

**POLICING MADNESS: *A case study analysis of the
management of mental illness in custody settings in
England and Wales***

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Abstract

This thesis presents a collection of nine published works in key peer reviewed journals alongside five further papers, a book and a book chapter. The papers explore two interlocking themes the impact of deinstitutionalisation and the decline of the social state. The key argument here, informed by not only secondary research, in the form of a large scale literature review, but also primary research examining the management of mental distress in custody settings, is that these policies have led to an increased role for the police in responding to people with mental health problems experiencing a crisis. Analysis of the combined results arising from the empirical studies carried out with Greater Manchester Police (GMP) and Lancashire Constabulary in the period 2006 to 2011, provides a holistic overview of the key role and perceptions of the Custody Sergeant in the management of those experiencing some form of mental health problem. In addition to the empirical work that has been undertaken, the research examines the socio-legal context of policing and mental illness. The work identifies and evaluates the philosophical, ethical and organisational challenges presented by the increased role for the police in the provision of mental health services. The empirical research comprises a case study (Yin 1984) investigation of the custody setting and the custody sergeant's role within it. This is then used as a basis for the socio-legal papers which present an analysis of the impact of two major social policies - deinstitutionalisation and the expansion of the use of punitive responses to marginalised individuals.

Group 1: Papers 1 - 5 : Socio-legal context

- 1: Cummins, ID (2006):** A path not taken? Mentally disordered offenders and the criminal justice system *Journal of Social Welfare and Family Law*, 28 (3) pp. 267-281.
- 2: Cummins, ID (2011):** The other side of silence The role of the appropriate adult post-Bradley , *Ethics and Social Welfare*, 5 (3), pp. 306-312.
- 3: Cummins, ID (2012)** Policing and Mental Illness Post Bradley *Policing; A Journal of Policy and Practice* pp 1-12
- 4: Cummins, I (2013)** Using Simon's "Governing through crime" to explore the development of mental health policy in England and Wales since 1983 *Journal of Social Welfare and Family Law*. 34 (3), 325-337
- 5: Cummins, I (2013)** Policing and Mental Illness in the era of deinstitutionalisation and mass incarceration: A UK Perspective, *International Journal of Criminology and Sociological Theory* 6(4)

Group 2: Papers 6-9: Empirical Work

- 6: Cummins, ID (2007):** Boats against the current; vulnerable adults in police custody. *The Journal of Adult Protection*, 9 (1) pp. 15-24
- 7: Cummins, ID (2008):** A place of safety? Self-harming behaviour in police custody" *The Journal of Adult Protection*, 10 (1) pp. 36-47
- 8: Cummins, ID and Jones, S (2010):** Blue remembered skills: mental health awareness training for police officers *The Journal of Adult Protection*, 12 (3) pp. 14-19.
- 9: Cummins, ID (2012):** Mental Health and Custody: a follow-on study *The Journal of Adult Protection*. Vol. 14 Iss: 2, pp.73 - 81

For convenience, when the papers are referred to in the text they are in **BOLD** with the paper number in brackets -e.g. **Cummins, 2006 (paper 1)**

Supportive Evidence

In addition to the nine papers integral to the thesis, there are a number of published works that provide additional information or perspectives on the papers included in the portfolio. These papers are listed as supportive evidence.

Journal Articles

10: Cummins, I (2010), Mental health services in the age of neo-liberalism *Social Work and Social Policy in Transition*

11: Cummins, I (2011), Distant Voices Still Lives: Reflections on the media reporting of the cases of Christopher Clunis and Ben Silcock *Ethnicity and Inequalities in Health and Social Care*, 3(4).

12: Cummins, I (2015), 'Reading Wacquant: Social Work and Advanced Marginality', *European Journal of Social Work*

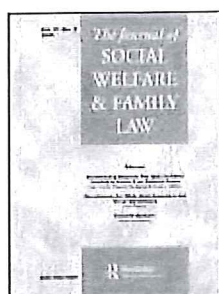
13: Cummins, I (2015), Discussing race, racism and mental health: Two mental health inquiries reconsidered *International Journal of Human Rights in Healthcare*.

14: Cummins, I & Edmondson, D 2015, Policing and Street Triage *Journal of Adult Protection*

Book Chapter

15: Cummins, I 2010 *The relationship between mental institutions beds, prison population and the crimes rate in: Prison mental health: vision and reality* RCN , NACRO, CENTRE for MENTAL HEALTH , LONDON, UK, pp.22-25

Appendix Two: Supporting Papers



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

Ian Cummins

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

Ian Cummins

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 Scencedirect). 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-institutionalisation policies, such as 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 than 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 where 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

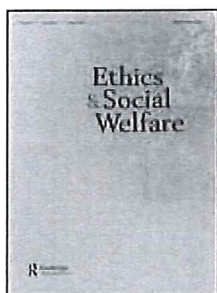
note that the view that people with mental health problems are violent was the most difficult to tackle. A greater confidence in community services will only come from an improvement in services that tackles the long-standing underfunding, poor organisation and lack of a commitment to inter-professional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



'The Other Side of Silence': The Role of the Appropriate Adult Post-Bradley

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'The Other Side of Silence': The Role of the Appropriate Adult Post-Bradley

Ian Cummins

The publication of the Bradley review in the United Kingdom is a watershed in the development of policy regarding the way that the Criminal Justice System responds to individuals with mental health problems. It then goes on to explore one aspect of that response: the role of the Appropriate Adult under the Police and Criminal Evidence Act (1984).

Keywords Mentally Disordered Offenders; Appropriate Adult

Introduction

Mental Illness and the Criminal Justice System

The legal system and penal policy in the United Kingdom and similar legal jurisdictions does not regard offenders with mental health problems as a distinct group. The range of mental health needs and the great differences in patterns of offending make it difficult to make generalisations in this field. In addition, there are a number of ethical and philosophical issues that arise here relating to the diagnosis and treatment of mental illness (Eastman & Starling 2006). As Eastman and Starling note, a purely bio-medical model of illness cannot be applied in an easy fashion to mental illness. In addition, psychiatry and psychiatric diagnosis have a role to play in the Criminal Justice System (CJS). The main focus of these debates has been on to what extent, if any, mental illness should be seen as a mitigating (or possibly aggravating) factor when courts are considering sentencing (Morse 1999). However, mental illness is a factor to be taken into account in decisions from the point of arrest onwards. For example, the police have powers under section 136 of the Mental Health Act (MHA 1983) to remove an individual to a place of safety so that they can be assessed by a psychiatrist and an Approved Mental Health Professional (AMHP). The Crown Prosecution Service Code (CPS 2010) is clear that the fact that someone is suffering from a mental illness is a

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factor to be considered in charging decisions. This article is concerned with one area of the CJS: the interviewing of detained persons in police custody and the role of the Appropriate Adult.

The Police and Criminal Evidence Act (PACE) 1984

In 1972, Maxwell Confait was murdered in London. Three youths—Colin Lattimore (18), Ronnie Leighton (15) and Amhet Salih (14)—were convicted of arson with intent to endanger life. Lattimore was also found guilty of manslaughter. Leighton was convicted of murder. The basis of the prosecution case against all three individuals was confession evidence. The three youths eventually appealed successfully against these convictions. The confessions had been obtained under duress (Fisher 1977). Following the successful appeal, a Royal Commission was established. This reported in 1981. The changes that it proposed were incorporated into PACE (1984). The introduction of PACE led to the abolition of the 'Judges' Rules' which had governed the conduct of interviews of suspects. The new framework included, for example, the tape recording of interviews. These provisions apply in all cases. However, PACE went further and identified three groups that were to be offered additional protections. The three groups were juveniles, adults with learning difficulties and adults with mental health problems. Modern criminal justice systems have largely recognised that juveniles, by virtue of their age, should be treated differently to adults when issues of criminal responsibility are considered. Space does not allow for a wider consideration of these issues. However, it is interesting to note that one of the signs of the shift towards *neo-liberal penalty* (2009) is the idea that children can and should be put on trial, particularly for the most serious offences, in adult courts (Matthews 2005).

The Appropriate Adult (AA) has an overarching duty to ensure that individuals are aware of their rights under Code C (para. 31) whilst in custody. In most cases, the detained person will be in custody so the AA will have to ensure that this is the case when they arrive at the police station. If the detained person is not legally represented or has waived the right to be so, the AA can decide not to proceed with the interview until representation has been arranged. This point is explored in more depth below. In addition, Code C (para. 11.16) emphasises that the AA should ensure that the interview is conducted properly and fairly and is not 'oppressive'. The AA can make representations at any review of detention or other procedures such as fingerprinting (Code D paras 1.11–14).

One feature of the AA role is that it appears to be relatively rare in cases of adult detained persons. Actual figures are very difficult to obtain (Cummins 2006). The evidence from the prison system is that mental health problems—particularly those of a very severe nature—are common amongst this group (Singleton *et al.* 1998). Cummins (2007) found that the lack of training that police officers receive, the poor sharing of information across services and the inherent difficulties in making an assessment of any individual's mental state within

pressured custody, rather than wilful disregard of the PACE, are major contributory factors. The overall effect is that the aim of diversion from custody as outlined in Home Office circulars 66/90 and 12/95 has not been met (Home Office 1990, 1995). Penrose (1939) suggested that there is an almost hydraulic relationship between custody and psychiatric services. Deinstitutionalisation and the failure to develop robust community care services for adults with severe mental health problems offer strong support for this hypothesis (Cummins 2011).

In PACE guidance 1E, it is suggested that a trained AA should take on the role. However, it is clear that a range of individuals including relatives, volunteers and carers, as well as social work staff, take on the role. In Medford *et al.* (2003), there is an example of a doorman from a hotel next to the police station taking on the role. This is, hopefully, an isolated example. However, it highlights a fundamental weakness and contradiction in the role. If this is a key role—protecting vulnerable people in the CJS—it cannot be exercised in such a haphazard fashion. Youth Offending Teams (YOTs) now have responsibility for ensuring that AAs are available for interviews involving juveniles. In many cases, a service-level agreement has been reached with large voluntary agencies to meet this requirement. This ensures that a pool of experience and expertise is built up. No similar responsibility as yet exists for the interviewing of adults. Bradley's recommendations highlight the need to ensure that there is a pool of experienced trained staff available to take on the AA role. The current economic climate means that the likelihood is that the role will be taken on by voluntary or third-sector organisations. The role of the AA is a complex and demanding one that is actually full of contradictions. In the current adversarial system, the AA is in the middle—not quite an advocate, not quite a referee.

Bartlett and Sandland (2003) have argued that there is confusion at the heart of the role that the AA is asked to play. This confusion stems from the ambiguity of such terms as 'facilitate communication' and 'fair interview'. The role crosses the welfare and justice axis. The law in this area has stemmed from cases where the question at issue was the suitability of the individual acting as an AA. Pierpoint (2000) has highlighted the way that a parent taking on the role can possibly undermine the position of detained juveniles. Such an argument could be similarly deployed in cases of adults being questioned when the AA is a family member or has a close relationship with the individual in custody. This is supported by the decision in *DPP v. Blake* where an estranged father was not seen to be neutral. In *R v. Morse*, it was held that a father should not have taken on the role as his low IQ meant that he was unable to understand fully the scope and nature of the role. Incidentally, it would be possible to argue that this test, if applied widely, would exclude high numbers of individuals—for example those who act in the role without training—from the position. The legal position was further confused by the decision in *R v. Cox*. The confession evidence of a woman was held to be admissible despite the fact that her mother, who acted as the AA, had learning difficulties and mental health problems.

Discussion

The role of the AA raises a number of moral and ethical questions. The first set of questions relates to the protections that individuals should have when being interviewed by the police. The fundamental issue is should groups have special protections and if so which groups? Following on from this, what should be the nature of those protections and how should those protections be exercised?

Medford *et al.* (2003) conclude that the role has become a largely administrative one with AAs contributing very little to the interview process. The numbers of adult interviews with an AA present do not appear to square with the numbers of prisoners with mental health problems. If it is accepted that there are groups of individuals who are more vulnerable, then it is a proportionate response to ensure that those individuals are given additional protections. The counter argument is that the AA could undermine the autonomy of the detained person. For example, the AA can overrule the individual's decision to refuse legal representation. This is particularly the case when adults are concerned but it can be equally applied in cases where juveniles are '*Gillick competent*'. If we accept that individuals have capacity then the decision should be theirs to make; we cannot then overrule it if the outcome is one that we do not support. There is a danger in an even wider return of the restrictive paternalism that has been a feature of modern mental health services (Laurance 2002; Sayce 2000).

There is a lack of clarity in legislation and practice here. The protections of PACE should apply if the custody has reason to believe that the detained person has a mental health problem. This is not, of course, the same as being acutely unwell. The fluid and changing nature of mental health problems does not mean they are all necessary relevant to these sorts of decisions. The decision-making schema outlined in *Re C* would be applicable in these cases. If an individual is able to retain information, understands it and the implications of their course of action then they are deemed competent to make a decision. If an individual decides that they do not want legal advice, we might seek to dissuade them but to override their autonomy solely on the basis of their mental health status is an enormous shift. As Banks (1995) argues, social work ethics is very clearly influenced by Kantian notions of autonomy and a respect for persons. However, in practice, the law allows for individual autonomy to be overridden. Individuals, who are not regarded as mentally ill are free to refuse legal advice. This might be regarded as foolish, naive or misguided but it is not a decision that could be overruled.

One feature of the *Risikogesellschaft* (Beck 1992) is the development of a culture where risk is the determining factor in decision making. One perverse outcome of these developments is actually the restriction of individual choice. These restrictions impact disproportionately on groups across society. The protection of individuals in the custody of the state in any area should be a key concern for the wider society. If we were to conduct a thought experiment, Rawls' work (1971) would suggest that individuals would accept these additional

protections as just. In Rawls' schema, individuals accept such institutions as decisions are made in an original position behind a '*veil of ignorance*', i.e. in this case the individual would not know whether they would benefit from the protections as they do not know whether society would deem them to be mentally ill. In addition, the protections do not disadvantage another group, as in all other respects, for example the burden of proof, the system remains the same.

White (2002) argues that the role of the AA needs to be clarified and one way to do this would be to extend legal privilege to those taking on the role. This would change the position of the AA fundamentally. The AA would then not be neutral but part of the defence. This would not tackle the issues that have been raised here. It is difficult to see what it would add to the process. As noted above, the role of the AA is a fuzzy one. There is evidence that the additional protections it is meant to afford individuals are not offered to large numbers of detained persons who are interviewed. There are a number of responses here. The first, influenced by Szasz-style libertarianism (Szasz 1963), is to suggest that mental illness is never to be a consideration when making decisions within the criminal justice system. This would include removing the role of the AA within this jurisdiction but also the use of any psychiatric institutions in criminal sentencing. I would argue that this is inherently unjust. For example, it would have led to the original decision in the trial of the Andrea Yates case being carried out. The State of Texas would have executed a clearly acutely psychotic woman.

A more functional argument is to suggest that PACE (1984) is, in fact, unworkable legislation. Research by Cummins (2007, 2008) indicates that custody officers have little, if any, training in mental health issues. They are then put in positions where they are being asked to assess individuals' mental state. This is an inherently difficult process, let alone undertaking it in the pressured environment of the custody area. In addition, that large numbers of detained persons are intoxicated (Payne-James *et al.* 2009) makes the assessment even more complicated. The overall effect is to place the responsibility for assessment on a group of professionals who lack the training or support to undertake the role properly. To suggest that in response to these difficulties we abandon the role of the AA is cynical in the extreme. The more measured response is to explore ways to overcome the logistical and other difficulties that have led us to the current position. The Bradley review is very clear on this point. Its recommendations, including transferring the commissioning of healthcare services in police custody suites to the NHS, would strengthen the safeguards to all citizens in police custody.

In conclusion, it is helpful to return to first principles. In an era when the state is seeking to and has reduced the rights of suspects, it is worth asking why and how the role of the AA came about. It was part of a series of measures to protect vulnerable individuals from abuse within the criminal justice process, particularly the danger of self-incrimination. The evidence from a series of cases is that the need for those protections still exists. As Haley and Swift (1988) suggest, the overarching aim is for the courts to hear more reliable evidence. It is in the

interests of all citizens to support such moves. The clear message of the Bradley review is that support for those with mental health problems, who come into contact with the CJS, needs to be increased. The Bradley review has recognised that these systems have to be strengthened. This includes more robust systems to support the role of the AA. The social work profession, as part of its commitment to social justice, welcomes such moves and will do all it can to support them.

References

- Banks, S. (2006) *Ethics and Values in Social Work* (3rd edition), Basingstoke, Palgrave.
- Bartlett, P. & Sandland, R. (2003) *Mental Law Policy and Practice*, 2nd edn, Oxford University Press, Oxford.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*, trans. M. Ritter, Sage, London.
- Bradley, Lord K. (2009) *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*, DH Publications, London.
- Crown Prosecution Service (CPS) (2010) *The Code for Crown Prosecutors*, available at: <www.cps.gov.uk>.
- Cummins, I. (2006) 'A Path not Taken? Mentally Disordered Offenders and the Criminal Justice System', *Journal of Social Welfare and Family Law*, Vol. 28, no. 3, pp. 267–81.
- Cummins, I. (2007) 'Boats against the Current: Vulnerable Adults in Police Custody', *Journal of Adult Protection*, Vol. 9, no. 1, pp. 15–24.
- Cummins, I. (2008) 'A Place of Safety: Self-harming Behaviour in Police Custody', *Journal of Adult Protection*, Vol. 10, no. 1, pp. 36–47.
- Cummins, I. (2011 forthcoming) 'Deinstitutionalisation; Mental Health Services in the Age of Neo-liberalism', *Social Policy and Social Work in Transition*.
- Eastman, N. & Starling, B. (2006) 'Mental Disorder Ethics: Theory and Empirical Investigation', *Journal of Medical Ethics*, Vol. 32, no. 2, pp. 94–9.
- 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.
- Haley, M. J. & Swift, A. (1988) 'P.A.C.E and the Social Worker: A Step in the Right Direction?', *Journal of Social Welfare and Family Law*, Vol. 10, no. 6, pp. 355–73.
- 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.
- Laurance, J. (2002) *Pure Madness: How Fear Drives the Mental Health System*, Routledge, London.
- Matthews, R. (2005) 'The Myth of Punitiveness', *Theoretical Criminology*, Vol. 9, no. 2, pp. 175–201.
- 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. 253–66.
- Morse, S. J. (1999) 'Craziness and Criminal Responsibility', *Behavioral Sciences and the Law*, Vol. 17, no. 2, pp. 147–64.
- Payne-James, J. J., Green, P. G., Green, N., MacLachlan, G. M. C., Munro, M. H. W. M. & Moore, T. (2009) 'Healthcare Issues of Detainees in Police Custody in London', *Journal of Forensic and Legal Medicine*, Vol. 16, no. 4, pp. 189–95.

- Penrose, L. S. (1939) 'Mental Disease and Crime: Outline of a Comparative Study of European Statistics', *British Journal of Medical Psychology*, Vol. 18, no. 1, pp. 1–15.
- Pierpont, 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.
- Rawls, J. (1971) *A Theory of Justice*, Harvard University Press, Cambridge, MA.
- Sayce, L. (2000) *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion*, Macmillan, Basingstoke.
- Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric Morbidity among Prisoners in England and Wales*, HMSO, London.
- Szasz, T. (1963) *Law, Liberty and Psychiatry*, Macmillan, New York.
- 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.

Legal Cases

DPP v. Blake

Re C

R v. Cox

R v. Morse

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

Policing and Mental Illness in England and Wales post Bradley

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Abstract The Bradley Review (2009) is a major analysis of the treatment of people with mental problems and learning disabilities within the Criminal Justice System (CJS). The legal system and penal policy in UK and similar legal jurisdictions do not regard offenders with mental health problems as a distinct group. However, within the CJS, the fact that an individual has a mental health problem can be taken into account in key decisions such as arrest, charging, entering a plea, and sentencing. This article will examine the legal powers that police officers have in England and Wales in this area. It will then go to examine the implication of this role for police training.

Introduction

The UK government commissioned the Bradley Review (2009) to look at the experiences of people with a mental health problem or a learning disability across the Criminal Justice System (CJS). This article begins with a consideration of the ways that the CJS and mental health services overlap. This has been the case since the development of modern penal and health systems but has been exacerbated by the policy of 'de-institutionalization' which has been pursued in virtually all industrialized countries since the early 1960s. The impact of the development of community care on the role of the police is considered. Mental health-related work is a very significant aspect of police work. Police officers can have a key role to play in situations in which individuals are experiencing some sort of crisis related to mental health

problems. The Sainsbury Centre's (Bather *et al.*, 2008) study suggested that up to 15% of incidents dealt with by the police include some sort of mental health issue or concern. It also calls for the exercise of a range of skills. The police have considerable discretion in terms of their response (Bittner, 1967). They may well be the emergency service that is first contacted by the relatives if those in acute distress, who are, for example, putting themselves or others at risk. If a person is acutely distressed in a public place then the likelihood of some form of police involvement is increased significantly. This article will explore two key areas: section 136 of the Mental Health Act (MHA, 1983) and the Police and Criminal Evidence Act (PACE, 2004). Section 136 MHA 1983 allows police officers to intervene and remove an individual to a 'place of safety' to be assessed by a

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psychiatrist and an Approved Mental Health Professional (AMHP). PACE (1984) provides special protections to adults with mental health problems if they are arrested. Adults with mental health problems have to be interviewed with an Appropriate Adult (AA) present. This is an additional protection provided by PACE (2004). The AA role (Cummins, 2011) is to facilitate the interview process.

De-institutionalization

The issue of the people with mental health problems entering the CJS and not receiving adequate health care is not a new one. As long ago as 1780, Howard (1780) noted that prisons were housing more 'idiots and lunatics'. He also highlighted the detrimental effects that this had on the prison regime for both sets of prisoners. Similar observations and criticisms have been made at various times since. The period of de-institutionalization has seen 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 has a shift in the position of law enforcement agencies. They have had to deal with increased numbers of people experiencing mental health problems. Cummins (2006, 2011) has outlined the ways in which mental health care in the 'penal state' (Wacquant, 2009) has been increasing delivered via the CJS. As Cummins (2010a, b) has argued it is difficult, if not impossible to provide adequate mental health care in overcrowded prison systems.

The above developments outlined above appear to support the hypothesis that Penrose (1939) put forward nearly 70 years ago. He argued that the way that a society decides to deal with those who behave in ways that challenge norms is decided by a range of factors. These will depend upon the prevailing social and political climate, changes in normative behaviour, and the resources that are available. According to Penrose's hypothesis, the level of

need in terms of institutional care will remain fairly constant. Therefore, in a society that has 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 to meet adequately the level of need, such individuals will be drawn into the CJS. Penrose's original hypothesis chimes with the experiences of the development of the policy of Community Care in the 1980s and 1990s. Gunn (2000) highlights the fact that the previous 20 years 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-institutionalization policies. A similar shift has occurred in USA (Borum, 2000).

Policing and mental illness

Despite the fact that mental health issues are a very important factor in day to day police work, it is an area that is neglected in police training. Pinfold (2003) suggests that police officers hold a number of stereotypical views about mental illness with the idea that there is a link between mental illness and violence being the most strongly held. This viewpoint is supported by Cotton (2004). Cummins (2007) showed that the majority of officers have little input in this field. As a result the skills and knowledge that they acquire is largely through experience on duty or from their senior colleagues. This is a long standing issue (Sims and Symonds, 1975; Tesse and van Wormer, 1975). It appears to be a common feature in policing in the industrialized world (Fry *et al.*, 2002). The study by Janus *et al.* (1980) showed that the benefits of training include increased empathy on the part of officers for those experiencing mental health problems.

Since the introduction of the policy of de-institutionalization, there have been concerns that people with mental health problems would be seen as

potential targets for crime. The media focus on individuals with mental health problems as violent (Cummins, 2010a, b) has ignored the experiences of this group as victims of crime. The Chicago study by Teplin *et al.* (2005) found that more than 25% in a sample of over 900 individuals with severe mental illness had been victims of violent crime in the previous 12 months. Depending on the type of violent crime, the people with severe mental health problems were between 6 and 23 times more likely to be a victim than the general population. The systematic reviews and meta-analysis by Hughes *et al.* (2012) support these disturbing findings. This review also included studies exploring the experiences of adults with learning disabilities. The analysis highlights the fact that adults with any form of disability face an increased risk of violence than non-disabled adults. In addition, it is individuals with severe mental health problems who face the greatest risk, 24% of this group had been the victim of violence in the previous year. The analysis points out that there are a number of methodological issues in this field, particularly in relation to the reporting of crime. However, there is a key message for the police and other agencies: people with severe mental health problems face a significantly increased risk of being a victim of violent crime. The possible impacts of being a victim of violent crime might well be exacerbated.

It has been a long stated aim of policy to divert people with mental health problems from the CJS at the earliest opportunity. This policy was outlined in the Home Office circular 66/90 and 12/95. The police station could be a key locus for this diversion or perhaps more accurately accessing of mental health care. The provision has been patchy and led to frustration for police officers (Vaughan *et al.*, 2001; Curran and Matthews, 2001). However, to access to appropriate mental health services for those in contact with the CJS, as the Bradley Report shows, is still fragmented and disjointed. Models of good practice exist, but there are not spread widely enough.

Borum *et al.* (1998) argue that though responding to situations where people are experiencing acute mental distress is a significant aspect of policing, departments did not feel the general response was a good one. In addition, they suggest that it is only in jurisdiction where specialist crisis police teams had been established that officers felt well equipped to deal with these sorts of situations. Teplin (1985) study of police–citizen encounters demonstrated the patterns of offending among the mentally ill and the wider population were broadly similar. Bonovitz and Bonovitz (1981) study outlined the increased level of police contact. In the study there was a 227.6% increase in a 4-year period. Robertson (1988) identified the increased vulnerability of the mentally ill to arrest.

Police officers in Gillig *et al.*'s 1990 study felt that what they really needed was access to information about an individual's past history as well as rapid support from mental health staff. Watson *et al.* (2004a) found that knowledge of an individual's mental health history has a negative impact on how the police respond—in this study the police were less likely to take action on the information provided if the individual had a history of mental illness. However, there is evidence that the police have skills in this area (Smith, 1990). Watson *et al.* (2004b) show that in certain situations officers are sympathetic to the needs of people with schizophrenia. The importance of this area of police work is emphasized in the study of suicides by Linsley *et al.* (2007). This showed that the police were the profession that the person who had taken their own life was most likely to have had contact within the 3 months prior to their death. IPCC (2006) has highlighted the need to ensure that risk assessments are carried out to ensure that vulnerable individuals are supported following their release from custody.

The police have become increasingly involved in supporting community-based mental health services (Meehan, 1995). This is likely to increase with the introduction of community treatment

orders in England and Wales with the reform of the 1983 Mental Health Act. The increased contact has led some forces to explore different models of policing to response to mentally ill people experiencing acute distress. These include crisis intervention teams including specially trained officers. Deane *et al.* (1999) identify three possible responses: a police-based specialized police response, a police-based specialized mental health response, and a mental health-based mental health response. These reflect the balance among the professionals on the teams. Steadman *et al.* (2000) emphasize that improved inter-agency working has a key role to play in ensuring that people with mental health problems are not sent to prison inappropriately. The study by Lamb *et al.* (1995) indicates that joint teams can both meet the needs of severely mentally ill people and help avoid the criminalization of acutely distressed individuals.

The Mental Health Act Commission has regularly highlighted its concerns about the way that other Health and Social work agencies have struggled to establish effective working relationships. The Police are likely to become involved in mental health work in a number of ways. The police can be the first contact that individuals have with any service. For example, if a person is acutely unwell or behaving in a concerning way then a relative or member of the public is most likely to call the Police. Police powers under section 136 MHA allow officers to intervene in such circumstances. Other possible areas include supporting Approved Mental Health Professionals (AMHPs) carrying out a MHA assessment or executing a warrant under section 135 MHA. The police are increasingly involved in the management of patients on the ward. These are clearly vital roles. However, it should be noted that there are all situations, which involve dealing with people who are likely to be extremely distressed. Police officers' perception of people with mental health problems is, therefore, inevitably influenced by the skewed nature of this sample. However, the day to day evidence of their working lives may serve to confirm this prejudicial view.

Section 136 Mental Health Act 1983

Section 136 (MHA 1983) gives the police the power to remove someone who appears to be suffering from a mental disorder in a place accessible to the public, to a place of safety. The grounds for the use of this power are that the person appears to be in immediate need of care and control and the police officer thinks it is necessary to do so in the person's interest or for the protection of others. The place of safety should normally be accident and emergency, but police stations can be used as well. There have been ongoing concerns about the use of police cells. In a number of areas, Mental Health Trusts have developed 'section 136 suites' at psychiatric units. An individual can be detained under section 136 for up to 72 h. During this period their mental state has to be assessed. The development of 'section 136 suites' acknowledges that police stations and/or accident and emergency departments are not appropriate environments for the considered professional assessment of individuals experiencing severe mental distress.

The use of section 136 MHA is a very significant police power. It is very worrying that there does not appear to be a rigorous recording system to collate information about the extent and circumstances of its use. There are distinct regional variations in practice and limited statistical information is provided (Bartlett and Sandland, 2003). Dunn and Fahy (1987) suggest that this is because it does not readily fit into the canteen culture of what constitutes appropriate police work. Mokhtar and Hogbin (1993) argue that the police underuse section 136 MHA. The Mental Health Act Commission (MHAC, 2005) tried to collate the statistics from each local authority in England and Wales. The level of the problem is, perhaps, best illustrated by the fact that the MHAC only received replies from 30% of the 118 authorities that were contacted. As the MHAC notes (2005, p. 281), the Code of Practice requires that all agencies have a joint policy to ensure that there is effective

monitoring of the use of section 136 MHA. Even if it was not a requirement of the Code of Practice, one would assume that agencies would seek to monitor the use of a power which is exercised in such difficult circumstances and has such implications for the individuals concerned. In addition, there appears to be confusion among professionals as to the exact nature of powers under section 136 (Lynch *et al.*, 2002).

In paragraph 4.168, the MHAC (2005) analyses the use of section 136 in the period 2003/04. It is hardly surprising that the greatest use of the power occurs in the London area. One of the outcomes of de-institutionalization has been the development of a new geography, which sees the institutions replaced by the poorest urban environments (Kelly, 2005). One would expect that the use of such a power would be higher in urban areas of higher population density, which experience multiple social deprivations. One of the impacts of the development of community-based services for people with severe and enduring mental health problems has been that these are the areas in which marginalized groups are more likely to live. Despite this there are significant variations between the large conurbations. For example, there were 360 recorded uses in Manchester but hardly any in Birmingham. One might have expected a very similar pattern of use to emerge given the similar geographical and demographic factors that apply in both settings.

In addition to the differences in the use of section 136, there are clear regional differences in outcome identified in the report. The most striking feature is the fact that virtually all those who were arrested using section 136 in London were subsequently admitted to hospital with 40% being detained under section 2 or 3 MHA. This can be contrasted with the South West where only admission was the outcome in only 12% of cases. This is an area that needs to be explored further. However, there are a number of tentative explanations. It is possible that the average Metropolitan police officer is more likely to have working experience of mental

disorder and so will use the powers of section 136 appropriately. A less optimistic explanation is that the pressure on psychiatric beds, mental health services, and all agencies in the capital combine to mean that officers only use section 136 MHA where the individual's behaviour is so disturbed that an admission to hospital is very difficult to avoid. It is vitally important to note that admission to hospital is not the sole criteria by which the use of section 136 should be judged. As in all mental health assessments, the guiding principles of the Code of Practice apply. Spence and McPhillips (1995) found that schizophrenia was the most common diagnosis in cases where section 136 was used but individuals regarded as having a personality disorder were the subject of the most assessments. This was explained by the repeated presentations among this group. A similar pattern of increased police contact for personality disordered individuals was found in the study by Gandhi *et al.* (2001).

The Independent Police Complaints Commission (IPCC) carried out a major study of the use of section 136 MHA in 2005/06. This study highlighted the fact that 11,500 people were taken to police stations while 5,900 were taken to a hospital for assessment. The report also highlighted that there were large variations between forces in the use of the power. For example, in the Cheshire and Merseyside forces the rate was 1 per 10,000 people in custody while in Sussex it was 277 per 10,000. The biggest factor in the differences in these rates was the availability of alternatives to the police station—i.e. where agencies are able to provide appropriate health care settings to assess distressed individuals, the use of police cells can be avoided. This does not explain all the variations as one has to consider local factors. For example, suicide rates vary. The risk factors for suicide increase in areas of economic deprivation (Rehkopf and Buka, 2006). Police forces in such areas are more likely to be called to situations where the use of section 136 is required. Other local factors will include well-known 'suicide spots'. The figure for the Sussex force is explained by the fact that the

force covers Beachy Head, a headland which is the scene of 20 suicides a year. The study also reinforced the findings of a vast literature which demonstrates that black people experience discrimination in mental health services (Browne 2009). In this study, black people were almost twice as likely as white to be subject to section 136 MHA.

Jones and Mason (2002) carried out a study of the use of section 136 from a service-user's perspective. This study has very powerful messages for all services working in this area. As noted above, this is a difficult area for police officers, who are being asked to carrying out a mental health assessment, often without appropriate training. However, this study emphasizes that the service-user perspective section 136 is a custodial rather than a therapeutic experience.

Some of the elements at play here are difficult to overcome. Section 136 is an arrest. This will involve the person being searched, having their rights read to them and so on. This creates the impression that the person has been arrested for being mentally ill. Essentially, this is the case. In the study, service users felt that the police did not have their mental health needs at the forefront of their decision making. The emphasis was on wider public protection. It is interesting to note that it was felt that officers adopted a much more sympathetic approach in A + E. This implies that a more health-orientated approach was adopted in a hospital setting. The experience in custody was often extremely distressing. The service users interviewed highlighted the detrimental effects of being placed in a white paper suit—whether or not there was any indication that this was necessary for their protection.

It is now widely accepted that a police station, in ideal circumstances, would never act as a place of safety for those experiencing acute mental distress (Cummins, 2007). This is a view that was shared by officers interviewed in the research. The reasons for this are readily apparent. Police stations cannot be regarded as 'safe' in these circumstances—this is not a criticism of officers who have to manage these situations. Police stations are not designed

with the needs of the acutely mentally ill at the forefront. The physical environment for those detained should be seen as being anti-therapeutic. Cells have very limited facilities, generally there are no nursing staff available. On occasions, because of concerns about self-harm or suicide those detained will have clothes taken away from so they cannot be used as ligatures. In addition, there will almost certainly be some delay as the appropriate staff are contacted to organize a MHA assessment or act as an appropriate adult. This is a far from satisfactory situation. In extreme examples, it may well constitute a breach of article 3 of the ECHR as it amounts to inhumane and degrading treatment. From the custody officer's viewpoint, this is a nightmarish situation as they are expected to manage a very distressed individual without adequate resources.

The Police and Criminal Evidence Act (1984)

PACE (1984) was introduced following the Confait case. Maxwell Confait was murdered in London in 1972. Three juveniles were convicted of his murder mainly on the basis of confession evidence. The convictions were subsequently quashed as the confessions had been obtained under duress (Fisher, 1977). A Royal Commission was established which was reported in 1981. The changes that it recommended formed the basis of PACE (1984).

PACE (1984) provided a wider series of protections for those being interviewed in police custody. For example, the 'Judges' Rules', under which interviews were carried out, were abolished and all interviews were to be tape recorded. PACE (1984) provided special protections to three groups: juveniles, adults with learning difficulties, and adults with mental health problems. The most significant of these is the fact that such individuals have to be interviewed with an AA present. The role of the AA is something of a hybrid (Cummins, 2011). In the adversarial system of England and Wales, the AA role is somewhat ambiguous. The main thing is to

ensure that these groups receive additional protection as they are identified as being at particular risk. Advice on ensuring the safety of those with mental health problems forms part of 'Guidance on the Safer Detention and Handling of Persons in Police Custody' (ACPO, 2006). However, the guidance itself is not comprehensive. In any event, for it to be followed successfully, it is dependent on police officers making appropriate assessments of individuals' mental states. As outlined in this article, there are a number of obstacles here including the lack of training police officers receive in relation to mental health issues and a police culture, which at times appears to be dismissive.

The assessment of mental health problems in the custody environment is very difficult (Cummins, 2007). As noted above, police officers have very little training in this area and so are very reliant on their own professional experience. In addition, it is often very difficult to gain access to information from other agencies. The IPCC study of section 136 MHA, for example, noted that almost two-thirds of these arrests occurred outside of office hours. If the individual has been in police custody previously, there may be a marker or warning put on their record on the Police National Computer (PNC) that they have a mental health problem or have self-harmed. In many cases, the custody sergeant is largely reliant on information provided by the detained person. The custody environment is a busy, pressurized one with little, if any privacy; these when combined with the stigma attached to mental illness mean that individuals may feel less likely to disclose such information to the police. In addition, as Payne-James (2010) demonstrates significant numbers of people brought into custody are intoxicated or under the influence of drugs. This makes the assessment of mental illness even more complicated. Cummins (2006) highlighted the fact that it was difficult to obtain figures for the numbers of adult interviewed with an AA present. The lack of training for police officers, the nature of the custody environment, and a reticence to disclose information combine to produce very

low figures particularly when compared with the extent of mental health problems identified in other areas of the CJS (Singleton, 1998).

Liaison with psychiatric units

There is increasing concern about the conditions that exist on the wards in psychiatric units throughout the country (MHAC, 2009). Unfortunately, this means that police officers have had an increasing role to play in dealing with situations on the wards. MHAC (1993) expressed grave concerns that police were being asked to assist in the compulsory administration of medication. This is clearly not an appropriate use of police resources. Given the lack of training that officers receive in mental health issues, it is difficult to see how they could replace nursing staff. It is inevitable that acute psychiatric wards will have to deal with situations, which involve aggressive and violent behaviour. On the whole, one would expect that these would be managed within the unit without the need for police involvement. There are a number of dangers if this is not the case and the police become the first port of call. Such a policy might unwittingly lead to patients being dragged into the CJS. Constant calls to a psychiatric unit in such situations are hardly likely to foster good working relationships among agencies. It might be argued that it could serve to reinforce stereotypical views about mental health services and the people who use them.

Despite the commonly held view, people with mental health problems are much more likely to be victims than perpetrators of crime. Individuals, who are receiving in-patient treatment, are obviously owed a duty of care by the professional staff involved. This includes supporting those who may have been the victims of crime. This is a very problematic area. There is evidence (MIND, 2000) that patients who are the victims of very serious offences are not well served by the agencies and the CJS. The problems that effect the prosecution of, for example, those accused of sexual offences do not cease because

the offence takes place in a hospital. In fact, there are likely to be greater barriers to the successful prosecution of offenders not least of which is the view that is taken of the victim's ability to appear as a witness in any subsequent Court proceedings. There are many factors at play here. Psychiatric units need to take steps to minimize violent incidents and also develop robust policies to ensure that if the police do have to become involved a balance is struck between the demands of the clinical management of patients and the wider interests of justice.

The failure to obtain a complete picture or for professionals to share information has been a key feature in the reports on inquiries (Ritchie 1994) into the failures that have scarred the development of community-based mental health services. In other areas of police work, for example, investigations of abuse against children or the management of sex offenders, systems have been developed to manage the sharing of information. However, these situations are of a different nature to the likely police involvement with people with mental health problems.

Confidentiality is, clearly, a key principle of the delivery of other areas of health care. There is no substantive reason why this cannot be the case in mental health services. However, it would be naive not to acknowledge that there are particular difficulties raised in this field. The stigma attached to mental illness means that there is the potential that disclosure will have unforeseen negative consequences for those using services. As noted above, police officers along with other professional groups can hold stereotypical views. Therefore, disclosure of mental health status could lead to such individuals receiving a poor level of service. In addition, there is a need to ensure that behaviour is placed properly in context. In this field, there will be circumstances where the need to the wider public or family and carers will mean that the principle of patient confidentiality cannot be an absolute one. This does not mean that the fact that someone uses mental health services should act as a green light to remove this fundamental right.

Police training

Police officers can have a key role to play in a number of situations where individuals are experiencing acute mental distress. The demands on police training are enormous. Despite the fact that mental health-related issues form such a key part of police work, it is an area that is somewhat neglected in police training. One of the most significant issues is police attitude to people with mental health problems. Pinfold *et al.* (2003) have highlighted the impact that mental health awareness training can have on challenging stereotypical attitudes among officers. Cummins and Jones (2010) outlined a very successful model of training that was adopted by the Dyfed and Powys force in Wales. This is an experiential model of learning and involves student officers spending part of their training at the local acute psychiatric unit where they become involved in the care of patients. In addition, officers work with a range of community-based mental health professionals. The overall aim of this programme is not only to provide the student officers with background mental health knowledge but also to provide an insight into the structure and workings of the agencies in their area that they are most likely to come into contact with in their work as police officers. One of the great strength of this model is the input from individual service users and service-user groups. The training programme has received very positive feedback from service users who feel that it has had led to a change in police attitudes. For example, a woman in an acutely paranoid state admitted to hospital with police involvement informed staff that it was the first time that she had not handcuffed on admission to hospital.

The Bradley Review

In 2008, the government commissioned a report to look at the experiences of people with mental health problems or learning disabilities in contact with the CJS. It should be noted that individuals in these groups are more likely to be victims than

perpetrators of crime. The Bradley Review reported in April 2009 and made a series of recommendations about how agencies can work together more effectively to meet the needs of vulnerable adults. The review also highlighted examples of good practice including innovative areas of joint working between the police, social work agencies, health care providers, and the voluntary sector. The most important recommendation that Bradley makes relates to the provision of health care in custody settings. At the time of writing, this is commissioned on a force by force basis. Bradley argues that the police should follow the lead of the prison estate and transfer health care to the NHS. This would be a radical move and would address a number of issues identified above. A number of forces have entered into arrangements whereby mental health nursing staff are based in custody settings to assess detained persons or offer advice. From a public health point of view, the custody setting could provide an opportunity to engage difficult to reach populations with health care services. McGilloway and Donnelly (2004) study in Belfast shows the potential benefits of such schemes.

Conclusion

One of the effects of de-institutionalization has been to increase the contact between those with mental health problems and the police and prison systems (Robertson, 1988; Singleton *et al.*, 1998; Shaw *et al.*, 2004). Wolff (2005) outlines the way in which asylums have been replaced by poor housing in the most economically deprived areas of major cities. The mentally ill are disproportionately represented in the homeless population. The modern civic and urban landscape has led to the reduction of public space and the policing/surveillance of those spaces in more punitive fashion. As Davies (1992) argues the architecture of cities excludes the urban poor not just physically but also psychologically. In addition, Barr (2001) argues that the policy of 'zero tolerance' where

civic authorities introduce a series of measures to tackle low level public order or nuisance offences disproportionately impact on the mentally ill. In addition to effectively criminalizing homelessness, they serve to further embroil the severely mentally ill in the Criminal Justice and prison systems. Others have argued that the asylum has been replaced not by the community-based mental health services that were envisaged but bedsits, housing projects, day centres, and soup kitchens. The argument here is that individuals are physically living in the community and are denied the opportunity to be active citizens.

The above process of 'transinstitutionalization' (Moon, 2000) is the context in which the police carry out their role as 'street psychiatrists' (Lamb *et al.*, 2002). Policing always involves an element of discretion and individual judgment. This is particularly the case regarding working with individuals who are acutely distressed. Individual officers have to make a decision on how to exercise their legal powers or deal with the matter in some other way. Policing is about more than the detection of crime or apprehension of offenders. Wolff (2005) has gone further and suggests that police officers have always had a quasi-social work function in this field. However, as Husted *et al.* (1995) argue this is not something their training or police culture value highly. The conventional methods of coordinating services have not been successful (Wolff, 1998). These problems are not limited to North America and Europe (Kimhi *et al.*, 1998).

MIND (2007) has highlighted the negative impact of police involvement from the perspective of those using mental health services. Police officers often have a significant role to play in mental health services. Lamb *et al.* (2002) provides a rationale in terms of public protection for police involvement. This role has been expanded by the failure to develop robust community-based services in the era of de-institutionalization (Pogrebin, 1986). This adds to the well-documented frustration that police officers feel when dealing with mental health services (Brown *et al.*, 1977; Graham, 2001).

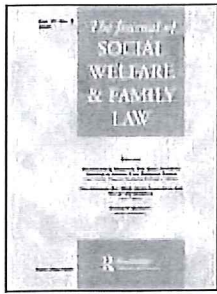
As Stone (1982) argues there is always likely to be an overlap between the CJS and mental health systems. The police are bound to have a significant role to play in this area. The best resourced community-based mental health systems imaginable would not be able to function without working alongside the local police force. The legislative framework in England and Wales provides a sound basis for such work. However, the history of de-institutionalization and the failure to develop strong community mental health services (Cummins, 2011) have meant that the CJS and the police have become the mental health care providers of last resort. The Bradley Review may well prove to a watershed for policy in this area. Its recommendations, along with a new emphasis on police mental health awareness training, provide an opportunity to tackle the issue of fragmented, disjointed, and occasionally mutually suspicious services that have scarred the policy landscape for too long. Throughout this process, there needs to be an increased focus on the needs of people with severe mental health problems who are victims or potential victims of crime.

References

- Aboleda-Florez, J. and Holley, H. L. (1998). 'Criminalization of the Mentally Ill: Part II. Initial Detention.' *Canadian Journal of Psychiatry* 33: 87–95.
- ACPO/National Centre for Policing Excellence. (2006). *Guidance on the Safer Handling of Persons in Police Custody*. London: ACPO.
- Barr, H. (2001). 'Policing Madness: People with Mental Illness and the NYPD.' In McArdle, A. and Erzen, T. (eds), *Zero Tolerance: Quality of Life and the New Police Brutality in New York City*. New York: NYU Press.
- Bartlett, P. and Sandland, R. (2003). *Mental Law Policy and Practice*, 2nd edn. Oxford: Oxford University Press.
- Bather, P., Fitzpatrick, R. and Rutherford, M. (2008). *Briefing 36: The Police and Mental Health*. London: Sainsbury Centre for Mental Health.
- Bittner, E. (1967). 'Police Discretion in Emergency Apprehension of Mentally Ill Persons.' *Social Problems*, 14: 278–292.
- Bonovitz, J. C. and Bonovitz, J. S. (1981). 'Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective.' *American Journal of Psychiatry* 138(6): 973–976.
- 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* 28: 332–337.
- Bradley, K. (2009). *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London: DH.
- Browne, D. (2009). 'Black Communities, Mental Health and the Criminal Justice System.' In: Reynolds, J., Muston, R., Heller, T. et al. (eds), *Mental Health Still Matters*. Basingstoke: Palgrave MacMillan.
- Brown, S., Burkhart, B. R., King, G. D. and Solomon, R. (1977). 'Roles and Expectations for Mental Health Professionals in Law Enforcement Agencies.' *American Journal of Community Psychology* 5(2): 207–215.
- Carey, S. J. (2001). 'Police Officers' Knowledge of, and Attitudes to Mental Illness in Southwest Scotland.' *Scottish Medical Journal* 46: 41–42.
- Cotton, D. (2004). 'The Attitudes of Canadian Police Officers Toward the Mentally Ill.' *International Journal of Law and Psychiatry* 27(2): 135–146.
- Cummins, I. D. (2006). 'A Path Not Taken? Mentally Disordered Offenders and the Criminal Justice System.' *Journal of Social Welfare and Family Law* 28(3): 267–281.
- Cummins, I. D. (2007). 'Boats Against the Current: Vulnerable Adults in Police Custody.' *Journal of Adult Protection* 9(1): 15–24.
- Cummins, I. D. (2008). 'A Place of Safety: Self-harming Behaviour in Police Custody.' *Journal of Adult Protection* 10(1): 36–47.
- Cummins, I. D. (2010a). 'Distant Voices Still Lives: Reflections on the Impact of Media Reporting of the Cases of Christopher Clunis and Ben Silcock.' *Ethnicity and Inequalities in Health and Social Care Journal* 3(4): 18–29.
- Cummins, I. D. (2010b). 'Deinstitutionalisation: Mental Health Services in the Age of Neo-liberalism.' *Social Policy and Social Work in Transition* 1(2): 55–74.
- Cummins, I. D. (2011). '"The Other Side of Silence": The Role of the Appropriate Adult Post Bradley.' *Journal of Ethics and Social Welfare* 5(3): 306–312.
- Cummins, I. D. and Jones, S. (2010). 'Blue Remembered Skills: Mental Health Awareness Training for Police Officers.' *Journal of Adult Protection* 12(3): 14–19.
- Curran, S. and Matthews, K. (2001). 'The Psychiatrist Will Be with You in a Day or Two. Unnecessary Delays in Assessing the Mentally Ill in Police Custody in Scotland.' *Scottish Medical Journal* 46(2): 37.
- Davies, M. (1992). *City of Quartz: Excavating the Future in Los Angeles*. London: Verso.
- Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M. and Morrissey, J. P. (1999). 'Emerging Partnerships

- Between Mental Health and Law Enforcement.' *Psychiatric Services* 50: 99–101.
- Dew, K. and Badger, S. (1999). 'Police Perceptions of the Mental Health Services and the Mentally Ill.' *New Zealand Medical Journal* 112: 36–38.
- Dunn, J. and Fahy, T. A. (1987). 'Section 136 and the Police.' *Bulletin of the Royal College of Psychiatry* 11: 224–225.
- Fisher, H. Sir (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*. London: HMSO.
- Fry, A. J., O' Riordan, D. P. and Geanelos, R. (2002). 'Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia.' *Health Social Care and Community* 10(4): 277–286.
- Gandhi, N., Tyrer, P., Evans, K., McGee, A., Lamont, A. and Harrison-Read, P. (2001). 'A Randomized Control Trial of Community-oriented and Hospital-oriented Care for Discharged Psychiatric Patients: Influence of Personality Disorder on Police Contacts.' *Journal of Personality Disorder* 15(1): 94–102.
- Gillig, P. M., Dumaine, M., Stammer, J. W., Hillard, J. R. and Grubb, P. (1990). 'What Do Police Officers Really Want from the Mental Health System.' *Hospital and Community Psychiatry* 41(6): 663–665.
- Graham, J. (2001). 'Policing and the Mentally Disordered.' *Scottish Medical Journal* 46(2): 38–39.
- Gunn, J. (2000). 'Future Directions for Treatment in Forensic Psychiatry.' *British Journal of Psychiatry* 176: 332–338.
- Home Office. (1990). *Provision for Mentally Disordered Offenders*. Circular 66/90.
- Home Office. (1995). *Mentally Disordered Offenders: Inter-Agency Working*. Circular 12/95.
- Home Office. (1995). *Police and Criminal Evidence Act 1984 Codes of Practice*. London: HMSO.
- Howard, J. (1780). *The State of the Prisons in England and Wales*, 2nd edn. Warrington and London: T. Cadell.
- Hughes, K., Bellis, M., Jones, L. *et al.* (2012). 'Prevalence and Risk of Violence Against Adults with Disabilities: A Systematic Review and Meta-analysis of Observational Studies.' *The Lancet* 379(9826): 1621–1629.
- Husted, J. R., Charter, R. A. and Perrou, B. (1995). 'California Law Enforcement Agencies and the Mentally Ill Offender.' *Bulletin of the American Academy of Psychiatry and Law* 23(2): 315–329.
- IPCCC. (2006). *Deaths During or Following Police Contact*. Available online at: www.ipcc.gov.uk.
- IPCCC. (2008). *Police Custody as a Place of Safety: Examining the use of Section 136 of the Mental Health Act 1983*. Available online at: www.ipcc.gov.uk.
- James, D. (2000). 'Police Station Diversion Schemes: Role and Efficacy in Central London.' *Journal of Forensic Psychiatry* 11: 532–555.
- Janus, S. S., Bess, B. E., Cadden, J. J. and Greenwald, H. (1980). 'Training Police Officers to Distinguish Mental Illness.' *American Journal of Psychiatry* 137(2): 228–229.
- Jones, S. L. and Mason, T. (2002). 'Quality of Treatment Following Police Detention of Mentally Disordered Offenders.' *Journal of Psychiatric and Mental Health Nursing* 9: 73–80.
- Kelly, B. (2005). 'Structural Violence and Schizophrenia.' *Social Science and Medicine* 61: 721–730.
- Kimhi, R., Barak, Y., Gutman, J. *et al.* (1998). 'Police Attitudes Toward Mental Illness Ad Psychiatric Patients in Israel.' *Journal of American Academy of Psychiatry and the Law* 26(4): 625–630.
- Lamb, H. R., Shaner, R., Elliott, D. M., DeCuir, W. J. and Foltz, J. T. (1995). 'Outcome for Psychiatric Emergency Patients Seen by an Outreach Police-Mental Health Team.' *Psychiatric Services* 46: 1267–1271.
- Lamb, H. R. (2001). 'Outcome for Psychiatric Emergency Patients Seen by an Outreach Police-Mental Health Team.' *New Directions for Mental Health Services* 90: 67–76.
- Lamb, H. R., Weinberger, L. E. and DeCuir, W. J. (2002). 'The Police and Mental Health.' *Psychiatric Services* 46(12): 1267–1271.
- Linsley, K., Johnson, N. and Martin, J. (2007). 'Police Contact Within 3 Months of Suicide and Associated Health Service Contact.' *British Journal of Psychiatry* 190: 170–171.
- Lynch, R. M., Simpson, M., Higson, M. and Grout, P. (2002). 'Section 136, The Mental Health Act 1983: Levels of Knowledge Amongst Accident and Emergency Doctors, Senior Nurses, and Police Constables.' *Journal of Emergency Medicine* 19: 295–300.
- McGilloway, S. and 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* 13(3): 263–275.
- Meehan, A. J. (1995). 'From Conversion to Coercion: The Police Role in Medication Compliance.' *Psychiatry Quarterly* 66(2): 163–184.
- MHAC. (1993). *Biennial Report 1991-1993*. London: HMSO.
- MHAC. (2005). *In Place of Fear? The Mental Health Act Commission Eleventh Biennial Report 2003-2005*. London: HMSO.
- MHAC. (2009). *Coercion and Consent the Mental Health Act Commission Thirteenth Biennial Report 2007-2009*. London: HMSO.
- Mental Health Act. (1983). London: HMSO.

