to be arrested for relatively minor offences (Teplin, 1984; Robertson, 1988; Pearson & Gibb; 1995).

A series of inquiries in the UK (Heginbotham *et al.* 1988; Rithchie, 1994) and the UK Government's own analysis of the failings of community services for people with

the most severe mental health problems (Department of Health, 1998) demonstrate that police officers have been called on to play a role in psychiatric emergencies on a regular basis. This is particularly the case in inner-city areas. The overall picture of the overlap of the mental health and criminal justice systems described by Wolff (2005) is a bleak one of fragmented services, the spatial concentration of individuals with the most complex needs in the most deprived areas of UK cities and large numbers of prisoners with severe mental health problems.

The Office of the Deputy Prime Minister's report on social exclusion and mental health (Office of the Deputy Prime Minister, 2004) highlights the barriers that those with mental health problems face in such areas as access to housing, employment and training, stigma and social isolation. It concludes that adults with mental health problems are amongst the most socially excluded groups. Kelly (2005) discusses the impact that this combination of social and economic factors can have on the course of schizophrenia and notes that individuals from lower socio-economic groups are younger at first presentation of symptoms and more likely to have longer periods of disengagement from services. Both factors are seen as indicative of poorer treatment outcomes. Studies from Eaton (1980) have identified the 'downward social drift' of schizophrenia and Kelly (2005) adapts the term 'structural violence' from the Liberation Theology movements of Latin America in order to describe the effects that poverty, racism and stigma have on the life opportunities and health of certain communities and concludes that: 'The adverse effects of social, economic and societal factors, along with the social stigma of mental illness constitute a form of 'structural violence' which impairs access to psychiatric and social services and amplifies the effects of schizophrenia in the lives of the sufferers'.

I will now consider in more depth this process through which people with mental health problems are more likely to come into contact with the police. Bittner long ago (1967) suggested that the police were reluctant to become involved in dealing with situations were the person has a mental health problem. As Robertson *et al.* (1995) argue, the police role is a very difficult and at times frustrating one. The major police function is clearly to detect crime and bring offenders before the Courts. Dunn and Fahy (1987) suggest that community interventions in psychiatric emergencies such as the use of section 136 MHA powers or the execution of a warrant under section 135 MHA are not seen, in the 'canteen culture', as real police work.

Officers can be called upon to perform the role of assessing mental health needs with little or no training. Mental health problems can be difficult to assess and are often masked by alcohol or drugs. In addition, one has to consider the inherent effect of the stresses of the situation. In the cases of people who are experiencing some form of mental distress, section 136 of the Mental Health Act 1983 allows for the officer to take that person to a place of safety if they appear to have a mental disorder and to be in 'immediate need of care or control'. As noted earlier, the main thrust of policy in this area is the diversion of people with mental health problems from the Criminal Justice system. If a person is arrested under section 136, they must be assessed by a psychiatrist and an approved social worker.

It is hardly surprising that the use of this power varies but it is worrying that the variations are so great. The key factor here is that the use of the power is dependent on the individual officer. Following Goldberg and Huxley's (1980) model of filters in psychiatric services, a similar process exists for diversion from the criminal justice system. An individual officer may have had wider training on mental health issues, be more experienced, know an individual or had previous contact with them. All such factors will play a part in the decision-making process. In addition, one would have to consider the nature of the incident that the officer is attending. Section 136 is clearly designed for dealing with episodes of acute distress. For it to be applicable, the officer must think that 'it is necessary to do so in the interests of that person or for the protection of other persons'.

There are concerns about the use of section 136. The first of these concerns how effective officers are in recognising mental disorder. However, Mokhtar and Hogbin (1993) have argued that the clinical presentation of patients in cases where section 136 has been used is not dissimilar to that of those patients detained under section 2 or 3. They suggest that this indicates that the police are under-using the power. Rogers (1990) found that in most cases where officers had used the powers under section 136, the psychiatric assessment that followed led to an admission to hospital. Taken together, these studies appear to suggest that officers use section 136 powers in appropriate cases. However, they also seem to imply that officers only invoke these powers in cases of the most extreme distress. Increased contact between people with mental health problems and the police might imply that section 136 MHA will be used on an increasing basis. Bartlett and Sandland (2003) argue that section 136 raises fundamental issues of civil liberties. There is, in effect, no right of appeal or monitoring of this police power. The crux of the matter here is that non-medical staff are being invested with the power to make a detention on mental health grounds. Carey (2001) argued that few officers felt that they had been trained sufficiently in dealing with mental health issues.

