There to help

Ensuring provision of appropriate adults for mentally vulnerable adults detained or interviewed by police

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Supporting papers

This briefing paper is based on a research project conducted by NAAN and ICPR between December 2014 and March 2015. The briefing is not directly referenced as all references and findings are contained within the supporting papers.

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1. Summary

The role of appropriate adults (AA) is to safeguard the welfare and rights of children and mentally vulnerable adults who are detained or interviewed by police. The Codes of Practice of the Police and Criminal Evidence Act 1984 (PACE) set out the purpose and powers of AAs, and the responsibilities of the police in this regard.

In December 2014, the Home Secretary commissioned the National Appropriate Adult Network to examine current AA arrangements for vulnerable adults, identify shortcomings in provision, and develop recommendations for ensuring provision for all who need it. The project entailed a review of existing literature and law (Papers A to C), new data from police forces, liaison and diversion services, AA services and custody officers (Papers D to E) and interviews and consultation involving senior stakeholders and individuals with direct experience of the criminal justice system (Papers F and G).

Findings

The main findings of the research and consultation undertaken for this project are:

1. There are significant shortcomings in current AA provision for mentally vulnerable adult suspects, particularly in terms of:
    - inadequate police practices with respect to identification of suspects' vulnerabilities and the need for AAs, and the recording of relevant data
    - limited availability of AAs;
    - variable quality of AAs.
2. Many vulnerable adults do not receive the support of an AA or receive it only for part of the custody process. This undermines their welfare, inhibits the exercise of their legal rights, risks miscarriages of justice and lengthens custody times potentially increasing the risk of self-harm.
3. The underlying causes of these findings include: the absence of statutory duties either to secure or to provide AAs for vulnerable adults; lack of appropriate training and screening tools for police; time pressures in the custody suite; diminishing public sector funding and a lack of clarity over responsibility for commissioning.
4. Legislative changes aimed at promoting equality (such as the Equality Act 2010) and national initiatives focused on vulnerable people in the criminal justice system (such as liaison and diversion services) provide a favourable policy and commissioning context for the enhancement of AA provision.
5. On the basis of a conservative estimate, 11% of adult suspects require an AA (as defined by PACE Code C); the annual cost of ensuring full provision of trained AAs from organised schemes, throughout the custody process and across England and Wales, is estimated at £19.5 million (£113,000 per local authority). Current national spending on AA provision for adults is estimated to be in excess of £3 million per year.

Recommendations

Recommendations for ensuring full AA provision for all vulnerable adults are:

1. To develop a new approach at a national strategic level and a vision shared by relevant departmental bodies, agencies and organisations that:

   In the interests of individuals' welfare and of justice, all mentally vulnerable adults should have access to the timely support of a competent AA throughout any period of detention in police custody or the conduct of any voluntary interview;

2. To locate AA provision within existing strategic frameworks, of which the preferred option is to incorporate AA services within the liaison and diversion framework
3. Establish AA provision within a clear and consistent national framework for local co-commissioning, with commissioning co-ordinated and informed by Health and Wellbeing Boards and Safeguarding Adults Boards
4. To develop enhanced national standards to provide national support for local co-commissioning;
5. To ensure consistent police record keeping on vulnerable suspects, identification of need for AAs, the securing of AAs, and where they came from;
6. To integrate simple screening questions in all police custody risk assessments and ensure all custody officers have received training on vulnerability and AAs;
7. To amend the PACE Codes of Practice to clarify and simplify their provisions on AAs;
8. To consider amending PACE 1984 to establish an explicit statutory duty on police officers to secure an AA for all mentally vulnerable adults; and to bring greater consistency to the approach of courts on the admissibility of evidence obtained in the absence of an AA;
9. To consider establishing a statutory duty to ensure provision of an AA when requested by police, to create parity with children's AA services;
10. To provide short-term programme funding of £3m to £5m per year to support the inclusion of AA provision within mainstream budgets. This could be to 2017 (subject to integration into the liaison and diversion framework and HM Treasury approval) or longer if required.