- MIND. (2007). *Another Assault: Mind's Campaign for Equal Access to Justice for People with Mental Health Problems*. London: MIND.
- Mizuno, M., Sakuma, K., Ryu, Y. et al. (2005). 'The Sasagawa Project: A Model for Deinstitutionalisation in Japan.' *Keio Journal of Medicine* 54(2): 95–101.
- Moon. (2000). 'Risk and Protection: The Discourse of Confinement in Contemporary Mental Health Policy.' *Health & Place* 6(3): 239–250.
- Mokhtar, A. and Hogbin, P. (1993). 'Police May Under Use Section 136.' *Medicine Science and Law* 33(3): 188–196.
- Penrose, L. S. (1939). 'Mental Disease and Crime: Outline of a Comparative Study of European Statistics.' *British Journal of Medical Psychology* 18: 1–15.
- Payne-James, J. (2010). 'Clinical Risk and Detainees in Police Custody.' *Clinical Risk* 16: 56–60.
- Pinfold, V., Huxley, P., Thornicroft, G. et al. (2003). 'Reducing Psychiatric Stigma and Discrimination. Evaluating an Educational Intervention with the Police Force in England.' *Social Psychiatry and Psychiatric Epidemiology* 38(6): 337–344.
- Platt, S. and Kreitman, N. (1990). 'Long Term Trends in Parasuicide and Unemployment in Edinburgh, 1968–1987.' *Social Psychiatry and Psychiatric Epidemiology* 25: 56–61.
- Pogrebin, M. (1986). 'Police Responses for Mental Health Assistance.' *Psychiatry Quarterly* 58: 66–73.
- Rehkopf, D. and Buka, S. (2006). 'The Association Between Suicide and the Socio-economic Characteristics of Geographical Areas: A Systematic Review.' *Psychological Medicine* 36: 145–157.
- Ritchie, J. (Chair) (1994). *The Report of the Inquiry into the Care and Treatment of Christopher Chunis*. London: HMSO.
- Robertson, G. (1988). 'Arrest Patterns Among Mentally Disordered Offenders.' *British Journal of Psychiatry* 153: 313–316.
- Shaw, J., Baker, D., Hunt, I., Moloney, A. and Appleby, L. (2004). 'Suicide by Prisoners.' *British Journal of Psychiatry* 184: 263–267.
- Sims, A. C. and Symonds, R. L. (1975). 'Psychiatric Referrals from the Police.' *British Journal of Psychiatry* 127: 171–178.
- Singleton, N., Meltzer, H. and Gatward, R. (1998). *Psychiatric Morbidity among Prisoners in England and Wales*. London: HMSO.
- Smith, J. P. (1990). 'Police Are Best at Community Care of Mentally Ill People in England.' *Journal of Advanced Nursing* 15(10): 1117.
- Spence, S. A. and McPhillips, M. A. (1995). 'Personality Disorder and Police Section 136 in Westminster: A Retrospective Analysis of 65 Assessments Over Six Months.' *Medicine, Science and the Law* 35(1): 48–52.
- Steadman, H. J., Deane, M. W., Borum, R. and Morrissey, J. P. (2000). 'Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies.' *Psychiatric Services* 51(5): 645–649.
- Stone, L. (1982). *An Exchange with Michel Foucault*. New York: Review of Books New York.
- Teplin, L. A. (1985). 'The Criminality of the Mentally Ill: A Dangerous Misconception.' *American Journal of Psychiatry* 142(5): 593–599.
- Teplin, L. A., McClelland, G., Abram, K. and Wiener, D. (2005). 'Crime Victimization in Adults With Severe Mental Illness Comparison With the National Crime Victimization Survey.' *Archives of General Psychiatry* 62: 911–921.
- Tesse, C. F. and van Wormer, J. (1975). 'Mental Health Training and Consultation with Suburban Police.' *Community Mental Health Journal* 11(2): 115–121.
- Vaughan, P. J., Kelly, M. and Pullen, N. (2001). 'The Working Practices of the Police in Relation to Mentally Disordered Offenders and Diversion Services.' *Medicine, Science and the Law* 41(1): 13–20.
- Wacquant, L. (2009). *Punishing the Poor: The Neo-liberal Government of Social Insecurity*. London: Duke University Press.
- Watson, A. C., Corrigan, P. W. and Ottati, V. (2004a). 'Police Officers' Attitudes Toward and Decisions About Persons with Mental Illness.' *Psychiatry Services* 55(1): 49–53.
- Watson, A. C., Corrigan, P. W. and Ottati, V. (2004b). 'Police Responses to Persons with Mental Illness: Does the Label Matter?.' *Journal of the American Academy of Psychiatry and the Law* 32(4): 378–385.
- Wolch, J. and Philo, C. (2000). 'From Distributions of Deviance to Definitions of Difference: Past and Future Mental Health Geographies.' *Health and Place* 6(3): 137–157.
- Wolff, N. (1998). 'Interactions Between Mental Health and Law Enforcement Systems: Problems and Prospects for Co-operation.' *Journal of Health Politics Policy and the Law* 23: 133–172.
- Wolff, N. (2005). 'Community Reintegration of Prisoners with Mental Illness: A Social Investment Perspective.' *International Journal of Law and Psychiatry* 28: 43–58.



Using Simon's Governing through crime to explore the development of mental health policy in England and Wales since 1983

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MAIN SECTION

Using Simon's *Governing through crime* to explore the development of mental health policy in England and Wales since 1983

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The reform of the Mental Health Act in 2007 saw the introduction of Supervised Community Treatment Orders (CTOs) in England and Wales. It is argued that this marks a fundamental shift in the rights of those subject to mental health legislation. This paper will explore the developments in mental health policy in the 1980s and 1990s that form the backdrop to the introduction of CTOs. It uses Simon's *Governing through crime* (2007) as a basis to explore the developments in mental health policy that resulted in the final introduction of CTOs. The paper explores the paradox at the heart of mental health policy. This paradox being that while the protections and the rights of the mentally ill have increased in a formal legal sense, this has not resulted in the achievement of full citizenship that the idealism of the original proponent of the closure of the asylums envisaged.

The policy of deinstitutionalisation was based on a series of progressive notions and explicit rights based approach to the treatment of citizens with mental health problems. However, the implication of this policy has not resulted in the end of stigma, marginalisation and discrimination. Many commentators would suggest that the asylums have now come to the community rather than the reverse. The mental health policy response to the failings of community care was one characterised by an increased managerialist culture with a focus on audit and risk. These events are discussed in terms of Cohen's (1972) notion of a 'moral panic'. In addition, they are analysed as part of Hall and others' view of the crisis of legitimacy faced by Welfare States from the early 1970s onwards. The eventual result was the introduction of CTOs. This marks a fundamental shift in the balance between individuals with mental health problems and the therapeutic state. It is argued that the fact that such a significant change has been introduced in the face of opposition from virtually all the key stakeholders in the area indicates that the 'mentally ill' and the 'mad' continue to be a marginalised.

Keywords: community treatment orders; deinstitutionalisation, governing through crime

Introduction

Simon's Governing through crime

Simon (2007) argues that the period of mass incarceration is a new form of statecraft. The main thrust of his argument is that new civil and political structures have developed. He terms this process '*Governing through crime*'. This is fundamentally different to the process of managing criminal behaviour that all states have to undertake. In his work he outlines the ways in which the perceived danger of being a victim of crime has had an impact on a range of behaviour and choices that citizens make. For example, the increase in sales of Sports Utility Vehicles (SUVs) in the US and the rise of the gated community

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are both directly linked to the fear of crime. Throughout areas of daily life, including schools and schooling, a fear of violent crime lies at the root of a number of policy developments.

For Simon, the roots of '*Governing through crime*' lie in the economic and political crisis of the 1970s and 1980s. The failure to manage the economic crisis led to a crisis in government legitimacy. The politicalisation of the law and order question was a feature of the elections that returned neo-liberal governments in the US and UK throughout the 1980s. Simon argues that the victim of crime, particularly violent crime came to act as the dominant model of citizenship. He provides several examples where violent crime has had a direct impact on the election process. The most famous of these is the case of Willie Horton, a convicted murderer, who raped a woman whilst he was on a period of weekend leave. This case was used by George Bush (Snr) in an attack advert on Dukakis in the 1988 Presidential campaign. In 1993 a 12-year-old school girl, Polly Klaas, was kidnapped and murdered by Richard Allen Davis. Following the public and political response to this appalling crime – Governor Wilson spoke at the funeral – Mike Reynolds, whose own daughter had been shot, used the case to support his campaign to introduce Proposition 184. This led directly to the introduction of the '*three strikes*' law in California, which has been such a driver of mass incarceration. As Simon argues the logic of such policies is to replace the perceived weakness of liberal Courts and judges with a clear populist response. In this process, the individual and ultimate social costs of mass incarceration are ignored.

Simon (2007) outlines the ways in which the optimism of the 1970s, when penologists saw prison as an institution that might well disappear, has been replaced by mass incarceration. In major works, *Prisons of poverty* (2009a) and *Punishing the poor* (2009b), Wacquant has argued that the US welfare state has been dismantled whilst the incarceration rates have grown exponentially. He argues that *welfare* has been replaced by *prisonfare*. The US welfare state that did not offer European levels of protection has been swept away. In its place, mass incarceration has taken on a key role in the management of the urban – largely black and male – population. As the welfare state has contracted in the US, the UK and other liberal democracies, then the penal state in all its forms has expanded. Wacquant (2005, 2008) has highlighted the extraordinary rates of incarceration of young African-American males. Alexander (2012) has termed these developments '*The new Jim Crow*'. There are some parallels in the UK. The *black manifesto* (2010) highlights the fact that African-Caribbean citizens are imprisoned at a rate of 6.8 per 1000 compared to 1.3 per 1000 among white citizens. Twenty-seven per cent of the UK prison population comes from a black minority ethnic background and over two-thirds of that group are serving sentences of over four years.

Schrag (2004) outlines the '*neo-populist*' terms, in which, law and order debate are consistently framed. As Garland (2004) suggests, this includes an element of distrust of experts, policy makers and political elites. The political Right has successfully exploited these populist themes. Simon observes that all violent crime poses difficult political questions for governments of all persuasions. These problems are particularly acute for parties on the Left as they have a belief in the possibility of rehabilitation. One feature of the period of mass incarceration has been a shift by social democratic parties in their position on crime, offending and prison. This is illustrated by the New Labour Governments in the UK, which did not halt the rise in prison numbers but, in fact, continued the policy of mass incarceration.

The expansion of the penal state occurred as the policy of reducing the number of inpatient mental health beds was reaching its height (Cummins 2010c). The combined effect of these policies has been to increase the number of people with mental health

problems coming into contact with the Criminal Justice System (CJS). Seddon (2009) has argued that there have always been people with mental health problems in the prison system. This has been a consistent feature of the modern prison. Following Foucault (1972), Seddon argues that there has never been a clear divide between the psychiatric and criminal justice systems. Singleton *et al*'s 1998 study remains the key study of psychiatric morbidity among prisoners. It found that more than 90% of prisoners had a mental health problem. In addition, 7% of male sentenced prisoners and 10% of men on remand had a psychotic illness. These figures have to be treated with some caution as the prison population is clearly not a cross-section of the general population. However, they do indicate the level of need. The *Corston inquiry* (2008) and the *Bradley review* (2009) have both highlighted the need for agencies in this field to address the mental health needs of offenders. For example, Corston explores the complex range of factors, which lead to such high levels of self-harm and suicide among women prisoners. As Appleby (2010) notes, despite significant improvements in prison mental health care, prison is not the place ethically or clinically where psychosis should be treated. A recent landmark judgment by the US Supreme Court *Brown v Plata* will have far-reaching implications for mass incarceration. The case was brought against the State of California. It was the last in a long line of cases in relation to the provision of medical care in the prison system. The decision in the case recognised that the overcrowding and poor provision of services in jails could and did amount to inhumane and degrading treatment. The financial implications of the case are huge (Simon forthcoming). The irony may well be that it is ultimately fiscal rather than moral concerns that lead to the collapse of the penal state.

Deinstitutionalisation

The policy of the closure of large psychiatric hospitals '*deinstitutionalisation*' has been pursued across developed societies. The policy has its roots in the challenges to the power of psychiatry and psychiatric institutions that were a feature of the 1960s. The treatment of the mentally ill is clearly an issue of human rights not just because it can include the imposition of compulsory treatment. The state has a responsibility to ensure the safety and dignity of those in its care. Institutionalisation thus becomes a fundamental issue of human rights. The old asylum regime was marked by a systematic erosion of the civic status of patients. Not only were these patients geographically and socially isolated from their fellow citizens, they were denied other rights such as the right to vote.

The physical conditions in asylums, as Goffman (1968) identifies, involved the loss of individuality and exercise of choice that form the basis of citizenship in a liberal democratic society. Barton (1959) identifies the effects of these regimes as creating 'institutional neurosis'. He suggests similarities between the behaviour of psychiatric patients and survivors of concentration camps – a more damning indictment of an allegedly therapeutic regime it is impossible to imagine. These findings were later supported by Scott (1973) who highlighted the levels of passivity and apathy among patients. The 1970s saw a series of scandals at long-stay hospitals. Martin (1985) highlights the way that closed institutions have the potential to become abusive environments. These include the lack of privacy and autonomy for patients. Large staff: patient ratios make it impossible to develop a functioning therapeutic environment. Staff received very little training and were largely isolated from mainstream services and the development of practice. In addition, in a number of institutions, staff were largely recruited from a small geographical area or local community. These factors combine to produce an environment where abuses can occur and if they do there are not systems to challenge them.

The development of community care can be seen as part of a wider development in liberal democracies where marginalised and discriminated against groups challenged these established norms. In 1955, there were 151,000 patients in psychiatric hospitals in England and Wales. Enoch Powell, as Secretary of State for Health, in the 1962 Hospital Plan announced that the long-term aim was to close these institutions. By 1984, there were 71,000 in-patients. Leff and Triemann (2000) argue that the first wave of community care was largely seen as a positive move. This period saw the resettlement of long-stay patients with improved quality of life and social functioning for the individuals. However, as early as 1976, John Pilger was reporting in the *Daily Mirror* of problems with the policy. He talks of 'Dumped on the streets and in the slums – 5000 people who need help' and describes Birmingham as 'The city of lost souls'.

The policy of deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of the mentally ill, did not achieve its utopian aims. Wolff (2005) and Moon (2000) argue that the asylum has been replaced by a fragmented, dislocated world of bedsits, housing projects, day centres or, increasingly, prisons and the criminal justice system. This shift has been termed '*transinstitutionalisation*'. This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them. Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor. Kelly (2005) uses the term 'structural violence' – originally from liberation theology to highlight the impact of a range of factors including health, mental health status and poverty that impact on this group.

Knowles (2000) highlights the ways, in which, the responsibility for the care of the 'mad' has moved from public to private institutions. She goes on to suggest that the restructuring of mental health services acted as a model for other 'problematic populations'. The fiscal retrenchment was accompanied by an idealised rhetoric of community and family support. This ignored the collapse of community that neo-liberalism entails but also the fact that the 'mad' had not been fully supported in the first place – hence asylums. In his discussion of asylum seekers, Bauman (2007) argues that in a world of 'imagined communities' they are the 'unimaginable'. The 'mad' in the process of 'transinstitutionalisation' can be said to perform a similar function, in but not 'of' the community.

As Cross (2010) suggests, pre-existing social representations of the 'other' are very powerful in their ability to create a new identity for social categories. In this case, the representation of the mad from the asylum era has followed those people into the community. The representation has changed – the mad are not now dishevelled creatures chained to walls – they are the homeless of the modern city living on the streets with all their belongings in shopping carts. Their presence on the margins is accepted as a feature of modern urban life. Knowles' (2000) ethnographic study of the experience of the mentally ill on the streets of Montreal, illustrated by a series of powerful black and white photographs, captures the ways that the mad exist alongside but are ignored by the wider society. To borrow a phrase from Bauman, the mad have become the 'internally excluded'. Cummins (2010) has outlined the ways, in which, the media debates about community care led not to calls for investment in community mental health services but changes to legislation – i.e. a demand for the return of institutionalised care.

1990s community care as a moral panic'

The term 'community care' came to be used as a shorthand for the reforms to health and social care introduced in the UK by the National Health Service and Community Care Act

(1990). This legislation was clearly driven in part by the Thatcherite agenda of reducing the welfare state and introducing element of the market into service delivery (Gilmour 1992). However, the reforms did place an emphasis on ensuring that institutional care was only used in circumstances when all community based options had been exhausted. This aim was to be applied to the whole range of services for adults and children with health and social care needs. However, the term soon became a shorthand for community based mental health services. It carried with it the negative connotations that are explored below.

The reporting and response to the policy of community care has many of the features of a *moral panic*. Cohen (1972) is concerned with the ways in which the media, particularly the press and later TV, produced a series of stereotypical representations of events. Furedi (1994) has identified the ways, in which, newspapers continue to highlight new threats or potential threats to readers' health and well-being. Crime is a constant and very significant feature of the news agenda. Cohen suggests that by their very nature *moral panics* are volatile and unpredictable. Butler and Drakeford (2005) highlight the very important impact that scandals have had on the development of social welfare policies in the UK. In the current 24-hour rolling news environment there is an even greater likelihood that an event or series of events will take on the form of a *moral panic*.

In Cohen's analysis, the *moral panic* begins with a period of concern about a social issue. These issues are very often related to youth culture and or deviant subcultures. This process produces a *folk devil*. In the reporting of mental health inquiries, the *folk devil* was clearly the 'schizophrenic' usually, male, usually black and usually violent. As noted above, Cross (2010) emphasises the continuing influence of representations of madness. These notions are transmitted through a range of popular cultural forms – song, film, TV drama and so. Cross is not arguing that modern cultural representations are continuations of older forms. However, he suggests it is important to recognise the similarities as well as the disjunctions. The physical representations of the 'mad' emphasise wild hair and physical size as signs of their irrationality and uncontrollability. It is interesting to note, in this context, the overlaps between these representations of the mad as almost bestial and deeply engrained racist stereotypes of black men – see Cummins (2010) for a discussion of the case of Christopher Clunis to illustrate this point.

Cohen goes on to suggest that in the *drama* of a *moral panic* a 'disaster mentality' is created akin to that which occurs at the time of a natural disaster. The features of this new societal mindset include rumour, false alarms, 'institutionalization of threat' and even mass delusion.

Stuart Hall (1997) used Gramsci's concept of *hegemony* to analyse the alleged 'discovery' of the new crime of 'mugging' in mid-1970s UK. Hall draws heavily on the work of Gramsci (1971) and Foucault (1972) in arguing a social constructionist (Burr 2003) position on the debate about the relationship between the mass media and 'reality'. The representation of different groups or issues has become a key focus of study for scholars of media and cultural studies (Hall 1997, Gripsrud 2002) and the question of whether the media reflects or constructs reality is central to the debate on representations. Branston and Stafford (1996, 78), for example, claim that the 'reality' represented in the media is 'always a construction, never a transparent window', while Kellner (1995, 117) argues that within media culture 'existing social struggles' are reproduced and that this has a key impact on the production of identities and the ways in which people make sense of the world.

One of the key questions for Hall is how dominant economic classes exercise their power within the political processes in advanced liberal democracies. He argues that this is a process of creating an impression of consensus rather than one of coercion. Hall argues

that consent is the most important mode of state functioning. The state is seen to represent the interests of all and to be the embodiment of series of national values. A 'crisis of hegemony' occurs when the state is threatened or challenged. This crisis might be triggered by economic conditions or the emergence of new cultural forms. The crisis creates a *moral panic*. Hall notes that the nature of a panic is that there is a 'discrepancy' between the perceived threat and the reaction to it. Hall seeks to explore how and why particular themes including crime and other deviant acts produce such a reaction. He argues that social and moral issues are much more likely to be the source of these panics. There are certain areas, for example youth culture, drugs or lone parents, where there are recurring panics.

Hall suggests that the panic is triggered by a particular event. He describes the ways, in which, these events cause 'public disquiet'. The response to this panic includes not only societal control mechanisms such as the courts but also the media becomes an important mediating agency between the state and the formation of public opinion. In the case of mental health in the 1990s, key figures included Marjorie Wallace – journalist and founder of Schizophrenia A National Emergency (SANE) and Jayne Zito – widow of Jonathan Zito and founder of the Zito Trust (Cummins 2010). As Hall argues such figures are seen as having expert knowledge and therefore play key roles in the development of public opinion.

The reporting of the community care in the 1990s had all the features of a moral panic (Butler and Drakeford 2005). The crux of the media reporting was that there was a new threat from the 'mad' who had been released from asylums where they posed an immediate violent threat to the local citizenry. The dynamic of the panic produces a call for 'something to be done'. In this case, the calls were not for the asylums to be rebuilt – this would have required a level of public investment that would not have been politically acceptable – but for new forms of surveillance and control. These developments are part of the response to the financial crisis and crisis of legitimacy that Welfare States faced from the mid-1970s onwards (Habermas 1976). Hallsworth and Lea (2011) outline the process of 'securitisation'. It is argued that, in this process, the state uses processes and technologies of risk management that were developed in responses to external threats such as terrorism to manage a range of different groups. As Wacquant (2007) argues the neoliberal attack on the fundamental basis of the welfare state served to 'criminalise poverty' and confine the poor to a marginalised status. The 'mad' are part of this new landscape of urban poverty.

Policy and legislative responses to the failings of 'community care'

The response of successive UK governments since 1983 to the developing crisis in the provision of mental health services has been to focus on the legislative and policy framework. The main themes of these developments are moves to more systematic surveillance of patients and the audit of mental health professionals.

The changes in mental health policy reflect wider developments in society. Young (1999) discussed what he termed the 'narrative of modernity'. He saw the Fordist regime of production as leading to a stable pattern of employment supported by a universalist welfare regime. Young suggests that this was an inclusive society – in comparison to the later neo-liberalism regimes it was. However, this society, as Foucault (1977) argues, was also built on exclusion and marginalisation. As Nye (2003) argues women, the poor and the mentally ill were seen as 'other'. As Yar and Penna (2004) note, in reality the mentally ill were among those groups excluded from the allegedly inclusive Fordist society.

The historical narrative of modernity includes an emphasis on the development of individualism and the progressive implementation of Enlightenment ideals. This view was challenged from the 1960s by a number of social movements which included mental health service user groups. As O' Brien and Penna (1998) suggest, the development of wider democratic forms had actually hidden the exclusion from civil society of marginalised groups.

The responses to the failings of community based mental health services are a reflection of and contribute to the development of the 'risk society' (Beck 1992). Giddens (1991) argues that the socio-economic and political changes, including: globalisation, technological developments, and new patterns in employment and changes in gender relations, have led to what Beck terms 'ontological insecurity'. The risk society or late modernity is thus characterised by an emphasis on individualism and challenges to traditional structures. Young (2004) calls this process of rapid social change the 'loosening of the moorings'. Beck (1992) argues that a 'risk consciousness' develops. Society is preoccupied with a whole new range of risks.

As the difficulties in mental health services increased, a series of measures were introduced. HC (90)23/LASSL (90)11 established the Care Programme Approach (CPA). The initial aim of the CPA was to develop a system of case management to ensure that services were provided to those in most need because of their mental health problems. It was a response to the failings of services highlighted by, for example, the *Spokes Inquiry* (DHSS 1988) into the murder of social worker Isabel Schwartz, as well as wider concerns about the rise in homelessness. As Simpson *et al.* (2003) argue, the aim of the CPA was initially to improve services. However, in its implementation, it shared a number of the wider characteristics of New Public Management (NPM) (Pollitt 2003). The establishment of the CPA brought with it added layers of bureaucracy and audit which did not seem to enhance the effective provision of mental health services. Each service-user who was registered on the CPA was meant to have a care plan, key worker and regular reviews. The system became more focused on audit than the provision of care. As Simpson *et al.* argue

There were few agreed procedures for risk assessments, care plans were often found to be ineffective and some areas had difficulty keeping up regular reviews. Service users and carers were more likely to be invited to reviews but often found them formal and intimidating and arranged at the convenience of medical staff. (2003, p. 493)

The introduction of the CPA was followed in 1993 by *Guidance on the introduction of supervision registers*. People considered to be 'at risk of harming themselves or other people' could be placed on a supervision register, with the aim of ensuring that they remain in contact with mental health services. The argument here is not that these particular individuals did not need support from community based mental health services. It is rather questioning not only the effectiveness of such measures as a means of enhancing the delivery of that support but also noting the role that such developments play in the construction of the 'mad' as dangerous and physically violent. It should be emphasised here that these are not individuals who have committed any offences. In such cases, it is possible to mount an argument that would lead to the curtailment of civil liberties.

The overwhelming majority of patients who met the criteria for inclusion on the supervision register would have been entitled to section 117 MHA aftercare provided to patients detained under section 3 MHA 1983. It should be noted that section 117 of the 1983 MHA established a clear duty on social services departments and local health authorities to provide aftercare to patients who had been detained under section 3 MHA. This section allows for the detention of a patient for up to six months in the first instance.

Section 117 MHA is unusual for a number of reasons. It provides that any services should be free of charge. The fact that such section with its commitment to free services was introduced by the first Thatcher government is noteworthy in itself. In addition, the obligation to provide such services is not time limited. The duty exists so long as the individual appears to be in need of the services provided. In this context, services have a very wide meaning. As the response to mental health crises becomes more holistic so the range of service provision widens.

One of the problems with the implementation of section 117 MHA was that it was not applied on a consistent basis. Some local authorities were charging for services; others were not. The House of Lords decision in 2002 in *Regina v Manchester City Council, Ex P Stennett* confirmed that services had to be provided free of charge. This had particular implication for the financial assessment of individuals, entitled to s 117 aftercare, who were living in or moving to residential care. The fact that it took 20 years for the law on this point to be clarified and the unlawful action of local authorities to be overturned and a judgment in favour of patients to be made indicates the marginalised status of individuals with severe mental health problems. The judgment received little, if any, wider publicity outside of the specialist mental health and social work journals. This placed a duty on *mental health service providers* to provide services to meet their needs. This implies that services had a duty to remain in contact with service-users and not the other way around.

HSG (94)/27 established Inquiries must take place following a homicide by a person with previous contact with Mental Health services. The Ritchie Inquiry (1994) into the care and treatment of Christopher Clunis made a series of recommendations including the setting up of specialist teams to work with the homeless mentally ill. The Inquiry also recommended that consideration be given to the introduction of CTOs. If such legislation had existed then, no doubt, Mr Clunis would have been made subject to its provisions. However, its possible efficacy in the turmoil of the inner-city mental health services of the time is highly questionable. The therapeutic state did not appear to have the resources to supervise Mr Clunis so it is not clear how this legislation would have changed that.

In 1995 the Mental Health (Patients in the Community) Bill introduced 'supervised discharge' a short-lived piece of legislation which can be seen as a forerunner of the Community Treatment Order legislation we have today. This was a rather confused piece of legislation. It attempted to impose conditions including their contact with mental health professionals on the discharge of patients detained under section 3. These policy developments share some common themes. The focus is on the surveillance – in its widest sense – of discharged patients. There is an implicit assumption that these tragedies have occurred because of patients have failed to take medication. The service context of high levels of need, poorly organised and underfunded services is ignored. Ironically, such a description is finally provided in *Modernising Mental Health Services* (DH: 1998). This policy document was introduced by the then Secretary of State, Frank Dobson with his famous observation that 'community care has failed'. Such policies not only add to the stigma that people with mental health problems face, they also inevitably deter individuals from seeking help.

The above forms the backdrop to the changes in policy and legislation. As argued below, these moves culminate in the introduction of the Community Treatment Orders. Yar and Penna (2004) see a paradox of modernity in that whilst this is an era of mass penal incarceration, the segregation of other groups including the mentally ill has decreased. Unfortunately, they have, in many cases, joined another or been moved to another socially excluded group: offenders. One of the effects of deinstitutionalisation has been to increase the contact between those with mental health problems and the police and prison systems

(Robertson 1988, Singleton *et al.* 1998, Shaw *et al.* 2004). Barr (2001) argues that the widespread policy of 'zero tolerance' disproportionately impacts on the homeless mentally ill. In 1987, the Mental Health Act Commission (MHAC) published a discussion document on community treatment. From this point on the debate about the introduction of CTOs was a feature of the mental health policy landscape. This debate was overwhelmingly framed in terms of the alleged efficacy of such orders – how they would enable patients to remain in the community and services to provide support. The evidence to support these contentions is debatable. However, the wider philosophical issues concerning the nature of citizenship, the use of compulsion in the provision of mental healthcare were pushed to the extreme margins of the public discourse.

Reform of the Mental Health Act and the introduction of Supervised Community Treatment Orders (SCTOS) in England and Wales

There is not the space here to discuss in detail the tortuous path of the legislation that eventually became the new Mental Health Act in 2007. The failings of community based mental health services in the 1980s and 1990s, which form part of the backdrop to this reform, are discussed in more depth below. Some of the key themes of the New Labour project and its view of the nature of citizenship are prominent features of this fundamental overhaul of mental health legislation. As Gostin (2007) argues, the reform of the 1959 MHA by the 1983 MHA can be seen in terms of a shift from an essentially paternalist view of mental health patients to a rights based module. For example, the Mental Health Act Commission was established to oversee the treatment and care of all those detained under the legislation. The 2007 reform is very much about a shift to the New Labour mantra that 'with rights come responsibilities'.

Soon after it came to power, New Labour established an Expert Committee to review mental health legislation. This was partly to ensure that it was compatible with the Human Rights Act (1998) but also to examine the position of those who needed treatment but not in inpatient settings. The fundamental argument here was that the legislation was not 'fit for purpose' as a range of treatments now existed that meant that patients did not need to spend long periods in psychiatric hospitals. The Richardson Committee report (1999) proposed legislation based on notions of reciprocity. These proposals were not accepted. A draft Mental Health Bill was introduced in 2002. This was a remarkable document as it had the effect of uniting a series of professional and service-user groups in opposition to it. The root and branch reform never materialised. A series of amendments to the 1983 MHA were introduced in 2007. These included the introduction of the CTO.

Some form of CTO exists in a number of jurisdictions across North America, Australia and New Zealand. The 2007 legislation in England and Wales was heavily influenced by the Australasian models. Section 3 1983 MHA allows for a patient to be initially detained in a psychiatric hospital for up to six months. If a patient is detained under section 3, then, on discharge from hospital, s/he can be made subject to supervised community treatment. Conditions, for example, to take medication, live at an approved address and allow staff access can be imposed. Under previous legislation, similar powers existed. However, the fundamental difference is that under a CTO an individual can be recalled to hospital if they do not comply with the conditions imposed. This recall can be enacted without any assessment of the individual's current mental state. Under previous guidance, a formal Mental Health Act assessment would have to be carried out by a psychiatrist, general practitioner and an approved social worker. The patient can be recalled for a period of up to 72 hours. This period would be used to start the patient on medication

The main arguments put forward to support CTOs are that they are essentially the least restrictive way to treat the most seriously mentally ill members of the community. It is argued that the CTO will only be used in cases where patients have experienced repeated compulsory admissions to hospital with all the mental distress and wider disruption to their lives that these admissions entail. It is thus argued that the initial restrictions on the freedom of the individual will eventually allow him or her to avoid the repeated restrictions on their liberty of numerous compulsory admissions to hospital.

Discussion

As Eastman and Starling (2006) observe, the treatment of the mentally ill was always a fundamental exploration of the balance between the rights and autonomy of the individual and a wider societal paternalism as represented by professional decision makers. This debate arises because of the nature of mental illness and its impact on individuals. Only the extreme wings of libertarian thought (Szasz 1963, 1971) do not accept the need for the therapeutic state to have powers to intervene when individuals are putting themselves or others at risk. The main themes of this discussion chime with those outlined in Simon's analysis of the development of penal policy. Both the main political parties subscribed to the view that the response needed to be based on an increasingly coercive legislative framework.

There is a paradox at the heart of the development of mental health policy. In a number of ways, the rights of the mentally ill are on a much stronger footing than they have ever been. Those who experience discrimination as a result of their mental health problems have greater legal protections. In cases of compulsory detention, there is a new legal framework introduced to ensure compatibility with the provisions of the HRA (1998). In addition, there is a wider public discussion and acknowledgement of the impact of mental illness. Stigma and fear remain but the physical segregation in asylums has gone. In addition, psychiatry, mental health social work, nursing and other disciplines have a wider range of interventions to alleviate distress to offer. However, the policies and legislation which will impact on those in greatest need do not reflect these progressive themes. The failure to provide a very vulnerable group – those suffering from severe mental illness who had been detained under section 3 MHA (1983) – with their legal entitlement to section 117 MHA aftercare was recast as a law and order issue. In doing so, a shift occurred in the balance between individuals and the state. It is a clear statement of the marginalised status of this group that this shift was hardly noticed by the wider community and there was certainly little effective opposition to it. The physical asylums may have gone but the CTOs may turn out to be the longest-lasting feature of their legacy. The legislation suggests that CTOs will only be used in very limited circumstances and for those patients who have experienced repeated admissions. It can actually be used for *any* patient detained under section 3 MHA. In addition, the early indications are that it is used in many more instances than was originally envisaged (Williams 2010).

Bauman (2007) argues *we* have seen the development of what he terms the 'personal security state'. One of the key ways, in which, the modern state claims legitimacy is by its ability to defend its subjects. In modern society, these threats or perceived threats are increasingly internal or domestic ones. The 'madman' of tabloid legend is one of these. Bauman (2007) suggests that states and political elites lose legitimacy if they are seen to fail to protect citizens. As Cummins (2010) has demonstrated, the UK government's response to the community care crisis of the early 1990s was largely carried out on the terms of reference provided by the tabloid media. There was little if any attempt to

challenge the underlying assumptions about the nature of mental illness or to acknowledge the limits on the role of community services. The response is to seek new forms of legislation or surveillance – as in the penal sphere – rather than to expand social welfare programmes to tackle the underlying causes. New Labour's wider discourse of rights and responsibilities was soon overlaid with a tabloid-influenced discourse of the risk posed by the 'mad'.

All the policy responses discussed share a fundamental belief that the problems in mental health services lie in the legislative framework rather than the organisation, structure and delivery of services. This resulted in CTOs being given an almost mythic status as the solution to the problems of community care. In addition, there was a belief that one of the causes of the collapse in services was the increased rights being afforded to patients (Cummins 2010). It should be emphasised here that this predates the introduction of the Human Rights Act and was in a period of Conservative governments, which up to 1992, had significant Commons majorities. In any event, as the path of the reform of the MHA discussed below demonstrates, there is not an easily recognisable powerful party political grouping which will defend the rights of the mentally ill. This is not meant, in any way to minimise the work of those that do, rather it is a comment on the relative political importance given to the issue. In addition, the terms of the debate are structured in such a way as to place great emphasis on a number of key themes: *violent offences committed by those, particularly young black men, in some form of contact with MH services, the new for some of Compulsory Treatment order and the so-called liberal perspective that dominates social work.*

Conclusion

Simon's '*Governing through crime*' superbly dissects the ways, in which, debates around law and order have not shifted. It also explores the ways those debates have come to have such a profound influence on the wider political culture. Using this framework provides an insight into the development of mental health policies in England and Wales. This issue does not have the same electoral profile as law and order – one of the reasons being that there is essentially a wide political consensus on these issues. The option of building new asylums was not available. This would have required a huge fiscal commitment from the state. There has been the establishment of a private sector in mental health care. This has seen the development of private or voluntary sector run residential and nursing homes. However, there are some important points of overlap. Simon has highlighted that it has so far proved very difficult to challenge the terms on which these debates are conducted. A similar phenomenon is apparent in mental health policy. Both these areas reflect a crisis in the legitimacy of the state in the face of fiscal and other pressures including high-profile cases. The impact of the media coverage of high-profile cases led to the creation of a climate of public opinion where '*something has to be done*'. In the mental health field this was the introduction of increasingly restrictive and bureaucratic approaches focusing on the doxa of the audit culture – registration, review and inspection. In this schema, the actual quality of service provision can be lost. The eventual result was the introduction of CTOs.

References

- Alexander, M., 2012. *The new Jim Crow; Mass incarceration in the age of colourblindness*. London: New Press.

- Appleby, L., 2010. Offender health reform is gathering pace. In *Prison Mental Health: vision and reality*. London: Centre for Mental Health.
- Barr, H., 2001. Policing madness: people with mental illness and the NYPD. In: A. Mcardle and T. Erzen, eds. *Quality of life and the new police brutality in New York City*. New York, NY: NYU Press, 50–84.
- Barton, W.R., 1959. *Institutional neurosis*. Bristol: Wright and Sons.
- Bauman, Z., 2007. *Liquid times: living in an age of uncertainty*. Bristol: Polity.
- Beck, U., 1992. *Risk society: towards a new modernity* (trans. M. Ritter). London: Sage.
- Branson, G. and Stafford, R., 1996. *The media student's book*. London: Routledge.
- Burr, V., 2003. *An introduction to social constructionism*. 2nd ed. London: Routledge.
- Butler, I. and Drakeford, M., 2005. *Scandal, social policy and social welfare*. 2nd ed. Bristol: Policy.
- Cohen, S., 1972. *Folk devils and moral panics*. London: Macgibbon and Kee.
- Cross, S., 2010. *Mediating madness mental distress and cultural representation*. Basingstoke: Palgrave Macmillan.
- Cummins, I., 2010a. Deinstitutionalisation: mental health services in the age of neo-liberalism. *Social policy and social work in transition*, 55–74.
- Cummins, I., 2010b. Distant voices still lives: reflections on the impact of media reporting of the cases of Christopher Clunis and Ben Silcock. *Ethnicity and inequalities in health and social care*, 18–29.
- Cummins, I., 2010c. The relationship between mental institutions beds, prison population and the crimes rate. In: *Prison mental health: vision and reality*. London: RCN, NACRO, Centre for Mental Health, 22–25.
- DHSS, 1988. *Report of the committee of inquiry into the care and aftercare of Sharon Campbell*. (Chairman: J. Spokes). London: HMSO.
- Eastman, N. and Starling, B., 2006. Mental disorder ethics: theory and empirical investigation. *Journal of medical ethics*, 32, 94–99.
- Foucault, M., 1972. *The archaeology of knowledge* (trans. A.M. Sheridan-Smith). London: Tavistock.
- Foucault, M., 1977. *Discipline and punish* (trans. A. Sheridan). London: Penguin.
- Furedi, F., 1994. A plague of moral panics. *Living Marxism*, 73 (November).
- Garland, D., 2004. Beyond the culture of control. *Critical review of international social and political philosophy*, 7 (2) (Special issue on Garland's *The Culture of Control*), pp. 160–189.
- Giddens, A., 1991. *The consequences of modernity*. Cambridge: Polity.
- Gilmour, I., 1992. *Dancing with dogma: Britain under Thatcherism*. London: Simon and Schuster.
- Goffman, E., 1968. *Asylums: essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin, 594–616.
- Gostin, L., 2007. From a civil libertarian to a sanitarian. *Journal of law and society*, 34 (4).
- Gramsci, A., 1971. *Selections from the prison notebooks*. London: Lawrence and Wishart.
- Gripsrud, J., 2002. *Understanding media culture*. London: Arnold.
- Habermas, J., 1976. *Legitimation crisis*. London: Heinemann.
- Hall, S. ed., 1997. *Representation: cultural representations and signifying practices*. London: Routledge.
- Hall, S., Critcher, C., Jefferson, T., Clarke, J. and Roberts, B., 1978. *Policing the crisis: mugging, the state and law and order*. Macmillan Education.
- Hallsworth, S. and Lea, J., 2011. Reconstructing Leviathan: emerging contours of the security state. *Theoretical criminology*, 15, 141–157.
- Holmes-Eber, P. and Riger, S., 1990. Hospitalisation and composition of mental patients' social networks. *Schizophrenia bulletin*, 16 (1), 157–164.
- Kellner, D., 1995. *Media culture: cultural studies, identity and politics between the modern and the post modern*. London: Routledge.
- Kelly, B., 2005. Structural violence and schizophrenia. *Social science and medicine*, 61, 721–730.
- Knowles, C., 2000. *Bedlam on the streets*. London: Routledge.
- Leff, J. and Trieman, N., 2000. Long-stay patients discharged from psychiatric hospital. *British journal of psychiatry*, 176, 217–223.
- Martin, J.P., 1985. *Hospitals in trouble*. Oxford: Blackwell.
- Moon, G., 2000. Risk and protection: the discourse of confinement in contemporary mental health policy. *Health & place*, 6 (3), 239–250.

- Nye, R., 2003. The evolution of the concept of medicalisation in the twentieth century. *Journal of the history of behavioural sciences*, 39 (2), 115–129.
- O'Brien, M. and Penna, S., 1998. *Theorising welfare: enlightenment and modern society*. London: Sage.
- Pilger, J., 1976. Dumped on the streets and in the slums 5000 who need help. *Daily mirror* 1976. Available from: studymore.org.uk/mh.htm [Accessed 28 November 2012].
- Pollitt, C., 2003. *The essential public manager*. Milton Keynes: Open University Press.
- Ritchie, J. (Chair), 1994. *The report of the inquiry into the care and treatment of Christopher Clunis*. London: HMSO.
- Robertson, G., 1988. Arrest patterns among mentally disordered offenders. *British journal of psychiatry*, 153, 313–316.
- Schrag, P., 2004. *Paradise lost: updated with a new preface: California's experience, America's future*. Berkeley, CA: University of California Press.
- Scott, R.D., 1973. The treatment barrier part 1. *British journal of medical psychology*, 46, 45–53.
- Seddon, T., 2009. *Punishment and madness: governing prisoners with mental health problems*. London: Routledge Cavendish.
- Shaw, J., et al., 2004. Suicide by prisoners. *British journal of psychiatry*, 184, 263–267.
- Simon, J., 2007. *Governing through crime: how the war on crime transformed American democracy and created a culture of fear*. Oxford: Oxford University Press.
- Simon, J., 2013. *Mass incarceration on trial: America's courts and the future of imprisonment*. London: New Press.
- Simpson, A., Miller, C. and Bowers, L., 2003. The history of the care programme approach in England: where did it go wrong? *Journal of mental health*, 12 (5), 489–504.
- Singleton, N., Meltzer, H. and Gatward, R., 1998. *Psychiatric morbidity among prisoners in England and Wales*. London: HMSO.
- Szasz, T., 1963. *Law, liberty and psychiatry*. New York, NY: Macmillan.
- Szasz, T., 1971. *The manufacture of madness*. London: Routledge and Kegan Paul.
- Wacquant, L., 2005. Race as civic felony. *International social science journal*, 57 (183), 127–142.
- Wacquant, L., 2007. *Urban outcasts: A comparative study of advanced marginality*. Bristol: Polity.
- Wacquant, L., 2008. Hyperincarceration, workfare, and the collapse of the dark ghetto. *The Boston review*.
- Wacquant, L., 2009a. *Prisons of poverty (contradictions)*. Minneapolis: University of Minnesota Press.
- Wacquant, L., 2009b. *Punishing the poor: the neo-liberal government of social insecurity*. London: Duke University Press.
- Wacquant, L., 2010. Class, race & hyperincarceration in revanchist. *America in daedulus*, 139 (3), 74–90.
- Williams, J., 2010. Are community treatment orders being over-used? *The Guardian*, 27 October 2010. Available from: <http://www.guardian.co.uk/society/joepublic/2010/oct/27/community-treatment-orders-mental-health?INTCMP=SRCH> [Accessed 28 November 2012].
- Wolff, N., 2005. Community reintegration of prisoners with mental illness: a social investment perspective. *International journal of law and psychiatry*, 28, 43–58.
- Yar, M. and Penna, S., 2004. Between positivism and post-modernity? Critical reflections on Jock Young's *The Exclusive Society*. *British journal of criminology*, 44, 533–549.
- Young, J., 1999. *The exclusive society: social exclusion, crime and difference in late modernity*. London: Sage.
- Young, J., 2004. Crime and the dialectics of inclusion/exclusion: Some comments on Yar and Penna. *British journal of criminology*, 44 (4), 550–556.

Policing and Mental Illness in the era of deinstitutionalisation and mass incarceration: A UK Perspective

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Abstract

The policy of deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of the mentally ill, did not achieve its utopian aims. Wolff (2005)/Moon (2000) argue that the Asylum has been replaced by a fragmented, dislocated world of bedsits, housing projects, day centres or increasingly prisons and the Criminal Justice system. This shift has been termed “*transinstitutionalisation*”. This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them. Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor. Kelly (2005) uses the term “*structural violence*” – originally from liberation theology to highlight the impact of a range of factors including health, mental health status and poverty that impact on this group. This paper will explore one aspect of this process – the impact on policing, particularly the assessment of mental health issues in the custody setting. The paper is based on research projects carried out with two police forces in the North West of England. Both the Police and Criminal Evidence Act (PACE 2004) and the Mental Health Act (2007) provide police officers with powers in relation to the arrest and detention of individuals experiencing mental distress. In addition, this legislation provides greater protections to individuals experiencing mental distress if they are interviewed by the police in connection with an alleged offence. The research uses Chan (1996)’s application of *bureaucratic field* and *habitus* to policing to explore ways, in which, the impact of *mass incarceration and deinstitutionalisation* have led to the increased marginalisation of the mentally ill.

Introduction

On 14th May 2010, when Kenneth Clarke returned to the Ministry of Justice, the prison population in England and Wales was 85,009. When he had previously been Home Secretary in 1992-93, the average prison population had been 44, 628 (Prison Briefing 2010). This represents a ninety per cent increase in a period when crime rates were generally falling. The prison system has been consistently overcrowded in this period despite a large expansion programme including the establishment of private prisons. Seddon (2009) identifies the period from the late 1970s onwards as the unravelling of “*penal welfarism*”. Mass incarceration has become a feature of advanced liberal democracies. In addition, ideas that prison might have some rehabilitative function have been marginalised to be replaced by what Irwin terms “*The Warehouse Prison*”.

Following, Martinson’s (1974) statement that in penal policy “*nothing works*”, there has been a shift in the emphasis to the identification of and subsequent attempts to manage risk. Penal policy has reflected or even led wider changes in society. In this area, there has

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been a fundamental shift from in the focus of the “disciplinary gaze”. Offenders are no longer seen as individuals who need to be rehabilitated so that they can become fully functioning members of society. They are rather a threat that needs to be managed – the living embodiment of Beck’s (1992) “risk society”.

As Bauman argues (2007), we have seen the development of what he terms the “personal security state”. One of the key ways, in which, the modern state claims legitimacy is by its ability to defend its subjects. In modern society, these threats or perceived threats are increasingly internal or domestic ones. The “madman” of tabloid legend is one of these. Bauman suggests that states and political elites lose legitimacy if they are seen to fail to protect citizens. As Cummins (2011) has demonstrated the UK Government’s response the community care crisis of the early 1990s was largely carried out on the terms of reference provided by the tabloid media. There was little if any attempt to challenge the underlying assumptions about the nature of mental illness or to acknowledge the limits on the role of community services. The response is to seek new forms of legislation or surveillance – as in the penal sphere- rather than to expand social welfare programmes to tackle the underlying causes.

In major works, *Prisons of Poverty (Contradictions)*(2009) and *Punishing the Poor: The Neo-liberal Government of Social Insecurity* (2009) and a series of articles, Wacquant has argued that the US welfare state has been dismantled whilst the incarceration rates have grown exponentially. He argues that *welfare* has replaced by *prisonfare*. The US welfare state that did not offer European levels of protection has been swept away. In its place, mass incarceration has taken on the role of the management of the urban, largely black and male urban poor. His arguments can be summarised thus

the converging political, economic and ideological currents implicated in the hobbling of the US social welfare state conjoined with the expansion of incarceration and criminal justice supervision both directed at the lowest end of the labour market.

Wacquant has used the term “centaur state” to describe the way that liberal and permissive policies exist for elites whilst the poor are subject to greater supervision and restriction. He sees this as a key feature of the neo-liberal project. Economic deregulation leads to general insecurity for the poor. This insecurity needs to be managed. He has highlighted the way that neo-liberal deregulation in the job market has led to a wider sense of social insecurity.

Bauman (2007) argues that society is now viewed as “network” rather than a “structure”. The wider fear of crime is part of these developments. These trends have been accompanied by the restructuring of the modern city. Bauman suggests that cities and city boundaries that were once seen as providing protection are seen as a locus of fear and anxiety. Davis (1998) the main features of the modern city are breakdown and division. They are sites where to protect “valorised spaces police battle the criminalized poor” (Davis 1998: 224). Since the economic crisis of the 1970s, political legitimacy has been increasingly maintained through the prism or metaphor of penal policy.

Deinstitutionalisation

One of the original aims of community care was an attempt to improve the care of one of the most marginalized groups in society. Whatever the original motives behind the establishment of the asylums, it was clear by the 1980s, and they were no longer sustainable. This was not only on the grounds of the largely inadequate care that was provided but also as was made explicit in the NHS + Community Care Act (1990) the economic policies of the government of the time meant that new funding arrangements were demanded. It is something of a false division to see institutionalisation and community care as opposites. In only the most radical work, such as Laing is there a denial of any need for some form of hospital provision for those experiencing the most severe forms of distress. Even Laing’s alternatives involve the

patient being removed from what he saw as the toxic family environment that produced their illness. The genus of community care is that prolonged periods of hospital care can in themselves be damaging and that services need to exist to intervene at early stage to provide support to those suffering from any form of mental distress. This is a public health model of service provision that ideally develops tiers that will meet individual and community need. The asylum system resulted in a complete imbalance in that the services such as they were, were almost all concentrated in this sector.

Cummins (2010) notes the media portrayal of community care in the 1990s is virtually all based on cases of homicide or serious injury. It is hardly surprising that the publications, which do much to contribute to the stigma users of mental health services face, did not fully support a more progressive approach to service provision. The response has been a call for more coercive legislation, one which ultimately was heeded by the New Labour administration. However, the other element of the criticisms of deinstitutionalisation comes from those who one might suppose support the principles of the policy but feel that its introduction has not been adequately financed.

Moon (2000) argues there is a geographical paradox at the heart of the development of community care services. As several commentators note (Philo 1987; Scull 1989) the asylums were based on seclusion and concealment. The institutions served to cut off this group from the wider population. The experience of being a resident was potentially so damaging that you might not ever resume your former role. However, the move towards community care has not challenged this. In fact, as Wolff (2005) suggests the institution has almost been reproduced in the community. Those with the most complex needs are often found living in the poorest neighbourhoods, in poor quality residential care homes, on the streets or increasingly in the prison system (Moon (2000), Singleton et al (1998)). The overall picture is a very bleak one, so bleak in fact that the asylum system appears to have some advantages in that it was, at least, a community.