As well as lacking confidence in their own abilities to deal with mental health issues, officers appear to have little confidence in the level of support that they receive from mental health services. Both Dunn and Fahy (1987) and the Home Office Review of the Police and Criminal Evidence Act 1984 (PACE) (2002) emphasise the slow, cumbersome and bureaucratic nature of support systems. Officers in the earlier study also felt that intervention from mental health services was inadequate, with individuals often ending up in similar situations and subsequently being re-arrested. Such factors contribute to the difficulties in successfully diverting mentally disordered offenders from the Criminal Justice system. Hiday and Wales (2003) argue that people with mental health problems are more likely than the wider population to spend time in custody and are less likely to be granted bail. Taylor and Gunn (1984) argued that mental illness in itself was seen as a risk factor and thus offenders were seen as being a greater risk because they were ill. In addition, this group's social circumstances and more chaotic lifestyles counted against them when bail decisions were being made. Finally, studies of police attitudes and practice indicate that arrest is seen by officers as a way of ensuring that a psychiatric assessment is carried out. (Hartford *et al.* 2005).

The Role of the Appropriate Adult under PACE

I will now move on to consider the development of the Police and Criminal Evidence Act 1984 (PACE), focusing mainly on the provisions of the Act as they effect the interviewing of adults with mental health problems. However, some of my comments will be applicable to vulnerable adults in the widest meaning of the term.

Maxwell Confait was found murdered in his bed-sit in London in 1972. He had been strangled and the bed-sit set on fire. In November 1972, three youths—Colin Lattimore (18), Ronnie Leighton (15) and Amhet Salih (14)—were all convicted of arson with intent to endanger life. Colin Lattimore was also found guilty of manslaughter, while Leighton was convicted of murder. The basis of the prosecution case against all three was confession evidence (Fisher, 1977). They appealed against the convictions in July 1973. These appeals were unsuccessful. In June 1975, the cases were referred to the Court of Appeal and in October of that year the convictions were quashed. The successful appeals were followed by a Royal Commission that reported in 1981. The changes that the Commission recommended were incorporated into PACE (1984).

The investigation into the murder of Maxwell Confait took place in a different cultural and political climate to the one that now exists. One obvious difference was that interviews were not, at that time, tape recorded. Police interviews were governed by the 'Judges' Rules' and the criminal justice system had yet to experience the shocks caused by a series of major miscarriages of justice. The confessions in the Confait case were obtained under duress. This was a salient factor in later miscarriages of justice during the 1970s and 1980s, including the cases of the Birmingham Six, the Guildford Four and the men convicted of the murder of Carl Bridgewater.

The introduction of PACE led to wider protections for those being interviewed by the Police. The 'Judges Rules' were abolished a new framework introduced, including the taping recording of interviews. However, three groups – juveniles, adults with learning difficulties and adults with mental health problems – have been afforded additional protection. It was felt that such individuals were at particular risk of self-incrimination, a view which reflected the influence of the welfare model on the development of the criminal justice system. On the whole, these measures have been widely accepted. In recent policy debates concerning the criminal justice system, the role of the appropriate adult has not featured.

Section 66 of PACE ensures that special safeguards exist when the Police are questioning or interviewing people with mental health problems. Evidence that has been obtained under duress can be excluded from any trial (section 76(2) (a)). There are further provisions in section 76 which relate to the admissibility of confession evidence obtained from vulnerable adults. The Confait case and subsequent work by Gudjonsson has established that vulnerable adults can be pressurised into making confession statements. Such statements can have a very powerful influence on the subsequent progress of the case, particularly on the decision of the jury.

As noted earlier, the decision to involve an appropriate adult rests, in effect, with the custody officer. When a professional has been contacted by the police, they have

to decide if they are best placed to take on the role. It is possible that they will be excluded because of some knowledge of the offence. We have seen that the involvement of an appropriate adult can be a somewhat haphazard affair. For example, it is possible that a mental health team is contacted when a professional from a learning disabilities background would have skills more relevant to the case. When taking the referral, the appropriate adult should obtain as much information from the police as possible. This would include: the nature of the alleged offence, the grounds for regarding the person as vulnerable adult, the timescale of the arrest and proposed interview and whether legal representation has been sought. Code C (Para 3.13) indicates that the appropriate adult can override the person's decision to refuse legal representation. This might be seen as an example of paternalism and the infantilisation of vulnerable adults.