2. Introduction

Adults with mental ill health, learning disabilities, autism and other mental vulnerabilities face significant disadvantages in the criminal justice system. They are more likely than others to be drawn into it. Once within it, they often report not understanding what was happening to them or why; being uncertain about what to say or do; feeling alone and not knowing to whom to turn for support. Such circumstances not only undermine the welfare of these individuals and threaten to exacerbate their vulnerabilities, but put them at risk of providing information to the authorities which is inaccurate, unreliable of misleading – and thus, ultimately, at risk of miscarriages of justice.

In order to mitigate these risks, the police are required to secure an appropriate adult (AA) whenever they detain or question 'mentally disordered' or 'otherwise mentally vulnerable' adults - including people with mental illness, learning disabilities, traumatic brain injury, dementia and autism. The AA has a defined role under the Police and Criminal Evidence Act (PACE) 1984 Codes of Practice: namely, to provide the support, advice and assistance necessary to ensure fair treatment, effective participation and guard against false confessions. AAs help the police to fulfil their responsibilities under PACE and are a critical safeguard against the abuse of police powers.

Against a backdrop of widespread concern about the adequacy of AA provision for vulnerable adults in police custody, in December 2014 the Home Secretary commissioned the National Appropriate Adult Network to conduct a short project to:

- examine current AA arrangements for vulnerable adults;
- identify any gaps or shortcomings in AA provision; and
- develop recommendations for ensuring provision for all who need it.

The project was overseen by an expert advisory group (see page 2) and undertaken in partnership with the Institute for Criminal Policy Research. The method consisted of the following:

- a review of the existing research literature and relevant legislation;
- a data request to all 43 police forces;
- an online survey of Metropolitan Police custody officers;
- an online survey of AA schemes;
- analysis of data from liaison and diversion trial sites;
- analysis of costs data;
- in-depth interviews with 13 senior stakeholders from criminal justice, health and AA services;
- a semi-structured discussion with members of the Working for Justice group (who have a learning disability and direct experience of the criminal justice system as suspects or defendants).

Sections three and four of this briefing present the main findings of these various strands of primary and secondary research. Section five sets out recommendations, based on the main findings, for ensuring full provision of AAs for vulnerable adults. Fully referenced reviews, complete findings and detailed analyses are presented in a series of supporting documents (Papers A to I).

3. Legislation and policy

3.1 Background to appropriate adults

In 1972, a 'mentally handicapped' man aged 18 and two children and were arrested on suspicion of the murder of Maxwell Confait. After long interviews they made a series of confessions. Their subsequent convictions were quashed by the Court of Appeal on the basis of scientific evidence.

A subsequent government inquiry found that interviews of the suspects had taken place without a parent or responsible adult, and had been 'unfair and oppressive to a person of his mental age'. The suspects were not informed of their right to legal advice or to communicate with another person. The inquiry recommended no person should be convicted where there had been a breach of the Judges' Rules (the existing set of rules governing police behaviour towards suspects), with particular concern for 'mentally handicapped' people and children. This led to the establishment of the Royal Commission on Criminal Procedure (1977-1981) which in turn led to the Police and Criminal Evidence Act (PACE) 1984 and its Codes of Practice. PACE Code of Practice C replaced the Judges' Rules and established the role of the appropriate adult (AA) to support children and vulnerable adults in the criminal justice system.

3.2 PACE and the legal framework for AAs

The Police and Criminal Evidence Act (PACE) 1984 and its Codes of Practice provide the legal framework of police powers and safeguards relating to such matters as arrest, detention and the interviewing of suspects. The PACE system comprises the Act; the Codes of Practice, which do not have the full force of law but set out how police powers under PACE should be used; and Notes for Guidance.

The Act itself contains no provisions relating to AAs for vulnerable adults; these provisions are, instead, spread out across Codes C, D, E, F and H. The Codes set out – with respect to both children and vulnerable adults who have been detained by the police – the purpose and powers of AAs; who may act as an AA; the threshold of vulnerability defining when an AA is required; the responsibilities of the police in regard to obtaining an AA; and the circumstances and procedures for which an AA must be present. Although the Codes focus on police detention, their requirements also apply, so far as is possible, to 'voluntary attenders': that is, individuals who are interviewed under caution but without arrest.

