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A place of safety? Self-harming behaviour in police custody

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abstract

The custody environment is not designed nor can it hope to meet the needs of individuals who are experiencing acute mental distress. The article reports the findings of analysis of the recorded incidents of self-harm that occurred in the custody of one English police force during an eight-month period in 2006. There were 168 such incidents in this period. The ratio of male/female detained persons, who harmed themselves was 3:1. The most common method used was a ligature either from the detained person's own clothes or the paper suits that are used in custody. Alcohol or substance misuse was identified as a clear risk factor. The police response is analysed and recommendations made for improved access to health care for those in custody.

key words

self-harm, police custody, vulnerable adults

Introduction

One significant outcome of the de-institutionalisation and bed closure programme in mental health services has been to increase the contacts between police officers and people experiencing severe mental health problems. This is not necessarily a role that officers have been trained to take on. This 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 (DoH, 1992) the level of mental health needs among prisoners seems to be rising inexorably. The historical under-funding and fragmentation of mental health services has meant that as Penrose (1939) suggested the criminal justice system has increasingly been forced to take on the role of providing basic health care. It should be noted that this is with a group, which, community-based services have always found difficult to engage. This has been for a variety of reasons including complexity of need and hostility to services.

The evidence indicates that not only are mentally ill people 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 to a very vulnerable group. However, this specific role is concerned with the exercise of justice rather than the mental health needs of those in custody. The extent and complexity of the mental health needs of the prison population has been well established. (Singleton *et al,* 1998). One would expect there to be similar levels of need among those whom the police arrest, as the groups are likely to share many characteristics. In addition, the custodial environment contains a number of elements, which means that it might be adding to rather than diminishing the risks involved.

There does not appear to be any substantial evidence that large numbers of individuals are being diverted from the criminal justice system at any early stage. There may be arguments about the causes, but it is generally agreed that the police have increasing 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, medicine and other disciplines have never been able to develop 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. The result has been a series of shifts between placing the emphasis on punishment, treatment, or a mixture of both.

The provisions of the Police and Criminal Evidence Act (PACE) (1984) provide valuable safeguards for vulnerable suspects. However, the current practice position raises concerns. It is clear that appropriate increased community resources have not adequately supported the policies of de-institutionalisation and bed closure. This view appeared to be shared by the new administration in *Modernising Mental Health Services: Sound, safe and supportive* (DoH, 1998). One result is the so-called 'criminalisation of the mentally ill', the drawing in 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 indicates that this policy has not succeeded.

There is evidence (see for example James, 2000; McGilloway & Donnelly, 2004) that early diversion schemes can be effective. In both studies, CPNs were attached to police stations to divert those involved in minor offences and attempt to engage this difficult to reach group with mental health care services. This study analyses police responses to incidents of self-harm by individuals while in custody. This issue crystallises a number of themes concerning vulnerable adults with mental health problems in police custody: lack of service provision, poorly trained officers and detained persons where the risk factors identified for suicide and self-harm are significantly increased.

Suicide

Suicide is a challenging and disturbing issue. The effect of suicide spreads to families, friends and professionals involved. Palmer (1993) notes that the relatives of an individual who takes their own life are left feeling confused or inadequate. Blank (1989) illustrates that these feelings of guilt, loss and anger may also affect professionals. Suicide is a problem that is being addressed by health policy makers across the world. In the UK, there were approximately 5,200 suicides per annum up to 2001 (Appleby *et al,* 2001). Suicide prevention has been a key feature of public health targets. The white paper *Saving Lives* (DoH, 1999a) set the target of a 20% reduction in the UK suicide rate by 2010. *The National Service Framework for Mental Health* (DoH, 1999b) highlighted the association between self-harm and subsequent suicide. This is supported by Foster *et al,* 1997, who suggest that up to 25% of individuals who commit suicide have presented at a general hospital following an incident of self-harm in the 12 months before they kill themselves. Indeed, the Royal College of Psychiatrists recommended in 1994 that all patients who have self-harmed and attend A&E, should be thoroughly assessed by the relevant mental health staff.