On arrival at the police station, the appropriate adult should check the information that they have been given already and examine the custody record. They should also ensure that the individual is given their rights under Code C paragraph 31 (The right to have someone informed that they are there, free legal advice, the right to consult the PACE Codes of Practice and to have a copy of the custody record) in their presence along with an explanation of the caution. In this initial period, the appropriate adult can clarify any issues relating to the initial arrest and detention.

The appropriate adult should also assess the vulnerability of the person. This can be another stage in the filters of diversion from custody. One of the reasons for involving the appropriate adult is because of their specialist skills and knowledge. I would argue that this is one of the strongest arguments for social workers taking on the role. Social workers with experience in mental health settings will have developed assessment skills. It is possible that an individual could be diverted from the Criminal Justice system at this stage or that a Mental Health Act assessment is arranged. The appropriate adult has to ensure that the person understands the process of interviewing. In addition, this would be the opportunity to raise any concerns that the person has about the detention.

During the interview, the appropriate adult should ensure that the interview is conducted properly and fairly and facilitates communication (Code C para 11.16), especially that it does not become 'oppressive'. Under PACE, the appropriate adult also has to state their name and role at the beginning of the tape and ensure that the interviewee is aware that they have the right to access to the tape recording. The appropriate adult should be an active participant in the interview, not an observer.

The appropriate adult can and should make representations at any review of the detention and witness any other procedures that follow the interview. These might include the taking of samples, fingerprinting and photographs. (Code D paras 1.11–14). The appropriate adult's role extends to witnessing any caution or charging (Code C para 16.1) and they also have the right to request copies of the custody record and a tape recording of the interview. In some cases, further interviews may be required so it will be necessary to ensure that an appropriate adult is present. Also, if the person is to remain in custody, it is important that information is provided the prison so that

their mental health needs are highlighted. Finally, the appropriate adult needs to make comprehensive notes as they might be called to Court at a later date. In addition, this might assist in future risk assessment or care planning.

The role of the appropriate adult is clearly full of contradictions. It was introduced with the clear intention of providing an increased level of protection for groups that were seen as particularly vulnerable. With the adversarial legal system in England and Wales, the appropriate adult's role is somewhere in the middle of the conflict between the suspect and the officers (moreover, the role of the appropriate adult also exists to support vulnerable people when they are witnesses. This is an important area, but one that I do not have the space to examine here). I next examine the extent to which appropriate adults are present at interviews, their roles, their effectiveness and the case law that has arisen since the introduction of PACE (1984).

Robertson *et al.* (1995) carried out an observational study of how people with mental health problems came into contact with the Criminal Justice System. This study was based at London police stations and courts and focussed on 37 suspects (1.4 percent) (n=2,721) who were considered to be 'actively mentally ill'. This sample highlighted that those who were mentally ill were more likely to have been arrested for a violence offence. The most common diagnosis was schizophrenia (25). Officers only formally interviewed 30 percent of the total sample (n=822). In this group, 10 were considered to be mentally ill. However, appropriate adults were present for only five of the interviews. The study argues that the decision to involve an appropriate adult in these cases was related to the serious nature of the offence. The implication being that the police were more careful to ensure procedural accuracy in such cases as officers wanted to avoid the interviews being ruled inadmissible.

The level of involvement of appropriate adults in PACE (1984) interviews does not appear to correlate with the increased contact between the police and people with mental health problems, nor with the levels of mental illness in the general population. A range of factors are at play here. These include a lack of awareness of mental health issues and organisational difficulties in the provision of appropriate services. Also, Parker (1992) argued that the Police have a vested interest in ensuring that the provisions of PACE (1984) are not applied. As well as the practical difficulties, in an adversarial system the process of involving an appropriate adult might be seen as giving the suspect an unnecessary advantage. Studies by Nemitz and Bean (1994, 2001) found that appropriate adults often took little active role in the interview process.