Home Office *Guidance for Appropriate Adults*, produced in 2003, defined the main responsibilities of an AA as being:

- To support, advise and assist the detained person, particularly while they are being questioned;
- To observe whether the police are acting properly, fairly and with respect for the rights of the detained person. And to tell them if you think they are not;
- To assist with communication between the detained person and the police;
- To ensure that the detained person understands their rights and that you have a role in protecting their rights.

Subject to a small number of exceptions, the police may legally ask any person over the age of 18 to be an AA, including a member of the general public. A wide variety of individuals and agencies currently fulfil the role, including: family members, carers, social workers, youth offending team (YOT) staff and statutory, private or voluntary sector providers. In some areas, AAs are volunteers from the local community, organised and supported by a local charity or agency.

Section 38 of the Crime and Disorder Act 1998 places a statutory duty on local authorities, via YOTs, to 'ensure the provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers'. This is the only definition of the AA role which appears in legislation. There is no equivalent statutory duty with respect to provision of AAs for vulnerable adult suspects.

Evidence obtained in breach of the Codes may be deemed inadmissible by the courts or result in a conviction being quashed on appeal (with particular reference to sections 76-78 of PACE, which deal with the admissibility of confession evidence). This gives the Code of Practice provisions on AAs some practical effect in law, albeit this is not consistently applied by the courts (see Paper C).

3.3 Other relevant legislation

Beyond PACE, a variety of other legislative developments have served to underline the importance of the AA role in safeguarding the rights and welfare of vulnerable individuals who are detained by the police. For example, sections 6 and 15 of the Equality Act 2010 define disability as a physical or mental impairment which has a substantial and long-term adverse effect on the individual's ability to carry out normal day-to-day activities. The Act requires the anticipation and prevention of discrimination against people with disabilities and requires service providers to make 'reasonable adjustments' to standard provisions, criteria, practices or physical features to avoid disadvantage. Section 149 of the Act establishes a proactive, public sector equality duty to eliminate any conduct prohibited by the Act and advance equality of opportunity. The provision of an AA is an example of a reasonable adjustment.

Article 2 of the Human Rights Act 1998 (right to life) imposes an obligation on the state to protect individuals in state detention whose life is at risk, including from suicide. Article 6 (right to a fair trial) sets out a number of minimum rights, which include being informed, in a way that the person understands and in detail, the nature of the accusation against them. Courts have interpreted Article 6 as applying to suspects interrogated in police custody (see Paper B). This has clear implications, in particular, for individuals with learning disabilities, autism and certain mental health conditions who may experience difficulty understanding the prosecution process.

Among other relevant legislation is the Mental Capacity Act 2005, Section 1 of which sets out five underpinning principles: presumption of capacity; the right for individuals to be supported to make their own decisions; the right to make 'unwise' decisions; best interests; and least restrictive intervention. Sections 35 and 36 establish Independent Mental Capacity Advocates (IMCAs) to safeguard people who are considered to lack capacity, and enable the local authority to 'make such arrangements as it considers reasonable' to ensure IMCA availability. Suspects identified as 'mentally vulnerable' under PACE should be presumed to have capacity. AAs can help to ensure the necessary support for people to make decisions and to ensure their best interests are considered.

3.4 Policy focus on mental vulnerability and justice

The connections between mental vulnerability and policing have been periodically highlighted in Home Office policy documents since 1990. In 2009, the Bradley Report examined this issue in close detail. A range of political and public policy commitments have been made in response to Lord Bradley's recommendations, aimed at improving responses to vulnerable people caught up in (or on the edges of) the criminal justice system.

A particularly significant development is the expansion of liaison and diversion schemes, under which mental health professionals based in police stations and courts carry out screening of suspects and defendants, and

make referrals to relevant services (whether as part of, or as an alternative to, the prosecution process). A large-scale government trial of liaison and diversion services is being conducted in sites across England, with a planned 50% population coverage by April 2015 and a possible national roll-out in 2017 subject to HM Treasury business case and ministerial approval.