Grobb (1995) concludes that community has not proved up to the task of providing humane and effective services for those with the most complex needs. Scull (1986) suggests that mental health services have been under funded and not been able to provide the continuity of care that the most vulnerable individuals in society need. These themes chime with the main conclusion of a series of inquiries into failures in community care services (Ritchie (1994) Blom -Cooper et al (1995)). However, the response has been to focus on individuals or the legislative framework. As Parton (1985) argues in another context by focusing on dangerous individuals one ignores dangerous conditions thus not tackling the real source of the risk.

Cross (2010) emphasises the continuing influence of representations of madness. These notions are transmitted through a range of popular cultural forms – song, film, TV drama and so. Cross is not arguing that modern cultural representations are continuations of older forms. However, he suggests it is important to recognise the similarities as well as the disjunctions. The physical representations of the “*mad*” emphasise wild hair, physical size as signs of their irrationality and uncontrollability. It is interesting to note, in this context, the overlaps between these representations of the mad as almost bestial and deeply engrained racist stereotypes of black men – see Cummins (2010) for a discussion of the case of Christopher Clunis to illustrate this point. As Cross suggests pre-existing social representations of the “*other*” are very powerful in their ability to create a new identity for social categories. In this case, the representation of the mad from the asylum era has followed those people into the community. The representation has changed – the mad are not now dishevelled creature chained to walls – they are the homeless of the modern city living on the streets with all their belongings in shopping carts. Their presence on the margins is accepted as a feature of modern urban life. Knowles (2000) ethnographic study of the experience of the mentally ill on the streets of Montreal illustrates this argument. She uses a series of black and white photographs to capture the ways that the *mad* exist alongside but ignored by the wider society. To borrow a phrase from Bauman, the *mad* have become the “*internally excluded*”

The thrust of mental health policy in the past fifteen to twenty years in England and Wales can be viewed as a political response to the agenda created by a media focus on homicides and other serious events. A range of policies and legal changes such as CPA, Supervised Discharge, Supervision Registers, Modernising Mental Health Services and National Service Frameworks have concentrated on essentially bureaucratic responses to the collapse of mental health services. The emphasis has been on a managerialist approach. This culminates in the reform of the Mental Health Act (1983) and the introduction of Community Treatment Orders. As in other areas of state provision, one of the effects of the introduction of neo-liberal ideas and the creation of a market in services has been to an increase in regulation. Wacquant's use of the term the centaur state is very applicable here as the increased regulation impacts on the poor (Kelly 2005).

Policing and Mental Illness

Police officers can have a key role to play in situations, in which, individuals are experiencing some sort of crisis related to mental health problems. The Sainsbury Centre's (2008) study suggested that up to 15% of incidents dealt with by the Police include some sort of mental health issue or concern. It also calls for the exercise of a range of skills. The Police have considerable discretion in terms of their response (Bitner 1967). They may well be the emergency service that is first contacted by the relatives of those in acute distress, who are, for example, putting themselves or others at risk. If a person is acutely distressed in a public place then the likelihood of some form of police involvement is increased significantly. The role of the police in this field, particularly the use of their powers under section 136 MHA and PACE (2004) see Cummins (2012) for a further discussion of the application of these powers. Despite the fact that this is a very important facet of day to day police work, it is an area that is neglected in police training. Pinfold (2003) suggests that police officers hold a number of stereotypical views about mental illness- with the idea that there is a link between mental illness and violence being the most strongly held. This viewpoint is supported by Cotton (2004). Cummins (2007) showed that the majority of officers have little input in this field. As a result the professional skills and knowledge that they acquire is largely through experience on duty or from their senior colleagues. This is an issue that has to be a common feature in policing in the industrialized world since the asylum closure programme began (Sims and Symonds; 1975, Tesse and van Wormer; 1975, Fry *et al*; 2002). Janus *et al*'s 1980 study showed that the benefits of training including increased empathy on the part of officers for those experiencing mental health problems. A more recent study Cummins and Jones (2010) has highlighted the benefits of a different approach to the training of police officers. The Dyfed and Powys force developed a new approach to the training of officers. This involved staff spending time on mental health units, receiving training from mental health staff and service-user groups. This model of training has been very successful. The feedback from both police officers and mental health service-users emphasized that this approach helps to challenge stereotypical views.

In the UK, successive governments as outlined in the circulars 66/90 and 12/95 have followed a policy of diversion of the mentally ill from the Criminal Justice system. The police station could be a key locus for this diversion or perhaps more accurately the accessing of mental health care. The provision has been patchy and led to frustration for police officers (Vaughan *et al*; 2001, Curran and Matthews; 2001). However, access to appropriate mental health services for those in contact with the CJS, as the Bradley Report shows, is still fragmented and disjointed. The historical neglect in this area is demonstrated by the fact that in the financial year 2004/05, the Home Office and National Institute for Mental Health in England (NIMHE) made £155,000 available to improve training. As the Mental Health Act Commission (MHAC) report suggests (2005:271), this amounts to about £1 for each officer in England and Wales. The National Policing Improvement Agency (NIPA) issued a briefing

note in 2010 offering guidance to staff on the recognition of both mental health problems and learning difficulties

Policing always involves an element of discretion and individual judgment. This is particularly the case regarding working with individuals who are acutely distressed. Individual officers have to make a decision on how to exercise their legal powers or deal with the matter in some other way. Policing is about more than the detection of crime or apprehension of offenders. Wolff (2005) has gone further and suggests that police officers have always had a quasi-social work function in this field. However, as Husted et al (1995) argue this is not something their training or police culture value highly. The conventional methods of coordinating services have not been successful (Wolff, 1998). These problems are not limited to North America and Europe (Kimhi et al; 1998).

MIND (2007) has highlighted the negative impact of police involvement from the perspective of those using mental health services. Police officers often have a significant role to play in mental health services. Lamb *et al* (2002) provides a rationale in terms of public protection for police involvement. This role has been expanded by the failure to develop robust community-based services in the era of de-institutionalisation (Pogrebin; 1986). This adds to the well –documented frustration that police officers feel when dealing with mental health services (Brown et al; 1977 Graham; 2001). Police officers in Gillig et al's 1990 study felt that what they really needed was access to information about an individual's past history as well as rapid support from mental health staff. This finding was supported by Stevenson et al (2011). Interestingly in this study, mental health service –users assumed that agencies shared information as a matter of course. Watson et al (2004a) found that knowledge of an individual's mental health history has a negative impact on how the police respond – in this study the police were less likely to take action on the information provided if the individual had a history of mental illness. However, there is evidence that the police have skills in this area (Smith: 1990). Watson et al (2004b) show that in certain situations officers are sympathetic to the needs of people with schizophrenia. Lamb et al (2001) demonstrate that joint working can tackle deeply entrenched positions of mistrust.

The police have become increasingly involved in supporting community-based mental health services (Meehan:1995). This is likely to increase with the introduction of community treatment orders (CTOs) in England and Wales with the reform of the 1983 Mental Health Act (MHA). The increased contact has led some forces to explore different models of policing to response to mentally ill people experiencing acute distress. These include crisis intervention teams of specially trained officers. Deane et al (1999) Steadman et al (2000) emphasise that inter-agency co-operation is a key factor if the inappropriate use of jails for the mentally ill is to be avoided. Lamb et al's (1995) study indicates that joint teams can both meet the needs of severely mentally ill people and help to avoid the criminalisation of acutely distressed individual

The Bradley Review

In 2008, the government commissioned a report to look at the experiences of people with mental health problems or learning disabilities in contact with the CJS. It should be noted that individuals in these groups are more likely to be victims than perpetrators of crime. The Bradley Review reported in April 2009 and made a series of recommendations about how agencies can work together more effectively to meet the needs of vulnerable adults. The review also highlighted examples of good practice including innovative areas of joint working between the police, social work agencies, health care providers and the voluntary sector. The most important recommendation that Bradley makes relates to the provision of healthcare in custody settings. At the time of writing, this is commissioned on a force by force basis. Bradley argues that the police should follow the lead of the prison estate and transfer healthcare to the NHS. This would be a radical move and would address a number of the issues identified above. A number of forces have entered into arrangements whereby mental

health nursing staff are based in custody settings to assess detained persons or offer advice. From a public health point of view, the custody setting could provide an opportunity to engage difficult to reach populations with health care services. McGilloway and Donnelly (2004) study in Belfast shows the potential benefits of such schemes.

The Custody Setting

The Police and Criminal Evidence Act (2004) provided key safeguards for the protection of vulnerable adults – that is, adults with mental health problems or learning disabilities – while in police custody. Along with the standard procedures and rights such as the provision of legal advice and the taping of interviews, such individuals have to be interviewed with an appropriate adult present. Custody sergeants have a key role to play in this process as they, in effect, carry out a risk assessment of every individual who comes into custody. Advice on ensuring the safety of those with mental health problems forms part of *Guidance on the Safer Detention and Handling of Persons in Police Custody* (ACPO, 2006). However, the guidance itself is not comprehensive. In any event, for it to be followed successfully, it is dependent on police officers making appropriate assessments of individuals' mental health needs. All individuals coming into police custody are assessed as to whether they are fit to be detained. Custody sergeants will carry out an initial screening exercise seeking medical or other support as required. This is a fluid process, but the initial decisions that are made are very influential.

There has been little research into the specific role of the custody sergeant under PACE (2004). Studies have examined the role of the appropriate adult which involve an indirect consideration of the custody sergeant role. However, there is not a specific study which explores the assessment of mental illness by police officer in this setting. Cummins (2008) carried out a study which examined the limited mental health awareness training that custody officers receive and their attitudes to this role. Skinns (2011) study of two custody suites does not consider the assessment of mental health issues by custody officers in any depth. The matter is referred to in a section looking at the way that the police work with volunteers acting as Appropriate Adults (AA). Skinns suggests that this assessment is carried out in conjunction with a doctor. This is not always the case – under PACE a formal medical assessment is not required for an AA to be involved.

The custody setting is a key part of the CJS but it is a largely neglected area of study. Skinns (2011) following the work of Choongh (1997) and Newburn and Hayman (2002) explore the way that the police fundamentally shape the nature of the custody environment. Despite an increasing range of other agencies and professionals – social workers, doctors, lawyers, drug workers, lay visitors and Appropriate Adults – having a role in the custody process this remains the case. The custody process is part of the police investigation and prosecution of crime. Choongh (1997) suggests that for the relatively small number of suspects who have regular contacts with the police, custody is used as a part of the mechanism to impose discipline and establish authority.

A Place of Safety?

The research in this field has concentrated on exploring the experiences of people with mental health problems coming into contact with the CJS. A study such as Singleton et al (1998) has tried to assess the extent of mental health problems amongst the prison population. Further studies have examined court diversion schemes and the experiences of particular groups of offenders, for example, women or BME groups. The research on policing and mental illness has focused on beat officers (Teplin: 1984) and/or their assessment of individuals experiencing acute mental distress (Jones and Mason: 2002). Pinfold et al (2004) examined police attitudes towards mental illness and ways to challenge stereotypical views. Cummins and Jones (2010) study compared two different approaches to the training of police officers.

The custody setting and the decision making of police officers is a key area but it is largely neglected in the literature relating to mentally disordered offenders.

The research that forms the backdrop to this paper (Cummins 2007, 2008, 2010 and 2012) examines the impact of the failings of community care policies and the development of the penal state as they play out in the context of the custody suite. As with the prison system, increasingly, deinstitutionalisation has led to this part of the CJS becoming involved in the provision of some form of mental health care. This research is strongly influenced by Chan's work particularly the use of Bourdieu's notion of *field* and *habitus*. The two studies that explored the responses to incidents of self-harm and the reasons for the involvement of Forensic Physicians (FP) highlighted the competing demands in terms of welfare and justice that custody sergeants face. Chan (1996) concludes that

Bourdieu's theory recognises the interpretive and active role played by police officers in relating policing skills to the social and political context. It also allows for the existence of multiple cultures since officers in different organisational positions operate under different sets of field or habitus.

Davies (1998) argues the architecture of modern cities excludes the urban poor not just physically and psychologically. In addition, Barr (2001) argues that the policy of "zero tolerance" where civic authorities introduce a series of measures to tackle low level public order or nuisance offences disproportionately impact on the mentally ill. As well effectively criminalizing homelessness, they serve to further embroil the severely mentally ill in the Criminal Justice and prison systems. Others have argued that the asylum has been replaced not by the community-based mental health services that were envisaged but bedsits, housing projects, day centres and soup kitchens. The argument here is that individuals are physically living in the community but are denied the opportunity to be active citizens. Stone (1982) argues there is always likely to be an overlap between the CJS and mental health systems. The police are bound to have a significant role to play in this area. The best resourced community based mental health systems imaginable would not be able to function without working alongside the local police force. The legislative framework in England and Wales provides a sound basis for such work. However, the history of deinstitutionalisation and the failure to develop strong community mental health services (Cummins; 2011) has meant that the CJS and the Police have become the mental health care providers of last resort.

The Bradley Review may well prove to be a watershed for policy in this area. Its recommendations, along with a new emphasis on police mental health awareness training, provide an opportunity to tackle the issue of fragmented, disjointed and occasionally mutually suspicious services that have scarred the policy landscape for too long. These studies highlight the nature of custody officers' involvement in the assessment of individuals with mental health problems who come into contact with the CJS. Seddon (2009) refers to a number of "decision points" in what might be termed the careers of psychiatric patients. These points include civil admission to hospital or transfer to hospital to prison. He does not include the custody setting as one of those points. This research shows that it is, for a group of individuals with mental health problems, a key "decision point". The implications for policy are that police officers need greater support from other professionals to ensure that it is a point where individuals have greater not reduced access to mental health services.

Discussion

Bourdieu's conceptual framework of *field*, *habitus* and *capital* provides a series of tools to analyse the development of policies in the mental health and penal spheres. In this context, I would argue that the overlap between mental health and penal policies means that this area would meet Bourdieu's (1998) definition of a *field* as a "structured social space, a field of forces". Garratt (2007) argues that a *field* has three key elements within it. The first is the impact that it has on the development of the *habitus* of individuals within it. He then goes on

to suggest that a *field* seeks to maintain its own autonomy but there is competition between the actors within that area. Within this area, one can identify a number of key actors who seek to dominate or control key areas of the *field*. Seddon (2009) suggests there has been an ongoing argument about the treatment of the mentally ill within the CJS and prison systems. Seddon argues that this is a specious argument because the mentally ill have always been found in these systems. However, one can see that elements of within this bureaucratic *field* have been jockeying for position. The result is the constant ebbing and flowing of policies and approaches.

The policy of community care was enthusiastically adopted by the Thatcher government because it both chimed with the individualism trope of the neo-liberal agenda and would lead to a reduction of public provision. There has been an expansion of the private provision of mental health care including residential and forensic services. Knowles (2000) characterises these developments as the creation of new "*post-asylum geographies of madness*". As Bourdieu (2001) noted "*It is characteristic of conservative revolutions that they present restorations as revolutions*" This is certainly applicable to the ways in which the public provision of mental health care has been decimated and replaced by a market driven system that further marginalises the mentally ill. Bourdieu saw a key role for "*critical intellectuals*" in attacking the impact of neo-liberalism on the public provision of social services. In the mental health area, there has been an absence of individuals willing to take on this role. Instead debates have been dominated by *doxa* such as *personalisation* which provide a cover for the decimation of services in the name of the ultimate neo-liberal ideal: *consumer choice*. As Turbett (2011) notes the cheerleaders for these developments ignore the fact that

The real victims of personalisation will be the hundreds of thousands of low-paid and low-status staff who work in agencies and actually provide the services that are threatened by the trend.

In addition, it should be added that there has been no discernible improvement in the provision of services. All the evidence is to the contrary.

As the *therapeutic state* declined the *penal state* expanded (Cummins 2006). Using the notion of *field* allows us to see these policies not as contradictory but as elements of a strategic battle. The police have a key role to play. For some commentators the combined effect of the shifts and changes outlined above has been the "*criminalisation of the mentally ill*". Borzecki and Wormith (1985) argue that for this thesis to hold two conditions need to apply. There needs to be higher levels of contact between mentally ill people and the police than the wider population and the arrest rate for those experiencing mental health problems would have to be shown to be higher. Hartford et al (2005) study is a statistical analysis of police recording of contacts and responses to calls in Ontario. The study confirmed the greater risk that people with mental health problems face in contacts with the police. There are two elements to this. The mentally ill were more likely to come into contact with the police. The result of this contact was shown to be more likely to result in custody. These findings have been supported in a range of studies which demonstrate that: the mentally ill are more likely to come into contact with the police, have a higher arrest rate, are at a greater risk of entering custody rather than being granted bail and are more likely to be arrested for relatively minor offences. (Teplin (1984), Pearson and Gibb (1995), and Robertson (1988)).

The notion of *field* encourages us to examine the influences on the development of policy in nuanced fashion. Gottschalk (2006) demonstrates that the Home Office was developing policies based on the assumptions that prison is "*an expensive way of making bad people worse*" before the right winger Michael Howard became Home Secretary. Howard was committed to a "*prison works*" approach. His appointment led to a complete change in the development of penal policy – for example moves to the increased use of community-based punishments were halted. At the same time as these developments were taking place, the official policy was that the mentally ill should be diverted from the CJS at the earliest opportunity (66/90 + 12/95). As the *penal state* continued to expand there were concerns about

how the prison system could cope with the increasing numbers of mentally ill. This led to the creation of specialist teams – *assertive in reach teams* to meet the mental health needs of those in prison. These services could not hope to meet the needs of this group Cummins (2010). There were also concerns about the experiences of particular groups within prison. Seddon (2009) notes that there have always been attempts to portray women offenders as mad simply on the basis of gender. In more recent times, the issue of women in prison has been given a high profile. A series of inspection reports, followed up by news and print media investigations highlighted the appalling conditions at the mental health wing of Holloway the largest women's prison. The role of prison reform groups and other campaign groups is a vital factor in the analysis of this *field*. For example, the Corston Inquiry (2007) was established following a series of suicides at Styal Women's Prison. The National Federation of Women's Institutes launched a campaign *Care not Custody* in 2008 to improve the provision of mental health care for women in prison. The NFWI is a very well-organised and influential group. It was able to gain access to ministers in a way that other groups would simply find impossible.

The interaction between the notions of *field* and *habitus* is crucial. Wacquant (1998) argues that in themselves they do not have the "*capacity to determine social action*". It is the interplay between the two that needs to be considered. Even if we assume that there is agreement across a *field*, it does not mean that all individuals in a given position within that *field* will act in the same way. Bourdieu was highly critical of grand theories such as Althusserian Marxism that did not leave any scope for individual agency. *Field* has a key role to play in the development of the *habitus* of any individual located there.

In terms of policing one of the key areas that has to be considered is "*police culture*". Sackmann (1991) defines culture as "*the collective construction of social reality*". A great deal of the analysis of policing focuses on "*cop culture*". There are a number of difficulties with using "*cop culture*" instrumentally. Chan (1996) argues occupational culture is not monolithic. Cop culture for Chan is "*poorly defined and of little analytical value*". In fact, Manning (1993) argues there clear differences between "*street cop culture*" and "*management culture*". The term "*cop culture*" is, in fact, a label for a form of *hegemonic masculinity* (Carrigan et al 1985) found in police settings. The major themes here would be: an emphasis on action as a solution to problems; a strong sense of group identity and hyper-masculinity manifesting itself in a series of misogynistic and racist attitudes. These attitudes would also include stereotypical views of the mentally ill and the idea that dealing with psychiatric emergencies was not "*proper policing*". In this schema, the police are hard-bitten, cynical and need to be aggressive to deal with the dangers that they face on a day to day basis. Reiner (2000) links the development of these cultural attitudes to the demands of police work itself rather than arising out of the wider society.

Goldsmith (1990) suggests that these cultural attitudes are part of a functional response to the demands of the post. Waddington (1999) takes issue with the way that "*canteen culture*" has been used uncritically. For Waddington, the culture of the police canteen is, very importantly an oral one. As he suggests, there is a gap between rhetoric and action. Despite the ongoing portrayal of police work as dynamic and exciting, the majority of it is not. To take one example, murder investigations involve a great deal of checking information, gathering statements and looking at tapes from CCTV, rather than the psychological profiling and car chases of the popular imagination. Loftus (2008) has noted how enduring these traits of police occupational culture are despite a raft of changes that one might expect to dislodge them – for example the recruitment of a more diverse workforce, greater public scrutiny and management moves to tackle these issues.

In the research undertaken in custody settings (Cummins 2007, 2008 and 2012), particularly in the interviews with custody sergeants, their perception of the role revealed a number of factors that influenced their attitudes and the development of a *habitus*. The custody sergeants saw their role as a key one in the administration of justice. However, they also emphasised that they were responsible for the welfare and safety of the detained persons whilst they were in custody. One major source of frustration for this group was the perceived lack of support from community mental health services. A key factor in this concern was also

the fact that the custody sergeants felt that they would be held personally responsible for any failings or if there was a serious incident or suicide. There was little confidence that they would be supported by senior management in such situations. Thus, there was a determination to be seen to have “*done things by the book*”. For example, in the Cummins (2012) study of decision making in custody, which explored the reasons why the police asked for a doctor to assess the mental state of a detained person, in the majority of cases it was to ensure that the person *was fit to be detained* in custody. This is essentially a decision that relates to the administration of justice rather than the welfare of the individual.

Conclusion

Wacquant (1998) suggests that Bourdieu concepts of *field* and *habitus* provide a tool box, with which, one can analyse individual actions and decisions within the context of the social relations that shape and limit their choices. In applying these tools to the issue of the treatment of the mentally ill within the CJS generally and police custody in particular, this allows for explanations that examine not only the development of grand policy but also the decisions that officers make on the ground. This approach creates a more nuanced appreciation of the factors that influence the decision making process. Garratt (2007) describes Bourdieu as a “*critical intellectual activist, foe of neo-liberalism and defender of embattled public services*” It should be noted that Bourdieu (1998) was concerned with the role that social work as part of the *Left hand of the State* could play in the mitigation of the impact of the neo-liberal project. He acknowledged that social workers found themselves trapped between the increased levels of social need and the demands of a bureaucracy seemingly wedded to the newspeak of neo-liberalist doxa. It is this message that needs to be reinvigorated if his work is to form the basis of a fight to tackle the damage done to the provision of mental health services.

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.
- ACPO/National Centre for Policing Excellence. (2006). Guidance on the Safer Handling of Persons in Police Custody. London: ACPO.
- Barr, H. (2001). Policing Madness: People with Mental Illness and the NYPD in *Quality of Life and the New Police Brutality in New York City*. New York. NYU Press Mcardle, A. and Erzen, T (eds).
- Bauman, Z (1997). *Postmodernity and its discontents*. New York: NYU Press.
- Bauman, Z. (2003). *Wasted Lives: Modernity and Its Outcasts*. Oxford. Polity.
- Bauman, Z. (2007). *Liquid Times: Living in an Age of Uncertainty*. Oxford. Polity.
- Bittner, E. (1967). ‘Police discretion in emergency apprehension of mentally ill persons’, *Social Problems* 14:278–292.
- Blom-Cooper, L., Hally, H., and Murphy, E. (1995). *The falling shadow: one patient’s mental health care 1978-1993*. London Duckworth.
- Bourdieu, P. (1998). ‘*The Left Hand and the Right Hand of the State*’, in P. Bourdieu *Acts of Resistance*, pp. 1-10. Cambridge: Polity.
- Bourdieu, P. (2001). *Acts of Resistance: Against the New Myths of Our Time*. Cambridge: Polity.
- 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* 28:332–337.

- 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*, 10:241-247.
- Brown, S., Burkhart, B.R., King, G.D., and Solomon, R. (1977). Roles and expectations for mental health professionals in law enforcement agencies. *American Journal of Community Psychology* 5(2):207-215.
- Carey, S. J. (2001). Police officers' knowledge of, and attitudes to mental illness in southwest Scotland. *Scottish Medical Journal* 46 41-42.
- Chan, J. (1996). Changing Police Culture. *British Journal of Criminology* (1996) 36 (1): 109-134.
- Choongh, S. (1997). *Policing as Social Discipline*. Oxford, Clarendon Press.
- Cummins, I.D. 2010 'The relationship between mental institutions beds, prison population and the crimes rate', in: *Prison mental health: vision and reality*, RCN, NACRO, CENTRE for MENTAL HEALTH, LONDON, UK, pp.22-25.
- Cummins, I.D. (2011). "The Other Side of Silence; The role of the Appropriate Adult: post Bradley The Journal of Ethics and Social Welfare. 5(3), pp. 306-312.
- Cummins, I.D. (forthcoming). "Mental Health and Custody: a follow-on study" *Journal of Adult Protection*.
- Curran, S. and Matthews, K. (2001). "The psychiatrist will be with you in a day or two. Unnecessary delays in assessing the mentally ill in police custody in Scotland. *Scottish Medical Journal* 46(2):37.
- Davis, M. (1998): *City of quartz: excavating the future in Los Angeles*. London. Verso.
- Deane M.W., Steadman, H.J., Borum, R., Veysey, B.M., and Morrissey, J.P (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services*.
- Fry, A.J., O' Riordan D.P., and Geanelos, R. (2002). Social control agents or frontline carers for people with mental health problems: police and mental health services in Sydney, Australia. *Health Social Care and Community* 10(4) 277-286.
- Garrett, P.M. (2007). Making social work more Bourdieusian: why the social work profession should enagage with the work of Pierre Bourdieu. *European Journal of Social Work* 10 (2) pp225-243.
- Graham, J (2001): Policing and the mentally disordered. *Scottish Medical Journal* 46(2) 38-9.
- Gillig, P.M., Dumaine, M., Stammer, J.W., Hillard, J.R. and Grubb, P. (1990): What do police officers really want from the mental health system. *Hospital and Community Psychiatry* 41(6) 663-665
- 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*, 28:1-11.
- Home Office (1990) Provision for Mentally Disordered Offenders, Circular 66/90 Home Office (1995): Mentally Disordered Offenders: Inter-Agency Working. Circular 12/95
- Husted, J.R, Charter, R.A. and Perrou, B. (1995): California law enforcement agencies and the mentally ill offender. *Bulletin of the American Academy of Psychiatry and Law* 23(2) 315 -329.
- Janus. S S, Bess, B.E., Cadden, JJ and Greenwald, H. (1980): Training police officers to distinguish mental illness. *American Journal of Psychiatry* 137(2): 228-9
- Kelly, B. (2005) 'Structural violence and schizophrenia', *Social Science and Medicine*, 61: 721-730.
- Kimhi, R., Barak, Y., Gutman, J., Melamed, Y., Zohar, M. and Barak, I. (1998). Police attitudes toward mental illness ad psychiatric patients in Israel. *Journal of American Academy of Psychiatry and the Law* 26(4):625-630.
- Laing, R. (1959): *The Divided Self*. London Tavistock.
- Laing, R. (1967): *The Politics of Experience and the Bird of Paradise*. Harmondsworth. Penguin.

- Lamb, H.R., Weinberger, L.E. and DeCuir, W.J. (2002). The police and mental health. Psychiatric Services.
- Manning, P (1993), 'Toward a Theory of Police Organization: Polarities and Change', paper given to the International Conference on Social Change in Policing, 3-5 August 1993, Taipei.
- 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.
- Meehan, A.J (1995): From conversion to coercion: the police role in medication compliance. *Psychiatr Quarterly* 66(2) 163-184.
- MHAC (2005): *In place of fear? The Mental Health Act Commission eleventh biennial report 2003-2005*. HMSO MIND (2007). *Another assault: Mind's campaign for equal access to justice for people with mental health problems*. MIND London.
- Moon (2000) Risk and protection: the discourse of confinement in contemporary mental health policy *Health & Place Volume 6, Issue 3*, 239-250.
- Newburn, T. and Hayman, S. (2002): Policing, Surveillance and Social Control: CCTV and Police Monitoring of Suspects. Cullopton, Willan.
- 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* 38(6):337-344.
- Pogrebin, M. (1986): Police responses for mental health assistance. *Psychiatr Quarterly* 58 66-73.
- 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*, 153: 313-316.
- Robertson, G., Pearson, R. & Gibb, R. (1995) Entry of Mentally Ill People into the Criminal Justice System, Home Office, London.
- Rogers, A. (1990) 'Policing mental disorder: Controversies, myths and realities', *Social Policy and Administration*, 24: 226-237.
- Steadman, H.J., Deane, M.W., Borum, R. and Morrissey, J.P. (2000): Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services* 51 (5) 645-649.
- Stone, L. (1982) An Exchange with Michel Foucault, New York Review of Books, New York.
- Teplin, L. (1984) 'Criminalising mental disorder', *American Psychologist*, vol. 39, pp. 794-803.
- Sackmann, S. (1991) *Cultural Knowledge in Organizations*. Newbury Park, CA: Sage.
- Scully, A. (1977): *Decarceration: Community Treatment and the Deviant - A Radical View*. Englewood Cliffs, NJ: Prentice-Hall.
- Scully, A. (1986). Mental patients and the community: a critical note. *International Journal of Law and Psychiatry* 9:383-392.
- Scully, A. (1989): *Social Order/mental Disorder: Anglo-American Psychiatry in Historical Perspective*. Berkeley University of California Press.
- Seddon, T (2007): *Punishment and Madness*. Abingdon. Routledge - Cavendish.
- Sims, A.C. and Symonds, R.L. (1975): Psychiatric referrals from the police. *British Journal of Psychiatry* 1: 171-178
- Singleton, N., Meltzer, H., and Gatward, R. (1998): *Psychiatric Morbidity among Prisoners in England and Wales*. London HMSO.
- Smith, J.P (1990): Police are best at community care of mentally ill people in England. *Journal of Advanced Nursing* 15(10): 1117.
- Teplin, L.A. (1985): The criminality of the mentally ill: a dangerous misconception. *American Journal of Psychiatry* 142(5) 593-599.

- Tesse, C.F. and van Wormer, J. (1975): Mental health training and consultation with suburban police. *Community Mental Health Journal* 11 (2) 115-121.
- Turbett, C (2011) *Personalisation in Social Work (Transforming Social Work Practice series)* *Br J Soc Work* 41 (7): 1406-1408.
- Vaughan, P.J, Kelly, M. and Pullen, N. (2001): The working practices of the police in relation to mentally disordered offenders and diversion services. *Medicine, Science and the Law* 41(1) 13-20
- Wacquant, L (1998): "Pierre Bourdieu" in *Key Sociological Thinkers* ed R. Stones, Palgrave Houndsmill.
- Wacquant, L. (2008): *Urban outcasts: a comparative sociology of advanced marginality*. Cambridge. Polity.
- Wacquant, L. (2009): *Punishing the poor: the neoliberal government of social insecurity*. Durham, N.C. Chesham. Duke University Press
- Wacquant, L. (2009): *Prisons of poverty* Minneapolis. University of Minnesota Press
- Waddington, P. (1999): Police (Canteen) sub-culture: An Appreciation. *British Journal of Criminology* 39(2):287-309
- Watson, A.C., Corrigan, P.W. and Ottati, V. (2004): Police officers' attitudes toward and decisions about persons with mental illness. *Psychiatr Services* 55(1) 49-53
- Watson, A.C., Corrigan, P.W. and Ottati, V. (2004): Police responses to persons with mental illness: does the label matter? *Journal of the American Academy of Psychiatry and the Law*. 32(4) 378-385
- Wolch, J. and Philo, C. (2000): From distributions of deviance to definitions of difference: past and future mental health geographies. *Health and Place* 6(3) 137-157
- Wolff, N. (1998): Interactions between mental health and law enforcement systems: problems and prospects for co-operation. *Journal of Health Politics Policy and the Law* 23(1):133-174.
- Wolff N (2005) Community reintegration of prisoners with mental illness: a social investment perspective. *International Journal of Law and Psychiatry* 28(1):43-58.



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Boats against the current: vulnerable adults in police custody

abstract

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One effect of the policy of deinstitutionalisation has been to increase police contact with people, who are experiencing the effects of acute mental illness. Policy documents such as Home Office circular 66/90 recognise that adults with mental health problems are especially vulnerable within the criminal justice system. The overall aim of policy is that vulnerable adults should be diverted to mental health services at the earliest opportunity unless the offence is so serious that this would not be in the public interest. However, there is little concrete evidence of the success of this policy. The result is that police officers have an increasing role to play in working with individuals experiencing acute mental health problems. In this process, custody officers have a key role to play as decision-makers as to whether the protections that PACE (1984) offers to vulnerable adults should apply. This article is based on a small-scale indicative research study, which examined how officers make these decisions and the training that they receive relating to mental health issues.

key words

offenders
mental illness
custody officers
protection

Introduction

The Police and Criminal Evidence Act (1984) provided key safeguards for the protection of vulnerable adults – that is, adults with mental health problems or learning disabilities – while in police custody. Along with the standard procedures and rights such as the provision of legal advice and the taping of interviews, such individuals have to be interviewed with an appropriate adult present. Custody sergeants have a key role to play in this process as they, in effect, carry out a risk assessment of every individual who comes into custody. Advice on ensuring the safety of those with mental health problems forms part of *Guidance on the Safer Detention and Handling of Persons in Police Custody* (ACPO, 2006). However, the guidance itself is not comprehensive. In any event, for it to be followed successfully, it is dependent on police officers making appropriate assessments of individuals' mental states. As outlined in this paper there are a number of obstacles here including: the lack of training police officers receive in relation to mental health issues, and a police culture, which, at times appears to be dismissive.

This article is based on a small-scale indicative study carried out in 2006 with an urban police force. The project was concerned with the process, by which custody officers decide that the PACE (1984) safeguards should apply. Custody officers have a central role to play, as the decision that an appropriate adult should be involved is one that they have, in effect, to make. All individuals coming into police custody are assessed as to whether they are fit to be detained. Custody officers will carry out an initial screening exercise seeking medical or other support as required. This is a fluid process, but the initial decisions that are made are very influential. The additional protections of PACE (1984) will not be applied if the individual is not assessed as being vulnerable.

Overview

People with mental health problems, who enter the criminal justice system (CJS), face a number of difficulties. The most obvious one is that the CJS does not exist to provide health care to vulnerable members of society. It might be argued that this is a *de facto* outcome of the failings of community care. However, this does not alter the fact that the role of the police is the reduction and prevention of crime, as well as detection and the subsequent prosecution of offenders. This problem seems to have been a consistent feature of modern industrial societies. As long ago as 1780, John Howard (1780) highlighted the fact that more '*idiots and lunatics*' were being imprisoned.

Arboleda-Florez and Holley (1998) argue that one unforeseen consequence of the policy of the closure of long-stay hospitals is a shift in the position of the criminal justice system. As the system has to deal with increased numbers of people experiencing mental health problems, it has taken on a fundamental role in the provision of care in the community. This is occurring despite policy initiatives set for assertive outreach teams to engage those most at risk, in diversion from custody schemes. This phenomenon appears to support the hypothesis that Penrose (1939) put forward nearly 70 years ago. He argued that the way that a society decides to deal with those who behave in ways that challenge accepted norms, is decided by a range of factors. These will include the prevailing social and political climate, changes in what society considers to be normative behaviour and the resources that are available.

As a result of the policy changes and historically, police officers increasingly have a key role in the mental health field. Specific powers exist within the Mental Health Act (MHA) (1983), for example, to remove a person who appears mentally disordered and

in need of care or control to a place of safety (section 136 MHA). In addition, police officers are involved on a day to day basis in a number of areas, for example, supporting other professionals during MHA assessments, executing warrants under section 135 MHA or dealing with violent or aggressive incidents at psychiatric units. It is important to remember that people with mental health problems are citizens living in a range of circumstances. Therefore, like all citizens there are a variety of ways that individuals may have contact with the police.

This article is based on a pilot study, which took place with an urban police force to examine the skills officers require and the training that they receive in order to be able to work effectively with people with mental health problems. Among the issues that this study considered, were the training needs of officers who take on the role of custody sergeant. These officers have a key role under the PACE Act (1984) in terms of ensuring that all those in custody are safe. This will include arranging for medical assessments if required. PACE (1984) affords specific protections to vulnerable adults with mental health problems and therefore, the custody officers are central in the process of identifying cases where these protections should be applied. Police officers cannot be expected to take on the role of community psychiatric nurses or social workers. However, it is apparent that they need specific mental health awareness training that is more than merely a consideration of legal police powers or the Police and Criminal Evidence Act (1984).

Mental health issues and the criminal justice system

Penrose's (1939) hypothesis suggests that the level of need for institutional mental health care will remain fairly constant. Therefore, in

a society that has well-resourced mental health systems, 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 to meet the level of need, such individuals will be drawn into the criminal justice system. Penrose's original hypothesis chimes with the experiences of community care policies in the 1980s and 1990s. Gunn (2000) highlights the fact that the previous 20 years have seen 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 deinstitutionalisation policies (Wolff, 2005). For some commentators the overall effect of the shifts and changes outlined above has been the '*criminalisation of the mentally ill*' (Borzecki & Wormith 1985).

In the literature, the increased risks that people with mental health problems face in the criminal justice system have been identified. The first is that they are much more likely to be drawn into the system in the first place (Hartford *et al*, 2005). Further studies highlight that this group is more likely to be arrested for minor offences and less likely to be granted bail (Teplin, 1984; Robertson *et al*, 1996; Robertson, 1988). In this context, mental illness itself is seen as a risk factor. In addition, these individuals are much more likely to have the sort of chaotic lifestyle that will make them appear a less attractive option for bail. (Taylor & Gunn, 1984). The result is that people with mental health problems are likely to spend longer not shorter periods in custody (Hiday & Wales, 2003).

The above studies are largely based on the North American experience of deinstitutionalisation. However, as inquiries in the UK (see for example, Ritchie, 1994) and the analysis presented in *Modernising Mental Health Services* (DoH, 1998) outline, there is an increasing overlap between the

criminal justice system and community-based mental health services. The overall picture as painted by Wolff (2005) is a very depressing one. The vision of the original architects of community care has not materialised. Instead, fragmented, under-funded services struggle to meet the needs of the most marginalised members of the community.

The Office of the Deputy Prime Minister (ODPM) report on social exclusion (2004) highlights the barriers that people with severe mental health problems face in playing a full role as a citizen. These include access to housing, employment and training, stigma and social isolation. A history of offending is a barrier in itself, the effects of which can be multiplied by mental health problems. There is interplay between economic and social factors and the risks of severe mental illness. Eaton (1980) highlighted '*the downward social drift of schizophrenia*', and Kelly (2005) uses the term '*structural violence*' (adapted from liberation theology) to analyse the way that economic and health factors combine to restrict the life opportunities of people with severe mental health problems. It is within this policy and service context that the police roles considered below are acted out.

Policing and mental health issues

Despite the studies above which have established that people with mental health problems are more likely to come into contact with the police, Bittner (1967) suggests that the police are reluctant to become involved in dealing with situations where the person has a mental health problem. He suggests that it is not seen as proper police work as it is concerned with welfare rather than the apprehension of offenders. The increased contact, as a result of deinstitutionalisation outlined above, has exacerbated some of these difficulties. Robertson *et al* (1995) argue that there is a clash here between two

police functions: the detection of crime and bringing the offender before the courts and the wider welfare role that police officers perform. This process becomes more complex in this area as the police role may be to access mental health services, including formal assessments under the Mental Health Act (1983). Dunn and Fahy (1987) suggest that the sorts of 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. Furthermore, individuals presenting with mental distress are often masked by alcohol or drugs. In addition, one has to consider the inherent effect of the stresses of being held in custody.

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 be in '*immediate need of care or control*'. As noted above, 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 approved social worker. It is hardly surprising that the use of this power varies; however, it is worrying that the variations are so great (Bartlett & Sandland, 2004). The Mental Health Act Commission (MHAC) 2005 outlined a number of concerns including poor recording of the use of the power and significant regional variations. In addition, the report highlighted the ongoing concern that police stations were being used as the designated place of safety for those detained using the section 136 MHA powers.

A consideration of Goldberg and Huxley's (1980) model, which identified a series of filters that operate to influence in psychiatric

services, reveals the existence of a similar process for diversion from the criminal justice system. An individual officer may have received more in-depth training on mental health issues, be more experienced, know an individual or have had previous contact with them, and would draw on these factors as part of the decision-making process. In addition, one would have to consider the nature and severity of the incident that the officer is attending.

As noted above, police officers actually receive little training that relates to wider mental health issues. The training that they do receive is focused on procedural or legal issues such as their powers under section 136 MHA. In addition to this lack of training, police officers appear to have limited confidence in wider health and social care systems (Dunn & Fahy, 1987; Home Office, 2002). These studies highlight a number of frustrations that officers felt including delays, bureaucracy and ineffective interventions by health or social care systems. This final point emphasises the different organisational perspectives or a clash of organisational values. One can understand the frustration of officers called to a situation that they thought had been resolved earlier. It is probably a feeling shared by the other professionals involved. However, it is in most cases, a reflection of the complexity of the issues involved rather than a failing on the part of health or social care professionals involved. Despite this, studies of police attitudes and practice indicate that arrest can be seen by officers as a way of ensuring that a psychiatric assessment is carried out (Hartford *et al*, 2005).

The term 'vulnerable adult' is very difficult to define. PACE (1984) relies on the terms mentally disordered and mentally handicapped when it seeks to identify those who might be in need of additional protection in custody. The reality of the experience of arrest and detention is that it is likely to put any one of us at some risk. There are a

number of factors that would need to be considered here including the nature of the offence. However, it is possible that there are particular increased risks that adults with mental health problems may be more likely to face. The first is the impact on their mental health of being in custody. In addition to the stress of being arrested, there is the bleak nature of the environment, in which one is held. To try to ensure the safety of those in custody, cells are very basic. There may also be additional stresses, for example, if an individual is deemed at risk of self-harm or suicide, they will have their clothes removed and are given a paper suit to wear. Such moves, designed to protect individuals are in themselves distressing. The work of Gudjonsson and Mackeith (2002) demonstrates that those who are psychologically vulnerable or suffering from mental illness can give unreliable testimony including false confessions. It is therefore very important that steps are taken to protect such individuals in custody.

Training needs

All of the above, results in an identified need for greater training of police officers to develop the awareness and recognition of mental health problems. Carey (2001) and Dew and Badger (1999) identified 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 as officers can be called back, either by mental health

professionals, carers or family members, to intervene in a situation they thought had been dealt with.

Police attitudes to people with mental health problems certainly need to be examined in more depth. The Pinfold *et al* study (2003) demonstrated that short training courses can tackle some of the deeply engrained stereotypes about mental illness with the benefits including 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 mental health services will only come from an improvement in services that tackles the long-standing issues of under-funding, poor organisation and lack of a commitment to inter-professional working that have dogged mental health services for far too long. Steps are being taken to improve the training of police officers. In the financial year 2004/05, the Home Office and NIMHE made £155,000 available to improve training. However, as the MHAC report suggests (2005:271), this amounts to about £1 for each officer in England and Wales. The historical neglect of this area means that it will need investment over a sustained period to redress the deficit.

The research literature has focused on identifying the extent of mental health problems among the specific populations in the criminal justice system (Singleton *et al*, 1998) and examining the possible links between mental illness and offending (Taylor & Gunn, 1984). There have also been wider studies exploring the effects of the policy of deinstitutionalisation (Wolff, 2005). Studies of the role of the appropriate adult, report on the low numbers of police interviews where an appropriate adult attends (Nemetz & Bean, 1994), the limited role that appropriate adults play in the interview and the range of

individuals who take on the role (Medford *et al*, 2003). The other area that has been examined is the provision of service. Bucke and Brown (1997) found that in 60% of these cases a social worker took on the role of the appropriate adult. Evans and Rawstone (1994) found that there were increased difficulties for social services departments in providing staff to take on this role out of standard office hours. However, the literature has not considered in significant depth the process by which police officers decide that an adult is vulnerable within the meaning of PACE (1984).

The assessment process that custody officers carry out is a complex one. It requires a range of skills not the least of which is the ability to work in a highly pressurised environment. There appear to be a number of variables that may be affecting the decision-making process. These will include the skills, training, experience and attitudes towards mental illness of the arresting officers and the custody sergeant, the local systems that have been established, the nature of the offence, the circumstances of the arrest and the presentation of the individual, who has been arrested. To this, one might add environmental factors such as the other pressures in the custody suite and on the officer at the time.

Mokhtar and Hogbin's (1993) research on section 136 MHA indicates that police officers use the powers appropriately in cases where an individual's behaviour is extremely disturbed. However, mental health problems exist on a continuum with such cases at one end of it. As outlined above, there are a number of variables that might influence decision-making. Establishing clear causal links between them is problematic. For example, length of service is one variable, but it is difficult to establish the exact nature of its impact. One would expect more experienced officers to be more aware of mental health issues and thus be more skilled

in this area. However, it is also possible that length of service has a negative effect as it may make officers more distrustful of community mental health services.

The pilot study

The research was carried out in the spring of 2006. An initial approach was made to one police force in an urban area of England, which agreed to take part in the project and it formed part of a general review of custody management issues. As seen above, custody officers have a key role to play under PACE (1984) in that they have to ensure that vulnerable adults are properly protected while in custody. This group of officers have overall responsibility for the process. Their experiences should therefore provide an insight into a range of issues in this area. As an initial scoping exercise, a series of 10 semi-structured interviews was carried out with custody officers. The force covers a large urban area, as it moves to more centralised systems, not all stations actually hold people in custody. Interviews were arranged at the 10 stations where individuals were held in custody. This meant that the interviews covered a range of settings with a variety of practice arrangements with local SSDs, PCTs and voluntary agencies. The police stations were also based in areas that were culturally, ethnically and demographically diverse. My initial discussions were held with an inspector with responsibility for the development of policies to ensure the safety of those in custody. Gaining access is always likely to be an issue in such settings. The inspector and I agreed a provisional timetable for the interviews. It was agreed that I should carry out the interviews during a handover period as this meant that two sergeants would be on duty. This would hopefully ensure that an officer could be interviewed. All stations were emailed details of the project and a

proforma outlining the very broad areas of interest that would form the basis of the interview.

On one occasion, it was not possible to carry out the interview because of operational demands placed on the officers. The nature of this research project raises a number of ethical issues. Although I had obtained ethical approval for the study via the usual university channels and all the interviewees gave their written consent to take part, there is always, in a hierarchical organisation such as a police force, a concern that pressures may have been placed on individuals to take part. At the beginning of each interview, it was emphasised that those involved could refuse to answer any question or withdraw from the study at any stage. No officers chose to do this.

Given the nature of the project and the setting, confidentiality also had to be considered. Any case examples discussed were anonymous. I did not have or seek access to any individual custody records. This study is part of a wider examination of the operation of PACE (1984) within the area. The focus of these interviews was to gather information about the training needs of custody sergeants with regard to mental health issues but also to explore the operational pressures that exist. The advantage of the approach here is that a qualitative method allows the researcher to look at individual cases in some depth. The issue that was of most concern was the way that individual officers make a decision that the specific provisions of PACE (1984) should be applied.

Following the interviews, a short questionnaire was developed in the hope that a wider range of views could be captured quickly. As a method, the questionnaire lacks the subtlety of the interview. This is particularly true in this setting as the complexities of the issues do not lend themselves to the sorts of responses

questionnaires generate. The questionnaire was sent out via police HQ to all custody officers. Unfortunately, the number of responses was low (20 replies) at less than 10%. There are a number of explanations for this. The turn around time was relatively short – but it should be noted that usually the response rate tends to tail off rather than increase. As in any organisation, there will be a number of absences because of sickness, annual leave or the shift system. However, the combination of such factors would not account for such a poor response rate. The most likely explanation is, hardly surprisingly, that the questionnaire did not count as a working priority for the officers involved.

Findings

All 10 officers interviewed emphasised the difficulties in making the assessments that PACE (1984) requires. The environment and pressures to ensure that delays in the booking in system are kept to a minimum meant that the assessment was carried out very quickly often with a lack of privacy. The public nature of the environment made it difficult for individuals to disclose any mental health history. The problems in assessment are exacerbated by the fact that mental health problems can be masked or exacerbated by alcohol and drugs. Obviously, significant numbers of those arrested are intoxicated. This means that it is difficult to identify the cause of disturbed behaviour. There might be clear indications that somebody is drunk, but this is not always the case. The situation with other substance misuse can be even more complicated as intoxication might mirror the symptoms of mental illness. The increased availability and use of street drugs along with the failures of community care has meant that the problems of mental illness and substance misuse overlap. In all the interviews, officers highlighted that large numbers of those

coming into custody state that they have been prescribed medication for specific mental health problems, depression/anxiety being the most common. Despite the recognition of the extent of these problems, the number of cases where an appropriate adult was involved was generally very low.

Most of the officers stated that they had received little or no specific training about mental health issues either as a constable or before they had taken on the role of custody sergeant. The training that was given in this area largely related to procedural issues under PACE (1984). Examples were given of training that had been organised on a local level. This involved inter-professional training and sessions with nursing and social work staff. This model of training was very positively regarded by those officers who had received it. There were no arrangements in place in this area for refresher training or continuous professional development.

As part of the interview, I asked the officers to take me through the procedure that is followed when someone is taken into custody, from the point of view of the custody sergeant. The custody record is now a computerised record. Part of this is a standardised risk assessment that is completed for all those in custody. This involved asking a series of questions about mental health history, use of drugs and alcohol, and self-harm. This was a starting point, as officers used a combination of their own interpersonal skills and experience in such situations to determine whether further specialist assistance was required. All the officers emphasised that risk assessment is a fluid process. A recurring theme in the interviews was that a duty of care is owed to those in custody. This was held to be ultimately the responsibility of the sergeant on duty, who it was felt would receive little support from management. The prospect of the devastating personal and professional effects of a death in custody loomed large in the working lives of the officers I interviewed.

There were no specialist facilities in any of the police stations. People with mental health problems had to be accommodated in the cells available. All the officers felt that this was a far from satisfactory situation. During the interviews, examples were given where the risk assessment had not succeeded in identifying an individual, who had later seriously harmed themselves. This included a young woman who had used a hidden razor blade to harm herself. The police station is not a therapeutic environment. It was widely acknowledged that the physical layout and conditions in the custody suites mean that officers or other professionals can do little more than ensure that a person is physically safe. There were concerns raised that if attempts were made to develop specialist services, that this would exacerbate the problems in this area as other agencies would seek to use such facilities inappropriately resulting in increased police involvement, not less.

Section 136 MHA (1983) can result in the police station being used as the place of safety. For the custody sergeants, this was seen as one of the worst custody scenarios that they might face on duty, and was to be prevented if at all possible. The individual was likely to remain in custody for a prolonged period while a MHA assessment was carried out, and if necessary a bed found. In three interviews, it was felt that once the person reached the police station, other agencies did not give the situation the proper priority. This was an echo of some of the wider frustrations expressed about community-based mental health services.

In both the initial interviews and the responses to the questionnaires, officers highlighted their concern about the lack of formal training that they had received. In the interview stage, examples were given of steps taken to tackle this, for example, input from a local approved social worker to examine the workings of section 136 MHA. However, there was a lack of a structured framework or

recognition for the need for continuous professional development in this field. This reflected the themes identified in the literature. The result was that officers relied on their professional experience or, on occasions, previous knowledge of individuals in custody in order to carry out assessments.

Discussion

PACE (1984) provides valuable safeguards for vulnerable suspects. However, current practice raises cause for concern. The policy of deinstitutionalisation has not been adequately supported by the range of community-based services and resources that its pioneers envisaged. This view was confirmed in *Modernising Mental Health Services: sound, safe and supportive* (DoH, 1998). One effect of this woeful provision has been an increased role for the police. The evidence so far from the prison estate (Singleton *et al*, 1998) is that diversion from custody is an aspiration rather than a successful policy.

In the environment outlined above, police officers and custody officers have an essential role to play. Diversion will be most effective if it can take place at as early a stage as possible. There is evidence (James, 2000; McGilloway & Donnelly, 2004) that this can be effective. In both of these studies, CPNs were attached to police stations to divert those involved in minor offences and attempt to engage a difficult to reach group with mental health services. Police stations cannot meet the needs of acutely unwell individuals. The physical environment and lack of nursing staff to support officers makes this impossible. Despite these difficulties, however, police stations are likely to remain the default 'place of safety'. Individuals who pose an immediate physical risk to themselves or others, or where a serious

offence has been committed, will continue to be placed in custody. The findings of this initial pilot study indicate that custody officers, on the whole, do not receive an appropriate level of mental health training to equip them with the skills to carry out this complex and demanding role. One effect is that the protective function, which the role of the appropriate adult provides, is enjoyed by relatively few adults in police custody. For this to be addressed successfully, not only will the training needs of police officers have to be revised, but the fractured and dislocated structure of community based mental health services will also have to be overhauled.