The role of the appropriate adult is a complex and demanding one, requiring a mix of skills and knowledge. These would include an understanding of the legal process and, ideally, some specialist mental health knowledge. In guidance 1E it advises that a trained appropriate adult is the best choice. However, as the Home Office (2002) review makes clear, in practice this is often not the case. The role of the appropriate adult is often taken on by volunteers, carers, relatives and professionals. In Medford *et al.* (2003), a doorman even took on this role. As White (2002) argues, this situation is fraught with possible complications and an untrained appropriate adult may do more harm than good. In addition, it is important to recognise that individuals, even

professionals, can find the situation of the PACE (1984) interview intimidating. Ensuring that an interview is conducted fairly and in a non-oppressive manner will inevitably include situations requiring professionals to challenge police conduct. Harkin (1997) indicates that even social workers find custody suites intimidating. It is probable that this will be even more so for those working in a voluntary capacity. Despite the appropriate adult having a key role to play, no official qualifications or training are required for those carrying out the role. The disjointed nature of service and training provision was noted by the Runciman Commission in 1993.

The appropriate adult does not enjoy legal privilege in the way that a defence solicitor would. It is therefore possible that they will be called as a witness at a subsequent trial (the most famous example of this being the trial of Rosemary West). The case law that has grown surrounding the appropriate adult has largely been concerned with the suitability of the person taking on the role. In DPP v. Blake, it was found that the estranged father of a juvenile should not have taken on the role because he was not sufficiently neutral. On different grounds, it was held that the father in R v. Morse should not have acted as an appropriate adult because his low IQ score meant that he could not understand the serious nature and wide scope of the role. However, a subsequent decision in R v. Cox confuses this point. In the Cox case, a mother with both a learning difficulty and severe mental health problems acted as the appropriate adult. If she had been the suspect, she would not have been interviewed without an appropriate adult. However, the confession evidence of her daughter was deemed admissible. Such decisions do not appear to chime with the underlying reasons for the introduction of the role and might serve to reduce the role to a purely administrative function rather than a cornerstone of attempts to protect vulnerable people. The decision in R v. Aspinall made it clear that the role of the appropriate adult is to safeguard the suspects' rights, but this is in addition to, not instead of, the solicitor's role in this regard. Bartlett and Sandford (2003) argue that the details of the role that the appropriate should play are still unclear. They see at the heart of this a confusion as to what the terms 'facilitate communication' and 'fair interview' actually mean. In mental health cases, for example, can social workers really be neutral if they have previously assessed an individual under the Mental Health Act (1983)? As Bartlett and Sandford rightly point out, in juvenile cases the PACE interview itself can be the point of a family conflict that means the parents are not neutral at all.

The final area I wish to consider is the effectiveness of the appropriate adult role and an examination of who actually carries out this role. The appropriate adult is a specialist role but it is not necessarily one that social workers perform on a regular basis. This serves to make it difficult to build up the skills, practice and confidence required to perform the role well. As far as people with mental health problems are concerned, in sixty percent of cases the role is carried out by a social worker (Bucke & Brown, 1997). Brown *et al.* (1993) found that the police were actually happier for social workers to take on this role. This is despite a general lack of confidence in mental health services and, it might indicate that if services can be delivered properly and in a timely fashion then organisational suspicion can be reduced. These findings

contrast with Pierpoint's (2001) study of the use of volunteers as appropriate adults in juvenile cases. In this study, volunteers were more effective. This probably reflects the family tensions and the difficult position of social workers in these cases. Research has highlighted the fact that on too many occasions the appropriate adult does little more than act as a passive observer during interviews. This was the case in Evans' (1993) study of interviews involving juveniles. The appropriate adult has a wider role in the custody process; for example, in ensuring that a suspect understands their rights and has appropriate breaks. Also, as noted earlier, the appropriate adult can override a decision to refuse legal representation. These are areas of the role that need to be explored further.

Discussion

One significant outcome of the de-institutionalisation and bed closure programme in mental health services has been to push police officers into greater contact with people experiencing severe mental health problems. This is not necessarily a role that officers have been trained to take on and results in a lack of awareness of, and confidence in dealing with, mental health issues. Similar problems exist within the prison system. Despite the diversion from custody (Reed Report, 1992; Home Office circular 66/90) the level of mental health needs amongst prisoners seem to be rising inexorably. The historical underfunding and fragmentation of mental health services has meant that, as Penrose suggested, the criminal justice system has increasingly been forced to take on the role of providing basic health care for a group which community-based services have always found difficult to engage (for a variety of reasons, including the complexity of need and hostility to services). Mentally ill people are not only being drawn into the criminal justice system, they are more at risk within that system. The role of the appropriate adult is an attempt to offer additional protection. However, it is difficult to disagree with the Home Office Review of PACE (2002) which concluded that: 'The present provision of AAs within the Custody Suite is chaotic and unstructured and recommends the establishment of a national policy for the scheme and the development and implementation of full national guidance'.