Other related initiatives include: the Crisis Care Concordat, which aims to bring about more coordinated crisis care for people with mental health problems; street triage, which entails collaborative working between mental health professionals and front-line police officers in response to incidents at which immediate mental healthcare and support is required; and the development of new screening tools to assist the identification of vulnerability.

One of the stated objectives of these initiatives is to improve the awareness and identification of vulnerabilities among individuals entering the criminal justice system. To the extent that this aim is achieved, it inevitably increases the demand for AAs, without necessarily bringing about any associated increase in supply. Another consideration in the context of the discussion of AA provision is the critical importance of co-ordination between related programmes, such that differing strands of activity mutually support rather than duplicate (or potentially undermine) each other; mechanisms are put in place to support sharing of learning, skills and expertise; and cost-effectiveness is maximised. One senior stakeholder interviewed for this project said:

> *There must be joined-up thinking between liaison and diversion, street triage, victim services (most offenders with mental health problems are also victims) and AA services. These four services need to be under the same umbrella and funded in the same way. Mental health agencies and the police do not link up and work well together; there is a huge tension. There is a real need for community advocates to help bridge that gap. There is a data disconnect and a professional disconnect.*

4. Gaps and shortcomings in provision

A series of research and policy reports have, over the past 15 years, highlighted gaps and shortcomings in provision of AAs for vulnerable suspects (see Paper A). In the past two years, NAAN has regularly been contacted by AA schemes and police forces stating that existing shortcomings in AA provision are worsening. Where specific provision for vulnerable adult suspects has existed, it has historically been provided or funded principally by adult social services (see Paper D). As the effects of public sector spending cuts have been felt, these services – which do not have a statutory footing – have reduced.

The findings of the primary research conducted for this project (see Papers D to G) reinforce and elaborate many of the concerns raised by prior work in this area. It is clear that there are three fundamental, and inter-related, problematic aspects of AA provision:

1. Inadequate identification of suspects' vulnerabilities and their need for AAs;
2. The availability of AAs is insufficient
3. The quality of AA provision is variable.

The net result of these problems is that many vulnerable suspects are not provided with an AA, or are not properly supported by the AA who is provided. This, in turn, compounds the disadvantage these individuals experience within the criminal justice system. It can delay the progress of cases through the system; add to suspects' distress, anxiety or confusion and inhibit or prevent the exercise of their legal rights; and contribute to miscarriages of justice. Furthermore, it generates increased costs, inefficiencies and risks for the police.

Before briefly considering the issues of identification, availability and quality in turn, it should be noted that there is a further, overarching concern which impedes efforts not only to address the existing problems with AA provision, but also to establish the scale of the problems. There are significant challenges with regard to the current data recorded by police on requests for, availability and use of, AAs. There is no standardised system of recording or retrieving data on AAs across police forces (reflecting, in part, the lack of standardised custody management information systems) making it impossible to obtain an accurate national picture with confidence. Limited or inconsistent recording practices within forces limit the availability of local data on levels of AA requests and AAs secured. In response to the data request submitted for this project, some forces stated that data on AAs could be retrieved only through a manual trawl of custody records, and some were unable to distinguish between multiple call-outs for a single custody episode and call-outs for separate custody episodes (see Paper D).

4.1 Identification of vulnerability and need for AAs

Since the 1990s, various studies have reported that the vulnerability of suspects frequently goes unrecognised by police officers. Research which has sought to estimate the prevalence of mental health problems, learning disabilities and other vulnerabilities among criminal justice populations encounters a range of methodological and definitional problems; nevertheless, on the basis of the existing research evidence it is reasonable to assume that between 11% and 22% of suspects detained by the police have a level of vulnerability that would meet the threshold for an AA (see Paper A).

However, police data obtained for this project (from 23 of the 43 forces to which the request was submitted) indicate that the percentage of custody episodes identified as requiring an AA in the year 2013/14 ranged between 0.5% to 9.2%, with the average rate of identification being 3.1% (see Paper D). These data must be treated with caution given the quality of data currently available; however, there appears to be significant under-identification of need for AAs and variability between forces.