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References

- Arboleda-Florez J & Holley HL (1998) Criminalization of the mentally ill: part II – initial detention. *Canadian Journal of Psychiatry* 33 87–95.
- Association of Chief Police Officers and the Home Office (2006) *Guidance on the Safer Detention and Handling of Persons in Police Custody* [online]. London: National Centre for Policing Excellence. Available at: http://police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/Safer_Detention_and_Handlin1.pdf?view=Binary [Accessed 24 January 2007].
- Bartlett P & Sandland R (2003) *Mental Health Law Policy and Practice* (2nd ed). Oxford: Oxford University Press.
- Bittner E (1967) Police discretion in emergency apprehension of mentally ill persons. *Social Problems* 14 278–292.

- Borzecki M & Wormith JS (1985) The criminalization of psychiatrically ill people: a review with a Canadian perspective. *Psychiatric Journal of the University of Ottawa* 10 241–247.
- 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. London: HMSO.
- Carey SJ (2001) Police officers' knowledge of, and attitudes to mental illness in southwest Scotland. *Scottish Medical Journal* 46 41–42.
- Department of Health (1998) *Modernising Mental Health Services, Sound Safe and Supportive*. London: HMSO.
- Dew K & Badger S (1999) Police perceptions of the mental health services and the mentally ill. *New Zealand Medical Journal* 112 36–38.
- Dunn J & Fahy TA (1987) Section 136 and the police. *Bulletin of the Royal College of Psychiatry* 11 224–225.
- Eaton WW (1980) *The Sociology of Mental Disorders*. New York: Praeger.
- 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*. London: HMSO.
- Goldberg D & Huxley P (1980) *Mental Illness in the Community*. London: Tavistock.
- Gudjonsson G & MacKeith J (2002) *Disputed confessions and the Criminal Justice System. Maudsley Discussion Paper 2* [online]. Available at: www.iop.kcl.ac.uk. [Accessed: 13 April 2005].
- Gunn J (2000) Future directions for treatment in forensic psychiatry. *British Journal of Psychiatry* 176 332–338.
- 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* 28 1–11.
- Hiday VA & Wales HW (2003) Civil commitment and arrests. *Current Opinion in Psychiatry* 16 (5) 575–580.
- Home Office/Cabinet (2002) *PACE Review Report of the Joint Home Office/Cabinet Office Review of the Police and Criminal Evidence Act 1984*. London: HMSO.
- Howard J (1780) *The State of the Prisons in England and Wales* (2nd ed). Warrington and London: T Cadell.
- Kelly B (2005) Structural violence and schizophrenia. *Social Science and Medicine* 61 721–730.
- Medford S, Gudjonsson G & Pearse J (2003) The efficacy of the appropriate adult safeguard during police interviewing. *Legal and Criminological Psychology* 8 (2) 253–266.
- Mental Health Act (1983) London: HMSO.
- Mental Health Act Commission (2005) *In place of fear?* [online]. Nottingham: Mental Health Act Commission. Available at: www.mhac.org.uk. [Accessed 24 January 2007].
- Mokhtar A & Hogbin P (1993) Police may under use section 136. *Medicine Science and Law* 33 (3) 188–196.
- NACRO (2005) *Mentally Disordered Offenders: Standard 1 Initial Contact with the Police* [online]. London: NACRO. Available at: www.nacro.org.uk. [Accessed 24 January 2007].
- Nemetz T & Bean P (1994) The use of the appropriate adult scheme: a preliminary report. *Medicine, Science and the Law* 34 (2).
- Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London: HMSO.
- Penrose LS (1939) Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* 18 1–15.
- 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* 38 (6) 337–344.
- Police and Criminal Evidence Act (1984) Codes of Practice A–G (2005 ed). London: HMSO.
- Ritchie J (Chair) (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- Robertson G (1988) Arrest patterns among mentally disordered offenders. *British Journal of Psychiatry* 153 313–316.
- Robertson G, Pearson R & Gibb R (1996) Police interviewing and the use of appropriate adults. *Journal of Forensic Psychiatry* 7 (2) 297–309.
- Robertson G, Pearson R & Gibb R (1995) *Entry of Mentally Ill People into the Criminal Justice System*. London: Home Office.
- Singleton N, Meltzer H & Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: HMSO.
- Taylor P & Gunn J (1984) Violence and psychosis I. Risk of violence among psychotic young men. *British Medical Journal* 288 1945–1949.
- Teplin L (1984) Criminalising mental disorder. *American Psychologist* 39 794–803.
- Wolff N (2005) Community reintegration of prisoners with mental illness: a social investment perspective. *International Journal of Law and Psychiatry* 28 43–58.

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

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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.

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

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; McGiloway & 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 SPSS (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.

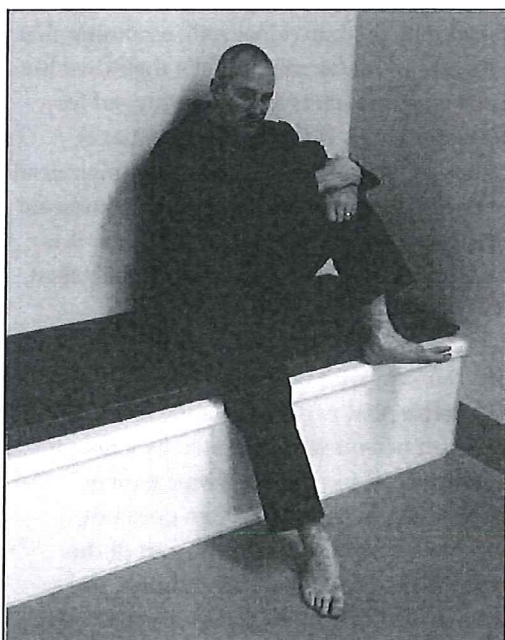
The custody officer has a vital role to play here. It should be acknowledged that this is a complex and demanding one. The environmental and work pressures are immense and it is widely recognised that the officers involved have generally been given little specialist mental health training. In addition, 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

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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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

References

- ACPO/National Centre for Policing Excellence (2006) *Guidance on the Safer Handling of Persons in Police Custody*. London: ACPO
- Blank M (1989) Suicide: the other victims. *Nursing Times* 85 28–30.
- Brock C & Griffiths A (2003) *Trends in Suicide by Method in England and Wales 1979–2001*. London: ONS.
- Cummins I (2007) Boats against the current: vulnerable adults in police custody. *The Journal of Adult Protection* 9 (1) 15–24.
- 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*. London: HMSO.
- Department of Health (1998) *Modernising Mental Health Services: Sound, safe and supportive*. London: HMSO.
- Department of Health (1999a) *Saving Lives: Our healthier nation*. London: HMSO.
- Department of Health (1999b) *A National Service Framework for Mental Health: Modern standards and service models*. London: HMSO.

- Diedrich C & Warelow P (2002) Suicide: a personal reflection. *Journal of Psychiatric and Mental Health Nursing* 9 169–173.
- Durkheim E (1897) *Suicide* (trans. JA Spaulding & G Simpson, 1979) London: Routledge & Kegan.
- Foster T, Gillespie K & McLelland R (1997) Mental disorders and suicide in Northern Ireland. *British Journal of Psychiatry* 170 48–54.
- Frisch NC & Frisch LE (1998) *Psychiatric Mental Health Nursing: Understanding the client as well as the condition*. Albany, New York: Delmar.
- Greer S & Bagley C (1971) Effect of psychiatric intervention in attempted suicide: a controlled study. *British Medical Journal* 1 (5744) 310–331.
- Hawton K, Fagg J, Simkin S, Bale E & Bond A (1997) Trends in deliberate self-harm in Oxford 1985–1995: implications for clinical services and the prevention of suicide. *British Journal of Psychiatry* 171 556–560.
- Ingram A, Johnson G & Heyes I (1998) *Deliberate Self-harm and Suicide by Detained Persons*. London: Home Office.
- IPPC (2006) *Deaths During or Following Police Contact* [online]. Available at: www.ipcc.gov.uk (accessed January 2008).
- James D (2000) Police station diversion schemes: role and efficacy in central London. *Journal of Forensic Psychiatry* 11 532–555.
- Joint Committee on Human Rights (2004) *Third Report* [online]. Available at: <http://www.publications.parliament.uk/pa/jt200304/jtselect/jtrights/23/2302.htm> (accessed January 2008).
- Jones SL & Mason T (2002) Quality of treatment following police detention of mentally disordered offenders. *Journal of Psychiatric and Mental Health Nursing* 9 73–80.
- Kelly B (2005) Structural violence and schizophrenia. *Social Science and Medicine* 61 721–730.
- Liebling A (1994) Suicide among women prisoners. *Howard Journal of Criminal Justice* 33 1–9.
- Linsley K, Johnson N & Martin J (2007) Police contact within three months of suicide and associated health service contact. *British Journal of Psychiatry* 190 170–171.
- McGiloway 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* 13 (3) 263–275.
- McLaughlin C (1994) Casualty nurses' attitudes to attempted suicide. *Journal of Advanced Nursing* 20 (6) 1111–1118.
- Morgan HG (1979) *Death wishes? The understanding and management of self-harm*. Chichester: Wiley.
- National Confidential Inquiry (2006) *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Figures* [online]. Available at: http://www.medicinemanchester.ac.uk/suicideprevention/nci/Useful/inquiry_annual_figures/ (accessed January 2008).
- NHS Centre for Reviews and Dissemination (1998) *Effective Health Care: Deliberate self-harm*. York: University of York.
- Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit report*. London: HMSO.
- Palmer S (1993) Para-suicide: a cause for nursing concern. *Nursing Standard* 7 37–39.
- Penrose LS (1939) Mental Disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* 18 1–15.
- Platt S & Kreitman N (1990) Long-term trends in para-suicide and unemployment in Edinburgh, 1968–1987. *Social Psychiatry and Psychiatric Epidemiology* 25 56–61.
- Pratt D, Piper M, Appleby L, Webb R & Shaw J (2006) Suicide in recently released prisoners: a population based cohort study. *The Lancet* 368 119–123.
- Royal College of Psychiatrists (1994) *The General Hospital Management of Adult Deliberate Self-harm: A consensus statement on standards for service provision*. London: Royal College of Psychiatrists.
- Shaw J, Baker D, Hunt I, Moloney A & Appleby L (2004) Suicide by prisoners. *British Journal of Psychiatry* 184 263–267.
- Singleton N, Meltzer H & Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: HMSO.
- Stone L (1982) *An Exchange with Michael Foucault*. New York: New York Review of Books.

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Blue remembered skills: mental health awareness training for police officers

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abstract

The Bradley Report (Bradley, 2009) has raised a number of important questions regarding the treatment of individuals who are experiencing mental health problems and find themselves in the criminal justice system. One of the key recommendations is that professional staff working across criminal justice organisations should receive increased training in this area. This paper explores the experiences of two professionals, a mental health nurse and a social worker, involved in providing training for police officers. It goes on to consider the most effective models of training for police officers.

key words

The Bradley Report, mental health problems, offenders, policing, mental health training

Introduction

Policing is a complex process. Police officers are called on to perform a number of roles in addition to detecting crime and arresting offenders. Police officers can have a key role to play in situations where individuals are experiencing some sort of crisis related to their mental health. They are the emergency service that is most likely to be contacted by relatives if those in acute distress are putting themselves at immediate risk. If a person in acute distress is in a public place, the likelihood of police involvement is increased significantly. Despite the fact that this is a very important facet of day to day police work, it is an area that is neglected in police training. Cummins (2007) showed that the majority of officers have little input in this field. As a result, the skills and knowledge that they acquire is largely through experience on duty or from their senior colleagues. This is a longstanding issue (Janus *et al*, 1980). Police officers, who had undertaken the training, showed increased empathy and understanding for those experiencing mental health problems. From the vantage point of 2009, the policy of diversion from the criminal justice system (CJS) outlined in the Home Office circulars 66/90, *Provision for Mentally Disordered Offenders* (Home Office, 1990) and 12/95 *Mentally Disordered Offenders: Inter-agency working* (Home Office, 1995) seems to have failed. However, access to appropriate mental health services for those in contact with the CJS, as Bradley (2009) shows, is still fragmented and disjointed. Models of good practice exist but these are not spread widely enough.

Steps were being taken to tackle this prior to the publication of *The Bradley Report* (Bradley, 2009). In 2004/05, the Home



Office and the National Institute of Mental Health in England made £155,000 available to improve training. As the Mental Health Act Commission (MHAC) report suggests (2005, p271) this amounted to £1 for every police officer in England and Wales.

One key element of training is to challenge some of the stereotypical views that police officers have of mental illness and about people experiencing mental distress (Pinfold *et al*, 2003; Cotton, 2004). Borum and colleagues (1998) argue that although responding to situations where people are experiencing acute mental distress is a significant aspect of policing, departments did not feel that the general response was a good one. In addition, they suggest that it is only in jurisdictions where specialist crisis police teams had been established that officers felt well-equipped to deal with these sorts of situations. Wolff (2005) has gone further. She suggests that police officers have always had a quasi-social work function in this field. As Penrose (1939) argued, there appears to be an almost hydraulic relationship between psychiatric and penal systems.

Police officers often have a significant role to play in mental health services. This role has been expanded by the failure to develop robust community-based mental health services in the era of deinstitutionalisation. (Teplin, 1984; Rogers, 1990; Cummins, 2006). The MHAC regularly highlighted its concerns that health and social work agencies had failed to establish effective working relationships with local police services. These concerns have also been a recurring theme in inquiries into homicides (Ritchie, 1994). Further evidence to support this was highlighted in the *Modernising Mental Health Services report* (Department of Health, 1998). As *The Bradley Report* highlights, people with mental health problems are drawn into the criminal justice system at all points. The police have specific powers under section 136 of the *Mental Health Act 1983* (HM Government, 1983) to intervene in cases where an individual

appears to need immediate assessment. Mokhtar and Hogbin (1993) argue that lack of training may lead to underuse of this power. There are a number of other scenarios where a police officer will need some understanding of mental health issues to carry out their job effectively. These will include liaison with local mental health units, situations where people with mental health problems are the victims of crime (Mind, 2000), and supporting other professionals to carry out *Mental Health Act* assessments. 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 the police arrest as the groups are likely to share many characteristics. Payne-James (1992) highlights the general and mental health care needs of those coming into custody.

The overall picture is one of increasing police contact with those who are experiencing some form of mental distress. This is against a backdrop of the majority of officers receiving very partial and inadequate training to equip them for the situations they face on a fairly regular basis. The result is a frustration with mental health services (Cummins, 2007; 2008). As well as police frustration, Mind (2007) highlighted that people with mental health problems often feel they are treated very poorly by the police. The messages from Jones and Mason's (2002) study of people who had been subject to section 136 of the *Mental Health Act 1983* are just as forthright.

'Police procedures in the police station removed more than just their personal possessions; it also stripped them of a sense of being an individual in the real world.'

In this section of the paper, we will outline two approaches to the training of police officers in the mental health field. The first was a joint working initiative between Hywel NHS Trust and Dyfed Powys Police. It had been acknowledged in the area for some time

that there was a need to improve the training of police officers in mental health awareness. A pilot study was undertaken that allowed police officers to spend time working in the local mental health unit as part of their initial training. This proved successful, and a service level agreement was established whereby all student officers undertook a programme of work in the mental health unit that covered the area of their base command unit as part of their basic training. The programme has now been developed further so that all student officers receive two days training in first aid in mental health. In addition, they spend four days at the acute psychiatric unit where they become personally involved in the care of individuals who are experiencing acute distress. As part of the programme, student officers are also introduced to community mental health teams, crisis resolution and home treatment teams, assertive outreach teams and the multidisciplinary teams working at the unit. The overall aim of this programme is not only to provide the student officers with background mental health knowledge, but also to provide an insight into the structure and workings of the agencies in their area that they are most likely to come into contact with in their work as police officers.

One of the great strengths of the Dyfed Powys model is that there is a very strong input from service users. The client group has welcomed the initiative and believes that there has been a positive change in attitudes by the police who have undergone the training. There are a number of examples of positive testimony. For example, a woman was admitted to hospital with police involvement in an acute psychotic and paranoid state. The officers involved had undergone the training. She informed staff that this was the first time that she had not been handcuffed during such an admission.

The police feedback has generally been very positive. The views of one officer that *'any opportunity whereby there is a greater understanding of what people with mental*

health problems go through can only be good' were not uncommon. However, it should be acknowledged that some officers struggled to see the relevance of the training for their work. The 'canteen culture' does not see this sort of work as 'real policing' as it lacks the supposed glamour of other aspects of the work.

The second approach comprised a classroom-based training course. Custody sergeants have a key role under the *Police and Criminal Evidence Act 1984* (PACE) (HM Government, 1984) in the assessments of all individuals coming into custody. The mental health awareness course outlined as follows was the direct result of research carried out with the force (Cummins, 2007). This highlighted the lack of training that custody officers had received in relation to mental health issues. It was felt that custody sergeants could act as role models for other staff and, as a result, the training could be cascaded downwards. It was acknowledged that this was not the most satisfactory approach. However, it was the only feasible one given the scale of the issue and the resources being allocated to it at that point. The training sessions were part of the much wider PACE training that custody officers undertake. This meant that they had to be 'shoe-horned' into a very full curriculum.

The sessions were usually about three hours long including breaks. The content was discussed beforehand with the sergeant who had overall responsibility for the course. He was very supportive of this initiative. The key areas to be explored were some introductory work about the extent of mental health problems, some ideas about signs and symptoms, and a focus on the issues that arise in custody settings. The sessions have run on the custody sergeants' courses over the past three years so have been refined to meet the needs of the group of learners involved more closely. For example, in the initial sessions, the research that had been carried out in the area was reported to the group. However, pressures on time meant that this section was

removed to allow more discussion of practice and case examples.

The sergeants' course was classroom-based, which clearly has limitations. However, the groups were usually small (10–12 officers) and, as is standard practice, the officer in charge of the course was present throughout. A number of fairly standard icebreaker exercises were used. These included a 'post-it' note exercise, where officers were asked to write down one question that they would like answering over the course of the session. The majority of these were very practice orientated such as '*why does it take so long to get a social worker/doctor to a police station?*'. A minority were of a more technical nature, for example, asking questions about medication and services. As the groups consisted of experienced officers, the answers to these questions usually came from group members themselves. The sessions also included a brief outline of the structure and range of services available to meet the needs of individuals with mental health problems. The feedback from the force training department and individual officers was generally very positive indeed. The practice issues that were most frequently raised were section 136 – particularly cases where the individual was not admitted to hospital; delays while people are in custody; difficulties in securing the services of an appropriate adult; and liaison with psychiatric units. These points actually reflect some of the wider concerns in *The Bradley Report*, but have been consistent features of this field for some time. These issues cannot be solved in a classroom; however the sessions not only enabled officers to vent their frustrations, but also provided a forum where some of the ways to resolve these difficulties could be explored. All sessions were formally evaluated by the officers.

Discussion

These are two examples of attempts on a local level to begin to tackle a number of complex

issues. The National Police Improvement Agency (NPIA) is in the process of finalising an e-learning package for all officers looking at mental health issues. Given the historical under-investment in training in this area and the large numbers of police and now civilian staff involved, this has to be a start. E-learning is the only way of ensuring that material is made available quickly and relatively easily to large groups of staff. However, it must be part of a wider process.

Both models had some measure of success. The strengths of the approach taken in Dyfed Powys are obvious. It gives officers a very clear picture of acute services and community-based mental health resources in the area in which they will be working. Service user experience is at the core of the programme. The powerful testimony from a member of a local service user group has been one aspect of the training that has produced the strongest feedback. The sessions took place away from the police training base. The officers were not in uniform for these sessions. It was felt that these factors had a very important impact on the conduct of the training. The officers were placed in a situation where their own views and possible prejudices could be challenged more effectively by the facilitator. The contacts made with local agencies can have an immediate positive impact in terms of improved multidisciplinary working. This approach requires a strong commitment from senior management. This is not only a question of providing the necessary resources and allocating time, but also supporting the project and recognising the value it has for the force and the wider community.

A classroom-based approach is clearly a limited one. It can only involve small numbers of staff. In this case, it was focused only on custody officers rather than the whole force. However, it allows for the challenging of some stereotypical ideas within these limitations. It also provides a forum for a constructive and positive discussion of the issues that face staff

who work in community-based mental health services. The aspects of the Dyfed Powys model that have been most effective – time on the unit and service user testimony – were not present here. The feedback indicated that the most valued parts of the classroom sessions were the discussion of practice examples, information provided about the structure of services and the insight into how other professionals approach the assessment of mental health problems.

One of the interesting aspects of these training courses is the importance of support from senior management. Without such support and commitment, such initiatives will almost certainly fail. The training of police officers requires that they cover an enormous amount of material. If, as the authors argue, mental health awareness training needs to be given a higher prominence and more time devoted to it, this will be at the expense of another area. In a managerialist culture, forces will need to demonstrate that such training presents good value for money. This is not always as easy as it might appear if the overarching measures are financial ones.

One of the aims of the training was to make officers question their own views and some of the stereotypes that are attached to mental illness. One recurrent feature of the classroom-based sessions was the response to a PowerPoint slide outlining some of the features of depressive illness. This initially provoked some flippant remarks such as 'That's me'. However, it opened the door to a discussion about the pressures and burdens faced by police officers in general and custody sergeants in particular. This is an area that is often neglected. This proved to be a very valuable part of the session. In these settings, experiential learning and/or the linking of service users' experiences with our own or those of family members is highly effective. It helps to break down stigma and the barriers between 'professionals' and 'service users'.

Conclusion

The Dyfed and Powys model was clearly the more effective approach. In some senses, it is far more challenging than a classroom session. The student officers were taken out of a policing environment. Although the officers were welcoming in the classroom sessions, it would be naïve to ignore the power that they had – as a group, in uniform and in the familiar environment of the police college. To roll out the Dyfed and Powys model requires a commitment and level of resourcing that might not be that easy to replicate across 43 police forces. The needs of these forces and the pressures that they face are markedly different.

Both approaches were based on key principles that should form the underpinning values of any work in this area. There was recognition that people using mental health services should be treated with dignity and respect. This should be the case with whichever mental health service they are in contact with. To challenge the stigma attached to mental health issues, professionals need to take account of and learn from the experiences of service users. Finally, sound interprofessional practice is based not only on a recognition of and respect for the skills of your fellow workers, but also of the organisational and other pressures that they face.

The Bradley Report calls for much improved training for staff across the criminal justice system in mental health issues. The review provides reams of evidence to support the case for an investment in such training. This will be an enormous logistical task as this is an area that has been neglected for far too long. Investment in training needs to be accompanied by a renewed commitment to ensuring that involvement with the criminal justice system does not mean that an individual's mental health needs are overlooked.

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References

- Borum R, Deane MW, Steadman HJ & Morrissey J (1998) Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. *Behavioural Sciences and Law* 16 (4) 393–405
- Bradley Lord K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.
- Cotton D (2004) The attitudes of Canadian police officers toward the mentally ill. *International Journal of Law and Psychiatry* 27 (2) 135–146.
- Cummins I (2006) A path not taken? Mentally disordered offenders and the criminal justice system. *Journal of Social Welfare and Family Law* 28 (3) 267–281.
- Cummins I (2007) Boats against the current: vulnerable adults in police custody. *The Journal of Adult Protection* 9 (1) 15–24.
- Cummins I (2008) A place of safety? Self-harming behaviour in police custody. *The Journal of Adult Protection* 10 (1) 36–47.
- Department of Health (1998) *Modernising Mental Health Services: Sound, safe and supportive*. London: Department of Health.
- HM Government (1983) *Mental Health Act 1983*. London: OPSI.
- HM Government (1984) *Police and Criminal Evidence Act 1984 and Codes of Practice 1988*. London: OPSI.
- Home Office (1990) *Provision for Mentally Disordered Offenders*. Circular 66/90. London: Home Office.
- Home Office (1995) *Mentally Disordered Offenders: Inter-agency working*. Circular 12/95. London: Home Office.
- Janus SS, Bess BE, Cadden JJ & Greenwald H (1980) Training police officers to distinguish mental illness. *American Journal of Psychiatry* 137 (2) 228–229.
- Jones SL & Mason T (2002) Quality of treatment following police detention of mentally disordered offenders. *Journal of Psychiatric and Mental Health Nursing* 9 (1) 73–80.
- Mental Health Act Commission (2005) *In Place of Fear? The Mental Health Act Commission eleventh biennial report 2003–2005*. London: TSO.
- Mind (2000) *Environmentally Friendly? Patients' views of conditions on psychiatric wards*. London: Mind.
- Mind (2007) *Another Assault: Mind's campaign for equal access to justice for people with mental health problems*. London: Mind.
- Mokhtar A & Hogbin P (1993) Police may underuse section 136. *Medicine Science and Law* 33 (3) 188–196.
- Payne-James JJ (1992) Work patterns of a Metropolitan police forensic medical examiner. *The Police Surgeon* 42 21–24.
- Penrose LS (1939) Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* 18 1–15.
- Pinfold V, Huxley P, Thornicroft G, Farmer P, Toulmin H & Graham T (2003) Reducing psychiatric stigma and discrimination. Evaluating and educational intervention with the police force in England. *Social Psychiatry and Psychiatric Epidemiology* 38 (6) 337–344.
- Ritchie J (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- Rogers A (1990) Policing mental disorder: controversies, myths and realities. *Social Policy and Administration* 24 226–237.
- Singleton N, Meltzer H & Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.
- Teplin L (1984) Criminalising mental disorder. *American Psychologist* 39 794–803.
- Wolff N (2005) Community reintegration of prisoners with mental illness: a social investment perspective. *International Journal of Law and Psychiatry* 28 (1) 43–58.

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Mental health and custody: a follow on study

Ian Cummins

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Abstract

Purpose – *The purpose of the paper is to report the findings of a small scale indicative research project. The project explores the assessment of detained persons in police custody by Forensic Physicians (FP).*

Design/methodology/approach – *A range of information was collected in every case where custody staff had identified a mental health concern and requested an FP assessment. As well as information about demographic factors, this would include questions regarding any links that the individuals had with community-based mental health services. As well as this information, anonymous custody records and force adverse incident records for the month were examined.*

Findings – *In the month of the project, 59 FP assessments were requested. Only six members of this group had any contact with community-based mental health services: two with a social worker, two with a CPN and two with a psychiatrist. Of this group, three had not been in contact with mental health services for over a month.*

Research limitations/implications – *The size of the cohort and variety of arrangements for providing nursing and social care support in custody settings may limit the generalisation of the findings.*

Practical implications – *This study highlights that there is a group of individuals whose mental health causes concern to the police in a custody environment. In this study, the overwhelming majority of the group have no contact with mental health services. The research supports the recommendations of the Bradley Review for wider health care provision in custody settings.*

Originality/value – *The paper highlights that fully effective community mental health services need to consider police custody settings as a key point for intervention.*

Keywords *Vulnerable adults, Police custody, Forensic physicians, Safeguarding, Adult protection, Mental health services*

Paper type *Research paper*

Introduction

This paper reports the findings from a study carried out into assessments carried out by Forensic Physicians (FP). The assessments were all undertaken in police custody settings where custody officers had concerns relating to the mental health of the detained person. A range of information was collected in every case where custody staff had identified a mental health concern and requested a FP assessment. As well as information about demographic factors, any links with community-based mental health services were explored. As well as this information, anonymous custody records and force adverse incident records for the month were examined. This study highlights that there is a group of individuals whose mental health causes concern to the police in a custody environment. In this study, the overwhelming majority of the group had no contact with mental health services. The research supports the recommendations of the Bradley Review for wider health care provision in custody.

The Bradley Review

In 2008, the government commissioned a report to look at the experiences of people with mental health problems or learning disabilities in contact with the criminal justice

system (CJS). It should be noted that individuals in these groups are more likely to be victims than perpetrators of crime. The Bradley Review reported in April 2009 and made a series of recommendations about how agencies can work together more effectively to meet the needs of vulnerable adults. The review also highlighted examples of good practice including innovative areas of joint working.

The Bradley Review highlights that the shift towards "neighbourhood policing" represents a clear opportunity to develop greater community links. The neighbourhood policing model is based on the following principles:

- provide visible and accessible police in every ward;
- enable local people to influence policing priorities in their area;
- facilitate interventions where joint action between communities and partners can solve problems and harness everyone's strengths; and
- provide sustainable solutions to problems which will be evaluated by the community.

In addition, Safer Neighbourhood teams have been established with the aim of ensuring that the police and a range of local community stakeholders work together to come up with solutions to local problems. One aspect of this work will revolve around the needs of mentally ill people. The Bradley Review emphasized the importance of police and court liaison and diversion services. The services provide improved screening and assessment of individuals with mental health problems so that they can be diverted from the CJS at the earliest opportunity.

One feature of the UK system is the variety of local initiatives. There is no national police force. In England and Wales, there are 43 forces, eight in Scotland and the Police Service of Northern Ireland. These forces vary in size enormously. In addition, health and social work services have different boundaries and organizational structures. One can see immediately the logistical difficulties that will arise in planning services and policies to cover such an area. The Bradley report, therefore, highlights a number of local initiatives that it hopes can be adapted or taken up in other areas.

The police custody setting

The Police and Criminal Evidence Act (PACE 2004) provided key safeguards for the protection of vulnerable adults – that is, adults with mental health problems or learning disabilities – while in police custody. Along with the standard procedures and rights such as the provision of legal advice and the taping of interviews, such individuals have to be interviewed with an appropriate adult present. Custody sergeants have a key role to play in this process as they, in effect, carry out a risk assessment of every individual who comes into custody. Advice on ensuring the safety of those with mental health problems forms part of *Guidance on the Safer Detention and Handling of Persons in Police Custody* (ACPO/National Centre for Policing Excellence, 2006). However, the guidance itself is not comprehensive. In any event, for it to be followed successfully, it is dependent on police officers making appropriate assessments of individuals' mental health needs. All individuals coming into police custody are assessed as to whether they are fit to be detained. Custody sergeants will carry out an initial screening exercise seeking medical or other support as required. This is a fluid process, but the initial decisions that are made are very influential. Curran and Matthews (2001) emphasized that there are a series of almost inbuilt delays in the custody process. These delays are increased for people identified as experiencing mental distress as there will be a need to contact doctors, social workers and other professionals.

Policing and mental illness

Arboleda-Florez and Holley (1998) argue that one unforeseen consequence of the policy of the closure of long-stay hospitals has been a shift in the role of agencies such as the police, the prisons and the courts. They have had to deal with increased numbers of people experiencing mental health problems so that the provision of mental health care is a key part of their role (Cummins, 2006, 2011; Wacquant, 2009) This is despite policy initiatives such

as assertive outreach teams to engage those most at risk, diversion from custody and even mental health courts in certain US jurisdictions, which seek to provide appropriate mental health care to those caught up in or at risk of entering the CJS. The role of a police officer is a complex and demanding one. As well as the prevention of crime and arresting offenders, policing involves responding to a much broader set of social problems. This involves the exercise of significant discretion, particularly in the case of adults with mental health problems (Bittner, 1967). Wolff (2005) suggests that police officers have historically had a quasi-welfare role and this has particularly the case in the area of mental health.

Stone (1982) contends that there has never been a clear divide between mental health services and prisons and the courts. The result is that individuals with mental health problems have been drawn into the CJS at various points. Teplin (1985) called this process "the criminalization of the mentally ill". Wider social policy developments such as the "respect agenda" (Barr, 2001) and the poverty experienced by people with mental health problems (Kelly, 2005) have combined to accelerate this process. The Sainsbury Centre (2008) study suggests that up to 15 per cent of incidents dealt with by the police are related to mental health issues in one way or another. This includes responding to incidents where individuals are distressed to supporting victims of crime, who have been targeted because they experience mental illness. Linsley *et al.* (2007) examined cases of suicide. The study noted that the professional that those who had committed suicide were most likely to have contact with in the three months prior to their death was a police officer. The focus of this article is the experiences of people in custody. However, it should be noted that individuals with mental health problems are more likely to be victims of crime. MIND (2007) highlights the failings of agencies in meeting this group's needs as victims.

Mental health awareness is a key skill for an effective police officer. However, it is an area of training that is neglected. Pinfold *et al.* (2003) argued that this training is important to challenge the stereotypical views that dominate police thinking – the views that there is a link between mental illness and violence being a very entrenched belief. This was further supported by Cotton (2004). Cummins (2007) showed that the majority of police officers have little formal training in this area. The result is that they acquire skills and knowledge via experience or from more senior colleagues. The benefits of a different approach to training were demonstrated by Cummins and Jones (2010). The Dyfed and Powys force developed a training course for officers, which involved staff spending time on mental health units, receiving training from nursing staff and service-user groups. This approach has been very successful. Feedback from service-users emphasizes that officers, who have undergone the training adopt a much more sympathetic approach, particularly when involved in the formal process of admission to hospital (Cummins and Jones, 2010).

The failings of "community care" have increased the police role (Cummins, 2011). There is a strong possibility that this role will increase following the introduction of Supervised Community Treatment Orders in the reform of the Mental Health Act (2007). The changing role has led forces to explore a number of different models of policing in this field. These include crisis intervention teams of specially trained police officers (Deane *et al.*, 1999). Lamb *et al.*'s (1995) study indicated that joint teams of mental health staff and police officers could work together to meet the needs of those experiencing acute distress. Steadman *et al.* (2000) argued that the real key to a successful policy of diversion is inter-agency cooperation. The importance of inter-agency working to avoid tragedy is an important message from the series of inquiries that have scarred the development of services in this field (Ritchie, 1994; Butler and Drakeford, 2005).

Study design

The custody setting is a largely neglected area of study. Skinns (2011) following the work of Choongh (1997) and Newburn and Hayman (2002) explores the way that the police fundamentally shape the nature of the custody environment. Despite an increasing range of other agencies and professionals – social workers, doctors, lawyers, drug workers, lay visitors and Appropriate Adults – having a role in the custody process, this remains the case. The custody process is part of the police investigation and prosecution of crime.

Choongh (1997) suggests that for a small number of suspects who have regular contacts with the police, custody is used as a mechanism to impose discipline and establish authority. Policing, the courts and prisons are parts of society that is both familiar and hidden. They are familiar in that a large part of daily news and television drama is devoted to them, hidden in the sense that, for the majority of the population, they have little, if any, direct contact with them. Skolnick (1966) argues that the police as an organisation are the most hidden part of these systems. All researchers in this field face the problems of negotiating access. Punch (1989) discusses his work and the ethical problems he faced. Punch's work is a famous observational fieldwork study of police patrols in inner-city Amsterdam in the period 1974-1976. As he notes, such research, in effect involves negotiating different levels of access. Once the senior management had agreed that he could undertake the study, he then had to negotiate a whole series of relationships with the officers on the ground where the study took place.

Ethical considerations, as would be expected, played a major role in determining the final structure of this study. Any attempts to interview detained persons at the time of their arrest would not have been ethical. It was felt that a study which asked individuals to contact researchers after the period in custody would not only face ethical barriers but was also likely to fail. As a result, the study is based on an analysis of anonymised custody records. The initial data collection identified the cases where an FP had been involved because of mental health concerns. Additional information about the individual such as age, gender, and race and employment status, which is part of the custody record and collected for statistical and audit purposes was made available to the researcher. In addition, details of any contact with community-based mental health services, which were part of the usual FP assessment was collected. These processes ensured that there was an ethical firewall between the custody settings and the researcher. It would have been impossible for any individuals, police officers or doctors to be identified in the study.

In common with other forces, Lancashire Constabulary (LC) has a contract with an independent organisation for the provision of a range of medical assessments in custody settings. For contractual, auditing and other purposes a range of information is collected in relation to every assessment that doctors carry out in custody settings. Following discussions with a representative from the organisation (LC – Custody Management Criminal Justice) and the author, it was agreed that a range of information would be collected in every case where custody staff had identified a mental health concern and requested a FP assessment. As well as this information, anonymous custody records and force adverse incident records for the month were examined. A month was chosen for the study as it was felt that this would produce sufficient cases for analysis. This proved to be the case.

Findings

Information was provided on 58 cases where the FP had been called to carry out an assessment because the custody sergeant was concerned about the detained person's mental state. 50 of the cases involved men and eight were women. The overwhelming majority of the cases (41) were in the age range 20-49, but eight assessments were carried out on young people aged 16-19. The oldest person assessed in this study was 78 and the youngest 16. In majority of cases (31), there was no marker on the Police National Computer (PNC) to alert, custody staff to the fact that the individual had previously had mental health difficulties whilst in custody.

Such warning markers will clearly influence the custody officer's decision to ask for a medical assessment. Three of the cases in this study involved adults who had been detained under section 136 MHA. This meant that a formal medical assessment was legally required. The section 136 cases followed three complete different paths: one led to a further MHA assessment, in another the FP found no evidence of mental illness and the final one concerned whether the person was fit to be detained or interviewed. Jones and Mason (2002) explored the experiences of those subject to section 136, highlighting its essentially punitive nature. The final outcome in 21 FP assessments was that no mental health issue was identified by the medical assessment. In 16 cases, the FP concluded that the detained person was fit

to be detained and interviewed. In two of these cases, it was recorded that an Appropriate Adult should be involved at the interview stage. The conclusion of the FP in 6 cases was that a MHA assessment should be arranged. In these circumstances, the responsibility for this will move to local psychiatric and social services. Information relating to the final outcome of these MHA assessments was not available to this study. The final outcome was not recorded in the other cases in this study.

As indicated above, a range of other information was obtained from the custody records and as part of the assessment. This information was then summarised for the project. These questions were all related to the detained person's contact, if any, with community-based mental health services but also other relevant services such as drug and alcohol. Information was also obtained about the nature and frequency of these contacts. 42 of the cohort were registered with a GP. This obviously means that 16 were not. GPs clearly have a fundamental role to play in the UK healthcare system. Accessing healthcare becomes increasingly difficult without a registered GP. The lack of GP is a well-documented feature of individuals with a transient lifestyle – usually those with the highest healthcare needs – and is probably the main explanation of the figure here. Only six of the group – all men – stated that they had any contact with mental health or other community services. These individuals were asked to identify the professional that they had most contact with and how recently that had occurred. Two individuals were in contact with a social worker, two a CPN and two a psychiatrist. Three had seen the professional concerned in the last month, one in the last week and two had no recent contact with services. In only one of the cases that led to a formal MHA assessment, had the individual had any previous contact with mental health services – in that case he was in recent contact with a psychiatrist.

Discussion

The fieldwork, on which, this analysis is based took place in July 2009. The demographic and other factors do not appear to mark this group out from others in custody in terms of gender, race, employment status and condition on arrest. This majority of those where concerns were raised were white, unemployed and intoxicated when arrested. The literature discussed above indicates the high level of mental health need amongst all those in contact with the CJS. 4,058 people were in custody in the period studied. The first question that arises then why was FPs involved in less than 1.5 per cent of cases. This will reflect a number of factors including: the awareness and assessment skills of staff, the presentation of the individual concerned and any other information available to custody staff at the time. In addition, custody staff will have experience of dealing with distressed individuals. This along with other factors means that the FP will be involved in the cases where the concern is greatest. Research into the use of section 136 (Mokhtar and Hogbin, 1993) shows that the police can identify acutely psychotic behaviour. However, the vast majority of individuals experiencing a mental health problem do not present in this fashion. The assessment here is conducted by an experienced police officer, who has, even now, had very little specific training in relation to mental health issues. In addition, the officer will be largely reliant on their own judgement, as they do not have access to other information such as NHS records. Finally, the police are often very reliant on the detained person for background details. The stigma attached to mental illness might militate against individuals disclosing such information. These factors combine to explain the relatively low level of referral to FPs. In addition, Cummins' (2007) study indicates that custody officers a high threshold for the identification of mental illness.

The majority of FP assessments in the sample studied related to concerns regarding fitness to be detained/interviewed. It should be noted that in 21 of the cases, the FP assessment concluded that there was no mental health issue. This does not, of course, mean that the custody staff were incorrect in involving the FP. However, the involvement of the FP becomes an expensive and time consuming screening tool. The nature of the custody environment is such that there will always be such examples. In the period under study, this group constitutes about 0.5 per cent of the total number of those in custody but over a third of FP assessments. In six of the cases, the FP outcome is recorded as "detainee required sectioning"; five of these detainees were men.

The other aspect of the study was to explore the contacts, if any; this group had with community-based mental health services. Only six (0.14 per cent) – all men – of the group had had any contact with community-based mental health services. The point of contact included a psychiatrist, CPN and social worker. Three had been in contact with services in the week prior to their arrest. One detainee had seen a psychiatrist within the past month and the other detainees had had no recent contact with mental health services. In this group in some contact with mental health services, the FME assessment concluded that "detainee required sectioning" in two cases. Three assessments followed the use of section 136 MHA. None of these individuals had any recorded contact with mental health services.

The lack of contact with mental health services is an area that raises a number of questions. The study only explored cases where the concerns about individuals' mental health were such that an FP assessment was arranged. In the custody setting, this amounts to a reasonably high threshold for intervention. This is demonstrated by the fact that there were so few FP assessments for mental health concerns in the period under consideration. The current study cannot answer the question as to wider level of contact with mental health services of those, who come into police custody. The other area to consider is what actions, if any, are taken once the individuals leave police custody. As in this study, the majority of individuals are either bailed or no further action is taken and they are released from custody.

Information can be stored on the PNC. However, this is only relevant if the detainee is in contact with the police at some future point. The difficulties of sharing information with other agencies have yet to be overcome.

Conclusion

The study highlights a number of issues that arise in the custody setting. All the literature would indicate that there is an element of under-reporting or more accurately under identification of mental health problems in this study. The reasons for this are well documented. They amount to a combination of lack of information, limited training and the inherent difficulties of assessing mental illness in any environment, let alone in the custody setting. The majority of cases where individuals exhibit some form of mental distress are actually dealt with by the staff at the station. In this study, the FP was involved, because staff raised mental health concerns, in less than 1.5 per cent of cases. The majority of assessments were concerned with the issue of whether the person was fit to be detained/interviewed. This is clearly a matter of fundamental concern and likely to remain the most common reason for an FP assessment. In this area, custody sergeants will always be guided by the provisions of PACE 1984 which emphasise the need to seek such advice if they have any cause for concern. One of the key themes of the Bradley Review is the need to improve the training of staff across the CJS. In this study, the assessment by FPs is an expensive and time-consuming way of confirming that an individual is fit to be detained. This is clearly a very important consideration. However, the main driver in these assessments appears to be the administration of justice rather than wider concerns with the welfare of the person in custody.

In this study, the cohort of detainees whose mental state caused custody staff the greatest concern had little, if any, contact with community-based mental health services. The custody environment is a pressured and stressful one so one would expect it would have a negative impact on the mental state of detainees. However, this is a group where the concerns are such that medical advice has been sought. Systems need to be developed that will signpost these individuals to the relevant community agency that can offer them support. One of the key recommendations of the Bradley Review is that the NHS takes on responsibility for commissioning healthcare in custody settings. There have been moves in a number of areas for mental health nursing staff to be available in custody settings. If the Bradley recommendation is implemented – the current policy climate adds another barrier to its introduction – there are a number of possible benefits. The key one is the engagement of individuals with services.

It is calculated that the NHS spends 14 per cent of its budget on mental health services (A Future Vision for Mental Health). In England alone, the overall annual cost of mental ill health

is estimated at £77 billion. The majority of this figure derives from the long-term cost of economic inactivity. There are a whole series of other social costs such as poor physical health, social exclusion and the effects on individuals and families that are more difficult to quantify. The Foresight report (2008) "Mental capital and wellbeing: making the most of ourselves in the 21st century" emphasises that early intervention increases the chances of better long-term outcomes for mental disorders. Further studies demonstrate that early intervention leads to reduced hospital admissions, lower suicide rates and better engagement with services (Addington and Addington, 2007). The Bradley Review commissioned a review into the cost/benefit analysis of three key interventions in the CJS. One of these was the police stage. The difficulty in collecting data means that the findings are provisional. The figures suggest that a triage system of mental health assessment across all 43 police forces would produce savings of £300,000. In addition, there are a series of qualitative benefits which will also have financial benefits. These include; earlier assessment and intervention, access to appropriate mental health care and in cases where mental illness is the main cause of offending, reduced offending. Crisis driven access to services not only leads to poor health outcomes it also increases cost. This study highlights one example of this. The fundamental message of the Bradley Review is that support for those with mental health problems, who have contact with the CJS has to be increased across the board. The moves should be supported not just because of the possible economic benefits that accrue but rather because of a wider commitment to the general principles of social justice.

References

- ACPO/National Centre for Policing Excellence (2006), *Guidance on the Safer Handling of Persons in Police Custody*, ACPO, London.
- Addington, D.E. and Addington, J.M. (2007), "Attempted suicide and depression in schizophrenia", *Acta Psychiatrica Scandinavica*.
- Arboleda-Florez, J. and Holley, H.L. (1998), "Criminalization of the mentally ill: Part II – initial detention", *Canadian Journal of Psychiatry*, Vol. 33, pp. 87-95.
- Barr, H. (2001), "Policing madness: people with mental illness and the NYPD", in McArdle, A. and Enen, T. (Eds), *Zero Tolerance: Quality of Life and the New Police Brutality in New York City*, NYU Press, New York, NY.
- Bittner, E. (1967), "Police discretion in emergency apprehension of mentally ill persons", *Social Problems*, Vol. 14, pp. 278-92.
- Butler, I. and Drakeford, M. (2005), *Scandal, Social Policy and Social Welfare*, Palgrave Macmillan, Basingstoke.
- Choongh, S. (1997), *Policing as Social Discipline*, Clarendon Press, Oxford.
- Cotton, D. (2004), "The attitudes of Canadian police officers toward the mentally ill", *International Journal of Law and Psychiatry*, Vol. 27 No. 2, pp. 135-46.
- Cummins, I.D. (2006), "A path not taken? Mentally disordered offenders and the criminal justice system", *Journal of Social Welfare and Family Law*, Vol. 28 No. 3, pp. 267-81.
- Cummins, I.D. (2007), "Boats against the current: vulnerable adults in police custody", *The Journal of Adult Protection*, Vol. 9 No. 1, pp. 15-24.
- Cummins, I.D. (2011), "Deinstitutionalisation; mental health services in the age of neo-liberalism", *Social Policy and Social Work in Transition*.
- Cummins, I.D. and Jones, S. (2010), "Blue remembered skills: mental health awareness training for police officers", *Journal of Adult Protection*, Vol. 12 No. 3, pp. 14-19.
- Curran, S. and Matthews, K. (2001), "The psychiatrist will be with you in a day or two. Unnecessary delays in assessing the mentally ill in police custody in Scotland", *Scottish Medical Journal*, Vol. 46 No. 2, p. 37.
- Deane, M., Steadman, H., Borum, R., Veysey, B. and Morrissey, J. (1999), "Emerging partnerships between mental health and law enforcement", *American Psychiatric Association*.

Foresight Mental Capital and Wellbeing Project (2008), "Mental capital and wellbeing: making the most of ourselves in the 21st century", Final Project Report, The Government Office for Science, London.

Jones, S.L. and Mason, T. (2002), "Quality of treatment following police detention of mentally disordered offenders", *Journal of Psychiatric and Mental Health Nursing*, Vol. 9, pp. 73-80.

Kelly, B. (2005), "Structural violence and schizophrenia", *Social Science & Medicine*, Vol. 61, pp. 721-30.

Linsley, K., Johnson, N. and Martin, J. (2007), "Police contact within 3 months of suicide and associated health service contact", *British Journal of Psychiatry*, Vol. 190, pp. 170-1.

MIND (2007), *Another Assault: Mind's Campaign for Equal Access to Justice for People with Mental Health Problems*, MIND, London.

Mokhtar, A. and Hogbin, P. (1993), "Police may under use section 136", *Medicine Science and Law*, Vol. 33 No. 3, pp. 188-96.

Newburn, T. and Hayman, S. (2002), *Policing, Surveillance and Social Control: CCTV and Police Monitoring of Suspects*, Willan Publishing, Cullompton.

Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H. and 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. 337-44.

Punch, M. (1989), "Researching police deviance: a personal encounter with the limitations and liabilities", *British Journal of Sociology*, Vol. 40 No. 2, pp. 177-204.

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

Sainsbury Centre for Mental Health (2008), *The Police and Mental Health*, Sainsbury Centre for Mental Health, London.

Skinns, L. (2011), *Police Custody: Governance, Legitimacy and Reform in the Criminal Justice Process*, Willan Publishing, Oxford.

Steadman, H.J., Deane, M.W., Borum, R. and Morrissey, J.P. (2000), "Comparing outcomes of major models of police responses to mental health emergencies", *Psychiatric Services*, Vol. 51 No. 5, pp. 645-9.

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

Teplin, L.A. (1985), "The criminality of the mentally ill: a dangerous misconception", *American Journal of Psychiatry*, Vol. 142 No. 5, pp. 593-9.

Wacquant, L. (2009), *Punishing the Poor: The Neo-liberal Government of Social Insecurity*, Duke University Press, London.

Further reading

Bradley, L.K. (2009), *Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*, HMSO, London.

Cummins, I.D. (2008), "A place of safety? Self-harming behaviour in police custody", *The Journal of Adult Protection*, Vol. 10 No. 1, pp. 36-47.

Cummins, I.D. (2010), "The relationship between mental institutions beds, prison population and the crimes rate", *Prison Mental Health: Vision and Reality*, RCN, NACRO, Centre for Mental Health, London, pp. 22-5.

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

Home Office (1995), *Mentally Disordered Offenders: Inter-agency Working*, Circular 12/95, Home Office, London.

IPCC (2006), *Deaths During or Following Police Contact*, available at: www.ipcc.gov.uk

IPCC (2008), *Police Custody as a Place of Safety: Examining the Use of Section 136 of the Mental Health Act 1983*, available at: www.ipcc.gov.uk

James, D. (2000), "Police station diversion schemes: role and efficacy in central London", *Journal of Forensic Psychiatry*, Vol. 11, pp. 532-55.

MHAC (1993), *Biennial Report 1991-1993*, HMSO, London.

MHAC (2005), *In Place of Fear? The Mental Health Act Commission Eleventh Biennial Report 2003-2005*, HMSO, London.

MHAC (2009), *Coercion and Consent the Mental Health Act Commission Thirteenth Biennial Report 2007-2009*, HMSO, London.

McGilloway, S. and 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. 263-75.

HMSO (1983), *Mental Health Act*, HMSO, London.

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Appendix Two: Supportive Evidence

***DEINSTITUTIONALISATION: MENTAL HEALTH
SERVICES IN THE AGE OF NEO-LIBERALISM***

Abstract

The policy of deinstitutionalisation (the closure of large psychiatric hospitals and a move towards community-based mental health services) has been a feature of the development of services in liberal democracies. This policy was the result of a series of criticism of the abusive nature of institutional psychiatry. Though the policy has its roots in a body of essentially progressive ideas, the policy was pursued at a time when neo-liberal governments were in power – this is particularly the case in the USA and UK. The anti-statist, individualist themes of the critics have chimed with several tenets of neo-liberal ideas. The results of deinstitutionalization have been largely very poor. Community mental health services were largely underfunded, poorly organized and unable to cope with the demands placed upon them. In addition, other social problems such as mass unemployment, the destructive impact of increased substance misuse combined with the reduction in other aspects of welfare state provision meant that the institution was replaced, for many, by a bleak existence at the margins of urban society. More people with mental health problems were drawn into the criminal justice system.

Key words

deinstitutionalization; neo-liberalism; social exclusion; mental health services

Neo-liberalism

In the West, following World War II, governments largely followed a series of Keynesian economic policies. Governments invested in a range of public services such as health and education. Unemployment was at very low levels for most of the period 1945-74. This period of expansion came to an end with the oil crisis. The rise in the price of oil and subsequent inflation led to a retrenchment in the public sector. The late 1970s and early 1980s saw the election of a series of right wing Governments, most notably those of Margaret Thatcher and Ronald Regan, who were committed to solving these difficulties by reducing the levels of public spending.

In the period of the dominance of Keynesian economic policy, there were always dissenters on the right. The most influential of these was Friedrich Hayek subsequently knighted by the Thatcher government. His influential book, *The Road to Serfdom* was published in 1944. This is an attack on the whole notion of state intervention. For Hayek, the key political value is freedom and this is defined in the Hobbesian negative sense. In the political sphere, Hayek emphasizes that the notion that freedom can be obtained by any government planning or intervention is completely contradictory. Such approaches are doomed to fail.