There are several themes that emerge in the literature. The first concerns the relatively limited involvement of the Appropriate Adult throughout the custody process. Given what we know about the extent and complexity of the mental health needs within the prison population, one would expect there to be similar levels of need amongst those whom the police arrest. However, there does not appear to be any substantial evidence that large numbers are being diverted from the criminal justice system at any early stage. Whilst it is generally agreed that the Police have more contact with people with mental health problems, this trend is difficult to reverse and will remain a feature of police work for the foreseeable future. As Stone (1982) argues, policy-makers have always found it difficult to come up with a coherent strategy for dealing with the mentally ill who commit criminal offences. The

barriers to the development of such a policy in terms of philosophical agreement, resources and the support of the wider population remain deeply entrenched.

In examining the role of the Appropriate Adult, some fundamental questions need to be considered. The first and most fundamental is can the role be justified. The research reviewed earlier suggests that in many cases the AA acts as a passive observer of the proceedings and contributes very little. Medford *et al.* (2003) studied records of interviews with vulnerable adults and juvenile suspects. This study highlighted that social workers and volunteers are more likely to take on the role in adult cases while family members or parents often acted as appropriate adults for juveniles. It is interesting to note that the appropriate adult was more likely to intervene in the juvenile cases. This was explained by some of the family interventions being inappropriate—for example, in encouraging a juvenile to confess. This is partly why Pierpoint (2001) argues that volunteers are more effective and offer more protection in interviews with juveniles.

Whilst the appropriate adult can become a largely administrative role, with little contribution being made, Medford *et al.* conclude that the presence of the appropriate adult has an important effect on police behaviour. In interviews with adults, it increases the likelihood that legal representation is sought. This, in itself, must be a positive for the interests of justice. The study also indicates that the legal representative will be more forceful in such cases. The overall effect is that the interview is less aggressive. This is the result of a combination of factors, such as the police wanting to ensure that they are procedurally correct and that such interviews cannot be challenged at a later date. It should be noted that studies of the interventions that appropriate adults make concentrate on the interview. This is not that surprising. However, we have seen that the role is wider than this. One could carry out all the wider tasks of the role and not necessarily intervene in the actual interview. However, the general conclusion that too many appropriate adults remain passive observers is still valid.

A root and branch reform that would remove the role of the appropriate adult would serve to increase the vulnerability of a much marginalised group. The general thrust of the PACE review in this area is that the Police need more support from mental health services. The primary function of the appropriate adult is not one of diversion but to remove this layer of support would make it more difficult for police officers and could put individuals at increased risk. White (2002) has argued that legal privilege be extended to those taking on the role of the appropriate adult. I find it difficult to establish the benefits of such a change. It involves a fundamental shift in the balance of the role. In the adversarial legal system, the appropriate adult would shift from the current neutral to an almost representative function. The problems that have been highlighted revolve around the training and skills of individuals being asked to take on the role. Fennel (1994) has argued that the way to ensure that those with mental health problems are offered adequate protections is to develop a group of legal representatives with specialist knowledge and skills in this area. Members of the group would then be called in for such cases. This would negate the need for an appropriate adult. Such a scheme would require a significant investment in the

training of legal representatives and a commitment from the legal profession. It also involves a philosophical shift. I would suggest that the combination of the roles would be very difficult.