Modernising Mental Health Services: Safe, sound and supportive (DoH, 1998) highlighted the fact that suicide was the second most common cause of death in individuals aged under 35. People with severe mental health problems are one of the groups at highest risk

of suicide. The most common methods of suicide used by men in England and Wales in 2001 were hanging – including strangulations and suffocation (44%), drug-related poisoning (20%) and 'other poisoning' – including car exhaust fumes (10%) (Brock & Griffiths, 2003). The same study highlighted the fact that the most common methods of suicide in women were drug-related poisoning (46%), hanging – including strangulations and suffocation (27%), and drowning (7%).

The National Confidential Inquiry's reports *Safer Services* (Appleby *et al,* 1999) and *Safety First* (Appleby *et al,* 2001) indicate that approximately 25% of those who committed suicide in the UK had been in some form of contact with mental health services in the year before their death. The ratio of males to females is in the region of 3:1. For example, in 2004 3,589 men committed suicide while 1,294 women took their own lives (see ***table 1***). These figures need to be approached with some caution as there is anecdotal evidence to suggest that there is a reluctance to record a suicide verdict in the Coroner's Court unless there is overwhelming evidence of intent – for example a note. The highest number of suicides occur in the age group 25–44, in 2004, 2,059 (42%) people were in this group. This was followed by 1,522 (31%) if individuals in the 45–64 years group, and 821 (17%) in the over 65 years group. In the group aged 25 and under, 481 (10%) successfully committed suicide (see ***table 2***) (www.medicine.manchester.ac.uk/suicide prevention).

Suicide is a complex phenomenon. It is difficult to understand such a multifaceted event and often problematic to determine causes. In his classic study of suicide, Durkheim (1897) argued that those individuals, who were the least integrated into society, were the most likely to take their own lives. Frisch and Frisch (1998) argue that individuals who end their own lives have been overwhelmed by life events. Diedrich and Warelow (2002) suggest that for suicidal individuals,

> *'Life could be described as a traumatic experience likened to an emotional roller coaster ride, full of unending pain and*

Table 1 **Frequency of suicide in the general population by year and sex**
(National Confidential Inquiry, 2006)

	1997	1998	1999	2000	2001	2002	2003	2004
Male	4,018	4,275	4,009	3,801	3,675	3,664	3,687	3,589
Female	1,342	1,333	1,320	1,322	1,221	1,255	1,293	1,294
Total	**5,360**	**5,608**	**5,329**	**5,123**	**4,896**	**4,919**	**4,980**	**4,883**

Table 2 **Frequency of suicide in the general population by year and age group**
(National Confidential Inquiry, 2006)

	1997	1998	1999	2000	2001	2002	2003	2004
Age								
■ Under 25	669	642	585	563	523	494	521	481
■ 25–44	2,265	2,520	2,323	2,203	2,103	2,199	2,148	2,059
■ 45–64	1,513	1,564	1,517	1,527	1,466	1,487	1,488	1,522
■ 65+	911	882	904	830	803	739	823	821
Total	**5,360**	**5,608**	**5,329**	**5,123**	**4,896**	**4,919**	**4,980**	**4,883**

intense suffering. In the mind of this person, death is likely to be viewed as a peaceful resolution…' (p170).

Known risk factors are likely to include history of severe mental illness, alcohol or substance misuse and adult survivors of child sexual abuse (Platt & Kreitman, 1990). The occurrence of these risk factors is likely to be increased among those in police custody. Linsley *et al* (2007) carried out an analysis of 205 suicides that took place in a three-year period in north east England. Of this cohort, 41 (20%) individuals had some form of documented contact with a police officer in the three months prior to the taking of their life. This included contact either as a victim or alleged offender. As the authors suggest,

'As many people see a police officer in the three months prior to suicide as they see a mental health professional within 12 months prior to suicide' (p170).

The criminal justice system

The research in this area has concentrated on prisons. There has been relatively little examination of these issues in police custody settings. Shaw et al (2004) report on a national clinical survey based on a two-year sample of self-inflicted deaths in prisoners. In the period, 1 January 1999 to 31 December 2000 clinical and social information was collected on all self-inflicted deaths in prisons in England and Wales. In this period, there were 172 such deaths. The prison environment differs from the custody environment in a number of important respects – for example, the length of time that a person is likely to spend there. However, this research is of value here because all these individuals would have been in custody at some point. The risk and demographic factors highlighted will be of particular importance.