The Thatcher and Regan governments' economic policies were heavily influenced by Hayek and one of his modern disciples, Milton Friedman. Friedman argued that the control of the money supply was vital to reducing inflation. This approach was characterised by reducing public spending and the level of taxation. For neo-liberals, the role of government was essentially to create conditions in which the market could flourish. Therefore, the state should ideally only concern itself with ensuring the safety of the citizen and the realm. All other areas were most effectively left to the functioning of the market. Any other role for the state was bound to fail because of bureaucratic ineptitude as state employees were not subject to the rigours of a competitive market where inefficient organization naturally failed.

In addition, the expansion of the state comes at the cost of individual liberty. This is most forcibly argued by Novick (1974). State services inevitably reduce choice and allow for greater government interference in the lives of citizens. For Novick, taxation is almost presented as a form of theft. He argues that the highest individual contributors to the funding of government services are those who are least likely to use them. In a minimalist state, individuals make choices about which services they should support. The model here has echoes of Victorian philanthropy.

In the world of practical party politics, governments are coalitions rather than driven by purely ideological considerations. Despite her reputation as the Iron Lady, even Mrs. Thatcher had to make some compromises with the more traditional elements of her party (Gilmour 1992). However, the key themes of the Thatcher project were clear. Levels of direct taxation were reduced, State assets were sold ('privatization') and there was an emphasis on individualism. One area of the State that did not retrench was the penal and criminal justice systems. Wacquant (2009) argues the end of 'Fordism' saw the welfare state being replaced by what he terms 'the punitive state'. This included a shift in the balance between penal and welfare or social programmes and a large prison building programme. The deinstitutionalisation is not a criminal justice programme. However, the responses to its failure reflect the prevailing shift towards punitive responses.

Deinstitutionalisation and the development of community care

This section will explore the changes in mental health policies in England and Wales that have led to the development of community-based services for people with severe and enduring mental health problems. Though the focus is on the UK, similar themes emerge in the North American context. This section will include an analysis of the decline of the asylums and an examination of the crisis that mental health services faced in the early 1990s.

The most influential work in the literature of the crisis of the asylum is Goffman's *Asylums* (1961). Goffman's study of a large state

psychiatric hospital has been seen as a pivotal point. Goffman was concerned with the way that 'total institutions' function. In such institutions, he argued that there was a strict divide between staff and patients. The staff exercised control over all aspects of the patients' daily lives. The institution was so large it could only function if it worked to a strict timetable. The net result was that the organisational needs of the staff took precedence over any therapeutic needs of the individual patients. In this system, all aspects of daily living were monitored - if you were a patient they had to be carried out in front of staff. Two distinct and opposing cultures develop: that of the staff and patients. Goffman argued that patients need to maintain some sense of self, which they do by transgression - often in very minor ways. The staff then interpret these transgressions as evidence of illness or a lack of ability to stay within those ensuring that the individual remains incarcerated. The theme of the individual confronting a repressive and often incomprehensible system was brilliantly exploited by Ken Kesey (1963).

As Pilgrim and Rogers (1999) suggest, the asylum is set apart both physically and metaphorically from its general hospital counterpart. The general hospital was easy to access and usually found in the centre of towns and cities. The reverse is the case for the asylums. These institutions were built on sites away from the main centres of population thus physically separating the mentally ill from the rest of the population.

Scull (1977) sees the rise of the asylums as part of the Victorian response to the problems of urbanisation. In this analysis, asylums along with schools, factories and prisons have a key role to play in social control. Scull argues that as the mentally ill were deemed not to be economically useful, they had to be isolated and removed from society. The net effect was also to serve as a warning to the wider populace of the perils of non-conformity. In addition, this period saw the wider acceptance of a medical view of the causes of mental illness. The asylums therefore were the confirmation of the new status of psychiatry as a distinct branch of the medical profession. Nye (2003) argues that the development of this discourse was part of the wider Enlightenment project. He suggests that 'reason' was seen as the domain of the rich and powerful. The result

was that 'unreason' was thus found among the poor and marginalized – women, the mad and the criminal classes.

Foucault's (1977) analysis of the development of asylums and prisons has been incredibly influential and controversial. At this point, I will consider some of the main themes of his argument. Foucault is concerned with the exercise of power both by individuals and the state. Foucault does not accept the Enlightenment idea of progress and the belief that social problems can be solved by rational means. As Bauman (1997) argues, the changes in this period were as much about the control of emerging groups such as the urban, workless poor, as they were about solving problems. Urban problems were problems of order (Bauman 1997).

In his work both on prisons and asylums, Foucault argues that the development of these institutions represents an ideological shift. For Foucault the 'repressive hypothesis' fails to take account of the creative aspects of power. He sees it as a much fluid force. The focus for state intervention was no longer the body of prisoners or patients but their minds. He argues that this is a more pervasive form of social control. In this analysis, power and the power to punish are much more dispersed throughout the social system. It therefore operates on a number of levels. Foucault terms this ideology of discipline 'savior'. Expressions of this ideology can be found amongst all groups apart from the deviant and it operates as a mechanism of repression both of the self and others. This analysis recognises that it is not only the professions that are involved in the disciplinary mechanism of social control. The disciplinary mechanism becomes an internal one. The physical and psychological geography of institutions mirrored, in a number of respects, the monasteries. For example, incarcerated individuals were not allowed to speak to each other. Cells in prisons, asylums and religious orders were to separate the penitent. The focus of punishment thus became the internal prisoner, rather than the body of the prisoner.

As with the more traditional Marxist analysis of Scull, Foucault argues that the development of these institutions is part of series of bourgeois response to the threat posed by the urban poor. For Foucault, the level of investment required in these institutions is

such that if they did not serve this function they would not have been built. In his writings, Foucault draws attention to the symbolism of the institutions. Bentham's panopticon (Foucault 1977) becomes not just an architectural design but an embodiment of new society, whose institutions form a 'carceral archipelago' for the management of deviant populations be they criminals or the insane. For Foucault, it was this quarantining of the urban poor that was the aim of these institutions. Despite the failure on an individual level of prisons or asylums to create model citizens, they succeeded in warning the rest of the population of the consequences of breaching conventional norms. Foucault has termed these developments as the 'great confinement'. This period sees a fundamental shift in attitudes to mental illness and insanity. The outcome, for Foucault, is that the insane becomes the lepers of modern industrial capitalist society. Seddon (2007) in a consideration of the development of policy towards 'mentally disordered offenders' raises the question of how this group, which was seen as potentially treatable or might benefit from developments in psychology and psychiatry, came to be viewed through a prism of risk, management and control. He argues that the 'dividing practices' applied to this group reflect the shift from modernity to late modernity.

The accounts that Scull and Foucault give of the rise of the asylums can be seen as a response to the more traditional view that the asylums with all their faults should be seen as progress on the way to more enlightened treatment of the mentally ill. In this schema, the asylums are part of medical progress and the motives of the reformers are undoubtedly humanitarian and concerned with the relief of suffering (Jones (1960)). In this narrative of progress and reform, individuals such as Tuke in York are seen as pursuing an heroic path in the face of the hostility of the wider society. The resulting institutions were attempts to provide safety and succour for a variety of the weaker members of society. In this account, the issue of social control is barely considered, similarly for Scull or Foucault there seems to be no acknowledgement that some reforms might have been the result of humanitarian concerns.

The liberal progressive view of the development of asylums is based on a several key premises about the nature of mental illness and society. As Ignatieff (1985) argues, the orthodox view assumes

that mental illness is an identifiable feature of the human condition. Following on from this basic premise, is the idea that those who are involved in the management of mental health problems are motivated by humanitarian concerns for the relief of the distress of their fellow citizens. The final feature of this model is the acceptance of the dominant position of the medical profession in this process. This is seen as a logical outcome and allows for the application of rational, morally neutral medical knowledge to the symptoms of mental illness. The motor for change is a progressive impulse to find ways of improving services by the application of knowledge. As Rothman (1988) suggests, this leads to a peculiar narrative, in which reformers design new systems, then expose the failings of the new system and eventually replace it with another one. In this account, there is a danger that historical development is seen as linear and teleological. There are a number of implicit assumptions in this narrative: all change is progressive, the current system is the best available and the development of new knowledge will lead to further improvements. In many ways, the criticisms of community care follow a similar narrative structure.

The term anti-psychiatry covers a range of critical perspectives on psychiatry (Foucault (1977), Scull (1977), Laing (1959, 1967), Szasz (1971)). Such is the divergence of views that it would be simplistic to group together as a movement. However, a number of common themes can be identified. The first is a questioning of the assumption that mental illness exists in the way that psychiatrists and medicine suggests. In the critical accounts, there is a sceptical approach which sees mental illness as largely socially caused by the injustices of a capitalist society: poverty, racism, gender discrimination and social inequality are socially constructed. In progressive accounts treatment is seen as a therapeutic intervention, whereas from a critical perspective it becomes part of the means by which capitalist society maintains social order and reproduces the class divisions required to ensure its continued existence.

For Scull (1977) the squalid conditions in the 19th century asylums were inevitable. It would be impossible to think of an alternative as there was no system of welfare payments that existed to support these individuals. In addition, families often welcomed the removal

of a non-contributing member as this reduced the burden on the family as whole. As he points out, most of urban society, apart from a ruling elite, lived a marginalized existence in very poor conditions indeed. In such circumstances, those who could not make any contribution would be seen as an economic danger. For Foucault (1977), the investment in the asylums was justified because of the role they played in social control, not because of the humanitarian zeal of the builders of these institutions. Both approaches argue that what later come to be seen as the failings of the asylums - cruelty, squalid living conditions and inhumane treatment - are, in fact, inherent features of their design.

The revisionist accounts are, in themselves, part of the moves towards the policy of community care. The response has come from both medicine and the humanities. It is hardly surprising that medicine (Clare, 1976; Wing, 1978) has sought to challenge accounts of the development of psychiatry that emphasise the elements of social control inherent in the profession. It is, however, somewhat ironic that the most powerful denouncers of this aspect of the exercise of professional power are psychiatrists themselves - Laing, Szasz, Cooper. The 'medical defense' is based on the clear view that the main aim of medicine is humanitarian and altruistic, i.e. the relief of suffering. Within these accounts, there is an acceptance that certain practices would now be seen as cruel or even amount to torture. However, the argument is that this was the state of medical knowledge at the time. The intention was clearly therapeutic within the definitions of the period. This is not presented as a defense of cruel or inhumane practices. It is, rather, a counterbalance to the post-modernist trend to apply moral codes retrospectively. Wing (1978) and Clare (1976) highlight the role of doctors in pushing forward reform.

The critics of Foucault's work and other revisionist accounts have fallen into two very broad categories. The first focus on what are seen as the fundamental historical flaws in the arguments. Sedgwick (1982) has demonstrated that the links Foucault makes between the decline in the treatment of leprosy and the development of psychiatric asylums does not hold. For Foucault, prior to the 'great confinement', mentally ill people had essentially been

tolerated and allowed to live in society. At certain junctures, he argues that the 'mad' had a status which enabled them to act as commentators on society. The role of the Fool in Shakespeare would be an example of this. Sedgwick argues that this portrayal of the mentally ill as the lepers of modern society ignores the fact that mentally ill people had been held in various forms of custody prior to the period Foucault is discussing. Rothman (1971) highlights the fact that the institutions that are usually described as a response to the problems of urbanisation also developed in the USA, which was an overwhelmingly agrarian society at that point.

A second critical approach to Foucault's work is concerned with the nature of morality and humanity in this discourse. Rothman (1971) argues that, though Foucault's main thesis is conceptually attractive, it has imposed its own schema on a very complex story. He suggests that it is simply not possible to reduce the complex causes of the development of asylums to 'conspiratorial class strategies of divide and rule'. Wacquant put this view more strongly:

'... I empathically reject the conspiratorial view of history that would attribute the rise of the punitive apparatus in advanced society to a deliberate plan pursued by omniscient and omnipotent rulers, whether they be political decision-makers, corporate heads or the gamut of profiteers who benefit from the increased scope and intensity of punishment and related supervisory programs trained on the urban castoffs of deregulation.' (Wacquant, 2009:33).

The founders of such institutions often came from religious backgrounds - for example, Tuke at York - which would appear to be in conflict with their ascribed role as the oppressors of the wretched of the Earth. Ignatieff (1985) argues that the revisionist account falls because of a series of misconceptions about the nature of society and social order. He suggests that accounts that assume that the State holds a monopoly of power over social control simplify the complex ways in which laws, morality and public sanctions combine. A further paradoxical feature is that some professions that become associated with the maintenance of social order appear on the surface committed to a more equal and just society. The revisionist account is based on a premise that social order is mai-

ntained by a combination of moral authority and practical power. Foucault is forced to discount the motivations of individuals – in fact any such consideration would be outside of his analysis. His argument is so concerned with symbolism and process that it does not allow for individual motivation. This is both a strength and weakness. The strength comes from the radical challenge to the liberal progressive view. The weakness lies in the fact that, ironically, Foucault dehumanises staff in institutions. Stone (1982) goes further and suggests that this exposes the ultimately nihilistic streak in Foucault's work. All human relationships are analysed through the prism of power, domination and subordination. This ignores or denies the existence of other factors in relationships such as mutuality, humanity and interdependence.

The revisionist accounts of the rise of asylums are very challenging as they force the reader to consider what is meant by such terms as progress or humane treatment. In addition, though this is not always made explicit, there is a consideration of the history of the institution from the viewpoint of the incarcerated. This is instinctively more appealing than the narrative which sees the history of the asylums as the struggle of psychiatrists to humanise an inhumane system. However, there is a fundamental difficulty with the revisionist accounts in that they appear only to be able to consider or describe human relations in the language of subordination and domination. In challenging the notion of progress, there seems to be a denial of its possible existence whatsoever. For Foucault, the development of the 'surveillance' state seems to lead him to conclude the modernist attack on the custom, tradition and dogma of the ancient regime has led to the erosion of civil rights for most citizens. For Stone (1982), this has had a destructive impact on the development of mental health services and gave intellectual support to the push towards deinstitutionalisation.

Giddens (1991) argues that modernity is characterised by the scope and nature of change along with the emergence of new institutional forms that had not previously existed. One of the core beliefs of modernity is that rationality can be applied to the solution of social problems. Modernity brings with it a series of risks. The pre-modern or pre-industrial community is broken down by the

development of an industrial market economy, which lacks the traditional patterns of authority and deference. This can be seen as liberating as it allows for the development of individualism. However, it is also accompanied by a sense of ambiguity. For example, the modern city can be seen as offering the opportunity for individual self-expression or as a shifting amoral and alienating wasteland. In such an environment, social order and control will become more problematic. The older systems were based on individual, family, kinship and hierarchical ties. Modernity requires a shift to a Weberian bureaucratic approach. In the mental health field, the asylum can be seen as the triumph of this technocratic rationality,

The starting point for the crisis in asylums is usually identified as the late 1950s and the early 1960s. This period saw the emergence of 'anti-psychiatrists' such as Laing, Cooper and Szasz. It would be inaccurate to describe them as a group and only Cooper accepted the label of anti-psychiatrist. However, the themes that emerged in their work challenged the nostrums of the psychiatric profession. Psychiatry finds itself in an unusual position in modern medicine in that treatment can be imposed against the will of the patient. This group of thinkers was concerned to develop a form of psychiatry that would adopt a much more holistic approach which looked at the social causes of distress that their patients were suffering. This would necessarily involve a paradigm shift from the institutional, coercive, pharmacological care that dominated at that time to a voluntary, more psycho-dynamic, social and community-based modes of service. Szasz is an exception here. His arguments stem from a libertarian position which leads to conclude that psychiatric diagnosis is a process, which not only allows the State to restrict the liberty of individuals but also allows others to escape responsibility for their actions.

Scully argues that asylums were never humanitarian institutions and could never be despite the claims of their founders. The rates of admission to asylums had begun to decline in the 1930s. However, in 1954 there were still 154,000 patients in British mental hospitals. The criticisms of these institutions grew in the following decade. Barton (1959) identified the negative effects that institutionalisation could have on patients comparing the behaviour of patients

on long-stay wards to the observations of similar behaviour that he had observed amongst prisoners in concentration camps. Scott (1973) argued that the hospital itself made individuals passive. This meant that they would be unable to cope outside of the institution. This followed earlier work by Wing (1962), which had shown how the process of social withdrawal developed amongst long-stay patients. The majority of patients would fall into this category at this time. Overall the picture is one of a physically, socially and culturally isolated institutions cut off from the main stream of health care and the wider society.

In the UK, the moves away from a system based on institutional care were supported by the nascent service users movements. In addition, the aims and aspirations of these movements chimed with other protest movements in society in the 1960s such as the movement for civil rights, the feminist movement and gay rights. It should be noted that the history of psychiatry - and present day practice - is scarred by its use to abuse women, members of ethnic minority communities and gay men and lesbians. The failings in hospital-based care were highlighted further by Martin (1985). Martin identified the ways in which these institutions had become isolated from mainstream service provision. As noted above, these institutions were geographically isolated from the communities that they served. Within the institutions, wards could become isolated with small numbers of staff in charge of very large numbers of patients. In his study, Martin also highlighted the way that, on the worst wards, there was a lack of leadership from consultant staff. The final factor that allowed for abuse was the isolation of the patients themselves. Martin found that patients with regular visitors were less likely to be abused. The overall picture is a very depressing one: large numbers of patients, little therapeutic work, poorly trained and poorly paid staff, who lack a sense of a professionalism or a commitment to rehabilitation. If the hospital scandals that Martin studied were an impulse in the move towards community care, those policies in themselves have failed to prevent the repetition of such scandals (Fallon 1999), which have often identified similar themes.

The above is part of the liberal interpretation of the rise and fall of the asylums as it rests on the idea that the moves towards community care came about because of a humanitarian impulse to improve the quality of life for those suffering from long-term mental health problems. The most common explanation by policy makers for the decline of the asylums is the development of the new major tranquillisers. As Pilgrim and Rogers (1999) argue, this is a problematic explanation as it does not explain why community care came to an umbrella policy or approach that was adopted across a range of settings, including groups such as people with learning disabilities, who were not actually treated with the medication that was alleged to be at the heart of the revolution. Another barrier that such an explanation has to overcome is the differential rates of the implementation of the policy of deinstitutionalisation.

The general portrayal of the asylum is one of a large dehumanising institution, which acted as a warehouse for the insane. In the literature, there have been relatively few attempts to look at the asylum as a functioning organism. Gittins (1998) is a study of one long-stay hospital - Severalls Hospital in Essex. The value of this study is that it acknowledges the complexity of such institutions and the motivations of the staff. The hospitals were communities and formed the focal point of the working lives of staff. Such institutions were usually the main employers in an area. It was not uncommon for members or generations of the same family to work at the same place. In addition, it is often possible to overlook the fact that despite its many failings the asylum was home for patients.

As Gittins argues, for certain groups the asylum did fulfill its real role:

'It seems that for some, particularly women, the fact that they could withdraw from the outside world, from family time and body time dominated by endless pregnancies, poverty and abuse meant that life in Severalls could provide a time of peace and a possibility of asylum, in the original sense of the word'. (Gittins, 1998: 9).

Scull (1977) argues that following the post-war development of the welfare state, the fiscal cost of maintaining asylums was too prohibitive. He argues that costs had risen in the US because workers

had become more unionised thus increasing wage rates and the unpaid labour of patients was no longer used. The consequences of this policy have been an unmitigated disaster for the mentally ill, who have been abandoned in (Scull's term) 'deviant ghettos'.

Whatever the debates about the causes of deinstitutionalisation, it is clear that it is a policy that has been widely adopted, for example, in North America, Western Europe and Australia and New Zealand (WHO 2001). The same report highlights that long-term facilities are still the most common form of service provision - 38% of countries worldwide have no community-based mental health services. This reflects the variation in the structure and delivery of health services throughout the world (Hicking, 1994; Mizuno, 2005; Ravelli, 2006).

The justification for the development of community-based mental health services is founded on a moral and a clinical argument. It is a combination of idealistic and pragmatic approaches. The idealism can be seen in the civil rights arguments that were put forward. Community-based services, it was argued, would by definition be more humane. Lamb and Bachrach (2001) argue that this was based on a moral argument with little empirical evidence to support it. The pragmatic element was one of cost. The idealistic approach did not fully address the issue of cost. It is notoriously difficult to cost health care effectively. The hidden cost of community care meant that large savings were not made immediately. In addition, the initial cost of resettling patients with very complex needs, who had often spent most of their adult lives in hospital, meant that for a short period community care would prove to be more expensive than institutional care.

The Hospital Plan (1962) is seen as the official commencement of the deinstitutionalisation policy in England and Wales. Its aim was to ensure that there would be a reduction in bed use from 5.4 per 1000 to 1.8 per 1000 over a fifteen year period to 1977. The result of the policy can be seen in the fact that in 1955 there were 151,000 patients in hospital and the figure had fallen to 71,000 in 1984. The policy of deinstitutionalisation can be divided into three distinct sections or phases. This is because the policy

is really an amalgamation of a series of policies aimed at distinct groups of patients.

The first phase of the implementation was the resettlement of groups of patients who had been long-term residents of the large asylums. This process has been portrayed largely as a success, certainly when compared to the media discussion of community care in the late 1980s and early 1990s. Leff and Trieman's (2000) study of 737 resettled patients from Friern and Claybury Hospitals found that there was actually little improvement in the symptoms or social behaviour of the group but that the patients appreciated their new-found freedom. This group of patients were more likely to have been in hospital for longer. The long-term effects of institutionalisation combined with the severity of illness meant that it would be likely that these patients would need the most support to adjust to their new living environment. This work confirmed that the adjustment could be made, but that this could only be achieved with high levels of support from multi-disciplinary teams. This cohort of patients were the most likely to have received the highest level of support. This supports the argument that the move to community care services was about switching the use of resources rather than reducing the level of investment. Lamb (1993) warned that good community care does not cost less. In addition, he suggested that though there were some good services in existence, they had, in fact, only served the needs of a very small proportion of the severely mentally ill.

Langley-Hawthorne (1997) suggests that schizophrenia is one of the most costly illnesses in terms of the impact on the economy. The illness usually has its first onset in early adulthood when individuals are beginning to establish themselves in the world of work or obtaining qualifications in further or higher education. This is clearly a crucial time and disruption can have long-term effects on life opportunities. Schizophrenia is a term that covers a range of symptoms. Any estimate of cost has to adopt a very general approach in an attempt to measure lifetime costs. This would allow for variations in the onset of illness, the extent of the symptoms and the various treatment programmes that are adopted. The overall outcome is a very negative picture. The Office of the Deputy Prime

Minister's (ODPM) report on Social Exclusion (2004) uses a range of measures to demonstrate that those suffering from long-term mental health problems are one of the most marginalized groups in society. For example, amongst people with disabilities those suffering from mental illness are most likely to be unemployed.

The second wave of deinstitutionalisation is the phase that is most associated with the failure of community care. The first group of patients that had been discharged from long-stay hospital had been fully engaged with services - this was, of course, a function of the nature of the regimes that they had endured. Following this group, there was a new cohort of patients. This group had not experienced the same institutional environment. Members of this group of patients were likely to have been in hospital for shorter periods. The weaknesses and shortfalls in the implementation of community care were identified at an early stage (Lamb, 1984; 1988). Baron (1981) highlighted the fact that the public's negative views of mentally ill people was a barrier to re-integration. In addition, the appearance of increased numbers of homeless people, who were clearly experiencing mental distress served to re-enforce this prejudice. Aviram (1990) argued that the crisis in community care in the US reveals the desire of society for social control. For most commentators, apart from those Scull or Foucault who see it as the same policy by different means, community care is seen as a progressive set of ideals. However, it should be noted that the main shift towards community-based services occurred following the fiscal retrenchment of the 1970s and early 1980s.

Conclusions

Galbraith argued in *The Affluent Society* (1999) that public investment is needed in social goods in areas of provision where the private sector will not invest. This provision could be in types of services or social goods for particular groups. If this investment fails to take place the result is 'private affluence, public squalor'. The modern civic and urban landscape has led to the reduction of public space and the policing/ surveillance of those spaces in

more punitive fashion. As Davies (City of Quartz) argues, the architecture of cities excludes the urban poor not just physically, but psychologically.

The paradox of deinstitutionalization is that a policy that has its roots in progressive ideals and an optimistic vision of community cohesion has resulted in a situation where the figure of the homeless, itinerant acutely mentally ill has become a constant feature of the modern urban landscape. If this is not depressing enough, this scar on modern social policy seems to be accepted largely uncritically.

One of the effects of deinstitutionalisation has been to increase the contact between those with mental health problems and the police and prison systems (Robertson, 1988; Singleton et al, 1998; Shaw et al, 2004)). In addition, Barr (1988) argues that the policy of 'zero tolerance', where civic authorities introduce a series of measures to tackle low level public order or nuisance offences, disproportionately impact on mentally ill people. As well as criminalizing homelessness, they serve to further embroil severely mentally ill people in the criminal justice and prison systems. Others have argued that the asylum has been replaced not by the community-based mental health services that were envisaged, but by bedsits, housing projects, day centres and soup kitchens (Moon, 2000; Wolch and Philo, 2000; Wolff, 2005). The argument here is that individuals are physically present in the community but are denied the opportunity to be active citizens. Many of their major social interactions are with professional staff. Other social outcomes such as physical health and employment are very poor (Brown et al, 1999). People with schizophrenia are likely to be the poorest members of industrialized societies (Eaton, 1980). Kelly (2005) uses the term 'structural violence' (adapted from liberation theology) to outline the interplay between economic and health factors combining to restrict the life chances of this group. In the UK, the Office of the Deputy Prime Minister's (OPDM) report on social exclusion highlighted the deeply entrenched nature of the barriers outlined above. In 1998, when launching a new start for mental health policy in England and Wales, the Secretary of State for Health, Frank Dobson, famously stated 'community care has failed' (DH 1998). Unfortunately, the

focus on the response to this has been a legalistic one that ultimately led to the introduction of community treatment orders. This approach does not tackle the fundamental underlying issues. A policy based on the civic values and ideas of a community engagement would be far too effective (Mental Health Foundation 1994). The failure of deinstitutionalisation has led to the further marginalization of people who are severely mentally ill.

References

- Aviram, U. (1990) 'Community care of the severely mentally ill: is social control a 'necessary evil' in policy making considerations'. *Psychiatric Quarterly*, 61(2), pp. 77-86.
- Baron, R.C. (1981) 'Changing public attitudes about the mentally ill'. *Hospital and Community Psychiatry*, 32(3), pp 173-178.
- Barr, H. (2001) 'Policing Madness: People with Mental Illness and the NYPD'. In Mardle, A. and Erzen, T (eds) *Quality of Life and the New Police Brutality in New York City*. New York. NYU Press.
- Barton, W.R. (1959) *Institutional Neurosis*. Bristol Wright and Sons.
- Bauman, Z. (1997) *Postmodernity and its discontents*. New York: NYU Press.
- Brown, B., Birtwhistle, J., Roe, L., Thompson, C. (1999) 'The unhealthy lifestyle of people with schizophrenia'. *Psychological Medicine*. 29, pp. 679-701.
- Davies, M. (1992) *City of Quartz: Excavating the Future in Los Angeles*. Department of Health (1998) *Modernising Mental Health Services sound safe and supportive*. London HMSO.
- Eaton, W.W. (1980) *The sociology of mental disorders*. New York. Praeger.
- Fallon, P. (Chair) (1999) Report of 'the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital'. London, HMSO.
- Foucault, M. (1977) *Discipline and Punish*. London: Penguin.
- Giddens, A. (1991) *The consequences of modernity*. Cambridge: Polity Press.
- Gilmour, I. (1992) *Dancing with Dogma: Britain under Thatcherism*. London: Simon and Schuster.
- Gittins, D. (1988) *Madness in its Place*. London: Routledge.
- Goffman, E. (1968) *Asylums: essays on the social situation of mental patients and other inmates Harmondsworth*: Penguin.
- Hicking, F.W. (1994) 'Community Psychiatry and deinstitutionalization in Jamaica'. *Hospital and Community Psychiatry* 45(11), 1122-1226.

- Ignatieff, M. (1985) 'State, Civil Society and Total Institutions'. In Cohen, S., Scull, A. (eds) *Social Control and the State: historical and comparative essays*. Oxford: Blackwell.
- Kelly, B. (2005) 'Structural violence and schizophrenia'. *Social Science and Medicine* 61, 721-730.
- Kesey, K. (1963) *One Flew Over the Cuckoo's Nest*. London: Methuen.
- Kimhi, R., Barak, Y., Gutman, J., Melamed, Y., Zohar, M., Barak, I. (1998) 'Police attitudes toward mental illness and psychiatric patients in Israel'. *Journal of American Academy of Psychiatry and the Law*.
- Laing, R. (1959) *The Divided Self*. London: Tavistock.
- Laing, R. (1967) *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin.
- Lamb, H.R. (1984) 'Deinstitutionalisation and the homeless mentally ill'. *Hospital and Community Psychiatry* 35(9), 899-907.
- Lamb, H.R. (1988) 'Deinstitutionalisation at the crossroads'. *Hospital and Community Psychiatry* 39(9), 941-945.
- Lamb, H.R. (1993) 'Lesson learned from the deinstitutionalization in the US'. *British Journal of Psychiatry*.
- Langley-Hawthorne, C. (1997) 'Modeling the Lifetime Costs of Treating Schizophrenia in Australia'. *Clinical Therapeutics* 19(6), 1470-1495.
- Leff, J., Trileman, N. (2000) Long-stay patients discharged from psychiatric hospital. *British Journal of Psychiatry*, 176, 217-223.
- Martin, J.P. (1985) *Hospitals in Trouble*. Oxford: Blackwell.
- Mental Health Foundation (1994) *Creating Community Care: Report of the Mental Health Foundation Inquiry into Community Care for People with Severe Mental Illness*. London: The Mental Health Foundation.
- Mizuno, M., Sakuma, K., Ryu, Y., Munakata, S., Takebayashi, T., Murakami, M., Falloon, I.R., Kashima, H. (2005) 'The Sasagawa project: a model for deinstitutionalisation in Japan'. *Keio Journal of Medicine* 54(2), 95-101.
- Moon, G. (2000) 'Risk and protection: the discourse of confinement in contemporary mental health policy'. *Health & Place* 6, 3, 239-250.
- Murphy, E. (1991) *After the Asylums: community care for people with mental illness*. London.
- Nye, R. (2003) The evolution of the concept of medicalisation in the twentieth century. *Journal of the History of Behavioural Sciences*, 39(2), 115-129.
- Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London, HMSO.

- Pilgrim, D. and Rogers, A. (1999) *Sociology of Mental Health and Illness*. Buckingham: Open University Press.
- Ravelli, D. (2006) 'Deninstitutionalisation of mental health care in the Netherlands: towards an integrative approach'. *International Journal of Integrative Care*, Vol. 6.
- Robertson, G. (1988) 'Arrest patterns among mentally disordered offenders'. *British Journal of Psychiatry* 153, 313-316.
- Rothman, D. (2002) *The discovery of the asylum: social order and disorder in the new republic*. New York: Aldine de Gruyter.
- Scott, R.D. (1973) 'The treatment barrier: Part 1'. *British Journal of Medical Psychology*, 46, 45-53.
- Sedgwick, P. (1982) *Psychopolitics*. London: Pluto Press.
- Scull, A. (1977) *Decarceration: Community Treatment and the Deviant - A Radical View*. Englewood Cliffs, NJ: Prentice-Hall
- Scull, A. (1986) 'Mental patients and the community: a critical note'. *International Journal of Law and Psychiatry*, 9, 383-392.
- Scull, A. (1989) *Social Order/mental Disorder: Anglo-American Psychiatry in Historical Perspective*. Berkeley: University of California Press.
- Seddon, T. (2007) *Punishment and madness: governing prisoners with mental health problems*. Routledge-Cavendish,
- Shaw, J., Baker, D., Hunt, I., Moloney, A., Appleby, L. (2004) 'Suicide by prisoners'. *British Journal of Psychiatry*, 184, 263-267.
- Singleton, N., Meltzer, H., Gatward, R. (1998) 'Psychiatric Morbidity among Prisoners in England and Wales'. London, HMSO.
- Stone, L. (1982) *An Exchange with Michel Foucault*. New York Review of Books.
- Szasz, T. (1963) *Law, Liberty and Psychiatry*. New York: Macmillan.
- Szasz, T. (1971) *The Manufacture of Madness*. London: Routledge and Kegan Paul.
- Wacqaunt, L. (2009) *Punishing the Poor: The Neo-liberal Government of Social Insecurity*. London: Duke University Press.
- Wing, J. (1962) 'Institutionalism in mental hospitals'. *British Journal of Social and Clinical Psychology*, 1, 38-51.
- Wing, J. (1978) *Reasoning about Madness*. Oxford: Oxford University Press.
- Wolch, J., Philo, C. (2000) 'From distributions of deviance to definitions of difference: past and future mental health geographies'. *Health and Place*, 6(3), 137-157.
- Wolff, N. (2005) 'Community reintegration of prisoners with mental illness: a social investment perspective'. *International Journal of Law and Psychiatry*, 28, 43-58.



Peer-reviewed paper

Distant voices, still lives: reflections on the impact of media reporting of the cases of Christopher Clunis and Ben Silcock

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Abstract

One of the main features of the reform of the *Mental Health Act 2007* was the introduction of community treatment orders (CTOs). CTOs represent a fundamental shift in the rights of people with severe mental health problems, who have been detained in hospital under section 3 of the *Mental Health Act* and subsequently discharged. The call for the introduction of CTOs or similar legislation has been a feature of mental health policy over the past 20 years. Despite the detailed discussion of the relationship between ethnicity and psychiatry, there has been very little attention paid to the way that race was a factor in the community care scandals of the 1990s. This article, through the consideration of two very high profile cases – Christopher Clunis and Ben Silcock, explores the media's influence on the construction of the debate in this area. In particular, it explores the way that the media reporting of the two cases had a role in not only perpetuating racial stereotyping, but also the stigmatising of those experiencing acute mental health problems. In addition, with the use of government papers obtained under the *Freedom of Information Act*, it considers the response to and the attempts to influence the media debate at that time.

Key words

Race; media; deinstitutionalisation; mental health problems.

Introduction

Attitudes towards mental health problems, despite a number of campaigns (Royal College of Psychiatrists (RCP), 2008), remain very negative (Wolff, 1997). Within these negative stereotypes, one of the most dominant views is that people with mental health problems are potentially

violent and/or dangerous. The mass media has a very important role to play in the construction and continued maintenance of these beliefs. Violent crime is rare and so is the likelihood that an individual will have direct contact with an incident. However, culturally violent crime is a dominating theme or area of interest – as a

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quick glance at the newspapers, TV schedules or the book bestsellers list will demonstrate. The stereotype of the 'deranged serial killer' or 'mad axe man' seems to hold a powerful sway on the public imagination. This paper will explore the way that the media, in particular the print media, reporting of two high profile cases involving mental health policy has helped to support and sustain this emphasis on the stereotypical view that people with mental health problems are violent. It will also explore the issue of race and psychiatry via the reporting of the *Inquiry into the Care and Treatment of Christopher Clunis* (Ritchie, 1994). In addition, it will consider the way that the construction of the debate helped to shape mental health policy culminating in the reform of the *Mental Health Act 2007* and the introduction of community treatment orders (CTOs).

Mental illness, stigma and the media

The Office of the Deputy Prime Minister's (ODPM) report on social exclusion (2004) uses a range of measures to demonstrate that those suffering from long-term mental health problems are one of the most marginalised groups in society. For example, among people with disabilities, those suffering from mental health problems are most likely to be unemployed. In addition, there is clearly a social stigma attached to mental health problems. There is a paradox here. The modern media is awash with individuals willing to put their most personal traumas on display for public consumption. The new narrative of celebrity is not complete without a battle to overcome some childhood trauma or adult addiction, preferably including a stay in a specialist clinic. Despite this very public display, attitudes to mental illness in the general population are still very heavily influenced by stereotypical attitudes. In addition, these attitudes seem to remain entrenched, despite the fact that more of the general population is seeking help for mental health-related difficulties.

The mass media and increasingly new media are the main sources of information for the majority of the population. The broadcast media has a general duty to remain impartial. Newspapers are more openly political with clear social agendas, which they think will reflect those of their readers and help to attract new ones. The charge against the media is that it perpetuates a series of negative stereotypes. These can be summarised as:

- 'people with mental health problems are violent'
- 'there are no effective treatments for mental illness'
- 'mental health problems are the result of personal weakness'.

Philo and colleagues (1996) argued that two-thirds of the stories that they examined were concerned with a person with mental health problems being violent in some way. A later study by Rose (1998) supported this finding and emphasised the way that the majority of reports relating to people with mental health problems were actually crime news reports. Apart from the 'celebrity confessional', there is little coverage in the media given to the experiences of service users, family members or carers.

Stigma has wide-ranging impacts, including on self-esteem, job and housing opportunities and family and personal relationships (Wahl, 1995). In addition, it also means that people will be reluctant to seek help from mental health services. The long-term effect is that mental health services, which probably have more to offer in terms of effective interventions than ever before, have not thrown over the images of straight-jackets and men in white coats.

Deinstitutionalisation

The policy of the closure of large psychiatric hospitals – 'deinstitutionalisation' – has been pursued across developed societies. The policy has its roots in the challenges to the power of psychiatry and psychiatric institutions that were a feature of the 1960s. As Sedgwick (1982) argues, the anti-psychiatry movement was international. The result was that there were a set of local and national influences at play. The emergence of 'anti-psychiatrists' such as Laing, Cooper and Szasz (Hopton, 2006) reflected this. It would be inaccurate to describe them as a group and only Cooper accepted the label of anti-psychiatrist. However, the themes that emerged in their work challenged the nostrums of the psychiatric profession. Psychiatry finds itself in an unusual position in modern medicine in that treatment can be imposed against the will of the patient. This group of thinkers was concerned to develop a form of psychiatry that would adopt a much more holistic approach, which looked at the social causes of distress that their patients were suffering. This would necessarily involve a

paradigm shift from the institutional, coercive, pharmacological care that dominated at that time to a voluntary, more psycho-dynamic, social and community-based mode of service. Szasz (1963; 1971) is an exception here. His arguments stem from a libertarian position, which leads to the conclusion that psychiatric diagnosis is a process, which not only allows the State to restrict the liberty of individuals, but also allows others to escape responsibility for their actions.

As Goffmann (1968) identified, the physical conditions in asylums involved the loss of individuality and exercise of choice that form the basis of citizenship in a liberal democratic society. Barton (1959) identified the effects of these regimes as creating '*institutional neurosis*'. He identified similarities between the behaviour of psychiatric patients and survivors of concentration camps – it is impossible to imagine a more damning indictment of an allegedly therapeutic regime. These findings were later supported by Scott (1973) who highlighted the levels of passivity and apathy among patients. The 1970s saw a series of scandals at long-stay hospitals. Martin (1985) highlights the way that closed institutions have the potential to become abusive environments. These include the lack of privacy and autonomy for patients. Large staff to patient ratios make it impossible to develop a functioning therapeutic environment. Staff received very little training and were largely isolated from mainstream services and the development of practice. In addition, in a number of institutions, staff were largely recruited from a small geographical area or local community. These factors combine to produce an environment where abuse can occur and if it does then there are no systems to challenge them. The development of community care can be seen as part of a wider development in liberal democracies where marginalised and discriminated against groups challenged these established norms. In 1955, there were 151,000 patients in psychiatric hospitals in England and Wales. Enoch Powell, as the then Secretary of State for Health, in the 1962 *Hospital Plan* announced that the long-term aim was to close these institutions. By 1984, there were 71,000 inpatients. Leff and Trieman (2000) argue that the first wave of community care was largely seen as a positive move. This period saw the resettlement of long-stay patients with improved quality of life and social functioning for the individuals.

A number of themes in policy come together in the development of 'community care'. Pilgrim and Rogers (2010) identify these as: the failure of the asylum model of care, advances in medication, the number of scandals in hospitals and the cost of asylums themselves. The overall aim was to replace institutional-based care with a series of community-based alternatives, including supported housing, crisis centres, social work and community mental health nursing teams with hospital-based care remaining as a back drop for those in the most acute distress. A similar shift has occurred in the organisation of services for physical illness. In addition, it was argued that these changes would allow for individuals to enjoy the rights of citizenship in the same ways as others. Scull (1977; 1986; 1989), a trenchant critic of the whole policy throughout his work, has pointed out that the term itself is a fine example of the Orwellian use of language. In its repeated use it becomes debased. The original progressive ideas behind the policy have been lost. The term has come to represent the complete opposite of its original meaning.

The policy of deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of people with mental health problems, did not achieve its utopian aims. Wolff (2005) argues that 'the asylum' has been replaced by a fragmented, dislocated world of bedsits, housing projects, day centres or, increasingly, prisons and the criminal justice system. This shift has been termed '*transinstitutionalisation*'. This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them. Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor. Kelly (2005) uses the term '*structural violence*' – originally from liberation theology – to highlight the impact of a range of factors that impact on this group, including health, mental health status and poverty.

The 1980s saw the continuation of the hospital closure programme and the resettlement of long-stay patients. The response of successive governments since the early 1980s to the developing crisis in the provision of mental health services was to focus on the legislative and policy framework. The main themes of these developments are moves to more systematic surveillance of patients and the audit of mental

health professionals. For example, following the 1993 *Guidance on the Introduction of Supervision Registers*, people who were considered to be 'at risk of harming themselves or other people' could be placed on a supervision register, with the aim of ensuring that they remain in contact with mental health services. HSG (94)/27 established that inquiries must take place following a homicide by a person with previous contact with mental health services. In 1995, the *Mental Health (Patients in the Community) Bill* introduced 'supervised discharge', which can be seen as an unsuccessful form of CTO. These measures were directed at a very small group of patients. However, there were wider policy developments that reflected similar themes. The Care Programme Approach was an attempt to ensure that services were more effectively co-ordinated. In itself this is clearly a good thing. However, the focus on these changes were largely internal. They reflect the wider shift to the risk society (Beck, 1992). In 1992, the UK government established the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. From a social work perspective, these policy changes, when combined with a shift to a care management or brokering role of service provision, have seen a fundamental change in focus. As Turner and Columbo (2008) argue, risk and risk management *not* notions of care have become the central hub for all service user contacts. There have been a series of developments such as home treatment, crisis resolution, child and adolescent mental health services (CAMHS) and early intervention schemes (Glover, 2006) which, it could be argued, reflect the earlier values of the community care ideal.

Data sources

For the media search, I carried out an electronic search using the Infotrac search engine. This provides access to a range of newspapers including: *The Guardian, The Observer, Independent, Daily Mirror, Times and Sunday Times, Daily Telegraph and Sunday Telegraph, Daily Mail* and the Press Association. I felt that this range would cover a sufficient range of opinions. I carried out similar searches on the BBC and other media outlets. The newspaper searches covered the period December 1992 to May 2006. This period was chosen as it began with the initial events but went on to cover the stages of the reform of the *Mental Health Act* (1983). I simply used the names of the two main individuals. This generated 655 articles for

Christopher Clunis and 51 articles for Ben Silcock. I wanted to explore not only the reporting of these two cases but also the subsequent media contexts in which they appeared. At this point, I did not explore the wider academic literature examining the issues raised. I then used the Nud*st software to analyse the contents of the articles. This allows searching for particular terms or combinations of terms. The main searches concentrated on: violence, mental illness, race and compulsory treatment. In my analysis of the newspaper coverage, I also grouped the publications into three categories: broadsheet, mid-market and tabloid and the placement of the articles into: editorial/comment, news or feature articles.

Christopher Clunis and the murder of Jonathan Zito

I will now examine separately the reporting of the cases and link that to the advice that was being given to the Secretary of State. One reason for choosing these two cases is the fact that they occurred in such a short period of time. The other is the contrast between the reporting of the two cases. In the case of Ben Silcock, the emphasis is placed on the way that mental health services had failed him and his family. The failure is to provide adequate treatment. The reporting is very sympathetic to the struggles that he and his family faced in dealing with what is portrayed as an essentially uncaring and bureaucratic system. The reporting in the Christopher Clunis case has focused on the failure of mental health services to protect the wider community. It is also argued that the emphasis in reporting reflects racial and class divisions with the voice of a black working class family being effectively marginalised. Hallam (2002) has looked at this area in terms of the possible direct effects on mental health policy. She concludes it is not possible that there is a direct cause and effect, although she does not focus on the issue of race in her discussion of the Clunis case. I will be using the media reporting of the case as a means of analysing attitudes to race, mental illness and ongoing inequalities in health and social care.

The first report of the stabbing of Jonathan Zito appeared in *The Times* on 19 December 1992. This was a very brief outline of Christopher Clunis' first appearance in court. The only details that were provided were that he was 19 years old and unemployed. A similar report was provided by the Press Association when the committal

hearing took place in February 1993. The case did not become a cause célèbre until the verdict in Christopher Clunis' trial in June 1993.

The reports of the outcome of the trial played on a series of deeply entrenched stereotypes that have characterised the portrayal of black men in general and those with mental health problems in particular. The stereotype of '*big, black and dangerous*' (Prins, 1993) is deeply engrained in mental health services and wider society (Wacquant, 2005). There is not the space here to fully explore the literature in the field of race and psychiatry. However, the key themes that emerge are:

- psychiatry has a historical role in the construction of racist stereotypes (Fernando, 1988)
- the over-representation of African-Caribbean service users among detained patients (Cope, 1989) – this work covers a period when Christopher Clunis was first in contact with mental health services
- black people are generally treated in a more coercive fashion within mental health systems, including forensic services (Fernando *et al*, 1998; Lelliot *et al*, 2001).

Prospero and Kim (2009) suggest that there is a wider impact of increased coercion on services and their relationship between minority communities. If services are seen as sites of coercion and risk, then those from minority communities will not seek out professional help at an early stage. Secker and Harding (2002) have highlighted that black service users' experiences are scarred by racist attitudes and behaviour. Christopher Clunis was not the only black man whose treatment was the subject of a community care scandal in the early 1990s. Heginbotham and colleagues' inquiry (1994) into the care and treatment of Michael Buchanan is another example. There are clear echoes of the Clunis case here, including the corrosive effects of racism – services construct black men through a lens of dangerousness while service users see services as coercive and to be avoided. Wacquant (2005) highlights the way that, despite the increasing removal of overtly racist terms from public discourse, the underlying assumptions underpinning these views remain.

The Press Association report of 28 June 1993 encapsulates the style, tone and content of most

of the reporting and subsequent comment. A binary opposition is established between Jonathan Zito – a '*talented musician*' and the '*powerfully built*' '6ft 4in' Clunis who '*was free to roam the streets despite his history of violence and mental illness*'. This reporting plays to a series of assumptions about black men that are never far from the surface – an emphasis on size, physical prowess, uncontrollable nature and the threat that they pose to the wider society. This also demonstrates the way in which the social construction of two issues intersect. The first is the issue of race and young black men as '*dangerous*' (Wacquant, 2005). The second is the representation of the people with mental health problems as violent. The reporting of community care in the early 1990s has the features of a moral panic (Cohen, 1973). Cohen (1973) describes its characteristics as '*a condition, episode, person or group of persons [who] become defined as a threat to societal values and interests*'. A response follows where those in power man '*the moral barricades*'. In this case, the media debate was dominated by calls for a change in the law. This was a move that governments from the late 1980s onwards supported.

The most dominant media image of Christopher Clunis is the picture shown in *Figure 1*. This picture was taken as he was being driven away from court having been sentenced for manslaughter. In the picture, he appears to be heavily medicated but this is not commented on. The picture is used to suggest his lack of remorse. It also allows for a racist message to be put across but without explicit racist language being used. The only element missing from this portrayal is black male sexuality. This link has been made subliminally in the media's subsequent portrayal of Jayne Zito (Neal, 1998). (I should emphasise that this is not in any way a criticism of the actions of the Zito family, which is, of course, not responsible for the racist ideas of journalists. The

Figure 1: The most dominant image of Christopher Clunis



Reflections on the impact of media reporting of the cases of Christopher Clunis and Ben Silcock

attempt to marginalise the suffering of families caught up in such awful events is one of the more tawdry features of the response of the libertarian Left, such as McLaughlin (2001) to the collapse of community care services in the 1990s.)

Echoes of the portrayal of Christopher Clunis can be found in a wide range of popular and historical sources (Litwack, 1980) and literature (Wright, 1940). Gilroy (2002) has highlighted the struggle to establish 'black Britishness'. The demonising and dehumanising process that began with the reports of Christopher Clunis' conviction has continued ever since. At regular points since June 1993, his name has featured in media reports. He has become a cipher. The extent and effect of this process is demonstrated by the number of articles that were found during my literature search. The overwhelming majority were not actually about Christopher Clunis but his name was used as shorthand for a narrative of community care. In addition to the racist nature of the reporting, another set of assumptions followed. The case was subsequently mentioned in relation to other violent crimes. The result is a simplification of a number of very complex issues. However, if one relied solely on the mainstream British media for information, one would be forced to conclude that people with mental health problems are homicidal; community care has let loose a feral group of patients, who refuse to take medication, which would prevent all these tragedies. This state of affairs has been brought about by an unholy combination of liberal social workers, psychiatrists and the 'civil rights lobby'. The solution is for the law to change so that medication can be forced on individuals living in the community.

Despite the strenuous campaigning efforts of a range of organisations and professions, including social workers, mental health policy debates continued to be dominated by the above paradigm of responses to it. The reform of the *Mental Health Act* (1983) illustrates this. The mass media is obviously very influential and powerful. However, media assumptions have been challenged by, for example, the Sainsbury Centre for Mental Health (Care Services Improvement Partnership (CISP)/Shift, 2006). The issue is the relative power of the organisations involved. It would be a mistake to ignore the powerful challenge mounted by black service user groups to the failings of mental health services. Black Mental Health UK was established in 2006 as an umbrella organisation for a number of groups

working to tackle the racial inequalities in this field. I use this example to give an example of some of the work done on a national and local level by dedicated community activists. One should not underestimate the courage of individual carers such as Clara Buckley – the mother of Orville Blackwood who was killed at Broadmoor Special Hospital. The *Inquiry into the death of David 'Rocky' Bennett* would not have come about without the campaigning efforts of his sister Dr Joanna Bennett.

In the discussion of the Ritchie Inquiry (Ritchie, 1994), there is a focus on organisational failures. The final report does contain background information about Christopher Clunis' family and other personal details. The media does not use these details to paint the more complex picture of him as a human being. This is a failure of imagination that the agencies involved in his care also made. An assumption was made that he had no contact with immediate family members. The report highlights that his family were not contacted at the time of *Mental Health Act* assessments. However, Christopher Clunis' sister did visit him. The Audit Commission (1994) report on community care services contains a letter from a man who owned a record shop where Christopher Clunis had been a regular customer before the onset of his mental health problems. The image is a stark contrast to the one that dominates in the media. He is described as a gentle, unassuming individual who was a very talented jazz musician. The story of how he went from this to the disorientated figure being driven away from the Old Bailey is not explored. In the coverage that I examined, there was only one article (*The Independent* on 19 July 1993) that considered these issues in any real depth.

Butler and Drakeford (2005) demonstrate not only the importance that individual scandals can have on the development of social policy, but also the reasons why particular cases become scandals. They emphasise that this process is the result of a confluence of factors: such as the nature of the event, the relationship between the victim and perpetrator and if an individual takes on the role of 'whistleblower'. Here, Jayne Zito took on this role by campaigning for an Inquiry.

In all of the newspaper reporting of the events leading to the murder of Jonathan Zito, there is an implicit assumption that Christopher Clunis was willfully refusing to co-operate with the agencies trying to provide him with the mental health care he clearly needed. The issue

of responsibility is a complex one. The decision in the legal action that Christopher Clunis subsequently took indicated that the Courts felt that he should be responsible for the failures in his care. This is a partial version of the truth. The most highly-funded, well-resourced, staffed and trained community mental health team might have found it difficult to engage Christopher Clunis because of the nature and severity of his mental health problems.