I would argue that the provisions of PACE (1984), if implemented on regular basis and adequately resourced, should provide sufficient safeguards for vulnerable suspects. However, the current practice position raises concerns. It is clear that the policies of de-institutionalisation and bed closure have not been adequately supported by appropriately increased community resources (Department of Health, 1998; Wolff, 2005). One result is the so-called 'criminalisation of the mentally ill', the drawing of those with mental health needs into the Criminal Justice System. Few would dispute that the aim of 'diversion from custody' is a laudable one. The current evidence from the prison estate is that this policy has not succeeded. There is evidence (James, 2000; McGilloway & Donnelly, 2004) that early diversion schemes can be effective. In both studies, Community Practice Nurses (CPNs) were attached to police stations in order to divert those involved in minor offences and to attempt to engage this difficult to reach group with mental health care services. There is a moral justification for the support of such policies in the idea of equivalence, that those in custody should receive the same level of healthcare as other members of society. In addition, such services may help to prevent repeat offending or an escalation in the level of offences committed. Some jurisdictions in the United States have introduced mental health courts to try to tackle this issue. The PACE review calls for the development of such schemes and for greater healthcare involvement at police stations. This is to be welcomed. I would argue that there is a need for an interprofessional approach, so that staff from medical and social care backgrounds are involved in the development and provision of such services. The review goes on to consider other wide-ranging suggestions, such as 'cell-blocking' charges and the development of more secure unit provision. The majority of offenders would not need this level of security.

White (2002) argues that there is a confusion about the exact nature of the role of the appropriate adult and the best way to protect vulnerable suspects in police custody. The judgment in R v. Lewis indicates that the role overlaps with that of the legal representative, given that it includes ensuring that the vulnerable suspects fully understand their legal rights. In addition to this quasi-legal role, there is a welfare role. The Code of Practice indicates that this role will, ideally, be taken on by a mental health professional. However, no single authority has overriding responsibility for the provision of this service. Throughout the UK, there is a patchwork of provision with a mixture of social work staff, volunteers and family members carrying out the role. In Bucke and Brown's study (1997) it was found that social workers took on the role in 60 percent of cases. Evans and Rawstone (1994) highlighted the fact that SSDs were better at providing social workers to take on this role during the day. It is clearly more logistically difficult when emergency duty teams are covering an area, with fewer staff and attempting to cover a wider range of service provision. PACE (1984) has its roots in a grave miscarriage of justice. As Haley and Swift (1988) argue, the

ultimate aim of these safeguards is to try and reduce the risk of unreliable evidence. This will not be achieved if these fundamentals are not addressed.

Williams (2000) argues that there is a need for wider training for those who act in the role of the appropriate adult. Lack of a consistent approach had been identified by the Royal Commission (1993). This lack of confidence and expertise is not limited to non-professional staffs who take on the role. Harkin (1997) discussed this in terms of the social worker's experiences and suggested that social workers can find the whole experience isolating and intimidating. The ambiguous nature of the role, the legal knowledge required and the fact that for many this is not a regular working occurrence serve to make this an area of difficult social work practice. As it stands, there are no formal qualifications required for taking on this role. The National Appropriate Adult Network is working to produce a set of national standards which will govern the recruitment, selection and supervision of all those who will take on the role.

Whatever systems and policies are put in place, they will still be dependent on the skills and professionalism of individual officers. Parker (1992) suggests that officers will seek to ignore PACE (1984) provisions, since they are time-consuming. In addition, in an adversarial system, you are not encouraged to do anything that will help the other side. If an officer does not recognise that an individual has a mental health problem, s/he will not put any policy aimed at protecting vulnerable individuals into place. There is an identified need for greater training for police officers in the awareness and recognition of mental health problems. Carey (2001) and Dew and Badger (1999) noted that few officers felt that they had been given sufficient training in this area and that most of the training took place 'on the beat'. It is also apparent that a lack of confidence in mental health services means that the police become disillusioned and cynical about the efficacy of involving their mental health colleagues. This may be part of a cultural or value clash about what is seen as a realistic intervention, with the police emphasising hospitalisation and medication. It is also a reflection of professional frustration.

Conclusion

It is impossible to sustain the argument that diversion from custody has been a success. One bleak interpretation of Penrose might be that it never can be; prisons always have and always will have a role in providing psychiatric care. To my mind, this is too defeatist. The channels that exist to link those in the criminal justice system with the mental health services that they require should be fully exploited. Despite the best efforts of staff, prisons cannot be expected to provide the levels of care that acutely mentally ill individuals require. Police attitudes to people with mental health problems certainly need to be examined in more depth and Pinfold *et al.*'s study (2003) demonstrated that short training courses can tackle some of the deeply engrained stereotypes about mental illness. This study found the benefits included improved communication between officers and subjects. The officers also felt more confident in their own dealings with these individuals. However, it is interesting to

note that the view that people with mental health problems are violent was the most difficult to tackle. A greater confidence in community services will only come from an improvement in services that tackles the long-standing underfunding, poor organisation and lack of a commitment to inter-professional working that have dogged mental health services for far too long.