Liebling (1994) has argued that the nature of the prison environment may increase the risk for suicide. In addition, the risk factors identified in the wider community such as alcohol and substance misuse, mental illness and generally poor coping skills are all increased among the prison population. The vast majority of prisoners are young men from the most disadvantaged and marginalised sectors of society. The suicide rate has been increasing among this group (National Confidential Inquiry, 2006). The most striking finding from the Shaw *et al* (2004) study is the comparison between the prison suicide rate and that in the general population. The age-standardised rates (1999–2001) were 4.5 per 100,000 for women and 14.5 per 100,000 for men. In the prison population, the figures were 184 per 100,000 and 129 per 100,000. The most common method, (92%; n=159) was hanging, with bedclothes often being used as a ligature. Almost one-third (32%; n=55) of these deaths occurred within the first seven days of imprisonment.

Suicide following custody

Pratt *et al*'s (2006) study of recently released prisoners indicates that the initial stages of returning to society are a period of increased risk for this group. There are clearly differences for those released following a custodial sentence and individuals released from police detention. The length of time in custody and its effects on the individual's family and other support networks are one obvious example. However, there are similarities, particularly the increased experience of risk factors. The Independent Police Complaints Commission (IPPC) examines all apparent suicides that follow a period of police custody. The IPPC's criteria for involvement are that the incident occurred within two days of release or that

something about the period of police custody may be relevant to the subsequent death. The IPPC indicates that there were 40 suicides in 2005/2006 that met these criteria. Of these 32 were within two days of release with 12 being within the first 24 hours. The IPPC is further investigating 19 cases. Fourteen individuals were reported to have mental health needs, with eight individuals being detained under the Mental Health Act (1983). Emphasising the role of alcohol or drugs as risk factors, 16 people had been arrested for possession of drugs or being under the influence or were known to be substance misusers. Ten of the cohort had been arrested in connection with sexual offences. Two individuals in this group were in custody for either taking or being in possession of indecent images of children.

Deliberate self-harm

Morgan (1979) identifies deliberate self-harm (DSH) as non-fatal acts including poisoning and physical self-harm. He emphasises that the individual is aware that the act was potentially harmful or that the amount of substance taken was likely to be excessive.

DSH is one of the five most common reasons for presentation at A&E departments across the country. There are about 150,000 cases of self-poisoning each year. Analgesics are the most common substances used (Hawton *et al,* 1997). DSH has been identified as a clear risk factor for completed suicide. Greer & Bagley's study (1971) indicated that in the year following an episode of DSH, the suicide rate is 100 times higher than that of the general population. *Our Healthier Nation* (DoH, 1998) contains targets for the reduction of the suicide rate. DSH is often seen as a response to overwhelming social, emotional or personal problems such as housing, unemployment, debt, conflict or loss in personal relationships.

The *National Confidential Inquiry into Suicides and Homicides* has an ongoing remit to examine policy and practice issues following such events, including suicides that occur in inpatient units. The Inquiry has produced two reports, *Safer Services* (Appleby *et al,* 1999) and *Safety First* (Appleby *et al*, 2001) along with a series of recommendations for services. As an example of such recommendations, patients with a history of DSH within the last three months should not be given supplies of medication covering more than two weeks. These reports also argued that there should be local arrangements for information sharing between mental health and criminal justice agencies.

A further report, *Effective Health Care: Deliberate self- harm* (NHS Centre for Reviews and Dissemination, 1998) summarises the features, which can be used to predict non-fatal repetition of self-harm or eventual suicide. In non-fatal episodes, the factors include previous history, psychiatric history, lower social class, unemployment, a criminal record, and antisocial personality and alcohol or drug problems. For completed suicide, the factors are older age, male, history of previous attempts, psychiatric history and living alone. Many of these factors would, of course, be highlighted among adults coming into police custody.