Modernising Mental Health Services: Sound, safe and supportive (Department of Health, 1998) makes it clear that mental health services were at the point of collapse in the major cities in the early 1990s. The Ritchie Inquiry (Ritchie, 1994) contains examples of good social work practice but these have to be placed in a context of systemic breakdown where individual practitioners are overwhelmed. In these circumstances, practitioners are expected to manage large caseloads, work with individuals with highly complex needs using very limited resources. Given this set of circumstances and the nature of his illness, it would be difficult to maintain that Christopher Clunis's frequent moves were part of a plan to avoid the tentacles of the therapeutic state. Another striking feature of the newspaper coverage was the way that this case was used as shorthand for the failings of community care or linked to other cases, which had little in common. For example, the *Newcastle Evening Chronicle* of 23 April 2005 carries a report of the trial of a man sentenced to life for rape. He had been on leave from a secure unit at the time of the offence. He had been sent to the unit following previous violent offences against women. There is little common ground between this event and the murder of Jonathan Zito.

Ben Silcock and the lions' den

The appearance of Ben Silcock in the world's media could have hardly been more dramatic. The picture of him in the lion's den at London Zoo appeared in virtually all the national newspapers on 1 January 1993. It was subsequently picked up and appeared around the world (eg. *Vancouver Sun* 2 January 1993). Most bizarrely some of the initial reports (eg. *Daily Mail* 1 January 1993; *Times* 2 January 1993) seem more concerned with the welfare of Arfer the lion than Ben Silcock. The *Daily Mail* assured its readers that there was no question of Arfer being put down and that 'British

zoos have an outstanding safety record'. It is a week later that the case becomes a campaigning issue for the *Daily Mail*. On 8 January 1993, the article that led to the briefing note I received was written.

The Silcock case was followed up by the *Daily Mail* at various points in the next five years. The contrast with the coverage of the Clunis case could not be starker. There is a clear agenda established that ties in with the well-established social views of the newspaper. In the setting of this agenda, Marjorie Wallace of SANE and a friend of the Silcock family have an important role. Marjorie Wallace is constantly called upon to pass comment on community care issues as a representative of carers and families without any suggestion that, as with all groups, there are a range of views. In SANE's view, families have been excluded from decisions about their relatives care. For the *Daily Mail*, this is another example of the way that 'political correctness' has come to dominate public discourse. Patient's rights have been given too high a priority with the inevitable results. Following this line of argument, the pendulum has swung too far in favour of individual rights. The other key feature of the social agenda that this case is used to support is the dangerous effects of cannabis use. In interviews with Mr Silcock and other members of his family, references are made to the changes in his personality that followed his drug use.

The overall impression of the coverage of the Silcock case is of a close loving family struggling to cope not only with the effects of a family member suffering from a terrible illness, but also trying to negotiate its way through a labyrinthine uncaring bureaucracy. This can be contrasted with the total absence of the Clunis family from the reporting of his case. On 9 September 1993, Ben Silcock was made subject to a section 37/41 order under the *Mental Health Act* (1983) following his conviction for attacking two police officers at a police station with a Stanley knife. Both *The Times* and the *Daily Mail* report the case highlighting the judge's comments about the effects of cannabis on Ben Silcock's mental health. The following day an interview with Sheila Silcock appeared in the *Daily Mail*. The interviewer was Marjorie Wallace. In the interview, Mrs Silcock outlines the difficulties that the family had faced in trying to obtain treatment for their son. The portrait is one of official indifference – social services did not want to get involved, doctors refused to act unless Ben Silcock approached them personally and to do otherwise

would have breached his civil rights. This is presented as the norm. The counter argument that these are actually examples of unacceptable practice that breach the *Mental Health Act* (1983) and the *Code of Practice* is never advanced. The following day an interview with Ben Silcock himself appeared, which is more positive, now that he is co-operating with treatment. It is somewhat unusual for the *Daily Mail* to carry sympathetic interviews with people who have been convicted of assaulting police officers.

There was a sharp contrast in the general approaches adopted by the different sections of the media. The coverage in the broadsheets was more heavily concentrated in the editorial/comment sections. This focused on the policy implications with the liberal *Guardian* and *Independent* calling for greater investment, while the conservative *Times* was more critical of the legislative framework. The bulk of the mid-market coverage was in the *Daily Mail* as the result of its campaign on the Silcock case. For the tabloid press, the initial picture of Ben Silcock in the Lions' den was not followed up in the same way that the *Daily Mail* followed the case. This is contrasted with the continued use of the Clunis case as a, largely inaccurate, point of reference.

The government response

Having examined the cases and the media coverage, I will now move on to discuss the documents that I have obtained under the *Freedom of Information Act* (2001). These documents are a series of briefing papers for the Secretary of State for possible parliamentary questions and a meeting with Mr Silcock. The role of the civil service here is to provide advice and guidance including consideration of expert opinion. These briefings were not party political documents, although the political context of the time needs to be considered. The Major Government had been rather unexpectedly re-elected in April 1992. However, the administration soon came under pressure in a number of areas. It came to be seen as ineffectual and unable to command the policy agenda. It had lost the uncritical support of some of its major supporters in the press. The coverage of 'community care' had largely been very negative. It was always associated with mental health issues, which is, of course, only a small part of community care. The Secretary of State for Health in this period was Virginia Bottomley, who prior

to entering politics had worked as a psychiatric social worker.

The advice in the Silcock case is a rebuttal of an editorial '*A shaming indictment of civilized society*' that appeared on 8 January 1993. The article claims that schizophrenia was not news until the *Daily Mail* 'discovered' Ben Silcock's story. It then suggests that '*There are hundreds of thousands – yes hundreds of thousands – of Ben Silcocks in our land*'. The piece brings together the themes identified that will recur – poor care, the burden placed on families and carers, the indifference of services. It concludes with a seven-point plan. In the week between the first report of the case and this article, the Secretary of State had already announced that a review of the *Mental Health Act* (1983) would take place. This review would consider the compulsory treatment in the community. In many ways, this is a politician's nightmare: a very high profile case calls for action but the real solutions are found in the long-term investment and development of service provision. The advice is really a primer on the development of community-based mental health services. In the newspaper coverage, the impression is always given that community care only began in the early 1990s. This is clearly not the case.

The briefing documents I have seen highlight the increased resources that have been pumped into mental health services, including: a rise in the number of CPNs (1,100 in 1981 to 3,600 in 1991), the mental illness specific grant was introduced in 1991 and in 1991/1992 it was £21 million supporting £30 million expenditure, increases in the numbers of psychiatrists and the development of day centre places. It has long been acknowledged that mental health services have been an under-resourced area of health and social care spending so these figures have to be examined in that context. The advice also contains a brief overview of schizophrenia. As the guidance notes there is a positive policy here of sustained investment in a long neglected area of health provision. This is an investment that took place in a period of reduced public spending. This story was not one that the media was keen to tell. As Muijen (1995) argues, the '*moral panic*' over community care had taken hold at this point.

The guidance that I have obtained in the Clunis case is in the form of three briefing papers that relate to community treatment orders or supervised discharge. The standard way of briefing the Secretary of State is to suggest 'lines to take' (questions and answers). I have assumed that the

questions could be raised in both parliamentary and media forums. The briefings do not include any specific political advice such as an attack on opposition policies. The advice is therefore a series of technical points looking at the implementation of supervised discharge and the use of the *Mental Health Act*. The guidance reflects the belief that the level of resources was not the most significant issue. The focus is on legal and bureaucratic systems for the management of those patients with the most complex needs. This is a feature of the development of mental health policies throughout the 1990s (CPA/supervision registers, supervised discharge) right up to the reform of the *Mental Health Act* (1983) itself. The recommendations of the Ritchie Inquiry and the review of mental health law that took place in January 1993 were very much in agreement on this point. This formed the basis for subsequent policy and legal developments such as supervision registers and the additional to the *Mental Health Act* (1983) that introduced supervised discharge. No real challenge is mounted to the debate as it has been framed by the print media. The issues of race, racism or the experiences of black people and their families are not addressed in any of the documents that relate to the Clunis case.

The above policy developments can be viewed as attempts to introduce community treatment orders by the backdoor. They only served to reinforce the prejudices outlined above. The real causes of the calamitous failures of community care that the Clunis and Silcock cases represent can be found in poorly organised, under-funded services, particularly in inner-city areas, struggling to support individuals with severe mental health problems. An argument that New Labour accepted. As both the Clunis and Silcock cases illustrate, this situation has been exacerbated by other deeply entrenched social problems including drug misuse and poor or inadequate housing. However, both the media and government responses come to focus on the legal framework. It would be difficult to sustain a case that the *Mental Health Act* (1983) had actively prevented professionals from intervening in either of the cases discussed. The failures are to be found in organisational structures unable to cope with the level of responsibility that they were required to exercise.

Conclusion

It was not until Frank Dobson launched *Modernising Mental Health Services: Sound, safe*

and supportive (Department of Health, 1998) that an official acknowledgement that community care services had failed the most marginalised and vulnerable members of the community was forthcoming. It is interesting to note that the issue of race was not addressed in policy terms in *Modernising Mental Health Services: sound, safe and supportive*. It was only after the *Inquiry into the death of Rocky Bennett* that the issues of racism in mental health services were moved higher up the policy agenda. The civil service advice that I have seen, was an attempt to shore up a position. The Secretary of State sought to defend a policy that was being attacked on all sides and was also the subject of a vitriolic media campaign. In addition, the government endorsed the view that the 'rights agenda' had taken over policy development. In these circumstances, the response was a move towards more coercive and restrictive legislation. This allowed mental health policy debates to become dominated by the high profile cases, which are, of course, totally unrepresentative of the needs of the majority of those experiencing any form of mental illness. The civil service advice that I have seen does contain some attempts to challenge the stereotypes that dominate media reporting. However, my analysis of subsequent reporting shows that its influence was, at best, marginal. The nature of the reporting did not change. The only positive elements were found in *The Guardian* or *The Independent* – newspapers that one would expect to support progressive social policies. It might be naivety or misplaced optimism to imagine that governments can actually successfully challenge the view that the media chooses to take of mental illness. As social work knows to its cost, for some media outlets bad news is the only story.

It is now over 15 years since the first appearance of Ben Silcock and Christopher Clunis in the British media. However, in the analysis that I have carried out of newspaper coverage, they seem to be inextricably linked as symbols or shorthand for a particular view of the shortcomings of community-based mental health services. This is a view that suggests these services have been too dominated by a rights agenda, which means that families are pushed to the margins in decision-making and professionals can only act in the most extreme circumstances. From this perspective, the solution lies in a cultural shift – which should be part of a wider challenge to the rights agenda – and more coercive legislation.

Reflections on the impact of media reporting of the cases of Christopher Clunis and Ben Silcock

The eventual reform of the *Mental Health Act* has reflected this. The tortuous path of reform has led to divisions among service user groups. The Zito Trust and SANE were both very supportive of community treatment orders. In fact the Zito Trust closed when the legislation was passed.

One very significant move in the 15 years since these events has been in the official response to the issues of race and mental health problems. As Browne (2009) argues, black people are still over-represented within mental health and the criminal justice systems. As he rightly points out, within mental health services this includes over-representation at every level from informal to formal admissions to special hospitals. The Ritchie Inquiry (1994) sidesteps this point. It is actually contradictory, in that it states it can find no evidence that the colour of his skin influenced the care that Christopher Clunis received. It is a denial of the nature of modern society and the lived experiences of black citizens. This is undermined by the inquiry's findings that agencies were too quick to label Mr Clunis as difficult to engage because of his physical stature or to assume that his mental illness was linked to drug misuse. Both of these attitudes are actually based on the oldest, crudest most racist stereotype of black men. The way that racist ideas can influence critical decisions is illustrated by one vignette from the report when nursing staff decide not to inform housing staff of Christopher Clunis's fascination with knives as they think housing staff will label him as '*big, black and dangerous*' (Prins, 1993). This action is risibly defended on the grounds that if other agencies had the information *they* would act in a racist way. There is some sort of tortuous logic buried in this reasoning. However, it is clear that racist attitudes and their projection onto others have played a role in the decision-making process. These attitudes, no doubt, persist. However, following the *David Bennett Inquiry*, the response was more akin to the Macpherson Inquiry into the murder of Stephen Lawrence. *Delivering Race Equality in Mental Health* is a programme of action to tackle the underlying issues of race and to improve the experiences of black mental health service users.

The guidance did not itself contain anything that was particularly unexpected. However, it lacks a plan for challenging the myths that had become so deeply entrenched in the media coverage. This is always going to be a difficult issue. The media focuses on individual cases but politicians cannot respond in this way for

a variety of reasons – for example, they cannot breach patient confidentiality and do not want to be seen as being unsympathetic to families. The other factor here is that the Government of the day shared some of these views as the subsequent policy developments demonstrated.

The problems that have dogged the development of community-based mental health services are a long way from being solved. Regrettably, these issues have led to a backlash against the progressive ideas that led to the closure programme in the first place. The press has played a key role in this process and has used high profile cases to do so. The challenge for those who oppose moves to more coercive mental health legislation is to tackle these myths at source. These cases not only demonstrate the causes, effects and personal costs of structural failings within mental health services, but also the impetus behind the eventual reform of mental health legislation and moves away from the original progressive ideals of community care. The media reports examined covered a 13-year period. For this paper, I looked at more recent material. *The Sun* report of 24 March 2009 illustrates that little has changed. Under the headline '*Zito's killer set for release*', it reports that Christopher Clunis is to be transferred to a medium secure unit – this is not quite the same as being '*set for release*'. The article is accompanied by the picture in *Figure 1*.

Implications for practice

- Media reporting of high profile cases has a profound influence on the development of mental health policy.
- Mental health professionals need to challenge racist stereotyping more effectively.
- The failings in community care had a profound influence in the introduction of more coercive mental health legislation.

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For this research, a newspaper search covering the period December 1992 to May 2006 was carried out using Infotrac. The separate search terms were 'Christopher Clunis' and 'Ben Silcock'. Civil Service advice was obtained under the *Freedom of Information Act* (2001).

References

- Audit Commission (1994) *Finding A Place: A review of mental health services for adults*. London: HMSO.
- Barton WR (1959) *Institutional Neurosis*. Bristol: Wright and Sons.
- Beck U (1992) *Risk Society: Towards a new modernity* (translated from the German by Mark Ritter). London: Sage.
- Browne D (2009) Black communities, mental health and the criminal justice system. In: J Reynolds, R Muston, T Heller, J Leach, M McCormick, J Wallcraft & M Walsh (Eds) *Mental Health Still Matters*. Basingstoke: Palgrave MacMillan.
- Butler I & Drakeford M (2005) *Scandal, Social Work and Social Welfare*. Bristol: Policy Press.
- Cohen S (1973) *Folk Devils and Moral Panics*. St Albans: Paladin.
- Care Service Improvement Partnership/Shift (2006) *Mind over Matter: Improving media reporting of mental health*. London: Sainsbury Centre for Mental Health.
- Cope R (1989) The compulsory detention of Afro-Caribbeans under the Mental Health Act. *New Community* 15 (3) 343–356.
- Department of Health (1998) *Modernising Mental Health Services: Sound, safe and supportive*. London: TSO.
- Fallon P (Chair) (1999) *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*. London: TSO.
- Fernando S (1988) *Race and Culture in Psychiatry*. London: Routledge.
- Fernando S, Ndegwa D & Wilson M (1998) *Forensic Psychiatry, Race and Culture*. London: Routledge.
- Freedom of Information Act* (2001) London: OPSI.
- Gilroy P (2002) *There Ain't No Black in the Union Jack*. London: Routledge.
- Glover G (2006) Crisis resolution/home treatment teams and psychiatric admission rates in England. *The British Journal of Psychiatry* 189 441–445.
- Goffman E (1968) *Asylums: Essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.
- Hallam A (2002) Media influences on mental health policy: long-term effects of the Clunis and Silcock cases. *International Review of Psychiatry* 14 (1) 26–33.
- Heginbotham C, Carr J, Hale R, Walsh T & Warnant C (1994) *Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan*. London: North West London Mental Health Trust.
- Hopton J (2006) The future of critical psychiatry. *Critical Social Policy* 26 57–73.
- Kelly B (2005) Structural violence and schizophrenia. *Social Science and Medicine* 61 721–730.
- Leff J & Trieman N (2000) Long-stay patients discharged from psychiatric hospital. *British Journal of Psychiatry* 176 217–223.
- Lelliot P, Audini B & Duffett R (2001) Survey of patients from an inner-city health authority in medium secure psychiatric care. *British Journal of Psychiatry* 178 62–66.
- Litwack L (1980) *Been in the Storm so Long – The Aftermath of Slavery*. New York: Random House.
- Martin JP (1985) *Hospitals in Trouble*. Oxford: Blackwell.
- McLaughlin K (2001) *A Mad Approach to Mental Illness* [online]. Available from: www.spikedonline.com.
- Muijen M (1995) Scare in the community: Britain in moral panic. In: T Heller et al (Eds) *Mental Health Matters*. Basingstoke: MacMillan.
- Neal S (1998) *Embodying Black Madness, Embodying White Femininity: Populist (Re) presentation and public policy – the case of Christopher Clunis and Jayne Zito*.
- Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London: TSO.
- Philo G, Secker J, Platt S, Henderson L, McLaughlin G & Burnside J (1996) Media images of mental illness. In: T Heller, J Reynolds, R Gomm, R Muston & S Pattinson (Eds) *Mental Health Matters*. Basingstoke: Palgrave Macmillan.
- Pilgrim D & Rogers A (2010) *Sociology of Mental Health and Illness*. Buckingham: Open University Press.
- Prins H (Chair) (1993) *Report of the Committee of Inquiry into the Death at Broadmoor Hospital of Orville Blackwood and Review of the Deaths of Two Other Afro-Caribbean Patients. 'Big, Black and Dangerous?'*. London: Special Hospitals Service Authority.
- Prospero M & Kim M (2009) Ethnic difference in the effects of coercion on mental health and the use of therapy. *Journal of Social Work Practice* 23 (1) 77–91.
- Ritchie J (Chair) (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- Rose D (1998) Television, madness and community care. *Journal of Community and Applied Social Psychology* 8 (3) 213–228.
- Royal College of Psychiatrists (RCP) (2008) *Fair Deal for Mental Health: Our manifesto for a 3 year campaign for tackling inequality in mental healthcare*. London: RCP.
- Scott RD (1973) The treatment barrier part 1. *British Journal of Medical Psychology* 46 45–53.
- Scull A (1977) *Decarceration: Community treatment and the deviant – a radical view*. Englewood Cliffs, NJ: Prentice-Hall.

Reflections on the impact of media reporting of the cases of Christopher Clunis and Ben Silcock

Scul A (1986) Mental patients and the community: a critical note. *International Journal of Law and Psychiatry* 9 383–392.

Scul A (1989) *Social Order/Mental Disorder: Anglo-American psychiatry in historical perspective*. Berkeley: University of California Press.

Secker J & Harding C (2002) Users' perceptions of an African and Caribbean mental health resource centre. *Health and Social Care in the Community* 10 (4) 270–276.

Sedgwick P (1982) *Psychopolitics*. London: Pluto Press.

Szasz T (1963) *Law, Liberty and Psychiatry*. New York: Macmillan.

Szasz T (1971) *The Manufacture of Madness*. London: Routledge and Kegan Paul.

Turner T & Colombo A (2008) In: R Tummey & T Turner (Eds) *Risk in Critical Issues in Mental Health*. Basingstoke: Macmillan.

Wacquant L (2005) Race as civic felony. *International Social Science Journal* 181 127–141.

Wahl OF (1995) *Media Madness: Public images of mental illness*. New Brunswick, NJ: Rutgers University Press.

Wolff G (1997) Attitudes of the media and the public. In: J Leff (Ed) *Care in the Community: Illusion or reality?* London: Wiley.

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

Wright R (1940) *Native Son Harmondsworth*. London: Penguin Modern Classics.

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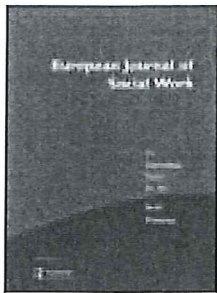
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Reading Wacquant: social work and advanced marginality

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Professor Loic Wacquant was born in Montpellier in 1960. He was educated in France before completing a Ph.D. in Chicago in 1994. He is currently Professor of Sociology at the University of California at Berkeley. His work is concerned with the impact of neoliberalism in the area of welfare and penal policy. Wacquant has published a number of highly influential books the most notable of which are *Les Prisons de la misère* (1999, translated in 20 languages; new and expanded English edition, *Prisons of Poverty*, 2009), *Body and Soul: Ethnographic Notebooks of an Apprentice Boxer* (2000), *Urban Outcasts: A Comparative Sociology of Advanced Marginality* (2008) and *Punishing the Poor: The Neoliberal Government of Social Insecurity* (2009). These works, along with the major papers listed in the bibliography, form the core of Wacquant's analysis of the impact of neoliberal welfare and penal policy. These papers consider three key areas: *advanced marginality*, *race (ethno-racial domination)* and *the rise of the penal state*. His significance as a commentator for social work, specifically, lies in his critical engagement with these three areas that have so shaped the development of modern welfare and penal policy. The article concludes that Wacquant's work provides a clear analytical framework for the study of the organisational and social contexts of contemporary practice. His work also calls for a more politically engaged social work practice—a form of practice that will move away from social work as a narrow bureaucratic activity dominated by risk management and return to core social work values.

Keywords: Wacquant; advanced marginality; neoliberalism; social work

Introduction

Key themes in Wacquant

In his trilogy of studies of *Urban Outcasts: A Comparative Sociology of Advanced Marginality* (2008), *Punishing the Poor: The Neoliberal Government of Social Insecurity* (2009), *Deadly Symbiosis* (forthcoming), Wacquant outlines the impact of the neoliberal economic policies on marginalised urban communities. The main focus of his work is the USA and France. His analysis highlights the long-term impacts of the decline in skilled, unionised work. Wilson in *When Work Disappears* (1996) and *The Truly Disadvantaged* (2012) outlined the impact on communities and family structure of the initial phases of the neoliberal restructuring of economies that took place from the mid-1970s onwards. During the post-war boom, governments across western liberal democracies were committed to full employment and an expansion of welfare provision. On the whole, the State was viewed as having a necessary and positive role to play in economic and social affairs.

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Policies of state intervention and a wider public sector were and are an anathema to neoliberal thinking with its emphasis on a small state and market forces. Friedman (1962) and the Chicago school argued that deregulation in the economic sphere was necessary to stimulate the market. For neoliberals, market mechanisms are the most efficient way for societies to organise the provision of goods and services. In this approach, market mechanism could and should be applied to all areas—including education, health and penal policy. This is justified by the argument that government intervention will mean markets are less flexible and therefore more inefficient. ‘Flexibility’ is an example of what Wacquant terms the ‘doxa’ of neoliberalism. Doxa derives from the Greek and means opinion or commonly held belief. Wacquant uses the term in the sense outlined by Bourdieu (1977/1972), i.e. terms that set the limit on what is sayable and thinkable. Such terms construct the limits of public discourse. Flexibility is used with considering the implications that this has for workers. The reality is that flexibility in employment will involve the removal of protections for workers. Thus deregulation (another doxa) has led to cuts or removal of the minimum wage and the repeal of employment law. As Hall, Critcher, Jefferson, and Roberts (2013) perceptively predicted, the response of parties of the Left to the rise of neoliberalism can be characterised as a form of ‘authoritarian populism’. This has included the acceptance or adoption of neoliberal doxa in the area of welfare and penal policy. In the UK, the ‘Troubled Families’ policy agenda which is discussed below is based on a number of assumptions that have their roots in Murray’s underclass hypothesis.

The impact of neoliberalism is not limited to the economic sphere. It has clear social, political and cultural impacts. Giroux (2011) argues that the impact of neoliberalism is to shrink the realm of democratic politics as the market pushes these values to the margin. Bauman (2007) suggests that the result is to create a world of ‘hyper-individualism’ where a sense of community or obligation to others begins to disappear. Harcourt (2011) has argued that even those markets that are usually regarded as ‘free’ are, in fact, subject to a raft of regulations and restrictions on entry. In *Culture of Control* (2001), Garland suggests that one of the paradoxes of late modernity is that surveillance, in the broadest sense, has expanded in all areas of life apart from the market.

Wacquant (2012) argues that most of the analysis of neoliberalism can be characterised by two very broad approaches. The first is tied to an essentially economic model that examines the impact of the application of the ‘market’ to areas of public and private life that were previously seen as ‘social goods’ or ‘beyond the market’. This comes about as state assets are sold—privatised—at below the market value and then commercially exploited. Under the Thatcher Government in the UK, this model was followed in social housing, public utilities and a number of other areas. Harvey (2005) has described this process as ‘accumulation by dispossession’. The second, derived from Foucault’s notion of *governmentality*, examines how power is de-centralised in late modern capitalist society. Foucault (2008) examines the construction of the modern discourse of citizenship with its emphasis on self-government and regulation. In this schema, neoliberalism is characterised as a shift in the relationship between the individual and the state. Reductions in state provision can be linked to the notion of the self-regulating citizen.

Wacquant (2012) argues that these two broad approaches ‘obscure what is neo about neo-liberalism’. He uses Bourdieu’s notion of the bureaucratic field as his main analytical tool for his dissection of the development of the ‘neoliberal Leviathan’. Wacquant argues that the neoliberalism is not the application of market mechanisms to wider areas of life. It is a political project that involves the dismantling of welfare provisions. Welfare

systems are replaced by 'workfare' or 'prisonfare' as means of regulating marginal urban populations. As part of this process the balance between what Bourdieu termed the *Left hand* and *Right hand* of the State tilts. For Bourdieu, the *Left hand* of the State represented what be very broadly termed social welfare—education, health and social work. The *Right hand* is the police, Courts and penal system. As Garrett (2007) notes, there is a danger in using this division in a simplistic way. Social work has always had a role to play in managing marginalised groups. Wacquant describes the shift as a move from the *protective (feminine and collectivising)* to the *disciplinary (masculine and individualising)*. This shift involves an expansion of the penal state—i.e. the use of the police, Courts and the prison system and the reduction in spending on social welfare.

One of the most striking features of a number of modern democracies—particularly the USA but also the UK—is the expansion of the penal and criminal justice system. Wacquant's work is mainly concentrated in the USA. As he argues, the fact that governments, allegedly committed to the reduction of the state, have presided over the huge expansion of that sector of the state most concerned with the discipline of citizens is worthy of comment in itself. The statistical evidence is overwhelming. Wacquant (2009, p. 214) shows that the spending on the wider penal system increased by over 350% in the 20 years to 2001. The USA now holds over 25% of the world's prisoners. The impact on the African-American community, in particular, has been devastating (Clear, 2009; Drucker, 2011; Mauer, 2006). Alexander (2012) argues this has served to create a new 'caste'—or marginalised, disenfranchised young black men who are effectively cut-off the basic social and economic rights of modern citizenship including access to social and educational programmes and even more fundamental rights including the right to vote. Simon (2007) sees these trends as coming together to create a new political meme which he calls 'Governing through Crime'. The main features of this new culture include an increased concern with personal safety and responses such as gated communities and SUVs which provide a sense of security for the middle class, and the importance of individual high-profile cases. For example, the brutal abduction and murder of Polly Klass in California in 1993 was followed by a campaign that led to the introduction of the 'three strikes law' in 1994. This law sentences offenders who have been convicted of a third felony to life imprisonment.

Wacquant (2008, 2009a, 2009b) argues that the growth of social insecurity and the expansion of the penal state are key features of the neoliberal political project. Wacquant is particularly scathing on the role of think-tanks in the spreading of the 'doxa' of the penal state such as 'prison works', 'zero tolerance' and 'broken windows'. He outlines the ways in which these ideas have spread across the Atlantic. They have become key features of the development of a range of social policies in the UK. The Blair Government in particular adopted these ideas with enthusiasm in a raft of policies including, for example, anti-social behaviour orders (ASBOs). Wacquant throughout his work identifies the ways in which the *rehabilitative ideal* (Garland, 2001)—i.e. the belief that offenders can change and that it was a proper role of the state to assist this process—has all but disappeared. It has been replaced by a focus on risk and risk management. As Garland (2001) argues offenders have moved from being considered fellow citizens in need of support to rehabilitate themselves into sites of risk. As Beck (1992) notes risk and risk management have become key societal themes which structure and lead public policy. Wacquant (2008) argues that the Police, Courts and Prisons now represent 'a core political capacity through which the state both produces and manages inequality, identity and marginality'. In this regard, Wacquant stands

somewhat apart from other contemporary analysts of the expansion of the penal system. He argues that it is one of the core components of neoliberalism.

Wacquant identifies the role that think-tanks and public intellectuals such as Wilson and Keeling (1982) have in the spread of neoliberal penal orthodoxy and the link to increased rates of incarceration. Wacquant rejects what he sees as a conspiracy theory approach which seeks to analyse a 'prison industrial' complex. His methodological approach is to take Bourdieu's key conceptual tools—field, habitus and capital—to analyse the development of policies in the penal sphere. Bourdieu (1998) defined a field as a 'structured social space, a field of forces'. Thus within any field there are a range of actors—in penal policy this would include political figures, civil servants, charities, professional bodies representing the police, and so on. Whilst actors in any field will seek to maintain the autonomy of that field, there is also competition within it to secure or advance the actors own position. An example from UK penal policy will serve to illustrate this approach. Gottschalk (2006) demonstrates how the Home Office in the late 1980s and early 1990s sought to introduce a range of community-based alternatives to imprisonment all based on the premise that 'prison is an expensive way of making bad people worse'. A volte-face took place with the appointment of Michael Howard as Home Secretary in 1991 who promptly announced that 'prison works'. In England and Wales, the rate of incarceration increased following this and in the New Labour years (1997–2010). Between June 1993 and June 2012, the prison population in England and Wales increased by 41,800 to over 86,000 (Ministry of Justice 2013). As Wacquant notes, this growth in the use of imprisonment in the UK and USA continued under Clinton and Blair who led nominally progressive parties.

Wacquant's work is mainly concentrated in an analysis of the inter-relationship between the US welfare and prison systems. However, he argues that mass incarceration has been exported along with the other key tenets of neoliberalism. In this process, successive British governments, particularly Blair's administration, have been the keenest adherents of this general approach. The result has been the introduction a raft of measures (Butler & Drakeford, 2001) which were aimed at using social policy as a means imposing societal norms on the marginalised. This was a conscious political move. The *Third Way* (Giddens, 1998) includes a very deliberate move to recast the welfare state. Progressive parties sought to distance themselves from what they saw as a vote losing 'tax and spend' agenda. As Saunders (2005) argues, measures that, in the past, were seen as vital to relieving poverty were now seen as rewards for anti-social behaviour.

In applying his analysis to policy developments in the UK, there are clear dangers in drawing simplistic historical parallels. One of the key elements of Wacquant's arguments concerning the expansion of the penal state is an analysis of the ways in which US policies and ideas have been exported to Europe. He sees part of his role to warn European policy-makers of the dangers of following the US model of punitive responses to the social insecurity that is endogenous to neoliberalism.

The USA's history of slavery, racial segregation and discrimination forms the historical backdrop to Wacquant's analysis the modern penal system. In Drake and Cayton's (1993) classic study, the ghetto is described as a 'black city within the white'. This is clearly not to deny the impact of Jim Crowism and racial segregation. However, it acknowledges that there were communal aspects and social organisations such as the Church that acted as a buffer against the wider society. The ghetto was thus a socially, ethno-racial defined space with clear psychological and physical boundaries (Slater, 2009). As Wacquant (2008) notes the ghetto was home to both professionals and

working-class African-American. Ghettoization is a 'distinctive modality of racial domination that encompasses all members of a group'. Thus, it can help to develop communal solidarity but also increases access to social capital. One of the most important impacts of neoliberalism is the fact that it means the creation and maintenance of such social institutions is much more difficult. Traditional patterns of employment also helped foster community welfare organisations—unions, sports and social clubs, and so on.

Wacquant (2008) has argued powerfully that the concept of the 'ghetto' has been misused by policy-makers, politicians and academics in their analysis of the development of advanced urban marginality. From the late 1990s onwards in the UK and across Europe, there has been an ongoing *moral panic* (Cohen, 2011) about the 'ghettoization' of socially deprived urban areas. For Wacquant, the use of the term 'ghetto' to describe areas of urban poverty in neoliberal societies is completely misleading and inaccurate. In his analysis of developments in Western Europe, Wacquant uses the term 'anti-ghetto' to describe the stigmatised areas of urban poverty. He argues that the residents of new 'anti-ghettos' have all the same negative social connotations placed upon them. Wacquant explores the ways that these neighbourhoods have become 'terra non grata'. Such areas are in stark contrast to the traditional notion of a ghetto, which as outlined above was an area of ethno-racial segregation. The anti-ghetto lacks the social and class features of the classic ghetto concept. The economic and social insecurity that is a key feature of neoliberalism means that the social and cultural institutions might have acted as a buffer against impacts on working-class communities have struggled to survive.

In his analysis of social stigma attached to living in these marginalised areas, Wacquant (2010) using Goffman (1963) and Bourdieu et al. (1999) as starting points, explores the ways in which this 'underclass' discourse not only corrodes the sense of self of residents but also destroys social ties. The importance of these works for social work is clear. The majority of social work takes place in these communities, which share many of the features that Wacquant outlines: high rates of poverty, few social resources and amenities, poor housing, high rates of crime and problems such as substance misuse. His work concentrates on the penal system and thus is mainly focused on the experiences of young men—in the US context black men. Social work is still largely focused on work with women and children in these marginalised communities.

In his classic outline of the philosophical underpinning of neoliberalism, *State, Anarchy and Utopia* (1974), Nozick argued it should and would lead to a minimal state. This is a 'night-watchmen view'—the role of the state that provides protection for individuals via the legal system. The state in this model is limited to that function and nothing else. As Fraser (2013a) argues, some of the language of progressive politics and wider rights have been adopted into a neoliberal narrative. In so doing, the focus on social solidarity has been all but abandoned. As she points out, the feminist critique of the paternalism of the welfare state, which was clearly progressive, has been almost subsumed by the neoliberal attacks on the 'nanny state'. The result is that the ground has been cleared for the marketisation and subsequent retrenchment of large areas of state provision. The impact of these measures falls disproportionately on women either as workers in areas such as residential care where wages and employment protections are reduced or as users of services.

A key mantra of Thatcherism was that it would lead to the 'rolling back of the state' (Gimour, 1992). This should be understood as the removal of the state from areas of economic activity but also the introduction of market forces into social welfare. Wacquant's work explores the ways, in which, the role of the 'night-watchman' state in

managing the working class and the poor has been expanded and aggressively strengthened under neoliberalism. This part of a wider discourse with its roots in Murray's (1990) *underclass* hypothesis that constructs the poor in eugenicist terms (Slater, 2012). Tyler (2013, p. 38) explores the way that this 'hygienic govern-mentality' was reflected in Sarkozy's comment that the young residents of the banlieues were 'racaille' (scum) that needed to be washed away with a 'Karcher'—a high pressure cleaner. In her analysis of the response to the 2011 UK Riots, Tyler (2013) shows the ways, in which, those involved were portrayed as vermin. Wacquant's work demonstrates the linkages in this shift from a 'War on Poverty' to a 'War on the Poor'.

Challenges to Wacquant

Wacquant's work locates him firmly on the progressive Left of the political spectrum. The criticism of Wacquant's work can be divided into three broad categories, which will be examined below. The challenges to his work come from those who, on the whole, can be characterised as largely sympathetic to the main thrust of his work. The targets of his intellectual ire on the Right have not engaged in any prolonged intellectual debate with him.

Wacquant is unique amongst contemporary penal scholars in arguing that the expansion of *prisonfare* and *workfare* are endogenous features of the political project that is neoliberalism. Garland (2001), Simon (2007) and Harcourt (2011) provide different perspectives but have in common a focus on analysing the punitive drive in terms of the culmination of a number of cultural shifts. Wacquant argues these are not cultural shifts in the sense of being solely about attitudes, but they are real and concrete. For Wacquant, the penal state not only serves to manage the urban poor, but it also consolidates the dominance of neoliberal elites and reinforcing the cultural tropes of neoliberalism. Jones (2010) takes a slightly different approach to the fundamental question of the nature of the state. He argues that Wacquant is over-reliant on the notion of the bureaucratic field as an analytical tool. Jones suggests that what he terms 'the political institutional geography of the capitalist state is lacking'.

Lacey (2008) argues that the emergence of an international framework of human rights has seen the penal and justice systems come to be used as measures of the legitimacy or otherwise of the state. Post-9/11, critics of the War on Terror have increased this rhetorical emphasis. As Lacey (2008, p. 5) notes, the subtitle of *Simon's Governing through Crime is How the War on Crime Transformed American Democracy and Created a Culture of Fear*. There is a very important theme here that can also be identified in the work of Beckett, Garland (2001) and Alexander (2012). The changes clearly have the potential to affect all citizens as anyone might appear before the courts at some point. However, these changes disproportionately affect the urban poor and members of racial minorities. They reflect a new cultural shift that sees offenders not as fellow citizens in need of help to become integrated members of the community but as sources of risk. The corollary of this view is that the role of the state is not to support programmes of rehabilitation but to ensure that these risks are adequately managed. These underlying attitudes are not restricted to penal policy but seep out into a number of areas including social work.

One of the most consistent criticisms of Wacquant's hypothesis is that he attempts to generalise from the USA to all liberal democracies. The fundamental issue that needs to be explored here is the linkages between political cultures and what might be termed

'penal cultures'. As noted above, Wacquant is very clear on this point—an era of neoliberalism has led to a huge expansion of the penal system. It is striking that the two countries USA and the UK—with governments most committed to the neoliberal agenda of deregulation and welfare reform—have since the 1980s seen the greatest expansion in the use of imprisonment. Cavadino and Dignan (2006) used a typology of political economy—neoliberal, conservative-corporatist, social democratic and oriental corporatist—as a starting point for the analysis of the rates of imprisonment in 12 industrial societies. They argue that a neoliberalism produces economic and social policies that produce what they call 'exclusionary cultural attitudes' to the marginalised. This is an echo of Wacquant's emphasis on individualism as one of if not the key cultural trope of neoliberal ideology. If everything is explained in such terms then offending—like poverty and any number of other social problems—is matter of individual agency. The other forms of political economy in Cavadino and Dignan's typology have a greater focus on civic notions of either equality or citizenship. The result as Lacey (2008, 115) suggests is that liberal market economies 'where the trope of individualism is culturally so deeply entrenched find it harder to resist the punitive trend'. The classic social democratic welfare states of Northern Europe have not become involved in this penal arms race. This is not simply a question of welfare and penal systems; it also reflects the wider public culture, including modes of political representation (Lacey, 2008). The opening chapter of *Punishing the Poor* highlights that there are different routes to the development of penal policy. As Wacquant concludes each state creates its own penal policy reflecting the structure and workings of the bureaucratic field within it.

Measor (2013) argues that Wacquant's work does not sufficiently acknowledge two key areas—resistance and gender. The central tenet of this argument is that Wacquant's work ignores gender politics or pushes the experiences of women and the increased surveillance of new welfare regimes to the margins of his analysis (Gelsthorpe, 2010). The focus of his work on the penal state undoubtedly focuses on the experiences of men. Even if one accepts that there is a certainly inevitably to this, Wacquant does not explore the experiences of women in the penal state in real depth. His concept of 'prison fare' is not explicitly defined as a male one but his analysis is essentially focusing on young men. Measor (2013, p. 135) goes on to suggest that Wacquant presents a 'picture of the "assistantal" classes as a deprived people flattened by brutal circumstances that fix them in place'. This seems at odds with not only Wacquant's methodological position but particularly with work such as *Body and Soul: Ethnographic Notebooks of an Apprentice Boxer* which provides a detailed study of how (it should be noted) men negotiate modern urban environments.

Wacquant and social work practice

Wacquant's work provides a detailed analysis of the social impact of neoliberal economic policies. One of his key themes is to explore the ways that marginalised neighbourhoods and their citizens have become both physically and psychologically cut-off from the wider society. This is a direct result of a range of economic and social policies that Wacquant terms 'criminalisation of poverty'. This is a rejoinder to the work of those such as Murray that see poverty as the result of the individual moral failings of the poor. In *Prisons of Poverty* he outlines the development of 'a new government of social insecurity wedding the "invisible hand" of the deregulated labor market to the "iron fist" of an intrusive and omnipresent punitive apparatus'. His work shows the ways neoliberal

economic policies impact on the social structures of urban communities. Existing networks of social capital have come under tremendous pressure as society becomes more atomised. For example, in his discussion of the impact of the expansion of imprisonment, Wacquant highlights the impact on not just individuals but also communities. It is in these areas that his insights can form the basis for a more engaged, less bureaucratic form of social work practice. Social workers can contribute to the development of social networks and other forms of social capital working alongside individuals and communities.

Wacquant's work should also be seen as having an important contribution to the analysis of the shift in the relative position of social work. Social work as a profession very much identifies itself as part of the *Left hand* of the State (Garrett, 2007). However, this value base has been systematically attacked and undermined in the UK. There are a number of policy initiatives which impact on social work that reflect this shift. For example, in the UK, the *Troubled Families Agenda* defines such families as follows 'Troubled families are households who: are involved in crime and anti-social behaviour, have children not in school, have an adult on out of work benefits and cause high costs to the public purse.' At the time of the introduction of this policy in 2012, the UK Government claimed that there were 120,000 such families and solving their problems would save £9 billion a year. Both these figures are not supported by any real evidence. However, of more significance is the fact that the agenda was introduced at the same time as changes to the benefits system most likely to impact on families in this group. For example, a cap on housing benefits payments was introduced. This meant that families claiming housing benefit, which is paid to landlords, in areas where the average rents were high—particularly London—would be moved to areas where rents were cheaper. In addition, such policies ignore those families under pressure that have not been defined as 'troubled'. The impact of poverty and austerity clearly has the potential to undermine any constructive work with such families. It is harder to get your children to school 'ready to learn' if you are living in overcrowded accommodation and reliant on food banks to feed them. The *Troubled Families Agenda* brings together several themes of neoliberal social policy—the need to reduce public expenditure at the same time as making moral statements about the status of those subject to them. There is scope for social workers to use these areas where the symbolism of social policy is clearly at odds with the economic reality on the ground as a creative space to challenge the notions that underpin these policies. The insights that Wacquant provides show that welfare and penal policies have a symbolic role in the demonising of the poor. This extends to their being pursued even when, as here, they are not economically rational.

There are many examples where social workers and other professionals have become involved in campaigns to resist the impact of neoliberal retrenchment of social welfare provision. This is true on a national scale as well as more localised campaigning. National Campaigns would include the response to the so-called 'bedroom tax' which was introduced in April 2013 in England. Changes that were introduced to housing benefit meant that the rent paid was reduced for what was termed 'under occupancy'. These new punitive regulations meant that if a tenant was deemed to have one spare bedroom they lost 14% of the rent allowance. In the run up to its introduction it was argued by its supporters that the 'bedroom tax' would be fairer—it would ensure that social housing would be more equitably allocated—but also it would reduce expenditure. Social workers and social work agencies have been vocal in their opposition to the tax highlighting not only the suffering it creates but also its inefficiency.

In setting out an agenda for a re-engaged progressive social work the Social Work Action Network produced a manifesto in 2004 that argued the impact of neoliberal social policies has highlighted that 'social work has to be defined not by its function for the state but by its value base'. This is a call for a return to social work based on the development of genuine personal relationships. This is far removed from the bureaucratic model that not only deprofessionalises social work but also results in poor service outcomes.

Wacquant's work provides a stark contrast to those who see class as an analytical tool that is no longer valid. Beck (2000) has described class as a 'zombie category', suggesting that the 'idea lives on even though the reality to which it corresponds is dead' (p. 80). As Garrett (2013) notes in Giddens's (1998) *Third Way*, which established his credentials as New Labour's intellectual guru, class seems to have been replaced by financial capitalism. In this process, Fraser (2013b) has argued that representation rather than redistribution has become the focus of social movements. Wacquant totally rejects the idea that the class has lost its power as a tool for analysis—in fact, he sees it as of increasing significance for the analysis of social policy. Wacquant's study of the expansion of the penal system and the development of what he has termed the 'anti-ghetto' emphasises the continued importance of class and racial divisions in the production of modern urban societies across liberal democracies. His work argues that these social, economic and spatial divisions are the inevitable result of the neoliberal inspired assault on welfare and social spending. He produces a telling analysis of the impact of the expansion of what Bourdieu termed the *Right hand* of the State.

Squires and Lea (2013) argue that the initial characterisation of neoliberalism as a 'retreat of the state' have proved to be totally inaccurate. Wacquant's work demonstrates that far from retreating the state has actually been reconstructed and re-engineered. The nature of that state function has, however, undergone a number of significant shifts. Wacquant outlines the development of a 'centaur state'. In this new model, the state has retreated from a number of areas mostly notably the regulation of the market. However for the urban poor the state scope and extent of state regulation have increased, with the expansion of the use of imprisonment being the clearest demonstration of this phenomenon. As part of this re-engineering, the agencies of the *Left hand* of the State have, in Wacquant's phrase, been 'colonised by the doxa, tropes, techniques and rationale of the Right hand'. Social workers can use Wacquant's analysis as the starting point to reclaim the core values of the profession moving risk assessment, monitoring, surveillance and budgetary concerns to the side lines. There are clearly many examples of individual social workers who do this on a daily basis. There are successful at carving out a creative space within bureaucratic and other structures, where they can focus on working alongside individuals, families and communities to tackle the difficulties they face. Garrett (2007) described Bourdieu, as a 'critical intellectual activist, foe of neoliberalism and defender of embattled public services', Wacquant could and should be described in similar terms.

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Notes on contributor

Ian Cummins worked as a mental health social worker and probation officer before taking up academic posts. His research reflects this practice experience concentrating on mental health issues in the CJS with a focus on policing. In addition, he seeks to examine the impact of the increased use of imprisonment on individuals and the wider community.

References

- Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York, NY: New Press.
- Bauman, Z. (2007). *Liquid times: Living in an age of uncertainty*. Bristol: Polity.
- Beck, U. (1992). *Risk society: Towards a new modernity*. London: Sage.
- Beck, U. (2000). *What is globalization*. Cambridge: Polity Press.
- Bourdieu, P. (1977/1972). *Outline of a theory of practice*. (R. Nice, Trans.). Cambridge: Cambridge University Press.
- Bourdieu, P. (1998). *On television and journalism*. London: Pluto.
- Bourdieu, P., Accardo, A., Balazas, G., Beaud, S., Bonvin, F., Bourdieu, E., ... Wacquant, J. D. (1999). *The weight of the world social suffering in contemporary society* (1st reprint). Cambridge: Polity Press.
- Butler, I., & Drakeford, M. (2001). Which Blair project? Communitarianism, social authoritarianism and social work. *Journal of Social Work*, 1, 7–19. doi:10.1177/146801730100100102
- Cavadino, M., & Dignan, J. (November 2006). Penal policy and political economy. *Criminology and Criminal Justice*, 6(4), 435–456.
- Clear, T. (2009). *Imprisoning communities: How mass incarceration makes disadvantaged neighborhoods worse*. New York, NY: OUP.
- Cohen, S. (2011). *Folk devils and moral panics (Routledge Classics)*. Oxford: Routledge.
- Drake, C., & Cayton, H. (1993). *Black Metropolis: A study of Negro life in a northern city* (4th ed.). Chicago, IL: University of Chicago Press.
- Drucker, E. (2011). *A plagues of prisons: The epidemiology of mass incarceration in America*. New York, NY: New Press.
- Fraser, N. (2013a). How feminism became capitalism's handmaiden—and how to reclaim it. *The Guardian*. Retrieved February 10, 2015, from <http://www.theguardian.com/commentisfree/2013/oct/14/feminism-capitalist-handmaiden-neoliberal>
- Fraser, N. (2013b). *Fortunes of feminism: From state-managed capitalism to neoliberal crisis*. London: Verso.
- Friedman, M. (1962). *Capitalism and freedom*. Chicago: University of Chicago Press.
- Foucault, M. (2008). *The birth of biopolitics: Lectures at the Collège de France. 1978–1979*. (G. Burchell, Trans.). Basingstoke: Palgrave.
- Garland, D. (2001). *The culture of control crime and social order in contemporary society*. Oxford: OUP.
- Garrett, P. (2013). *Social work and social theory making connections*. Bristol: Policy Press.
- Garrett, P. M. (2007). Making social work more Bourdieusian: Why the social professions should critically engage with the work of Pierre Bourdieu. *European Journal of Social Work*, 10(2), 225–243.
- Gelsthorpe, L. (2010). Women, crime and control. *Criminology and Criminal Justice*, 10, 375–386. doi:10.1177/1748895810382373
- Giddens, A. (1998). *The third way: The renewal of social democracy*. Oxford: Blackwell.
- Gimour, I. (1992). *Dancing with dogma*. London: Simon and Schuster.
- Giroux, H. (2011). Neoliberalism and the death of the social state: Remembering Walter Benjamin's angel of history. *Social Identities*, 17, 587–601. doi:10.1080/13504630.2011.587310
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identities*. New York, NY: Simon & Schuster.
- Gottschalk, M. (2006). *The prison and the gallows the politics of mass incarceration in America*. Cambridge: Cambridge University Press.
- Hall, S., Critcher, C., Jefferson, T., & Roberts, B. (2013). *Policing the crisis: Mugging, the state and law and order*. Basingstoke: Palgrave Macmillan.

- Harcourt, B. (2011). *The illusion of free markets: Punishment and the myth of natural order*. Cambridge, MA: Harvard University Press.
- Harvey, D. 2005. *A brief history of neo-liberalism*. Oxford: Oxford University Press.
- Jones, M. (2010). 'Impedimenta state': Anatomies of neoliberal penalty. *Criminology and Criminal Justice*, 10, 393–404. doi:10.1177/1748895810382380
- Lacey, N. (2008). *The prisoners' dilemma: Political economy and punishment in contemporary democracies*. Cambridge: Cambridge University Press.
- Mauer, M. (2006). *The race to incarcerate*. New York, NY: New Press.
- Measor, L. (2013). Loic Wacquant, gender and cultures of resistance. In P. Squires & J. Lea (Eds.), *Criminalisation and advanced marginality: Critically exploring the work of Loic Wacquant* (pp. 129–151). Bristol: Policy Press.
- Murray, C. (1990). *The emerging ritish underclass (choice in welfare)*. London: IEA.
- Saunders, P. (2005). *The poverty wars reconnecting research with reality*. Sydney: UNSW Press.
- Simon, J. (2007). *Governing through crime how the war on crime transformed American democracy and created a culture of fear*. Oxford: OUP.
- Slater, T. (2009). 'Ghettos' and 'anti-urbanism' entries. In R. Kitchin & N. Thrift (Eds.), *The international encyclopaedia of human geography*. London: Elsevier.
- Slater, T. (2012). The myth of 'Broken Britain': Welfare reform and the production of ignorance. *Antipode*, 46(4), 948–969.
- Squires, P., & Lea, J. (Eds.). (2013). *Criminalisation and advanced marginality: Critically exploring the work of Loic Wacquant*. Bristol: Policy Press.
- Tyler, I. (2013). *Revolting subjects social abjection and resistance in neoliberal Britain*. London: Zed Books.
- Wilson, W. J. (1996). *When work disappears: The world of the new urban poor*. New York, NY: Vintage.
- Wilson, W. J. (2012). *The truly disadvantaged: The inner city, the underclass and public policy* (2nd ed.). Chicago, IL: University of Chicago Press.
- Wilson, J., & Keeling, G. (1982). Broken windows: The police and neighborhood safety. *Atlantic Monthly*, 249, 29–38.

Wacquant: Key works

The following major works, journal articles and papers are the basis of the discussion of Wacquant's work

- Wacquant, L. (2008). *Urban outcasts: A comparative sociology of advanced marginality*. Cambridge: Polity Press.
- Wacquant, L. (2009a). *Prisons of poverty*. Minneapolis, MN: UM Press.
- Wacquant, L. (2009b). *Punishing the poor: The neoliberal government of social insecurity*. Durham, NC: Duke University Press.
- Wacquant, L. (2010). Urban desolation and symbolic denigration in the hyperghetto. *Social Psychology Quarterly*, 20(2) (Summer 2010), 1–5.
- Wacquant, L. (2012). Probing the meta-prison. In Preface to J. I. Ross (Ed.), *The globalization of supermax prisons*. New Brunswick: Rutgers University Press.

Academic papers

All these papers are available from <http://loicwacquant.net/> they are divided into the following themes

Urban marginality

- A Janus-Faced Institution of Ethno racial Closure: A Sociological Specification of the Ghetto. pp. 1–31 in Ray Hutchison and Bruce Haynes (eds.), *The Ghetto: Contemporary Global Issues and Controversies*, Boulder, Westview, 2011.
- "Designing Urban Seclusion in the 21st Century." *Perspecta: The Yale Architectural Journal* 43 (2010): 165–178.
- "The Body, the Ghetto and the Penal State." *Qualitative Sociology* 32-1 (March 2009): 101–129.