References

Aboleda-Florez, J. & Holley, H. L. (1998) 'Criminalization of the mentally ill: Part II'. Initial detention, *Canadian Journal of Psychiatry*, vol. 33, pp. 87–95.

Bartlett, P. & Sandland, R. (2003) *Mental Law Policy and Practice*, 2nd edn, Oxford University Press, Oxford.

Bittner, E. (1967) 'Police discretion in emergency apprehension of mentally ill persons', *Social Problems*, vol. 14, pp. 278–292.

Borum, R. (2000) 'Improving high risk encounters between people with mental illness and the police', *Journal of the American Academy of Psychiatry and the Law*, vol. 28, pp. 332–337.

Borzecki, M. & Wormith, J. S. (1985) 'The criminalization of psychiatrically ill people: A review with a Canadian perspective', *Psychiatric Journal of the University of Ottawa*, vol. 10, pp. 241–247.

Brown, D. (1997) *PACE Ten Years On: A Review of The Research* (Home Office Research Study no. 155), HMSO, London.

Brown, D., Ellis, T. & Larcombe, K. (1993) *Changing the Code: Police Detention under the Revised PACE Codes of Practice*, HMSO, London.

Bucke, T. & Brown, D. (1997) *In Police Custody: Police Powers and Suspects Rights under the Revised PACE Codes of Practice* (Home Office Research study no. 174), HMSO, London.

Carey, S. J. (2001) 'Police officers' knowledge of, and attitudes to mental illness in southwest Scotland', *Scottish Medical Journal*, vol. 46, pp. 41–42.

Department of Health and Home Office (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. Final Summary Report*, HMSO, London.

Department of Health (1998) *Modernising Mental Health Services, Sound Safe and Supportive*, HMSO, London.

Dew, K. & Badger, S. (1999) 'Police perceptions of the mental health services and the mentally ill', *New Zealand Medical Journal*, vol. 112, pp. 36–38.

Dunn, J. & Fahy, T. A. (1987) 'Section 136 and the police', *Bulletin of the Royal College of Psychiatry*, vol. 11, pp. 224–225.

Eaton, W. W. (1980) *The Sociology of Mental Disorders*, Praeger, New York.

Evans, R. (1993) 'The conduct of police interviews with juveniles', *Royal Commission on Criminal Justice Research Study 12*, HMSO, London.

Evans, R. & Rawstorne, S. (1994) *The Protection of Vulnerable Suspects* (A report to the Home Office Research and Planning Unit. Cited in Brown, D. (1997) *PACE Ten Years On: A Review of the Research* (Home Office Research Study no. 155), HMSO, London.

Fennell, P. (1994) 'Mentally disordered suspects in the criminal justice system', *Journal of Law and Society*, vol. 21, pp. 57–71.

Fisher Sir, H. (1977) *Report of an Inquiry by the Hon. Sir Henry Fisher into the Circumstances Leading to the Trial of Three Persons on Charges Arising out of the Death of Maxwell Confait and the fire at 27 Doggett Road London SE6*, HMSO, London.

Goldberg, D. & Huxley, P. (1980) *Mental Illness in the Community*, Tavistock, London.

Gunn, J. (2000) 'Future directions for treatment in forensic psychiatry', *British Journal of Psychiatry*, vol. 176, pp. 332–338.

Harkin, E. (1997) *Acting as an Appropriate Adult for Suspects with Learning Difficulties*, Social Work monograph 158: University of East Anglia.

Hartford, K., Heslop, L., Stitt, L. & Hoch, J. (2005) 'Design of an algorithm to identify persons with mental illness in a police administrative database', *International Journal of Law and Psychiatry*, vol. 28, pp. 1–11.

Heginbotham, C., Hale, R., Warren, L., Walsh, T. & Carr, J. (1994) *The Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan*, NW London Mental Health Trust, London.

Hiday, V. A. & Wales, H. W. (2003) 'Civil commitment and arrests', *Current Opinion in Psychiatry*, vol. 16, no. 5, pp. 575–580.

Home Office (1990) *Provision for Mentally Disordered Offenders*, Circular 66/90.