Self-harm in police custody

The report produced by the Association of Chief Police Officers (ACPO) in 2006 *Guidance on the Safer Detention and Handling of Persons in Police Custody* identifies that the risk of self-harm or suicide is increased during the early hours of detention in police custody. As well as the factors associated with suicide identified above, there are additional risk factors associated with the custody process and experience. The nature of the alleged offence can increase the vulnerability

of the detained person, for example, sexual offences, child abuse or offences linked to the possession of child pornography. Detainees, who are intoxicated by either drink or drugs or withdrawing from these substances are also an at risk group. In addition, there are times within the process when risk increases including after interview, on being charged, following visits or the refusal of bail. This serves to emphasise that the risk assessment that officers carry out needs to be a dynamic, fluid and ongoing process.

A detailed study of DSH and suicide in police custody was carried out by Ingram *et al* in 1998. The study was based on a consideration of all deaths from DSH in police custody in the period between 1990–1994 and incidents of DSH in Lancashire police custody, one of which resulted in death. As with the wider population, the most common method used to harm oneself was hanging, followed by cutting, head butting or punching walls and suffocation (often by wetting and swallowing toilet paper). Nearly 50% of these incidents occurred within the first hour of reception into custody. The study also highlighted the fact that the risk of self-harm increased with prolonged periods of detention – defined as over six hours in duration. A possible explanation of this pattern is that the initial shock of detention explains the first wave of incidents. There then follows a second group of incidents where the corrosive effects of the custody environment, the growing realisation of the impact of being arrested or a combination of these factors, have a detrimental effect on the mental health of the detained person.

This study emphasises the importance of carrying out a full ongoing risk assessment of all individuals who come into custody. This would include the assessment that forms part of the computerised custody record, accessing the Police National Computer (PNC). Information may also be available via local intelligence, previous custody records or the fact that staff have had previous contact with the detained person at some point. Custody officers carry out their own assessment of the risks including asking very direct questions such as, *'have you deliberately harmed yourself while in custody?'* The custody environment is not and can never realistically be a therapeutic environment. However, it is likely to remain the case that vulnerable individuals, or those exhibiting very disturbed behaviour will be brought into police custody. Custody officers are often largely reliant on the detained person for information about their personal circumstances and background.

As Ingram *et al* (1998) suggest there are a number of barriers, in addition to the custody environment that might combine to prevent the detained person revealing a history of self-harm. One of these is that it is virtually impossible to maintain confidentiality in most custody suites as they are open plan and very busy with individuals coming and going continuously. Detained persons are usually booked in at the main desk, where the custody sergeant is located. In addition, there is the stigma attached to self-harm itself. Medical and social care services have struggled to shake off the 'therapeutic pessimism' ie. the belief that nothing can be done, so it is hardly surprising if this affects police officers. In addition, Cummins (2007) has highlighted the frustrations that police officers feel when trying to access appropriate support for detained persons who have mental health problems. Part of this stems from feeling that this is not a core policing role. In addition, Cummins (2007) has emphasised the fact that the training that police officers receive in relation to mental health issues is generally very limited. Individuals who do harm themselves have reported negative attitudes from nursing staff (McLaughlin, 1994). This becomes a vicious circle, which makes it less likely that individuals then approach services for assistance.

Policy considerations

A death in custody is a clearly tragic event for all involved. Police forces have a duty of care not only to detained persons, but also to the staff in their employment. These responsibilities have been extended under human rights legislation. The parliamentary Joint Committee on Human Rights (JCHR) considers these issues in its third report, which examines deaths in custody – including those that took place in prisons and mental health units. The report emphasises that article 2 of the Human Rights Act – the *right to life* – creates a positive duty:

> *'When the state takes away the liberty of an individual and places him or her in custody, it assumes full responsibility for protecting that person's human rights – the most fundamental of which is the right to life'* (p7).

The JCHR argues that the only way for these issues to be tackled is for a statutory duty to be placed on health care trusts to provide appropriate services for those detained under section 136 Mental Health Act.

Methodology

The research took place in late 2006. It is standard police procedure to record all incidents of self-harm that take place in custody. The researcher was given access to an anonymous summary of parts of the custody record for each detained person where an incident of self-harm had been recorded. These summaries included basic information such as the age, gender and race of the detained person, the alleged offence, and the date and time of arrest. The period covered by the research was February to September 2006. There were 168 recorded incidents in the period covered by the project during which there were over 48,000 arrests. The information provided was then analysed using SPPS (computer statistical analysis programme). The aim was to examine the links between variables such as age or gender, identify patterns of risk behaviour and to use this data as a basis for improving future practice.