- "Ghettos and Anti-Ghettos: An Anatomy of the New Urban Poverty." *Thesis Eleven* 94 (August 2008): 113–118.
- "Territorial Stigmatization in the Age of Advanced Marginality." *Thesis Eleven* 91 (November 2007): 66–77.
- "Decivilizing and Demonizing: The Remaking of the Black American Ghetto," pp. 95–121 in *The Sociology of Norbert Elias*. Edited by Steven Loyal and Stephen Quilley. Cambridge University Press, 2004.
- "The New 'Peculiar Institution': On the Prison as Surrogate Ghetto." *Theoretical Criminology* 4–3, Special issue on "New Social Studies of the Prison" (2000, edited by Mary Bosworth and Richard Sparks): 377–389.
- "Deadly Symbiosis: When Ghetto and Prison Meet and Mesh." *Punishment & Society* 3–1 (Winter 2001): 95–133.

Race

- "The Puzzle of Race and Class in American Society and Social Science." *Benjamin E. Mays Monographs* 2-1 (Fall 1989): 7–20.
- "For an Analytic of Racial Domination." Political Power and Social Theory 11 (*Symposium on "Rethinking Race"* with Ann Laura Stoler, Patricia Dominguez, David Roediger, and Uday Singh Mehta), 1997: 221–234.
- From Slavery to Mass Incarceration *New Left Review* (2002) 41–60 "Race as Civic Felony." *International Social Science Journal* 181 (Spring 2005): 127–142.

The rise of the penal state

- "Probing the Meta-Prison." Preface to Jeffrey Ian Ross (ed.), *The Globalization of Supermax Prisons*, New Brunswick, Rutgers University Press, 2012.
- "Three Steps to a Historical Anthropology of Actually Existing Neoliberalism." *Social Anthropology*, 19-4 (November), with responses by Johanna Bockman, Mathieu Hilgers, Jamie Peck/Neil Brenner/Nik Theodore, and Steve Collier: 66–79.
- "Prisoner Reentry as Myth and Ceremony." *Dialectical Anthropology* 34-4 (December 2010), Forum on "The Prisoner Reentry Industry": 604–620.
- "Class, Race and Hyperincarceration in Revanchist America." *Daedalus*, thematic issue on "The Challenges of Mass Incarceration," 140-3 (Summer 2010): 74–90.
- "Crafting the Neoliberal State: Workfare, Prisonfare and Social Insecurity." *Sociological Forum* 25, no. 2 (June 2010): 197–220. With responses by John Campbell, Bernard Harcourt, Margit Mayer, Jamie Peck, Frances Piven, and Mariana Valverde. *Theoretical Criminology* 14, no 1, February 2010)
- "Ordering Insecurity: Social Polarization and the Punitive Upsurge." *Radical Philosophy Review* 11-1 (Spring 2008): 9–27.
- "The Scholarly Myths of the New Law-and-Order Doxa." pp. 93–115 in *The Socialist Register* 2006.
- "The Penalization of Poverty and the Rise of Neoliberalism." *European Journal on Criminal Policy and Research*, special issue on Criminal Justice and Social Policy, 9-4 (Winter 2001): 401–412.

Lectures

- Urban Marginality and the State: <http://youtu.be/3JPaguOSA2E>
- Bringing the Penal State Back: <http://youtu.be/KoumuRRwOqY>



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Discussing race, racism and mental health: two mental health inquiries reconsidered

Ian Cummins

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Abstract

Purpose – *The failings of “community care” in the late 1980s and early 1990s led to a number of inquiries. The purpose of this paper is to examine one of these key issues that is rarely if ever at the forefront of the inquiry process – the experiences of young black men of African-Caribbean origin within mental health services and the Criminal Justice System (CJS).*

Design/methodology/approach – *It sets out to do this by exploring the way in which two inquiries, both from the early 1990s, approached the issues of race, racism and psychiatry. The two inquiries are the Ritchie Inquiry (1994) into the Care and Treatment of Christopher Clunis and Report of the Committee of Inquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients (Prins, 1994). The Ritchie Inquiry was established following the murder of Jonathan Zito by Christopher Clunis. The Prins Inquiry examined the circumstances of the death of Orville Blackwood at Broadmoor Special Hospital.*

Findings – *These two inquiries are used as contrasting case studies as a means of examining the approaches to the questions of race and racism. However, the attitudes and approaches that the inquiries took to the issue of race are startlingly different. The Prins Inquiry takes a very clear position that racism was a feature of service provision whilst the Ritchie Inquiry is much more equivocal.*

Originality/value – *These issues remain relevant for current practice across mental health and CJS systems where young black men are still over-represented. The deaths of black men in mental health and CJS systems continue to scar these institutions and family continue to struggle for answers and justice.*

Keywords *Race, Mental health, Racism, Inquiries*

Paper type *Research paper*

Introduction

The inquiry culture

The policy of “deinstitutionalisation”, i.e. the closure of large psychiatric hospitals or asylums and their replacement with community-based mental health services has been followed across most industrialised nations. The term “community care” came to be used as a short hand for this range of policy developments. In England and Wales, from the mid-1980s onwards this policy was increasingly controversial. In particular, it was seen as leading to a rise in urban homelessness (Cummins, 2010). The media focused on a number of high-profile cases of violent criminal offences committed by individuals with previous contact with mental health services (Cummins, 2011). The failings of “community care” in the late 1980s and early 1990s led to a number of inquiries exploring what had gone wrong in individual cases. The media reporting had all the features of a “moral panic” (Cohen, 2011) including calls for reform of mental health legislation.

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One feature of the Government response was to establish a series of inquiries into such cases. Brown (2004) suggests that an inquiry serves to provide an "authoritative account" of an event or series of events. In addition, they should provide a means to examine the failings of the institutions or individuals involved. As well as providing an account for families – an account that might be available in a trial – then the inquiry seeks to make recommendations that will prevent such events occurring in the future. The inquiry culture is an increasing feature of the revised structures of public services (Pollitt, 2003). In Beck's (1992) *risikogesellschaft*, the inquiry can be seen as to give assurance that risks are being managed or will be in the future. Governments have been criticised for using the establishment of an inquiry as means of delaying dealing with potentially political toxic issues.

Inquiries and serious case reviews have become a feature of the landscape of health and social care services. It is clearly vitally important that all professionals and agencies seek to learn the lessons from serious or critical incidents. However, there are potential drawbacks to the development of an inquiry culture. These include the fact that such investigations become a scapegoating exercise rather than a genuine attempt to address organisational, cultural or professional failings. Jones (2014) in his discussion of the Baby P case shows, in a very high-profile case, the ways that the real questions about professional practice can become marginalised. As Stanley and Manthorpe (2001) show staff often are reliant on the media reporting of an inquiry report, rarely having the time to access or consider the full document. In addition, there is a danger of a form of "inquiry fatigue" developing whereby staff and professionals feel that "all inquiries say the same thing" so important messages are missed.

As outlined below, one of the responses to the crisis in community care in the 1990s was the establishment of a series of inquiries. Two mental health inquiries from the Ritchie Inquiry (1994) into the Care and Treatment of Christopher Clunis and the Report of the Committee of Inquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients (Prins, 1994) are used here as case studies for a wider analysis. These inquiries were chosen because of their historical overlap. In addition, they provide a basis for an examination of the experiences of young black men in both community and in-patient settings. The Ritchie Inquiry (1994) was the most high-profile inquiry from this period receiving extensive media coverage, particularly in the tabloid press. The Prins Inquiry is not as well-known and received limited media. In this context, the two inquiries are used to explore aspects of mental health services. The focus is the ways, in which, the inquiries examine the issues of race. There are important differences that need to be borne in mind. For example, Prins was examining an institutional culture while the Ritchie Inquiry covered a much wider range of services and agencies. A case study approach was adopted for the analysis. Yin (1984, p. 23) describes a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context". This can involve a longitudinal study of a single case but this is not necessarily so. A case study is not intended as a study of the whole organisation or system (Yin, 1984). Here it is a way of examining the gap between expressions of a commitment to equal treatment and the cultural or organisational realities.

"Community care" in the late 1980s and early 1990s in the UK

The term "community care" came to be used as a short hand for the impact of the policy of deinstitutionalisation of psychiatric services in the UK. The policy of deinstitutionalisation had its roots in a progressive vision of the replacing the discredited Asylum with community-based mental health services predicated on liberal civic values. The reality was far from this vision. As Moon (2000), Wolch and Philo (2000) and Wolff (2005) demonstrate the Asylum was replaced by a fragmented, patchwork of bedsits, poor housing, day centres and homelessness. Knowles' (2000) study of the ways, in which, the "mad" negotiate this new urban landscape highlights the ways, in which, the decline of the Asylum led to a shift from public to private provision of service. As she notes, this is a model that has been increasingly followed for other "problematic populations". In addition, the expansion of the penal state (Wacquant, 2009a, b) has seen the mentally ill increasingly drawn into the Criminal Justice System (CJS) (Cummins, 2006). This overall process has been termed "transinstitutionalisation". A combination of an idealised rhetoric of community and the fact that the policy was introduced during a period of neo-liberal inspired financial retrenchment and reductions in public service meant that the civic ideals of the challenge to indignities of the Asylum (Barton, 1959; Goffman, 1968; Martin 1985) were never fully realised

(Cummins, 2010). The previous dominant image of the mad: wild madman chained in an asylum, was replaced by that of a homeless, acutely mentally ill man pushing all his belongings in shopping cart around the centre of major cities (Cross, 2010). It should be noted that this image was frequently a racialised one. Kelly (2005) has adopted the term "structural violence" from liberation theology as a means of exploring the impact of race, poverty, homelessness and mental illness on this group.

Drakeford and Butler (2006) have examined the impact that such high-profile scandals have on the development of public policy in the social welfare field. The focus of the Government response by successive administrations has been to focus on changing the mental health legislation and policy framework. As with other areas of public service provision, there was a focus on the auditing of professional practice and accountability. These moves culminated in the reform of the Mental Health Act in 2007 and the introduction for the first time in England and Wales of Supervised Community Treatment Orders. This allows for the certain groups of discharged patients to be immediately recalled to hospital if they breach conditions – for example, they do not take medication. This sort of legislation is an increasing feature of the mental health policy landscape. These changes were, partly a result of series of official inquiries and high profile cases in this period where discharged patients had committed very serious offences including homicides (Cummins, 2010). Cummins (2013) argues that these developments in the mental health field can be viewed in a similar light to the impact of the media reporting of violent crime on penal policy. In the late 1980s and early 1990s the focus was on legislative solutions rather than an examination of the structural weaknesses of service provision.

Racism and mental health services

The history of psychiatry and mental health services is scarred by racism – i.e. prejudice and discrimination based on the belief that human beings can be classified or divided into distinct biological groups and that these "races" possess distinct and inherent characteristics and traits (Kohn, 1996). As Nye (2003) notes in the process of the rise of medicalisation it was minority groups – women, racial and sexual minorities who became the focus of what Foucault (1991) terms "the disciplinary gaze". The legacy of racism remains with us today in the UK. As *The Black Manifesto (1990 Trust)* (2010) produced by a range of community groups demonstrates this is not just an issue for mental health services. Such discrimination can be found across the delivery of health and public services including, education, health, housing and employment. As Kelly (2005) argues there is a dynamic relationship between these factors and mental health.

In *Breaking the Circles of Fear* (Keating *et al.*, 2002), the ways, in which, many young black men experience mental health services is outlined. The overall view is that this still remains, in too many areas, a coercive rather than therapeutic experience as *Breaking the Circles of Fear* and *Delivering Race Equality* (2005) highlight. This depressing picture of the continued emphasis on coercion has a much wider impact. Prospero and Kim (2009) explore the ways, in which, this historical legacy and current practice combine to deter black people from seeking help at an early stage. This continues to be a fundamental problem that mental health services, despite a range of policy initiatives have failed to tackle. It is only if professionals openly and honestly engage in debate about these issues that progress can be made.

It is well established that there are significant variations in the experiences of different ethnic groups in mental health services (Bhui *et al.*, 2003). One of the most consistent findings in the literature is that people of African-Caribbean origin, particularly young men with mental health problems are over-represented in prison populations and secure forensic mental health services (Coid *et al.*, 2002). In addition, this group of patients is more likely to be treated with anti-psychotic medication with fewer in the group be offered psychotherapy or other less medically dominated forms of treatment (Sharpley *et al.*, 2001). The causes of these significant differences in health outcomes are complex. It is important to acknowledge the impact of wider societal forces – the social determinants of health which the WHO describes as follows:

The *social determinants of health* are the *conditions* in which people are born, grow, live, work and age. These circumstances are shaped by the *distribution of money, power and resources* at *global, national and local levels*" (www.who.int/social_determinants/en).

Race is clearly a factor that needs to be considered as one of the social determinants as minority communities are marginalised facing increasing poverty and other barriers, including racism, that will impact on physical and mental health.

Social attitudes to diversity have, on the surface at least, changed significantly over the past 30 years. However, structural factors have been much more resistant to change. This seems to be particularly the case in the CJS and forensic mental health services. *The Black Manifesto (1990 Trust)* (2010), for example, found that: 40 per cent of patients in the three special hospitals (Broadmoor, Ashworth and Rampton) are of African-Caribbean origin, the average stay for these patients is over nine years and 10 per cent of black patients in forensic settings have not committed a crime – they have been admitted to these units from general psychiatric wards (Leese *et al.*, 2006). It is important to emphasise here that the three special hospitals are national resources. One would not expect the ethnicity of patients to map that of the country but these figures are shocking. In the CJS, the figures provided are strong evidence. The manifesto highlights the fact that African-Caribbean citizens are imprisoned at a rate of 6.8 per 1,000 compared to 1.3 per 1,000 amongst white citizens. In total, 27 per cent of the UK prison population comes from black and minority ethnic (BME) background and over two-thirds of that group are serving sentences of over four years. Berman (2012) reports that in June 2011 13.4 per cent of the prison population, where ethnicity was recorded was black or black British. This group comprises 2.7 per cent of the general population. This is the context for the inquiries that will be discussed further below. It is not to suggest that other BME groups do not experience a range of difficulties in accessing appropriate mental health care, for example, women of South Asian heritage (Fenton and Sadiq-Sangster, 1996; Burr, 2002; Gilbert *et al.*, 2004; Ahmad *et al.*, 2005). However, the problem of over-representation of black men seems deeply embedded in the CJS and forensic mental health sectors.

These problems remain deeply engrained despite policy attempts to tackle them since the period under discussion here. For example, the Race Relations Act 2000 as well as outlawing race discrimination in public authorities not covered by the 1976 Act placed a general duty on public authorities to promote race equality. Delivering Race Equality (2005) was established following the inquiry into the death of David Bennett. This five-year action plan was an attempt to tackle these deep seated issues producing services that were more sensitive to community needs including a target of the recruitment of 500 community development workers. In 2010, DRE came to an end having failed to reach this target. The discussion of race has been marginalised by an adoption of a much broader “equalities” agenda. However, as Omonira-Oyekanmi (2014) recently noted current experiences of young black men within mental health remain very familiar to those of Orville Blackwood and Christopher Clunis. Omonira-Oyekanmi (2014) emphasises that it is still the case that young black men are still more likely to be detained under the MHA, restrained or be highly medicated. These personal experiences are supported by wider evidence from the Care Quality Commission (2011, 2013).

Orville Blackwood and Christopher Clunis

The following section provides background information on the two young men at the centre of the inquiries under consideration here. The information is based on that provided at the inquiries.

Orville Blackwood

Orville Blackwood was born in Jamaica in June 1960. He moved with his family to the UK as a young child. He became a naturalised British citizen in 1989. Blackwood faced a number of difficulties at school, he spent a short period in public care and struggled with literacy. As an adult, like a number of young black men in the early 1980s, he found it difficult to find sustained employment. He drifted into petty crime and served short prison sentences.

In his early 20s, Blackwood's mental health began to deteriorate. He began to neglect his personal hygiene and was often aggressive. His mood fluctuated dramatically. His first contact with mental health services occurred in January 1982 when he was admitted to hospital for a short period – he was described as “acutely disturbed, dishevelled, angry and suspicious”.

During this admission, he was threatening towards staff. He was subsequently admitted in August that year following a period where he experienced auditory hallucinations was unable to sleep and was behaving in a bizarre manner. During this admission, he was violent towards staff – he bit a nurse. Over the next four years, there then followed a pattern of repeated short admissions to hospital. On admission, Blackwood was in an extremely manic and agitated state, he was often sexually disinhibited and psychically aggressive towards staff or family members before his admission. Blackwood was consistently seen as a difficult to manage patient – he challenged the authorities but also lacked any “insight”.

In January 1986, Blackwood entered a local bookmakers' shop and threatened the staff with what appeared to be a gun – it was, in fact a toy. He was arrested immediately and assessed whilst in H.M.P. Brixton. At this point, there was no evidence of any mental illness. For this offence, he was sentenced to three years in prison. Whilst serving this sentence, he was transferred to H.M.P. Grendon Underwood. Grendon is a unique institution in the CJS, prison that is run along the lines of a therapeutic community. On his transfer, Blackwood was in a paranoid and aggressive state, he also attempted to hang himself. In October 1987, Blackwood was transferred to Broadmoor Special Hospital. Special hospitals have been established for those patients who represent a “grave and immediate danger to the general public”. The overwhelming majority of the patients have been convicted of the most serious crimes such as murder, manslaughter or sexual offences. This is not the case for all patients as some are transferred to these institutions because they cannot be managed in normal conditions. The special hospital is thus a cross between a high-security prison and a psychiatric hospital. Such an environment faces a number of challenges because of the clashes between the aims of a therapeutic approach and the need for the high levels of security. The special hospitals, because of the notoriety of some of the patients, are always the subject of a high level of media interest. As noted above all, young black men are over-represented in these settings.

As Prins (1994) outlines there was a pattern that developed over the course of Blackwood's admission to Broadmoor. As his symptoms and delusions became more paranoid, he became more aggressive. This led to higher dosages of medication being prescribed and the involvement of large numbers of staff to either restrain Blackwood or inject him with medication. The Prins Inquiry (1994) outlines the way that this pattern appears to have developed into entrenched positions on both sides. There are several further examples given where, in response to disturbed and agitated behaviour, Blackwood is restrained by large numbers of staff, placed in seclusion and then administered cocktails of large doses of medication. Orville Blackwood died in August 1991, at that time he was a patient at Broadmoor Special Hospital. He was the third black patient after Michael Martin and Joseph Watts to die in similar circumstances at the hospital within a seven-year period. In September 1991, an inquiry headed by the prominent academic Professor Herschel Prins was established and it reported in 1993.

The inquiry's remit was to “investigate the circumstances leading to the death of Orville Blackwood” as well as “to examine the reports of the Michael Martin and Joseph Watts inquiries to investigate any significant common factors between all three deaths”. All three men had died after having been placed in “seclusion”. Inquest verdicts of “accidental death” were returned. The pathologist in the Blackwood case noted the cause of death as “cardiac failure associated with the administration of phenothiazine drugs”.

Christopher Clunis

Christopher Clunis was born in Muswell Hill, London in 1963. Clunis did well at school – he obtained six O-levels and was studying for A-levels when he left to pursue a career in music. As a talented jazz guitarist, he found work on in bands on cruise ships. During this period, his parents returned to Jamaica as his mother suffered a stroke. She died in 1985 when Clunis was on tour. It was some time before the family could contact him with the news and he missed the funeral. These events seem to have had a profound and long-lasting impact on him. From 1986 onwards, Clunis's mental state seems to have deteriorated significantly. His personal care was poor and he began to dress in a bizarre fashion. He went to stay with a sister but he had to leave when he hit his niece. As the family struggled to support him, he moved to live with his father in Jamaica. It was during this period that he was first admitted to a psychiatric unit – Bellevue Hospital in Kingston.

In 1987, Clunis returned to live in London. It is this period up until his arrest for the murder of a stranger – Jonathan Zito – at a tube station in December 1992 that forms the bulk of the subsequent public inquiry. Clunis's mental health was such that he was admitted to hospital in June 1987. From that point onwards, a depressing pattern emerges of short admissions to hospital followed by an early discharge without adequate support followed by periods of homelessness or living in poor-quality hostels. During these admissions to hospital, Clunis had a history of sexually disinhibited and violent behaviour. There were a number of assaults on staff and other patients – including threats with knives and a screw-driver. At no point in this five-year period were agencies able to engage successfully with Clunis to tackle the long-standing difficulties that he faced. In this period, community-based mental health services were under tremendous pressure (Cummins, 2010). The factors that caused this, including, high levels of need, under-resourced and poorly organised services and lack of sufficient in-patient beds were finally acknowledged by the New Labour Government in the policy document *Modernising Mental Health Services* (Department of Health, 1998). This document is subtitled – *sound safe* (emphasis added) and supportive services as an indicator of the political emphasis of the response. When the document was introduced, the then Secretary of State for Health, Frank Dobson announced that "community care has failed".

Clunis was found guilty of manslaughter on the grounds of "diminished responsibility" in 1993. After his conviction, it was announced that a formal public inquiry would be held into his care and treatment. Clunis was sentenced under the provisions of the Mental Health Act (1983). Section 37 of that act allows the Court to sentence a person to be detained in a psychiatric hospital. Section 41 allows for restrictions to be placed on the circumstances, in which, an individual can be released – the effect of these conditions is that the individual can only be discharged following a tribunal headed by a judge. This is, in effect, an indeterminate sentence. The Ritchie Inquiry produced its final report in 1994. The terms of reference of the inquiry were:

1. to investigate all the circumstances surrounding the admission, treatment, discharge and continuing care of Christopher Clunis between May 1992 and December 1992;
2. to identify any deficiencies in the quality and delivery of that care, as well as interagency collaboration and individual responsibilities; and
3. to make recommendations for the future delivery of care including admission, treatment, discharge and continuing care to people in similar circumstances so that, as far as possible, harm to patients and the public is avoided.

After initial hearings, the inquiry decided to widen its remit to examine the entirety of Clunis's contact with mental health services.

How do the inquiries consider the issues of race and racism?

The two inquiries cover major areas of mental health services including community mental health services, all areas of the CJS and forensic mental health services. In addition, it is possible to examine both institutionalised care and aftercare provision, alongside the involvement of other key agencies such as the police. Here, the focus will be on the issues of race and racism. In particular, I am exploring how the inquiries approached these questions and the possible impact on the nature of the care and treatment provided to Orville Blackwood and Christopher Clunis. There is an enormous body of literature, which explores the issue of race and psychiatry generally and the experiences of young black men in particular (Browne, 2009; Cope, 1989; Fernando, 1988; Fernando *et al.*, 1998; Ndegwa and Olajide, 2006; Prospero and Kim, 2009; Sainsbury Centre for Mental Health, 2006). Both the inquiries considered the possible impact of racism in these two cases. However, the approaches that they took were almost diametrically opposed.

The Prins Inquiry

From its ironic and iconic title onwards, the Prins Inquiry into the death of Orville Blackwood was forthright in its criticism on the ways that young black men were treated by the CJS and psychiatric systems. One of the reasons for the establishment of Professor Prins' Inquiry was to

look again at the previous investigations into the deaths of Michael Martin and Joseph Watts. Both these inquiries concluded that there was “no direct evidence of racism at Broadmoor”. The Prins Inquiry (1994) felt that “the interpretation is based on some very crude measures of racism”, for example, reported incidents of direct racial abuse or the use of racial epithets. The inquiry reported that many of the features of a modern public service such as an Equal Opportunities policy, ethnic monitoring and service-user involvement were absent. The inquiry members were shocked when they were told that basic information such as the number of black patients was not collected in any systematic fashion.

The phrase “big, black and dangerous” is a short hand that the inquiry uses for the ways, in which, Orville Blackwood and other black patients were viewed. It is not a phrase that the inquiry invented; it was one that was openly used amongst nursing staff. One of the major manifestations of this culture was on the impact on the response to any signs of distress that black patients exhibited. There was an emphasis on seclusion and physical restraint involving large numbers of staff. Patients such as Blackwood were prescribed unusually high dosages of medication. The inquiry notes that the way, in which, the wider organisational culture created a very hostile environment where it was difficult to establish therapeutic relationships.

A contrasting view of Orville Blackwood as a patient and individual was presented to the inquiry by one of the doctors involved in his care. On p. 17 (Prins, 1994), Dr Burke – a black psychiatrist suggested that Blackwood was “not a without insight, rather he was a man with profound insight”. Blackwood consistently argued that he was being held in custody long after the expiry of his prison sentence. This was clearly the case as he would have been released from his original three year prison sentence long before August 1991. This claim was seen as evidence of his ongoing mental illness. It was a common theme in the construction of the “big, black and dangerous” stereotype that patients such as Orville Blackwood believed that they were only detained because of racist stereotyping not because of their mental health condition justified it. There is a fundamental issue of jurisprudence being raised here – the overlap of psychiatric and the CJS creates cases such as this one (Prins, 2010). Seddon (2007) argues that this overlap has always and will continue to exist because the categories of “offender” and “patient” are not fixed but fluid and permeable entities that are the creation of cultural, social and political views.

The Ritchie Inquiry

The Ritchie Inquiry adopts a very different view of the possible impact of race on the care and treatment of Christopher Clunis. The inquiry team’s view is outlined explicitly at the beginning of the final report:

We have tried throughout our investigations to keep a close eye on any evidence of prejudiced attitudes towards Christopher Clunis. We have asked witnesses for direct and indirect examples of racial discrimination which could have affected his care and treatment. We record no example of such prejudice or discrimination has become apparent to us, save for the possibility of too great a willingness to accept that he abused drugs.

The report, therefore, does not discuss these issues in any depth. Such a “colour blind” approach ignores or down plays the individual, cultural and ethnic heritage as part of the explanation for the failure to provide adequate mental health care to Mr Clunis.

Discussion

Following the murder of a black teenager Stephen Lawrence in London in 1993 and failures of the police in investigating the crime, a public inquiry was established. The judge who headed that inquiry, Lord Macpherson found that the Metropolitan Police had been guilty of “institutional racism”. The inquiry defined the term as:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people (The Stephen Lawrence Inquiry (1999)).

The failings of the regime at Broadmoor at that time of the death of Orville Blackwood surely met the criteria for "institutional racism". The result was all the creation and maintenance of a culture, in which, black patients who gave evidence to the inquiry, made it clear that they felt in physical danger. There were clear cultural difficulties between the almost totally white staff group and patients from ethnic minority groups. This is exacerbated by the profession of psychiatry and the background issues related to race outlined above. As the inquiry notes psychiatry is a "white middle class profession" and that "the social perspective is often missing when psychiatrists diagnose psychiatric patients from poor, black African-Caribbean communities".

The Ritchie Inquiry provides examples of the ways that the "big black and dangerous" stereotype permeated services. There are several interlinked elements here. As with Blackwood, there was an emphasis on physicality – accounts of Christopher Clunis frequently refer to "his considerable height and powerful build". The point here is that is introduced without any further comment – it is not clear how it is relevant to the provision of services or decisions about his mental health care. There are other similarities with the Blackwood case. For example, the cause of Clunis's problems was seen as abuse of marijuana. In the late 1980s, cannabis induced psychosis was a very common diagnosis in the cases of young black men in contact with mental health services. In addition, the fact that both Clunis and Blackwood were given a series of diagnoses is another well-documented feature (Fernando, 1988) of the black experience of psychiatric services. In his evidence into the death of Orville Blackwood, Dr Burke considered this issue of diagnosis – he did not accept that Blackwood was suffering from schizophrenia. In essence, he argued that the African-Caribbean young men that he met in the course of his work, as a result of the wider problems that they faced, were often very insecure. However, this was hidden by a series of projections and challenges to authority that were often interpreted as a form of paranoia. This was then constructed as an illness via the prism of deeply engrained racist stereotypes that emphasised the physicality of young black men.

There is one area of where there is significant difference in the approach to both men: violence. In the Blackwood case, at no time was there any attempt to minimise the potential for violent or aggressive behaviour. As the Prins Inquiry notes, this hypervigilance was a contributory factor to the series of violent incidents that occurred. The repeated use of seclusion and administering medication using large numbers of staff created a climate of fear rather than the building of a "therapeutic alliance". In the Clunis case, there a series of examples where violence is downplayed or minimised in reports to other agencies. The reasons given are that staff think other agencies will see Clunis as "big, black and dangerous" if they are given this information. Thus very relevant information regarding incidents of threats and assaults on staff and other patients is not shared. It certainly did little to assist Clunis who was clearly in need of long-term support to tackle the deeply entrenched problems that he experienced. It also put other people at risk. This is an example of the corrosive effects of institutional racism. It appears that staff felt that they risked being accused of racism, if they raised the issue of Clunis's past violent behaviour.

One of the most shocking areas of both reports is the treatment of the relatives of the two men. This reflects a series of long held historical views that pathologises the "black family". In the case of Christopher Clunis, as the Ritchie Inquiry (para 3.1.6.) puts it: "They treated him as single, homeless and itinerant with no family ties, the more they treated him as such the more he began to fulfil that role". Few, if any, attempts were made to contact his sister. Agencies were shocked to discover that she existed and had been in fairly regular contact with her brother in the period prior to the murder of Jonathan Zito. The Prins Inquiry noted that the treatment of the Blackwood family in the aftermath of their son's death was disgraceful. There were no clear procedures for informing the family. When his mother eventually was able to see her son's bodies, it was in a refrigerator at the mortuary and she was able to see other bodies at the same time. The inquiry panel, appalled by this evidence, specifically visited the mortuary to confirm that this was the case.

The marginalisation of family members and the refusal to be open about the events that led to their loved ones death, has been a feature of the authorities response to a series of deaths of black people in police custody, prison or psychiatric units. For example, Joan Bennett the sister of Rocky Bennett campaigned vigorously for a public inquiry into her brother's death. Rocky died in circumstances not unlike those of Orville Blackwood being restrained by staff whilst a patient in

a secure psychiatric facility (Blofeld, 2004). Part of the official policy response to such issues has been the establishment of Independent Advisory Panel on Deaths in Custody. The panel's work covers all forms of custody including mental health facilities. It is currently developing an "equalities project which will focus on understanding the evidence around proportionality and deaths in custody of BME offenders".

Conclusion

Wacquant (2005, 2009a,b) has highlighted the ways, in which, the dynamics of race have been recast in the era of mass incarceration and the post-Keynesian, deregulated economy and state. The two inquiries approach the issues of race and racism from completely different perspectives. The Ritchie Inquiry does not engage with the idea that racism by individuals or organisations may have had an impact on the care or treatment that Christopher Clunis received. It seems unsustainable to believe that race played no part at all in the failure of services or that Clunis never encountered racist behaviour. Professor Prins' report is a much more radical document. It documents and confronts racist attitudes and behaviour that existed at Broadmoor at the time. The report outlines an institutional culture that took little, if any real account of the individual, social and cultural needs of its black patients or their families. The final report is a damning indictment of the corrosive effects of a failure to challenge and tackle such behaviour.

Psychiatry, along with the CJS agencies has played a key role in creating the racist stereotype of the psychically aggressive violent black male. The reporting of the Clunis case (Cummins, 2010) was an example of this process. In addition, as Ellis and Davis (2001) argue the failings of community care were partly due to its construction as a way of managing the "dangerous other", which it failed to do. The "other" was largely constructed in a racialised and gendered form. As Garland (2001) suggests the moves away from a rehabilitative approach means that the "new penology" places a great emphasis on public protection and incapacitation. Risk and its management have come to be one the dominant drivers of the development of mental policy, legislation and service structures. Turner and Colombo (2008) go as far to that risk rather than care has become "defining feature of service-user contact". In Bourdieu's (1999) terms mental health services have become very much part of the "Right hand" rather than the "Left hand" of the state with a focus on the management of marginalised groups rather than the tackling of inequality, poverty and discrimination. This marginalisation is likely to increase as the politics of austerity become more firmly entrenched with the subsequent reduction in community services. Poor and marginalised communities are more reliant on these services so the impact of cuts disproportionately falls on them. For example, Black Mental Health UK (www.blackmentalhealth.org.uk) reported in April 2015 that funding for, Family Health Isis London's oldest black led mental health service had been cut just at a time when demand was increasing.

These inquiries both take place at the interface of the CJS and Mental Health systems. Both these systems continue to marginalise large numbers of young black men. As Gilroy (2002) notes the 1970s crisis in legitimacy of the welfare state led to a reconfiguration in the ways that the image of young black men was constructed by the State with an emphasis on the alleged physical threat that they posed. The policing of black communities has continually constructed them and particularly young, male members as a threat to social order (Hall *et al.*, 1978) Warner and Gabe (2004) argue that part of the social processes that led to the marginalisation of groups is that these groups are seen as "other". Thus the "other" also becomes associated with risk. Risk in the mental health and CJS is always the risk that that individual is seen to pose to the wider society. It is never constructed in terms of the risk that services or systems pose to individual's (Kemshall, 2002).

The final question that arises is whether these documents are simply historical events, interesting in and of themselves but with no significance or relevance for modern mental health professionals in the UK. As *Breaking the Circles of Fear* (Keating *et al.*, 2002) argues it is impossible to understand the current context of mental health services and their relationship with minority ethnic communities unless one understands the historical background. Despite policy initiatives,

there are ongoing concerns about the deaths of black men in mental health and CJS. The recent inquiry by Lord Adebawale (2013) into mental health and policing was initially commissioned following the death of Sean Riggs in police custody. Lord Adebawale took the decision to broaden the scope of the inquiry. The campaign by Sean Riggs family is another example of family members have to struggle with public bodies such as the police or mental health trusts to get answers about the circumstances of the death of a loved one whilst at the same time coping with a traumatic loss. The courage and determination of the families and their supporters should never be underestimated. At the time of writing, the inquest is beginning into the death of Kingsley Burrell. Mr Burrell was detained by police officers under section 136 MHA following an incident at a shop in Birmingham in March 2011. He was then admitted to hospital. He died whilst being restrained by both medical staff and police who had been called to the ward (www.inquest.org.uk). His sister, like the families of David Bennett and Sean Riggs has struggled for justice. It is clearly unacceptable that it takes four years for an inquest hearing to take place.

These inquiry reports are two of the major documents in that process – Prins used the term “big, black and dangerous” because the inquiry team had heard it used by staff but also because it encapsulates the racist stereotyping of young black men. The danger is the context of that use will be lost and it becomes used in a way that is totally contrary to the author’s intentions. As Thomas (2012) mental health services are not provided in a vacuum. He argues that “schizophrenia is emblematic of the oppression and mistreatment of black people by psychiatry”. The inquiries that have been examined here present polar opposite views of the problem of race, psychiatry and racist stereotyping. The Ritchie Inquiry tries to set aside or minimise the impact of cultural or racial factors in seeking to explain the history of Christopher Clunis’s contact with services. This individualised approach does not provide a sufficient explanation of the wider context of young black men’s experience of mental health services. Prins, on the other hand, confronts these issues head on with a clear message that this is what all mental health professionals should do.

References

- Adebawale, L. (2013), *Independent Commission on Mental Health and Policing Final Report*, London.
- Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U. and Stewart, D. (2005), “Voices of South Asian women: immigration and mental health”, *Women and Health*, Vol. 40 No. 4, pp. 113-30.
- Barton, W.R. (1959), *Institutional neurosis*, Wright and Sons, Bristol.
- Beck, U. (1992), *Risk Society Towards a New Modernity* (Trans by Mark Rittter), Sage, London.
- Berman, G. (2012), *Prison Population Statistics*, House of Commons Library, London.
- Blofeld, J. (2004), *Independent Inquiry into the Death of David Bennett*, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, Cambridge.
- Bourdieu, P. (1999), *The Weight of the World: Social Suffering in Contemporary Society*, Cambridge Polity, Cambridge.
- Brown, A. (2004), “Authoritative sense making in a public inquiry report”, *Organization Studies*, Vol. 25 No. 1, pp. 85-112.
- Browne, D. (2009), “Black communities, mental health and the criminal justice system”, in Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. and Walsh, M. (Eds), *Mental Health Still Matters*, Palgrave MacMillan, Basingstoke, available at: www.nacro.org.uk (accessed 19 July 2014).
- Burr, J. (2002), “Cultural stereotypes of women from South Asian communities: mental health care professionals’ explanations for patterns of suicide and depression”, *Social Science and Medicine*, Vol. 55 No. 2, pp. 835-45.
- Care Quality Commission (2011), “Count me census”, available at: www.cqc.org.uk (accessed 18 February 2015).
- Care Quality Commission (2013), “Monitoring the Mental Health Act in 2012/13”, available at: www.cqc.org.uk (accessed 18 February 2015).

- Cohen, S. (2011), *Folk Devils and Moral Panics*, Routledge Classics, Abingdon.
- Coid, J., Petruckevitch, A., Bebbington, P., Brugha, T., Bhugra, D., Jenkins, R., Farrell, M., Lewis, G. and Singleton, N. (2002), "Ethnic differences in prisoners 2: risk factors and psychiatric service use", *British Journal of Psychiatry*, Vol. 181 No. 6, pp. 481-7.
- Cope, R. (1989), "The compulsory detention of Afro-Caribbeans under the Mental Health Act", *New Community*, Vol. 15 No. 3, pp. 343-56.
- Cross, S. (2010), *Mediating Madness: Mental Distress and Cultural Representation*, Palgrave Macmillan, Basingstoke.
- Cummins, I.D. (2006), "A path not taken? Mentally disordered offenders and the criminal justice system", *Journal of Social Welfare and Family Law*, Vol. 28 No. 3, pp. 267-81.
- Cummins, I.D. (2010), "Deinstitutionalisation; mental health services in the age of neo-liberalism", *Social Policy and Social Work in Transition*, Vol. 1 No. 2, pp. 55-74.
- Cummins, I.D. (2011), "Distant voices, still lives: reflections on the impact of the media reporting of the cases of Christopher Clunis and Ben Silcock", *Ethnicity and Inequalities in Health and Social Care*, Vol. 3 No. 4, pp. 18-29.
- Cummins, I.D. (2013), "Using Simon's governing through crime to explore the development of mental health policy in England and Wales since 1983", *Journal of Social Welfare and Family Law*, Vol. 34 No. 3, pp. 325-37.
- Department of Health (1998), *Modernising Mental Health Services: Sound, Safe and Supportive*, HMSO, London.
- Drakeford, M. and Butler, I. (2006), *Scandal, Social Policy and Social Welfare*, 2nd ed., Policy Press, Bristol.
- Ellis, K. and Davis, A. (2001), "Managing the body: competing approaches to risk assessment in community care", in Edwards, R. and Glover, J. (Eds), *Risk and Citizenship*, Routledge, London, pp. 126-41.
- Fenton, S. and Sadiq-Sangster, A. (1996), "Culture, relativism and the expression of mental distress: South Asian women in Britain", *Sociology of Health and Illness*, Vol. 18 No. 1, pp. 66-85.
- Fernando, S. (1988), *Race and Culture in Psychiatry*, Routledge, London.
- Fernando, S., Ndegwa, D. and Wilson, M. (1998), *Forensic Psychiatry, Race and Culture*, Routledge, London.
- Foucault, M. (1991), *Discipline and Punish: The Birth of the Prison* (Trans by A. Sheridan), Penguin, London.
- Garland, D. (2001), *The Culture of Control: Crime and Social Order in Contemporary Society*, University of Chicago Press, Chicago, IL.
- Gilbert, P., Gilbert, J. and Sanghera, J. (2004), "A focus group exploration of the impact of izzat, shame and subordination and entrapment on mental health and service use in South Asian women living in Derby", *Mental Health Religion and Culture*, Vol. 7 No. 2, pp. 109-30.
- Gilroy, P. (2002), *Ain't No Black in the Union Jack*, 2nd ed., Routledge Classics, Abingdon.
- Goffman, E. (1968), *Asylum: Essays on the Social Situation of Mental Patients and Other Inmates*, Penguin, Harmondsworth.
- Hall, S., Critcher, C., Jefferson, T., Clarke, J. and Roberts, B. (1978), *Policing the Crisis: Mugging, the State and Law and Order*, Palgrave Macmillan, Basingstoke.
- Jones, R. (2014), *The Story of Baby P: Setting the Record Straight*, Bristol Policy Press.
- Keating, F., Robertson, D., McCulloch, A. and Francis, E. (2002), *Breaking the Circles of Fear*, Sainsbury Centre for Mental Health, London.
- Kelly, B. (2005), "Structural violence and schizophrenia", *Social Science and Medicine*, Vol. 61, pp. 721-730.
- Kemshall, H. (2002), *Risk, Social Policy and Welfare*, Open University Press, Buckingham.
- Knowles, C. (2000), *Bedlam on the Streets*, Routledge, Abingdon.

- Kohn, M. (1996), *The Race Gallery*, Vintage, London.
- Leese, M., Thornicroft, G., Shaw, J., Thomas, S., Mohan, R., Harty, M. and Dolan, M. (2006), "Ethnic differences among patients in high-security psychiatric hospitals in England", *British Journal of Psychiatry*, Vol. 188, April, pp. 380-5.
- Martin, J.P. (1985), *Hospitals in Trouble*, Blackwell, Oxford.
- Moon, G. (2000), "Risk and protection: the discourse of confinement in contemporary mental health policy", *Health and Place*, Vol. 6 No. 3, pp. 239-50.
- Ndegwa, D. and Olajide, D. (2006), *Main Issues in Mental Health and Race*, Ashgate, Aldershot.
- Nye, R. (2003), "The evolution of the concept of medicalisation in the late twentieth century", *The Journal of the History of Behavioral Sciences*, Vol. 39 No. 2, pp. 115-29.
- Omonira-Oyekanmi, R. (2014), "Black and dangerous? Listening to patients' experiences of mental health services in London", available at: www.opendemocracy.net (accessed 18 February 2015).
- Pollitt, C. (2003), *The Essential Public Manager*, Open University Press, Buckingham.
- Prins, H. (1994), *Report of the Committee of Inquiry into the Death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients*, SHSA, London.
- Prins, H. (2010), *Offenders, Deviants or Patients? Explorations in Clinical Criminology*, 4th ed., Routledge, Abingdon.
- Prospero, M. and Kim, M. (2009), "Ethnic difference in the effects of coercion on mental health and the use of therapy", *Journal of Social Work Practice*, Vol. 23 No. 1, pp. 77-91.
- Ritchie, J. (1994), *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, HMSO, London.
- Sainsbury Centre for Mental Health (2006), *The Costs of Race Inequality*, Sainsbury Centre for Mental Health, London.
- Seddon, T. (2007), *Punishment and Madness: Governing Prisoners with Mental Health Problems*, Routledge-Cavendish, Abingdon.
- Sharpley, M., Hutchinson, G., Robin, M., Murray, R. and McKenzie, K. (2001), "Understanding the excess of psychosis among the African — Caribbean population in England review of current hypotheses", *The British Journal of Psychiatry*, Vol. 178 No. 40, pp. s60-s68.
- Stanley, N. and Manthorpe, J. (2001), "Reading mental health inquiries messages for social work", *Journal of Social Work*, Vol. 1 No. 2, pp. 77-99.
- The Black Manifesto (1990 Trust)* (2010), *The Price of Race Inequality: The Black Manifesto*, 1990 Trust, London, available at: 1990trust.org.uk
- The Mental Health Act (1983), *The Mental Health Act*, HMSO, London.
- Thomas, P. (2012), "Black and mad", available at: www.madinamerica.com (accessed 19 August 2014).
- Turner, T. and Colombo, A. (2008), "Risk", in Turney, R., Turner, T. (Eds), *Critical Issues in Mental Health*, Palgrave, Basingstoke, pp. 161-75.
- Wacquant, L. (2005), "Race as civic felony", *International Social Science Journal*, Vol. 57 No. 183, pp. 127-42.
- Wacquant, L. (2009a), *Prisons of Poverty*, University of Minnesota Press, Minneapolis, MN.
- Wacquant, L. (2009b), *Punishing the Poor: The Neo-liberal Government of Social Insecurity*, Duke University Press, London.
- Warner, J. and Gabe, J. (2004), "Risk and liminality in mental health social work", *Health, Risk and Society*, Vol. 6 No. 4, pp. 387-99.
- Wolch, J. and Philo, C. (2000), "From distributions of deviance to definitions of difference: past and future mental health geographies", *Health and Place*, Vol. 6 No. 3, pp. 137-57.
- Wolff, N. (2005), "Community reintegration of prisoners with mental illness: a social investment perspective", *International Journal of Law and Psychiatry*, Vol. 28 No. 1, pp. 43-58.
- Yin, R.K. (1984), *Case Study Research: Design and Methods*, Sage Publications, Beverly Hills, CA.

Further reading

Department of Health (2005), *Delivering Race Equality*, HMSO, London.

Eastman, N. and Starling, B. (2006), "Mental disorder ethics: theory and empirical investigation", *Journal of Medical Ethics*, Vol. 32 No. 2, pp. 94-99.

Fernando, S. (2003), *Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism*, Brunner-Routledge, Hove.

Lelliot, P., Audini, B. and Dufferr, R. (2001), "Survey of patients from an inner-city health authority in medium secure psychiatric care", *British Journal of Psychiatry*, Vol. 178 No. 1, pp. 62-66.

Macpherson, W. (1999), *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny*, HMSO, London.

Secker, J. and Harding, C. (2002), "Users' perceptions of an African and Caribbean mental health resource centre", *Health and Social Care in the Community*, Vol. 10 No. 4, pp. 270-6.

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Carys Phillips, (2016), "Wales' safeguarding policy and practice: a critical analysis", The Journal of Adult Protection, Vol. 18 Iss 1 pp. 14-27 <http://dx.doi.org/10.1108/JAP-06-2015-0017>

Tony Stanley, (2016), "A practice framework to support the Care Act 2014", The Journal of Adult Protection, Vol. 18 Iss 1 pp. 53-64 <http://dx.doi.org/10.1108/JAP-07-2015-0020>

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Policing and street triage

Ian Cummins and David Edmondson

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Abstract

Purpose – In his recent report, Lord Adebawale (2013) described mental health issues as “core police business”. The recent retrenchment in mental health and wider public services mean that the demands on the police in this area are likely to increase. Mental health triage is a concept that has been adapted from general and mental health nursing for use in a policing context. The overall aim of triage is to ensure more effective health outcomes and the more effective use of resources. The purpose of this paper is to examine the current policy and practice in this area. It then goes on to explore the models of mental health triage that have been developed to try and improve working between mental health services and the police.

Design/methodology/approach – The paper outlines the main themes in the research literature regarding mental illness and policing, including a brief overview of section 136 MHA. It then examines recently developed models of triage as applied in these settings.

Findings – The models of triage that have been examined here have developed in response to local organisational, demographic and other factors. The approaches have two key features – the improved training for officers and improved liaison with mental health services.

Practical implications – Wider mental health training for officers and improved liaison with community-based services are the key to improving police contacts.

Social implications – The current pressure on mental health services has increased the role that the police have in responding to these sorts of emergencies. This situation is unlikely to change in the short term.

Originality/value – This paper contributes to the wider debate about policing and mental illness. It highlights the fact that section 136 MHA use has tended to dominate debates in this area to the detriment of a broader discussion of the police role.

Keywords Mental health, Policing, Triage

Paper type Research paper

Introduction

In his 2013 report, Lord Adebawale described mental health issues as “core police business”. There have been long-standing concerns about the role that police services are called upon to undertake in mental health work. These concerns include: the demands on police time and resources, the use of police cells as a place of safety under section 136 MHA, the response to young people and children in crisis, the lack of training that police officers receive and poor coordination of community-based mental health services. The recent retrenchment in mental health and wider public services has the potential to exacerbate the trend in these areas. As the Home Affairs Select Committee (HASC) (2015) notes mental health work will always be part of the wider police role but there are real concerns that increased demand will place too much pressure on stretched local resources. This might well put very vulnerable people at increased risk. It is clear that new approaches have to be considered. Mental health triage is a concept that has been adapted from general and mental health nursing for use in a policing context. A generic term “street triage” is used for the various models that have been adopted across forces. This term is used here when looking at these schemes. The overall aim of triage is to ensure more effective health outcomes and the more effective use of resources. This paper examines the

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current policy and practice in this area. It then goes on to explore the models of street triage that have been developed to try and improve working between mental health services and the police. It concludes that street triage has great potential. The benefits include better communication between mental health professionals and police officers, greater sharing of information that supports better decision making and an overall improved service for those in mental health crisis. However, more research needs to be undertaken to evaluate the effectiveness of the different models of street triage. At the moment, there is very little research that views of service-users, families and carers on the impact of street triage.

Mental health issues and the criminal justice system (CJS)

The interaction between the CJS and mental health systems continues to be an area of policy concern. The police have a key role in a range of scenarios that address mental health issues. These include dealing with individuals, who are experiencing acute mental distress, supporting colleagues in community mental health services and responding to incidents within mental health units. This area can be used to examine one of the wider questions policing research and policy – what is the role of the police, are they fundamentally a force or a service and what links the huge range of tasks that modern police officers are called upon to perform? As Cummins *et al.* (2014) highlight the media and popular culture representation of policing with its emphasis on the solution of violent crimes is far removed from the reality of day-to-day work. As Bittner (1967a, b) argued policing involves much more than the detection of crime and the apprehending of offenders. In fact, tackling crime does not constitute the majority of police work. In Bittner's (1970) famous phrase a police officer could be seen as "Florence Nightingale in pursuit of Willie Sutton" – Sutton was a famous bank robber. In his work, Bittner argued that the unifying factor in the bewildering range of police tasks from investigating serious crime to directing traffic was that they all potentially required the legitimate use of force. The police are a representation of Weber's definition of the State as the entity which has a "monopoly of the legitimate use of physical force".

Police involvement in mental health work has to be viewed as part of their role in wider community safety and the protection of vulnerable people. Wolff (2005) argues that the police have always had what might be termed a "quasi social work" role. However, as Husted *et al.* (1995) suggest it is not an area that is often valued that highly within police work. It does not fit with aspects of "cop culture" that Reiner (2000) identifies. For example, there is often not an immediate response in terms of action that can be taken. It is an area that does create particular challenges for police services (Carey, 2001; Lurigio and Watson, 2010). These challenges are both individual and organisational. Police officers do not receive a great deal of training in this area (Cummins and Jones, 2010). In addition, there is well-documented frustration amongst the police about the short comings in community-based mental health services and the potential impact that these have on their own role. Despite this background, at the time of writing, there is some cause for cautious optimism that there is finally a commitment to tackle these difficulties. Pilot schemes have been announced that will see mental health nurses being based in police custody suites to assist officers. This paper will explore models of service provision and their potential impact. The term street triage is used to describe the various configurations of services that have been developed by police and mental health services to respond to these issues. A note on terminology is required here. We will use the phrase service user. We recognise that all those in contact with the police because of a mental health crisis are or would regard themselves as service-users. However, for the purposes of this discussion, We would argue that the term is an appropriate one and preferable to a clumsy combination of patient, service user and member of the public.

The role of the police in modern mental health services

Lord Adebawale (2013) concluded that for the police, mental illness is "core business". His report was commissioned following a number of deaths in custody. A recurring feature of these awful events is that the person suffered from a history of mental illness (PCC, 2011). Lord Adebawale's analysis shows that the Metropolitan Police dealt with over 60,000 mental health-related incidents in 2012. This is an average of 160 incidents a day. One of the problems here is that mental health and illness are terms that cover such a wide range of human experiences. In a

survey carried out amongst officers, they categorised the nature of these “daily or regular” contacts as follows: victims (39 per cent), witnesses (23 per cent) and suspects (48 per cent). In their responses, two-thirds of officers indicated that they encountered unusual behaviour caused by alcohol or street drugs. The report also highlighted an area that is often overlooked in the policing and mental illness debate – the fact that people with mental health problems are at increased risk of being victims of crime. These risks appear to be significantly increased for violent offences. The report concluded that victims, who had a mental problem, generally felt that the service provided by the police fell below an acceptable level. The report confirmed the findings of the Sainsbury Centre for Mental Health (2008) investigation which indicated that 15 per cent of police work was related to mental health issues. In his evidence to the HASC Inquiry into Policing and Mental Health, GMP Chief Constable, Sir Peter Fahy went so far as to state that mental health work was the “number one issue for most front-line officers”.