Home Office (1995) *Police and Criminal Evidence Act 1984 Codes of Practice*, HMSO, London.

Home Office (2006) *Guidance for Appropriate Adults*, HMSO, London.

Home Office/Cabinet (2002) *PACE Review Report of the Joint Home Office/Cabinet Office Review of the Police and Criminal Evidence Act 1984*, HMSO, London.

Howard, J. (1780) *The State of the Prisons in England and Wales*, 2nd edn, T. Cadell, Warrington and London.

James, D. (2000) 'Police station diversion schemes: role and efficacy in central London', *Journal of Forensic Psychiatry*, vol. 11, pp. 532–555.

Kelly, B. (2005) 'Structural violence and schizophrenia', *Social Science and Medicine*, vol. 61, pp. 721–730.

McGilloway, S. & Donnelly, M. (2004) 'Mental illness in the UK criminal justice system: A police liaison scheme for Mentally Disordered Offenders in Belfast', *Journal of Mental Health*, vol. 13, no. 3, pp. 263–275.

Medford, S., Gudjonsson, G. & Pearse, J. (2003) 'The efficacy of the appropriate adult safeguard during police interviewing', *Legal and Criminological Psychology*, vol. 8, no. 2, pp. 253–266.

Mokhtar, A. & Hogbin, P. (1993) 'Police May underuse section 136', *Medicine Science and Law*, vol. 33, no. 3, pp. 188–196.

Mental Health Act (1983) HMSO, London.

Nemetz, T. & Bean, P. (1994) 'The use of the appropriate adult scheme (a preliminary report)', *Medicine, Science and the Law*, vol. 34, no. 2, pp. 161–166.

Nemetz, T. & Bean, P. (2001) 'Protecting the rights of the mentally disordered in police stations: the use of the appropriate adult in England and Wales', *International Journal of Law and Psychiatry*, vol. 24, no. 6, pp. 595–605.

Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*, HMSO, London.

Penrose, L. S. (1939) 'Mental disease and crime: outline of a comparative study of European statistics', *British Journal of Medical Psychology*, vol. 18, pp. 1–15.

Pierpoint, H. (2000) 'How appropriate are volunteers as 'appropriate adults' for young suspects? The 'appropriate adult' system and human rights', *Journal of Social Welfare and Family Law*, vol. 22, no. 4, pp. 383–400.

Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H. & Graham, T. (2003) 'Reducing psychiatric stigma and discrimination. Evaluating an educational intervention with the police force in England', *Social Psychiatry and Psychiatric Epidemiology*, vol. 38, no. 6, pp. 337–344.

Ritchie, J. (Chair) (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, HMSO, London.

Robertson, G. (1988) 'Arrest patterns among mentally disordered offenders', *British Journal of Psychiatry*, vol. 153, pp. 313–316.

Robertson, G., Pearson, R. & Gibb, R. (1995) *Entry of Mentally Ill People into the Criminal Justice System*, Home Office, London.

Robertson, G., Pearson, R. & Gibb, R. (1996) 'Police interviewing and the use of appropriate adults', *Journal of Forensic Psychiatry*, vol. 7, no. 2, pp. 297–309.

Rogers, A. (1990) 'Policing mental disorder: Controversies, myths and realities', *Social Policy and Administration*, vol. 24, pp. 226–237.

Royal Commission on Criminal Justice (1993) (Chair) Viscount Runciman of Oxford CBE FBA. Cmnd 22363 *Report*, HMSO, London.

Stone, L. (1982) *An Exchange with Michel Foucault*, New York Review of Books, New York.

Taylor, P. & Gunn, J. (1984) 'Violence and psychosis I. Risk of violence among psychotic young men', *British Medical Journal*, vol. 288, pp. 1945–1949.

Teplin, L. (1984) 'Criminalising mental disorder', *American Psychologist*, vol. 39, pp. 794–803.

Williams, J. (2000) 'The inappropriate adult', *Journal of Social Welfare and Family Law*, vol. 22, no. 1, pp. 43–57.

White, C. (2002) 'Re-assessing the social worker's role as an appropriate adult', *Journal of Social Welfare and Family Law*, vol. 24, no. 1, pp. 55–65.

Wolff, N. (2005) 'Community reintegration of prisoners with mental illness: A social investment perspective', *International Journal of Law and Psychiatry*, vol. 28, pp. 43–58.