Findings

Almost three-quarters of the detained persons who harmed themselves were men (73%; n=123) and only just over a quarter of the sample were women (27%; n=45). The overwhelming majority of individuals (93%; n=156) identified themselves as white British. In addition, almost three-quarters (73%; n=123) of the sample were unemployed at the time of their arrest. The most common form of employment was manual work (13%; n=22). The age spread of this cohort was: nine were under 15, 36 were aged 16–19, 53 were aged 20–29, 44 were aged 30–39, 19 were aged 40–49 and seven were 50–59. There was no one older than this in the sample. The custody officer recorded the condition of the detained person when they arrived in custody. The three most commonly recorded conditions were drunk (47%; n=79), under the influence of alcohol or drugs (19.6%; n=33) and 'normal' (21.4%; n=36). This accounts for the overwhelming number of detained persons in the sample. The other conditions identified included violent, confused, agitated and crying.

The sample was spread across the different police stations. The incidents were distributed throughout the week. More incidents were recorded on Mondays (19.6%; n=33) than any other day. Sundays saw the fewest incidents, with less than 10% occurring (8.9%; n=15).

The most frequent reason given for the arrest for almost three-quarters of individuals (72.6%; n=122) was that an offence had been committed; this was followed by the fact that a

breach of the peace had occurred (11.9%; n=20). Following on from this, the most common offences were public order matters (28%; n=47) and violent offences (31%; n=31). In 36 cases where there was a breach of the peace or the individual had been arrested on a warrant or for a breach of bail, no offence was recorded. A range of other offences were recorded including theft, fraud, burglary, sexual offences and robbery. The PNC contains a warning signal if there is information that the detained person is at risk. In just over one-third of cases (35.1%; n=59), there was no warning signal on the PNC. The three most common warning signals recorded were sel=self-harm (15.5%; n=26), vio=violence (12.5%; n=21) wea=weapons (13.1%; n=22). Fourteen detained persons had previously been identified as a suicide risk.

The most common method of self-harm was the making of a ligature either from the detained person's clothing in a third of cases (33.9%; n=57) or from the paper suit that they had been given to wear, in (26.2%; n=44) cases. Other methods included using an instrument (15.5%; n=26) or heading/ punching the walls of the cell (11.9%; n=20). The instruments used were usually items of cutlery. Three detained persons attempted to suffocate themselves by swallowing toilet paper and two had concealed items, which they subsequently used to harm themselves. In over half of cases 92 (54.8%; n=92), the detained person was not injured. In cases where injuries were sustained, the most common of these were superficial (13.1%; n=22), swelling or bruising (20.8%; n=35) and cuts or bleeding (9.5%; n=16). In one case, the detained person was found unconscious in their cell.

In the custody suite, there will be both police and civilian staff on duty. The custody sergeant is supported by both police officers and civilian custody staff. However, the patterns of deployment vary across the country. Police officers will have full powers. There is a very clear 'duty of care' owed by the force to any detained person in custody. The professional responsibility that this places on individual custody sergeants is keenly felt (Cummins, 2007). Custody officers are asked to record the actions taken following medical advice, the actions taken by police staff and also to recommend any steps that might be taken to avoid the repetition of such incidents. In over half of the cases (55.4%; n=93), it was recorded that no medical intervention was required. In 17 cases this information was missing. The most common medical intervention was the involvement of the forensic physician (9.5%; n=16). In a small number of cases (5.4%; n=9), the detained person was taken to hospital and in a further eight cases (4.8%) paramedics were called. In another eight cases (4.8%), police staff administered first aid. On two occasions, a formal mental health assessment was arranged for an individual following the incident.