As the HASC (2015) work noted, the police have always played a role in mental health services. However, there appears to have been an increase in the demands that it places on police officers. This is the result of a number of factors. The policy of deinstitutionalisation – i.e. the closure of the large asylums and their replacement by community-based mental health services – has been followed across Europe and North America (Cummins, 2011). The failure to develop adequate community mental health services and the impact on individuals is well documented (Moon, 2000; Kelly, 2005; Wolff, 2005). One impact of these failings has been for the police and CJS to become de facto providers of mental health care (Lamb *et al.*, 2002). This is the case across a number of jurisdictions. Wood *et al.* (2011, p. 6) show US police have become “front-line workers who often come into contact with persons with mental illness and must respond to their needs with whatever tools lie at hand” (emphasis added). This is reflected in the Australian context. Godfredson *et al.* (2010) concluded that responding to mental health-related incidents was a significant part of the working week for most officers. It is an area that police officers feel unprepared for by the current training (Cummins and Jones, 2010). This is a reflection of wider organisational cultures. As Pollitt and Bouckaert (2011) suggests the audit culture with an emphasis on risk and risk management that the new style of public management produces, can also lead to risk adverse practice. The IPCC role in investigations of serious incidents and deaths in custody means that officers can feel very exposed on a personal and professional level. The impact on individual officers who are involved in such cases is not to be underestimated.

Bittner (1967a, b) notes that policing requires the exercise of considerable discretion and individual judgement. Arrest and custody should be viewed as being at one end of a continuum. In Teplin's (1984) seminal study of policing and mental illness, she used the term “mercy booking” to describe the situation where the police arrest an individual because they felt that this would ensure that a vulnerable person would ensure that the person was given food and shelter – even if it was in custody. Morabito (2007) argues that police decision making is more complex than is allowed for in these situations. She argues that police decision making is shaped by a number of variables. These are termed “horizons of context”. This model provides a tool for the analysis of the decisions that officers make. In Morabito's model, there are three variable contexts. The scenic context refers to the range of the community resources that are available including the range of voluntary and statutory mental health services, access to training for officers and the working relationships between agencies. The discretion that officers can exercise is clearly limited by the range of services available. If community services are limited, then custody becomes regrettably a more likely outcome.

As well as the community resources, Morabito (2007) outlines two other “horizons of context”, which she terms temporal and manipulative. In this model, temporal refers to the individual and manipulative to the actual incident. There will be some incidents – for example in the rare cases when a violent crime has been committed – where the police for evidential and public protection reasons will have little alternative but to take the person into custody. At the other end of the scale, a very experienced officer dealing with a minor incident involving an individual they know well, will have much greater scope to exercise discretion. The scope will increase in areas where there are greater community mental health resources. As Morabito concludes there is a tendency to oversimplify the decision-making processes that police officers use in these complex and demanding situations. The local service, social and environmental contexts are thus vitally important.

Section 136 MHA

The Mental Health Act (MHA, 1983) outlines specific powers for police officers in the area of mental health. The most significant of these is section 136 (MHA). The use of section 136 MHA has become one of the key areas of debate in this whole field. It is important to examine some of the key issues as they have come to dominate much of the discussion. For example, the effectiveness of street triage schemes is often presented in terms of its impact on the use of section 136 MHA. Such an approach will not capture the full range of street triage work. It is, therefore, important that some of these issues are examined before street triage as an approach is examined in more depth.

Section 136 MHA allows an officer to take a person, who is in a public place and appears to be mentally disordered to a place of safety. Section 136 MHA is thus an emergency provision. If someone is detained under section 136 MHA, they must be assessed by a psychiatrist and an Approved Mental Health Professional. The MHA Code of Practice emphasises that the place of safety should be a health facility. It has been recognised that a busy and stretched A+E department is not an ideal environment for a patient who is experiencing acute mental distress. As a result, trusts have established dedicated section 136 MHA suites where these assessments can be carried out. In exceptional circumstances, a police cell can be used as a place of safety.

The quality of data for the use of s.136 is generally poor. However, it is accepted that the use of s.136 has generally increased since the mid-1990s. The majority of detentions take place outside of usual office hours when it is less likely that wider support services will be available (IPCC, 2008). This is addressed in the findings of this evaluation report. Research since the 1980s has consistently found that black and minority ethnic groups are significantly over-represented in s.136 detentions (Rogers and Faulkner, 1987; Dunn and Fahy, 1990; Bhui *et al.*, 2003). As Keating and Robertson (2004) note, a similar pattern of over-representation occurs across mental health services.

Her Majesty's Inspectorate of Constabulary (2013) study, "A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs" examined 70 cases in detail. In 57 (81 per cent) of cases, the reason for the use of the power was the perception of the level of risk that the patient would commit suicide or seriously harm themselves. The most common reason for the use of the police cell was that the service user was intoxicated, violent or both and the health-based place of safety would not accept them. Studies by Fahy (1989) and Borschmann *et al.* (2010) indicate that the "typical" s.136 patient is a young, single working class male, with a past history of mental illness who is not registered with a general practitioner.

One of the recurring difficulties when examining the use of s.136 concerns debates about outcomes. There is a tendency to argue that s.136 has only been used appropriately if the individual is admitted to hospital. The majority of s.136 orders in 2012/2013 did not lead to formal compulsory admission to hospital under the Mental Health Act 1983 (Health and Social Care Information Centre (HSCIC), 2013). This does not mean that the police use of the power was inappropriate. The test of s.136 is whether the police officer "thinks it is necessary to do so in the interests of that person or for the protection of other persons" (MHA, 1983, s.136.1). If a similar logic was applied to all MHA assessments then only those that resulted in formal admission would be appropriate. This does not stand any critical scrutiny. For example, any voluntary admission following the use of s.136 would somehow be seen as invalid. This contradicts not only sound mental health practice but also ignores the fundamental tenets of the MHA Code of Practice. In Borschmann *et al.*'s (2010) study of 32 the use s.136 by police in a South London Trust, of s.136 orders, 41.2 per cent did not lead to hospital admission, 23.1 per cent led to an informal admission and 34.4 per cent admission under the Mental Health Act 1983.

The case of *MS v. UK* which was decided in the European Court of Human Rights (ECHR) in 2012, demonstrates illustrates the potential difficulties that can arise. MS was detained under section 136 MHA following an assault on a relative. When he was assessed at the police station, it was decided that he needed to be transferred to psychiatric care. There then followed a series of delays and arguments between mental health services as to which unit would be the most appropriate to meet MS's mental health needs. This argument went on for so long that the 72 hour limit of section 136 (MHA) was passed. MS was still in police custody and this has a

dramatic impact on his mental state. For example, as a result of paranoid delusional ideas, he refused food. The ECHR held that the treatment of MS constituted a breach of article 3 which prohibits inhumane and degrading treatment. This is clearly an unusual case but it illustrates the potential issues that arise. The judgement made it clear that the initial decision to detain MS under mental health legislation was valid and justified. It is clear that the police cannot hope to tackle the root causes of these problems in isolation. In January 2014, ten pilot sites were announced where mental health nurses are to be allocated to police custody suites to assist in the assessment of service-users.

The HASC (2015) inquiry reflecting the nature of the broader debates about policing and mental health spent a significant period examining the use of section 136 MHA. This included exploring potential alternatives and reform of the legislation. One of the major issues here is the collection of the data on the use of these powers – one of the HASC recommendations is to strengthen information systems in this area. The most recent data from the National Police Chiefs Council (NPCC) (www.npcc.org.uk) on the use of section 136 MHA in England and Wales highlights the difference in the patterns of use. These have to be viewed through the lens of Morabito's "horizons of context" which allows for different local and regional demands or service provision. However, there are some very striking figures. There were 23,602 recorded uses of the power involving adults and 947 involving those under the age of 18. In total, 4537 adults and 161 young people were detained in police cells. Four forces Sussex (25), Lincolnshire (21), Hampshire (15) and Devon and Cornwall (25) accounted for 53 per cent of the detentions of young people in cells. This is clearly not meant as a criticism of those individual forces it highlights the huge variations that can and do occur.

The NPCC figures indicate that there has been a fall both in the use of section 136 (11.5 per cent) and the use of police cells (32 per cent). The Mental Health Crisis Care Concordat (2014) committed agencies to achieve a reduction of 50 per cent in the use of police cells as a place of safety. As noted above, the use of police cells as a place of safety is an issue of ongoing debate. Simon Cole (Chief Constable of Leicestershire) and former ACPO mental health lead for Mental Health forcefully argued at the HASC that it was simply unacceptable that police cells are used in these circumstances. He also emphasised that section 136 MHA can last up to 72 hours whereas the police have to charge or release an arrested person in 24 hours under PACE. The HASC report decides against calling for the prohibition of the use of police cells. However, it supports the proposal subsequently included in the Queen's Speech that their use for cases involving those under 18 should be outlawed. It also proposes that the time limit for section 136 MHA be reduced to 24 hours with strong support that a three-hour time limit as outlined in Royal College of Psychiatrist guidelines should be a target for all providers. These proposed reforms would address some of the issues outlined above.

The use of section 136 MHA is a very important area. It raises very important civil liberty issues as well as wider ones about the treatment of people experiencing mental health problems. As Latham (1997) points out it allows for an individual to detain someone. Unlike sections 5(2) and 5(4) of the MHA the person with the power has no medical training and no medical evidence is required for the power to be enacted. In fact, the purpose of detention under section 136 is for psychiatric assessment. However, it is important to bear in mind that this is just one area of mental health work, in which, police officers are potentially involved. There is a danger that debates about the working of section 136 overshadow the whole debate in this field.

Service user perspectives

Jones and Mason (2002) carried out a study of the use of s.136 MHA from a service-user's perspective. This study has very powerful messages for all services working in this area. In particular, this study emphasises that from the service-user perspective s.136 MHA is a custodial rather than a therapeutic experience. In the study, service-users felt that the police did not have their mental health needs at the forefront of decision making. It is interesting to note that it was felt that officers adopted a much more sympathetic approach in A&E departments. The experience in custody was characterised as extremely distressing. Riley *et al.* (2011) carried out interviews with 18 people who had been detained in police custody under s.136. This study emphasised that

there was general dissatisfaction with the whole process. In particular, it was felt that it made the individuals feel like criminals. Some detainees felt that their mental health had actually got worse because of their detention in police custody.

At the time of writing, there is some cause for cautious optimism that there is finally a commitment to tackle these difficulties. In a wider context, initiatives such as, Mental Health First Aid England (MHFA) was launched in 2007 with the support of the Department of Health: National Institute of Mental Health in England (NIMHE) as part of a national approach to improving public mental health. MHFA provides support and training to a range of front-line public services. In February 2014, the Crisis Care Concordat was signed by more than 20 national organisations in England in a bid to drive up standards of care for people in police custody. The Concordat, sought to build on other announcements on mental health care, notably liaison and diversion schemes (e.g. placing mental health professionals in police custody and court settings to help identify mental health problems in offenders as early as possible), street triage (e.g. mental health clinicians – typically trained nurses – accompany police officers when making emergency responses to people suffering from a mental health crisis. The nurses may also advise and support officers by telephone) and the Mental Health Action Plan (2014). As College of Policing Chief Executive Chief Constable Alex Marshall has stated: “The Concordat is a strong statement of intent of how the police, mental health services, social work services and ambulance professionals will work together to make sure that people who need immediate mental health support at a time of crisis get the right services when they need them” (College of Policing, 2014).

Models of street triage

Triage

This section will explore the concept of triage. It will then examine the differing approaches or models of service provision that are covered by the catch all term street triage. Until relatively recently, the focus of offender mental health provision has been on prisons rather than earlier in the CJS process. Triage is a well-established concept within general nursing and medicine. In this process, an early assessment allows for individuals at A+E so that they can be treated speedily in the most appropriate setting. This process allows for the more efficient allocation of medical resources. It is also suggested that triage provides for more effective patient outcomes (Fitzgerald *et al.*, 2010).

A+E can be a key point of contact for those experiencing acute mental distress. The first thing to acknowledge that A+E is a far from ideal environment for those experiencing acute distress. The noise, distress of other patients, the possibility of long delays, lack of amenities and staffing difficulties are all factors that contribute to this. As Clarke *et al.* (2009) argue mental health crises do not fit into the standard pattern of assessment and treatment at A+E. This is not to deny that there are complex interactions between social and other environmental factors in all forms of illness. However, in this context, mental illness is different. A mental health crisis may well be triggered by one recent event, for example a bereavement which might be easily identified. However, the underlying causes are more complex, likely to be deeply engrained and not immediately responsive to treatment in the same way as physical illness. The service-users in Clarke *et al.*'s (2009) study clearly felt that the emergency system did not meet their needs but they often “had nowhere else to go”. Other factors that were highlighted were the impact of waiting times and what is termed “diagnostic overshadowing” – i.e. the idea that any or all symptoms were put down to mental illness. As Rosenhan (1973) noted in his famous study, one of the most profound impacts of a diagnosis of mental illness is that all other behaviours become interpreted through that prism.

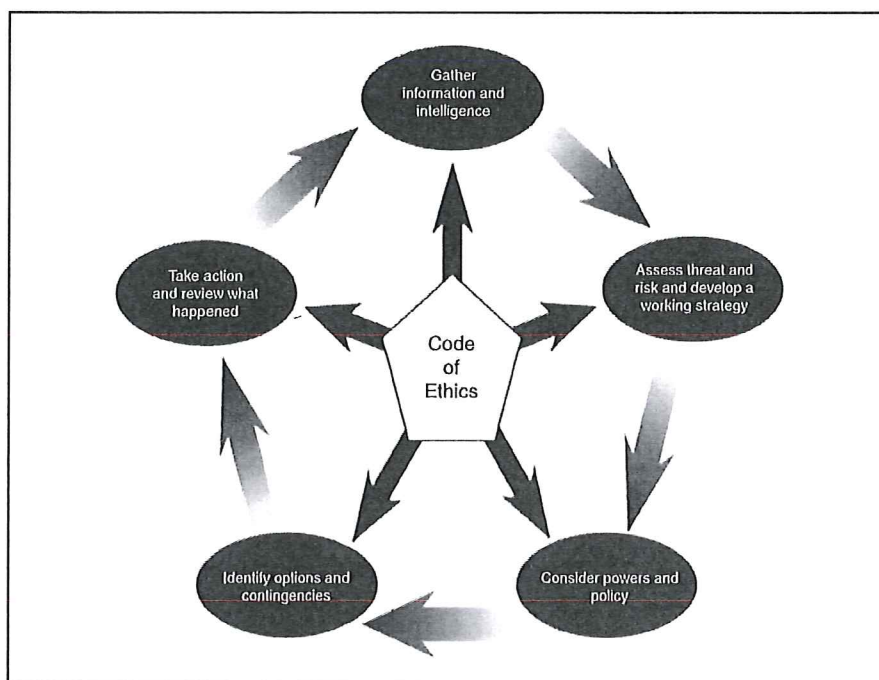
The physical environment makes A+E far from ideal environment for the assessment and treatment of mental illness. In addition, as Kirby and Keon (2004) note mental health can be an area where even experienced general nursing staff lack confidence. This is despite the fact that between 5 and 10 per cent of presentations at A+E relates to mental health issues. Mental health issues can be more difficult to assess, particularly if the patient is not well known. Background information that would help this process is often difficult or not possible to obtain. Spandler (1999)

showed that service-users felt nursing staff at A+E dealing with incidents of self-harm were often unsympathetic at best or hostile at worst to patients, particularly those who accessed the services on a frequent basis. As McDonough *et al.* (2004) note the shift to community services has meant that the number of mental health presentations at emergency departments has been increasing. In this context, the need for triage becomes even greater. Sands (2004) makes it clear that because mental health issues are, generally more difficult to assess and can be masked by factors such as alcohol and drug misuse triage is a longer and more complex process. As a result of these difficulties, models of mental triage have been developed. Clarke *et al.* (2009) outline one such model where cases are assessed on a scale from emergency – patient is violent, aggressive and suicidal to non-urgent where the patient has long-standing mental health issues and is not acutely unwell.

Policing and street triage

As outlined above, mental health triage is a difficult practice, organisational and logistical issue for specialist services. The pressures outlined above that impact on assessment are mirrored or replicated in community settings. As Seddon (2007) argues there is something of an unrealistic view that the mental health and CJSs can ever be two completely distinct entities. The boundaries between the two are “porous” (Lurigio, 2011). As Cummins (2013) has argued the pressure on community mental health services makes these boundaries more confused. In the context of policing, street triage has come to be used as a short-hand for a number of models of joint services with mental health staff and policing. These systems share the same aims as triage in that they combine some element of assessment with a recognition that individuals need to access the most appropriate services in a timely fashion. In addition, these models of service provision are trying to improve officers’ confidence in decision making in these situations. Street triage as an approach is in line with the recently developed National Decision Making Model (2013) (www.nationaldecisionmodel.co.uk/) for police officers. The model (Figure 1) is a five-stage approach to decision making for officers including gathering information but also considering if the police are the right agency to respond. If the police are the right agency then they also need

Figure 1 National decision making model



to explore what legal powers they should use. Street triage thus aims to support officers in making these decisions – by offering access to information but also alternatives to the use of statutory powers.

Lamb *et al.* (2002) identify possible models of police response. The models can be divided into three very broad types: specialist police offices response, specialist mental health professional response or some form of joint team. The first is the selection and training of designated specialist officers. The first and probably best known of these schemes is the Crisis Intervention Team (CIT) based in Memphis (Compton *et al.*, 2008). This model was established in 1988 following an incident when the Memphis Police shot dead a man who was suffering from a psychotic illness. The CIT officers deal with mental health emergencies but also act in a consultancy role to fellow officers. To become a CIT officer, personnel have to undergo intensive mental health awareness work as well as training in de-escalation techniques. The second approach is to have a joint mental health and police team that is on-call to respond to identified mental health emergencies. For example, both West Midlands and Leicestershire have established pilot projects using a patrol car with a mental health nurse in addition to police staff. In the USA, there are examples of specialist mental health teams that have been established to respond crises. The final model that Lamb *et al.* (2002) identify is a “phone triage” approach where mental health professionals are available to offer advice or information to patrol officers.

The CIT is a well-established model. In addition to the training of officers, one of the cornerstones of CIT is the fact that there is an agreement that the local hospital will accept all CIT referrals. Franz and Borum (2010) analysis suggests that this model continues to have a positive impact. The authors calculated that the “prevented arrest” rate over a five-year period in an urban county in Florida where the CIT model was introduced. One of the difficulties in this area is the collection of the data before CIT was developed. However, in the period analysed there were 1,539 calls that led to 52 arrests – an arrest rate of 3 per cent. The study estimated 342 arrests in such incidents in the previous five years before the introduction of CIT. Thus 290 arrests were prevented. Even allowing for a cautionary approach – for example – in some circumstances an arrest might be simply unavoidable – this shows the potential of such a models. As Watson *et al.* (2008) note two key factors in the success of the CIT model are the increased police confidence in dealing with these situations and the no “refusal policy” that is established with the local mental health units.

Hails and Borum (2003) carried out a review of 84 law enforcement agencies. They examined not only the amount of training provided to officers but also the use of specialist teams for responding to mental health incidents. They found wide variations in the levels of training provided – the median was six- and-half hours for basic recruits and an hour for in-service training. As the study notes, the training for basic recruits was also used to address the issues of substance misuse and learning disabilities. The study also examined the organisational responses to these issues. A total of 27 agencies provided relevant information. In total, 11 agencies they had access to mental health professionals “in house” that could assist officers. Hails and Borum classify this as a “police-based specialised mental health response model”. Nine followed the model of having specially trained officers – a model the authors’ term “police-based specialised police response model”. The final seven responses indicated that the police were able to contact a mobile mental health crisis team – a model classified as “mental health-based specialised mental health response model”. The study concluded that programmes such as the CIT model had the greatest potential to reduce the use of lethal force and arrests. The authors also argue that this model requires little organisational change to be developed and operate effectively.

Reuland *et al.* (2009) argue either a joint team or specialist mental health support has produced promising results. The gains can be seen both in health care outcomes and more effective use of police resources. There is an organisational cultural issue that needs to be addressed here. The usual measures of police outcomes such as response times or arrest rates cannot be neatly applied here. This is essentially a public health issue. An analysis that focuses purely on only one variable such as the arrest rate does not produce a complete picture. An example of the joint approach is Car 87 in Vancouver. In the ten years to 2002, Canadian police fatally wounded 11 seriously mentally ill people. This scheme was developed as part of the response to these cases. The project is a jointly funded between the police and local mental health services. In addition to a joint response it provides a phone triage service (www.vancouver.ca/police).

In England and Wales, the Cleveland Street Triage team was established in 2012. This is also a jointly health and police funded project that ensures that a mental health nurses are available to carry out assessment when police are called to an incident. The scheme has a broader remit as assessments also take place if there is a substance misuse problem or the individual has a learning disability. In the first year of the scheme, there were 371 assessments. Only 12 (3.2 per cent) resulted in section 136 assessments. Drug or alcohol-related problems were the main presenting issue in 129 cases. In total, 205 individuals were regarded as not having any "significant mental disorder". In total, 134 (36.1 per cent) were known to the local trust. This scheme highlights a number of key issues. The majority of these cases may well not be "psychiatric emergencies" in a clinical sense. They are representations of long-standing often deeply entrenched problems. This is not to down play their significance, it is rather highlights the need for a range of professional responses. For example, the issues of mental health and substance misuse are often inter-related. The use of police powers can also be seen to add to the stigma attached to mental illness. However, there is a possibility that the focus on the use of section 136 dominates discussions in this area. In particular, there is the danger that the use of section 136 is only seen as appropriate when the person is subsequently detained under section 2 or 3 MHA 1983. This is a very reductive measure. Any triage system will not remove the need for the use of such powers.

Edmondson and Cummins (2014) report the findings of an evaluation of a pilot scheme in Oldham Greater Manchester. In the pilot, police officers were able to ring a dedicated phone line that was staffed 24 hours a day by an experienced mental health nurse based at the local hospital. Police officers were able to discuss the circumstances of the call that they had responded to. The scheme was immediately valued very highly by the police officers. Service-users were given faster access to appointments or emergency assessments if required. The scheme meant that there was no need for service-users or police to attend the A+E department; they were fast-tracked to the section 136 suite which was a much more appropriate environment. The pilot was seen to increase police confidence. In addition, new approaches were developed. Officers often passed the mobile phone to the service-user who was able to speak directly to nursing staff. The scheme also improved inter-agency working. At a local level, it is often these personal working relationships that are as important as any other factor to the improvement of services.

Conclusion

One of the unintended consequences of the policy of deinstitutionalisation has been that all CJS agencies have had enlarged roles in mental health services. Wood *et al.*'s (2011) review of trends in the UK, Canada and the USA concludes that the same issues arise across the countries: a combination of reduced psychiatric provision and poorly funded community services has led to increased pressure on police officers who often receive little or no specific mental health training. Lurigio and Watson (2010) refer to the porous boundaries between the CJS and mental health systems. The police have increasingly found themselves part of both. In the UK, the wider policing agenda has meant that there has been a significant shift so that policing is concerned with more than the detection and arrest of offenders. Policing has always been about more than dealing with crime (Bittner, 1970). However, current trends have emphasised this role in dealing with wider social problems.

Mental health and policing is moving up the policy agenda. The Bradley (2009) report identified a series of the broader concerns about the experiences of vulnerable adults in the CJS have over the past 12 months there has been an increase focus on mental health issues as they impact on the day-to-day working of police officers. The debates in this area need to include a consideration of possible reform of section 136 MHA including ways of ensuring that police cells are not routinely used as places of safety. However, there is a danger that the focus on section 136 will push to the margins the wider role that police officers potentially have in this field. Lord Adebowale concluded mental health is core police business. I take the phrase mental health is "core police business" to mean that dealing with individuals experiencing mental distress is a key feature of the working week of most police officers. The models of triage that have been examined here have

developed in response to local organisational, demographic and other factors – for the example a response to a tragic incident or the commitment of individuals. It would be foolish to try to be very prescriptive in developing models of triage. However, all these schemes have two key features – the improved training for officers and improved liaison with mental health services. These elements are vital whatever the nature of the mental health crisis or incident that is being addressed. This is an emerging area with the potential for new forms of service configuration, practice and approaches to develop that will solve some of the long-standing problems in this field. The next stage is for street triage to become embedded in community mental health provision. A systematic evaluation of the models which must include service-user perspective then needs to take place.

References

- Adebawale, L. (2013), "Independent commission on mental health and policing report", available at: <http://mentalhealthpolicing-independent.wazoku.com> (accessed 3 October 2015).
- Bhui, K., Stansfield, S., Hull, S., Priebe, S., Mole, F. and Feder, G. (2003), "Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review", *The British Journal of Psychiatry*, Vol. 182 No. 2, pp. 105-16.
- Bittner, E. (1967a), "Police discretion in emergency apprehension of mentally ill persons", *Social Problems*, Vol. 14, pp. 278-92.
- Bittner, E. (1967b), "The police on skid row: a study of peace keeping", *American Sociological Review*, Vol. 32 No. 5, pp. 699-715.
- Bittner, E. (1970), "Functions of the police in modern society", NIMH, Washington, DC.
- Borschmann, R.D., Gillard, S., Turner, K., Lovell, K., Goodrich-Purnell, N. and Chambers, M. (2010), "Demographic and referral patterns of people detained under Section 136 of the Mental Health Act (1983) in a South London Mental Health Trust from 2005-2008", *Medicine, Science and the Law*, Vol. 50, pp. 15-18.
- Bradley, K. (2009), "The Bradley report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system", DoH, London.
- Carey, S.J. (2001), "Police officers' knowledge of and attitudes to mental illness in southwest Scotland", *Scottish Medical Journal*, Vol. 46 No. 2, pp. 41-2.
- Clarke, D., Dusome, D. and Hughes, L. (2009), "Emergency department from the mental health client's perspective", *International Journal of Mental Health Nursing*, Vol. 16, pp. 126-31.
- College of Policing (2014), available at: www.college.police.uk/About/Documents/Mental_Health_Crisis_Care_Concordat.pdf (accessed 3 October 2015).
- Compton, M., Bahora, M., Watson, A. and Oliva, J. (2008), "A comprehensive review of extant research on crisis intervention team (CIT) programs", *Journal of American Academy of Psychiatry and the Law*, Vol. 36 No. 1 pp. 47-55.
- Cummins, I. (2011), "Mental health services in the age of neo-liberalism", *Social Work and Social Policy in Transition*, Vol. 1 No. 2, pp. 55-74.
- Cummins, I. (2013), "Policing and mental illness in the era of deinstitutionalisation and mass incarceration: a UK perspective", *International Journal of Criminology and Sociological Theory*, Vol. 6 No. 4, pp. 92-104.
- Cummins, I. and Jones, S. (2010), "Blue remembered skills: mental health awareness training for police officers", *Journal of Adult Protection*, Vol. 12 No. 3, pp. 14-19.
- Cummins, I., Foley, M. and King, M. (2014), "'... And after the break': police officers' views of TV crime drama", *Policing: A Journal of Policy and Practice*, Vol. 8 No. 2, pp. 205-11.
- Dunn, J. and Fahy, T. (1990), "Police admissions to a psychiatric hospital. Demographic and clinical differences between ethnic groups", *The British Journal of Psychiatry*, Vol. 156 No. 3, pp. 373-8.
- Edmondson, D. and Cummins, I. (2014), "Oldham mental health phone triage/RAID pilot project evaluation report", available at: www.crisiscareconcordat.org.uk (accessed 10 October 2015).

- Fahy, T. (1989), "The police as a referral agency for psychiatric emergencies: a review", *Medicine, Science and the Law*, Vol. 29 No. 4, pp. 315-22.
- FitzGerald, G., Jelinek, G., Scott, D. and Gerditz, M. (2010), "Emergency department triage revisited", *Emergency Medicine Journal*, Vol. 27 No. 86, pp. 86-92.
- Franz, S. and Borum, R. (2010), "Crisis intervention teams may prevent arrests of people with mental illnesses", *Police Practice and Research*, Vol. 12 No. 3, pp. 1-8.
- Godfredson, J.W., Thomas, S.D.M., Ogloff, J.R.P. and Luebbers, S. (2010), "Police perceptions of their encounters with individuals experiencing mental illness: a Victorian survey", *Australian & New Zealand Journal of Criminology*, Vol. 44 No. 2, pp. 180-95.
- Hails, J. and Borum, R. (2003), "Police training and specialized approaches to respond to people with mental illnesses", *Crime & Delinquency*, Vol. 49 No. 1, pp. 52-61.
- Her Majesty's Inspector of Constabulary (2013), "A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs", available at: www.hmic.gov.uk (accessed 24 February 2014).
- Health and Social Care Information Centre (HSCIC) (2013), available at: www.hscic.gov.uk/mhmds (accessed 10 October 2015).
- Home Affairs Select Committee (HASC) (2015), "Policing and mental health", available at: www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf (accessed 3 October 2015).
- Husted, J.R., Charter, R.A. and Perrou, M.A. (1995), "California law enforcement agencies and the mentally ill offender", *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 23, pp. 315-29.
- IPCC (2008), "Police custody as a 'Place of Safety': a national study examining the use of Section 136 of the Mental Health Act 1983", available at: www.ipcc.org.uk (accessed 10 October 2015).
- IPCC (2011), "Deaths in or following police custody: an examination of cases 1998/99 to 2008/9", available at: www.ipcc.org.uk (accessed 10 October 2015).
- Jones, S.L. and Mason, T. (2002), "Quality of treatment following police detention of mentally disordered offenders", *Journal of Psychiatric and Mental Health Nursing*, Vol. 9 No. 1, pp. 73-80.
- Keating, F. and Robertson, D. (2004), "Fear, black people and mental illness: a vicious circle?", *Health and Social Care in the Community*, Vol. 12 No. 5, pp. 439-47.
- Kelly, B. (2005), "Structural violence and schizophrenia", *Social Science and Medicine*, Vol. 61 No. 3, pp. 721-30.
- Kirby, M.J. and Keon, W.J. (2004), "Mental health, mental illness, and addiction: overview of policies and programs in Canada", interim report of the Standing Senate Committee on Social Affairs, Science, and Technology, Ottawa.
- Lamb, H.R., Weinberger, L.E. and DeCuir, W.J. (2002), "The police and mental health", *Psychiatric Services*, Vol. 46 No. 12 No. 1, pp. 1267-71.
- Latham, A. (1997), "The Cinderella section: room for improvement in the documentation and implementation of section 136 of the Mental Health Act 1983", *Journal of Clinical Forensic Medicine*, Vol. 4 No. 4, pp. 173-5.
- Lurigio, A. (2011), "People with serious mental illness in the criminal justice system causes, consequences, and correctives", *The Prison Journal*, Vol. 91 No. 3, pp. 66-86.
- Lurigio, A. and Watson, A.C. (2010), "The police and people with mental illness: new approaches to a longstanding problem", *Journal of Police Crisis Negotiations*, Vol. 10 Nos 1-2, pp. 3-14.
- McDonough, S., Wynaden, D., Finn, M., McGowan, S., Chapman, R. and Hood, S. (2004), "Emergency department mental health triage consultancy service: an evaluation of the first year of the service", *Accident and Emergency Nursing*, Vol. 12 No. 1, pp. 31-8.
- Mental Health Action Plan (2014), available at: www.gov.uk/government/publications/mental-health-priorities-for-change (accessed 3 October 2015).
- Moon, G. (2000), "Risk and protection: the discourse of confinement in contemporary mental health policy", *Health & Place*, Vol. 6 No. 3, pp. 239-50.

The relationship between mental institution beds, prison population and crime rate

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Lionel Penrose (1898-1972) made an enormous contribution to the development of medical genetics, particularly in the study of Down's Syndrome (Harris, 1974). In addition, he was also concerned with the nature of the services provided for the mentally ill and those with learning disabilities. In this essay, I will explore his famous hypothesis regarding the use of prison and psychiatric care in the light of recent developments in both policy areas.

Penrose (1939 and 1943) put forward the intriguing hypothesis that there is a fluid relationship between the use of psychiatric inpatient beds and the use of custodial sentences. The 1939 paper was based on the analysis of statistics from European countries and argues that there was an inverse relationship between the provision of mental hospitals and the rate of serious crime in the countries studied – as one increases, the other decreases.

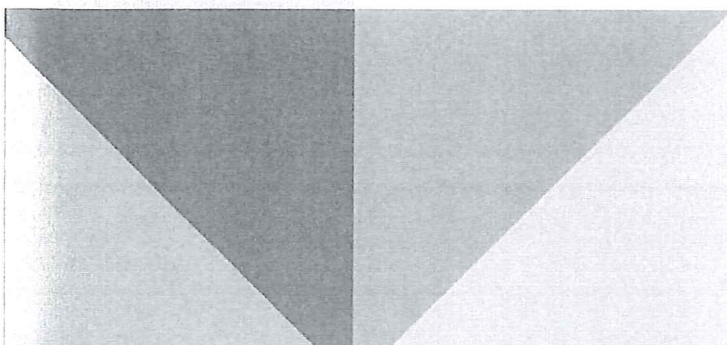
The 1943 paper was a study of the rates of hospital admission in different states in the USA and the numbers in state prisons. Later in his work, he argued that a measurable index of the state of development of a country could be obtained by dividing the total number of people in mental hospitals and similar institutions by the number of people in prison. Penrose's work in this area

concludes that society responds to challenging or bizarre behaviour in one of two ways – either by the use of the criminal justice system or the mental health system. The system with the greater capacity at the time takes on this role.

The problem raised by the use of the criminal justice system as a response to mental illness is not a new one. Howard (1780) noted that there were a number of "idiots and lunatics" in prison. He also argued that they did not receive appropriate care and if they did they "...might be restored to their senses and usefulness in life." Stone (1982) argues that this is a problem all urban societies have faced in one form or another. In addition, he suggests that it is one that has never been solved.

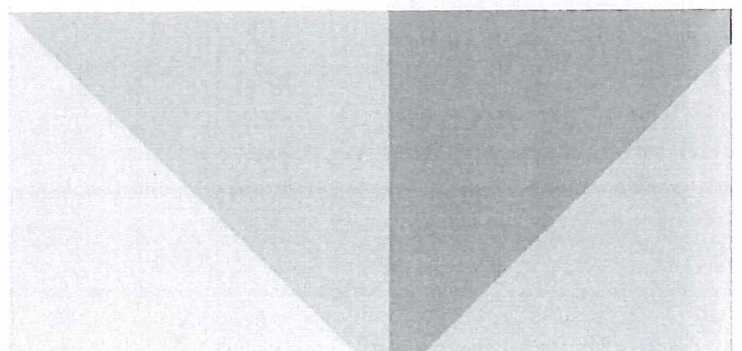
The justification for the development of community based mental health services is based on moral and clinical arguments. It is a combination of idealistic and pragmatic approaches. The idealism can be seen in the human rights arguments that were put forward. Community based services, it was argued, would be by definition more humane. Lamb and Bachrach (2001) argue that this was based on a moral argument with little evidence to support it. Clearly, the supporters of community based mental health services did not argue that asylums should be replaced by jails.

Deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of the mentally ill, did not achieve its aims. Wolff (2005) and Moon (2000) argue that asylums have been replaced by a fragmented and dislocated world of bedsits, housing projects, day centres or increasingly, prisons and the criminal justice system. This shift has been termed 'transinstitutionalisation'.



References

- Bradley K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, London: DH.
- Clark T and Rowe R (2006) Violence, stigma and psychiatric diagnosis: the effects of a history of violence on psychiatric diagnosis, *Psychiatric Bulletin*, 30, pp.254-256.
- Department of Health (1999) *The National Service Framework for Mental Health*, London: DH.
- Home Office and Her Majesty's Prison Service (2003) *Abuse, interventions and women in prison: a literature review*, London: HM and HMPS.
- James D, Farnham F, Moorey H, Lloyd H, Hill K, Blizzard R, Barnes T (2002) *Outcome of psychiatrist admission through the courts*, Home Office RDS Occasional Paper No 79, London: Home Office.
- Mind Factsheet: *Public attitudes to mental distress*, online: www.mind.org.uk
- National Institute for Mental Health in England (2003) *Personality Disorder: no longer a diagnosis of exclusion*, London: NIMHE.
- Prison Reform Trust (2009) *Too little, too late*, by K Edgar and D Rickford, London: Prison Reform Trust.
- Revolving Doors Agency (2007) *Prisons: Britain's "Social Dustbins"*, by J Corner, E Jones and R Honeyman, London: Revolving Doors Agency.
- Rumgay J (2004) *When victims become offenders: in search of coherence in policy and practice*, London: The Fawcett Society.
- Rutherford M (2010) *Blurring the boundaries: the convergence of mental health and criminal justice policy, legislation, systems, and practice*, London: Centre for Mental Health.
- Centre for Mental Health (2002) *Briefing 17: an executive briefing on breaking the circles of fear*, London: SCMh.
- Talbot, J (2008) *Prisoners' voices: experiences of the criminal justice system by prisoners with learning disabilities and difficulties*, London: Prison Reform Trust.
- TNS-BMRB (2010) *Public attitudes towards mental health*, London: DH.
- Wilson, D (2006) The prison trick, *The Guardian*, 17 June 2006.
- ⁱ "The criminal law is an unsophisticated instrument for determining blame. Apart from the specific defences of insanity and diminished responsibility, there is no specified way in which defences are framed which make allowances for the state of mind for a person who commits a criminal act. It must therefore be acknowledged that the criminal law may operate unfairly in relation to people labelled as mentally disordered offenders." Mind, cited in SCMh, Rutherford, page 39.
- ⁱⁱ *Time to Change* is England's most ambitious programme to end the discrimination faced by people with mental health problems, and improve the nation's wellbeing. www.time-to-change.org.uk
- ⁱⁱⁱ Ministry of Justice (2009) *Offender Management Caseload Statistics 2008*, Table 6.1, page 51.
- ^{iv} Prison Reform Trust (2009) *Bromley Briefings*, June 2009, page 43, London: Prison Reform Trust.
- ^v Revolving Doors Agency (2007) *Prisons: Britain's "Social Dustbins"*, by J Corner, E Jones and R Honeyman, London: Revolving Doors Agency, page 1.
- ^{vi} www.circles-uk.org.uk



This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them.

Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor indicators. Kelly (2005) uses the term 'structural violence', originally from liberation theology to highlight the impact of a range of factors including health, mental health status and poverty that impact on the mentally ill.

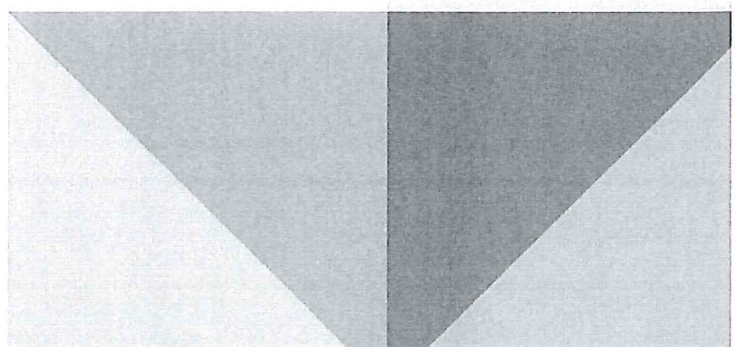
The response of successive governments since 1983 to the developing crisis in the provision of mental health services has been to focus on the legislative and policy framework.

The policy of deinstitutionalisation is followed across the world (Hicking, 1994; Mizuno et al, 2005; Ravelli, 2006). The World Health Organization (2001) highlights that long-term facilities are still the most common form of service provision – 38 per cent of countries worldwide have no community-based mental health services, whereas there has been a shift in service provision in North America and Europe towards this policy. At the same time, there has been a clear shift towards a more punitive prison policy. As Wacquant (2009) argues, throughout the industrialised world there has been a large prison building programme and investment in the criminal justice system. It should be noted that this process has been overseen by governments, particularly in the UK and USA with a commitment to reducing both the role of the state and public spending. Gunn (2000) and Kelly (2007) found that the reduction in the number of psychiatric beds in the UK occurred at the same

time as the rise in the prison population, as Penrose predicted. The clash of the two policies outlined above – hospital closure and prison expansion – at first seems to provide evidence to support Penrose; they also create significant challenges for all those working in these fields. As Lord Bradley (2009) has highlighted there is a need for all staff working in agencies in the criminal justice system to receive training in relation to mental health issues.

Large and Nielessen (2009) undertook a review of Penrose's original hypothesis using data from 158 countries. They suggest one of the main features of Penrose's argument is that there is a unchanging proportion of any population that will need, or be deemed to need, some form of institutional control. They concluded that though there was a positive correlation between prison and psychiatric populations in low and middle income countries, there was no such relationship in high income countries.

It is clear that in the UK, the prison population has risen significantly over the past 25 years. I remember working as a probation officer in the mid-1980s when there were great concerns that the prison population would break the 45,000 barrier. Wacquant (2009) argues that prison policy has replaced welfare services as a means of responding to the needs of marginalised individuals and communities. Successive governments of differing political persuasions have been seemingly addicted to the expansion of the use of custody despite its well-documented failings to achieve its avowed aims. In addition, as Barr (2001) demonstrates, the 'zero tolerance' approach widely adopted in the privatising and policing of public space results in more mentally ill people being drawn into conflict with various public authorities.



Discussion

It is possible to explore Penrose's hypothesis as a statistical argument about the use of two distinct institutional processes – prison custody and psychiatric care – and the investigation of the relationship between the two. I would argue that there are a number of dangers in this approach. It equates, however unintentionally, crime and mental illness. In addition, it fails to explore the reasons behind the changes in patterns of use of the two institutions. As Garland (2001) suggests, the increase in the use of prison continues despite the general reduction in the crime rate. Therefore, it is part of a wider change in society and government attitudes rather than simply a response to crime. The changes in the use of institutional psychiatric care are the result of a combination of social attitudes, improved medical and treatment approaches, recognition of the cost of in-patient treatment and recognition that citizens should not lose their civic and human rights because of mental ill-health.

The moral force of Penrose's arguments can perhaps be located in his Quaker beliefs. In a similar vein, in 1994 the Mental Health Foundation published *Finding a place*. This was the result of a general inquiry into the failings of mental health policy in the late 1980s/early 1990s that ultimately led to the *Ritchie Inquiry*. The messages of this report are very relevant to this discussion. Instead of starting from an organisational or service structure perspective, the report adopts a values one. It asks the fundamental questions:

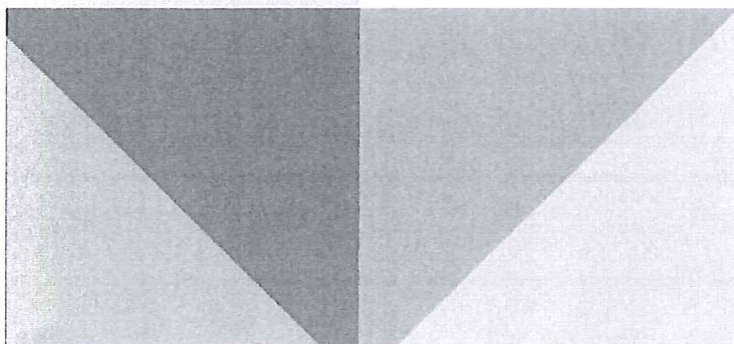
- what are the underpinning beliefs, on which, mental health services should be based?
- what is it that mental health services should seek to provide for those experiencing acute distress?

The answer is, in many ways, disarmingly straightforward: an appropriate place to live, an adequate income, employment and other activity, respect, trust, help and support. These reflect civic and human values of support and respect that should be at the core of public services – whatever their configuration.

The range of service initiatives that have been developed to address the mental health needs of those in our prisons are to be welcomed. However, these new ways of working should not obscure the fact that as a society we have become over-reliant on the use of prisons. As a result of this and other policies discussed above, the distinction between some areas of the criminal justice system and mental health services are increasingly blurred. All too often, policy decisions in this area are presented as if there is no alternative. The force of Penrose's initial papers today is the clear view that we, as a society, have a choice to do things differently. I would argue that the message of the *Bradley Report* is that this is a choice that we should exercise.

References

Barr H (2001) Policing madness: people with mental illness and the NYPD in *Quality of life and the new police brutality in New York City*, New York: NYU Press.



Bradley K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, London: DH.

Garland D (2001) *The culture of control: crime and social order in contemporary society*, Chicago: University of Chicago Press.

Gunn J (2000) Future directions for treatment in forensic psychiatry, *British Journal of Psychiatry*, 176 pp332-338.

Harris H (1974) The development of Penrose's ideas in genetics and psychiatry, *British Journal of Psychiatry*, 125 pp529-536.

Hicking F W (1994) Community Psychiatry and deinstitutionalization in Jamaica, *Hospital and Community Psychiatry*, 45(11) pp1122-1226.

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

Kelly B (2005) Structural violence and schizophrenia. *Social Science and Medicine*, 61 pp721-730.

Kelly B (2007) Penrose's Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners, *Irish Medical Journal*, 100, pp373-374.

Lamb H R and Bachrach L L (2001) Some perspectives on deinstitutionalization *Psychiatric Services*, Volume 52 Number 8.

Large M and Nielssen O (2009) The Penrose Hypothesis in 2004, *Psychology and Psychotherapy: Theory, Research and Practice*, 82 pp113-119.

Mental Health Foundation (1994) *Creating community care: report of the Mental Health Foundation Inquiry into community care for people with severe mental illness*, London: The Mental Health Foundation.

Mizuno M, Sakuma K, Ryu Y, Munakakta S, Takebayashi T, Murakami M, Falloon I R and Kashima H (2005) The Sasagawa project: a model for deinstitutionalisation in Japan, *Keio Journal of Medicine* 54(2): pp95-101.

Moon G (2000) Risk and protection: the discourse of confinement in contemporary mental health policy, *Health & Place* Volume 6, Issue 3, pp239-250.

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

Penrose L S (1943) A note on the statistical relationship between mental deficiency and crime in the United States, *American Journal of Mental Deficiency*, 47: 462.

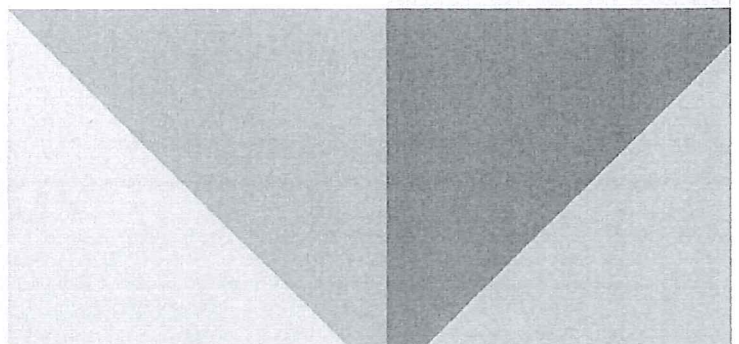
Ravelli D (2006) Deinstitutionalisation of mental health care in the Netherlands: towards an integrative approach, *International Journal of Integrative Care*, Volume 6.

Ritchie J (Chair) (1994) *The report of the inquiry into the care and treatment of Christopher Clunis*, London: HMSO.

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

Wacqaunt L (2009) *Punishing the poor: the neo-liberal government of social insecurity*, London: Duke University Press.

Wolff N (2005) Community reintegration of prisoners with mental illness: a social investment perspective, *International Journal of Law and Psychiatry*, 28, pp43-58.



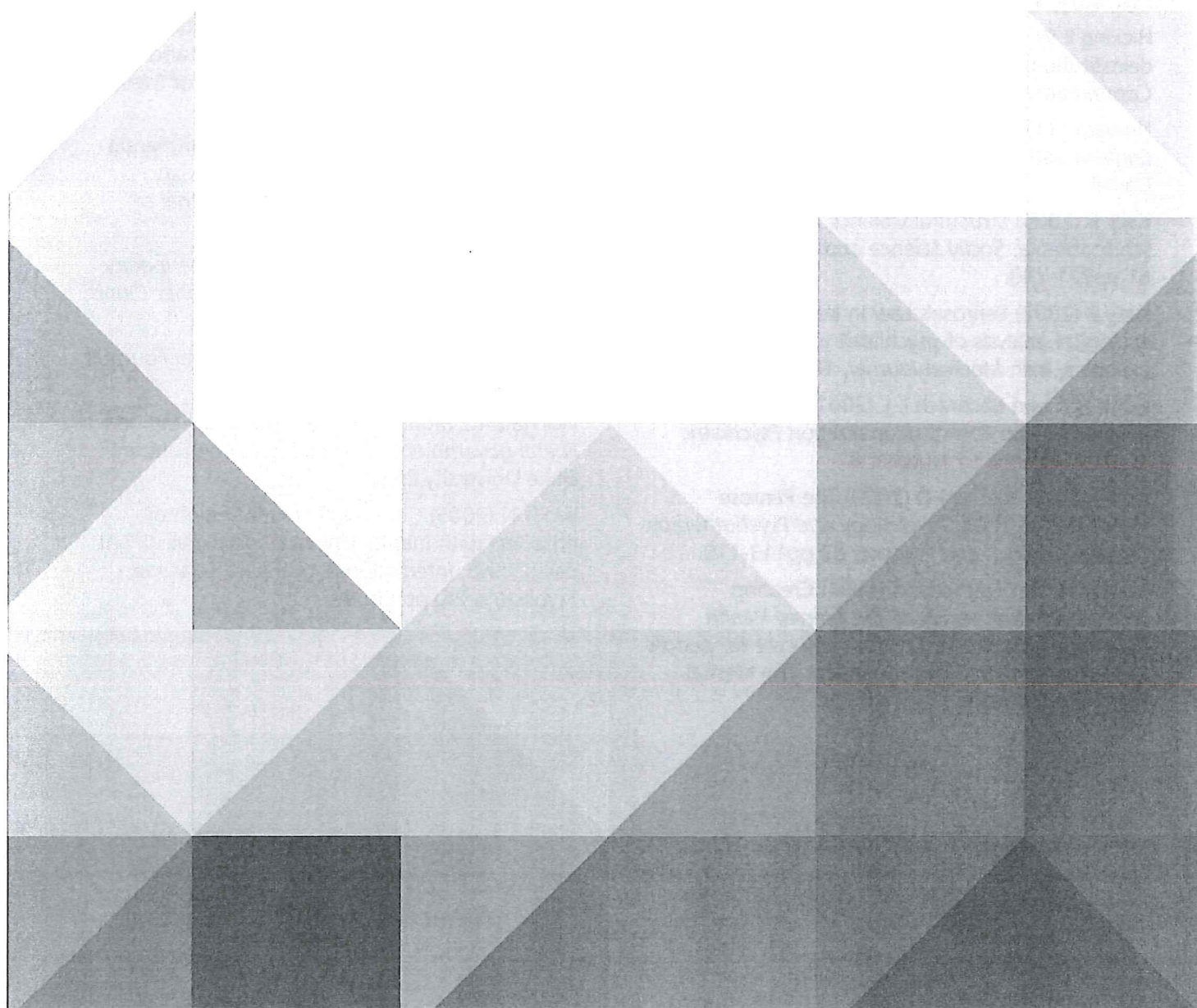
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Appendix Three : Confirmation from joint authors

Appendix Three: Confirmation from joint authors

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From: David Edmondson <D.Edmondson@mmu.ac.uk>
Sent: 16 February 2016 11:12
To: Cummins Ian
Subject: RE: Your Emerald article has been published

Hi Ian, good news about the article. I can confirm we are joint authors (50% each) on the below publication. Best regards, David

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Social Work in Film and Television (SWIFT) research network - Twitter @socialworkfilm

Recent book: Social Work Practice Learning (Sage, 2014)
Forthcoming joint-authored book: Skills Development for Social Work Practice (Sage, 2016)

Students: Please email me for tutorials and meetings

From: Lucy Spafford [LSpafford@emeraldinsight.com]
Sent: 01 February 2016 13:41
To: David Edmondson
Subject: Your Emerald article has been published

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Finally, many thanks again for publishing with us. I hope the above information proves useful.

Best regards,

Lucy Spafford

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Cummins Ian

From: Stuart Jones (Hywel Dda UHB - St David's Hospital Mental Health Services Division)
<Stuart.Jones@wales.nhs.uk>
Sent: 03 February 2015 13:10
To: Cummins Ian
Subject: Blue Remembered Skills

Hi Ian

I am writing to confirm that we are joint authors (50% each) of the above publication. I wish you all the best in your future endeavours.

Kind regards

Stuart Jones

Ward Manager

Low Secure Unit

Cwm Seren

Hafan Derwen

01267239595