The most common response by staff in custody was to increase the level of observation (29.2%; n=49). This information was missing in 25 cases. In six cases the detained person was given a paper suit to wear. Conversely, in 14 incidents the paper suit was removed. Other responses included the suggestion that clothing for detained persons should be improved, and a warning signal placed on the PNC about removing items or clothing. In a majority of cases, the individuals involved in these incidents did not remain in custody. In 30 cases (17.9%), the person was charged and bailed, while in a fifth of cases (19.6%; n=33), the person was released without being charged. In a small number of cases (6.5%; n=11), an adult caution was used, while in (10.7%; n=18) a penalty notice was issued.

Discussion

This is a relatively small-scale indicative study. The possibility exists that not all

incidents of self-harm that would meet Morgan's definition have been recorded. In addition, ethical and other factors meant it was not possible to obtain more background information about the individuals who harmed themselves. For example, details about any previous psychiatric history or contact with mental health services were not available. Linsley *et al* (2007) have demonstrated that police officers can be a key point of contact for this vulnerable group of individuals. This project had a number of similar findings to studies identified in the literature review. The clearest risk factor highlighted in these cases was alcohol. In a majority of cases, the individuals who harmed themselves were intoxicated. There is a difficulty here for officers trying to assess risk, as a number of detained persons are likely to be under the influence of alcohol or other drugs. Studies that have examined self-harm in prison settings have outlined the fact that the earliest period in custody is potentially dangerous. In this study, it was not possible to explore this issue. The fact that incidents of self-harm occurred in a very small minority of cases should not obscure the fact that being in custody is in itself a risk. Further study is required in this area to examine whether these incidents are part of a pattern of responses to stressful situations on behalf of those individuals or is unique to being in custody.

The most common methods of self-harm used in these incidents were ligatures and head butting/punching the cell walls. One of the interesting points raised here is the fact that blue paper suits, in themselves, do not prevent incidents of self-harm taking place. There are some indications that the fact of being placed in a blue paper suit might be a contributory factor towards self-harm. This issue needs to be explored in more depth but the views of service users quoted above indicate that there is a dehumanising process at work here. In addition, the suits themselves can clearly be damaged or be used as an instrument to self-harm. The suits are not used in isolation, as in all incidents where the detained person's clothing was removed, observation was increased. There will always be some circumstances in which a detained person's clothing might need to be removed for forensic examination, so the blue paper suit, or an equivalent will have to remain in use. The issue of detained persons using clothing or other items such as bedding, as ligatures is more problematic. It would be unacceptable for officers to place all detained people in paper suits as a matter of routine. It should be noted that one of the biggest complaints that those who had been detained under section 136 (MHA, 1983) had, was the use of this practice (Jones & Mason, 2002).

One might have expected that the weekends, or particularly pressured times such as Bank holidays would see an increased level of incidents because of the higher level of arrests in this period. However, Mondays saw the most recorded incidents. This is the day of peak cell occupancy because of the effects of courts weekend sitting arrangements, so the potentially corrosive effects of being in custody are a factor here. The ratio of male/female detained persons, who harm themselves is 3:1 in this study. However, women are arrested in much smaller numbers than men so the risks appear to be elevated for women.

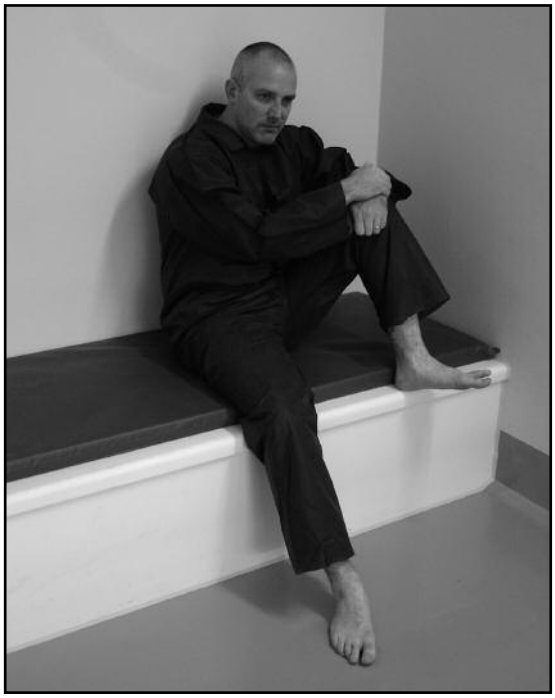
The detained persons who attempted to harm themselves had been arrested for a variety of offences. One of the difficulties that custody officers face is trying to assess the impact the arrest has on the individuals. The offence is, in some senses, not the key factor here. It is, rather, the possible impact of being arrested on that individual's sense of identity. A shoplifting offence might have an impact far greater than the monetary value of the goods stolen. This underlines the importance of risk assessment being fluid and individualised.

The custody officer has a vital role to play here. It should be acknowledged that this is a complex and demanding one. The environmental and work pressures are immense and it is widely recognised that the officers involved have generally been given little specialist mental health training. In addition, there is very rarely specialist medical support immediately available. In the majority of the incidents in this study, the custody staff appear to have largely dealt with the matter themselves. It was only in a minority of cases that medical assistance was sought. If the detained person was in need of urgent medical attention because of their injuries, then this was sought. However, in only two cases was a formal mental health assessment arranged. The most common response is to increase observations. There may be several factors at work here. This might reflect the custody officers' lack of confidence in the sort of support that mental health services might provide. In addition, these incidents will be emergencies. Once the immediate safety of the detained person has been ensured, it is possible that the other demands of the custody environment are given a greater priority. The experience that officers have of dealing with such situations may lead to an unconscious downplaying of their serious nature.

The recording systems for these incidents allow custody officers to make suggestions as to how they can be avoided in future. They rarely do this, perhaps reflecting a feeling that such incidents are inevitable. In addition, it does not appear from the records studied that a marker is put on the PNC as a matter of standard practice, that the individual has harmed themselves in custody. In most cases, there was no previous indication that the individual might be at risk in such settings. The level of detail provided about each incident varies significantly. On occasions, officers do appear to downplay the serious nature of the incident – for example by describing it as 'attention seeking' or, because they know the individual well, assuming that this was not an attempt to take their own life. Such an approach is to be discouraged for several reasons. It is a judgement that is impossible to make. In addition, it might lead to poor risk assessment. The records indicate that most of the individuals are bailed. It is not clear what, if any, further action is taken with the information at that stage.

As noted above, there was surprisingly little contact with other agencies. One of the difficulties that exists here is the fact that any detained person who is treated by a doctor in custody is, in effect, a private patient. The incident and action taken does not, as a matter of course, become part of the person's medical record. In addition, there were concerns from the police force involved that it would be in some circumstances breaching data protection if it passed on such information. It is possible that a closer study of the custody record will indicate that medical or social service agencies had been contacted for advice or guidance. However, a more likely explanation is a belief among custody staff that unless the medical intervention required is greater than basic first aid, then they will have to deal with the situation in any event. The possibility clearly exists that there is an under recording of these incidents, and this is an area that needs to be explored further.

The police force involved is responding to a number of the issues raised here. An alternative to the paper suit is being considered. The so-called 'suicide suit' is essentially a combination of large t-shirt and shorts. This might be less dehumanising than the paper suit. In addition, there are plans for improved CCTV in custody settings. The custody officers' course has been revamped to include a specific mental health awareness input along with refresher sessions for experienced staff. Systems are being developed to signpost individuals to the appropriate social work and mental health services.



Model wearing the new 'safer suit' to be used for high-risk persons in custody

Conclusion

This study highlights previous concerns about the safety of vulnerable adults in police custody. The incidents all posed a very serious threat to the safety, and in some cases, the lives of the individuals in custody. Police officers, in particular custody officers, are being placed in positions where they are assuming a quasi-mental health nursing role. This is a role for which, in the vast majority of cases, they have received little if any training, In addition, environmental, organisational and cultural factors mean that police officers often feel isolated from, or unsupported by community-based mental health services. There is a need for greater investment in the training of officers. However, the long-term solution lies in tackling the failures of deinstitutionalisation. In the interim, police officers need the support of mental health professionals. The locus for this support should be the police station itself. In addition, clearer protocols for the sharing of information needed to be established between all agencies working in this field and potential adult protection issues need to be dealt with. In public health terms, if targets for improved outcomes in mental health services are to be met, this is a key area for engaging with a group whose marginalisation (ODPM, 2004; Kelly, 2005) has inevitable impacts on individuals' mental health.

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