PACE Code C provides a sensible approach to identification, simply requiring police to recognise information or behaviour that gives them a suspicion that a person *may* be mentally vulnerable, rather than diagnose or identify conditions. Findings of the research conducted for this project, and existing research evidence, strongly suggest that there are two elements to the under-identification of need for AAs. One element is that the police frequently lack the expertise and training to recognise when a suspect may have a vulnerability. For example, many forms of vulnerability are complex and sometimes hidden and custody officers operate under significant time pressures. Moreover, they do not have access to appropriate screening tools to assist this process. The second element is that officers opt not to request AAs for a substantial proportion of those whom they do identify as vulnerable or who identify themselves as such. This appears to reflect officers' concerns about lack of availability of AAs and the likelihood of delay associated with securing them; a lack of clarity over the threshold for requiring an AA; and/or officers' scepticism about the need for AAs in some cases.

Data from liaison and diversion schemes submitted to this project reveal that, across eight sites, an average of only one in five of adults who had engaged with the schemes (and were therefore likely to be vulnerable) had received an AA (see Paper D). A rate close to 100% would be expected given that the threshold for an AA is at least the same as, if not lower than, that for liaison and diversion services. Furthermore, the lack of consistency in courts' responses to breaches of the PACE Codes may serve to encourage police officers to regard the securing of AAs for vulnerable suspects as optional rather than required (see Paper C).

4.2 Availability of AAs

It has been noted above that no agency has a statutory duty to provide AAs for vulnerable adult suspects, and those who act as AAs include suspects' friends and family members, carers, social workers, and members of the general public. Across the country, there is a patchwork of statutory, private and voluntary sector schemes which provide AAs – but police forces' access to such schemes is highly variable. Where friends or family members are not available, the police frequently struggle to obtain AAs for suspects deemed to require one, particularly outside office hours (see Papers A and E). The resultant delays can be of several hours, causing additional stress to suspects, increasing their care needs and potentially contributing to higher incidences of self-harm. Delays are wasteful of police time and cause procedural difficulties since suspects can only be held for a limited time.

The limited supply of AAs is not only a cause of delays but also means that, in some cases, AAs are not provided at all even where requested by officers, or not for all procedures during a suspect's period of detention (see Paper D). As suggested above, officers' perceptions of limited supply can have a negative effect on their preparedness to identify vulnerability and the associated need for an AA. Examples of pragmatic responses to this problem emerged in the custody officer survey conducted for this project (see Paper E). When asked what they do if unable to secure an AA for a vulnerable adult suspect, 36 out of 38 respondents stated that this scenario had arisen for them. Most respondents stated that they would consider releasing the suspect on bail to return at a time when an AA was available. This approach, while understandable, provides a short-term response rather than a solution. The justice process is delayed further, costs generated and the issue may or may not be solved at a later date. Other responses from custody officers included:

> *I would, in the first instance, re-assess the detainee and see whether an AA is still required.*
> *Everything I would do would be with the best of intentions in order to get the job done even if not completely 'by the book'.*

> *Consider range of available investigative disposals for subject, consider securing an AA by phone e.g. family member/relative etc. etc. to support/guide remotely.*

4.3 Quality of AAs

Another recurring theme in the findings of prior research, and the research conducted for this project, is the variability in quality of AAs obtained for vulnerable suspects, reflecting the wide range of backgrounds from which AAs come into the role. The police, service users and providers alike have raised concerns about the suitability of using family members as AAs – who are unlikely to be trained or have any knowledge relating to the AA role, and are sometimes over-involved with or, conversely, antagonistic towards the suspect. In contrast, it has also been recognised that an AA's familiarity with the suspect and capacity to offer personal, emotional support can be of benefit.

Studies suggest that the AA role is too complex for the short explanation that a busy custody officer can deliver to an untrained individual, and that a very limited amount of information about the role can render AAs even less effective than if they had none (see Paper D). It has been widely recommended by practitioners and others that only those who have received some level of training should act as AAs. The senior stakeholders interviewed for this project (see Paper F) largely supported the introduction of mandatory training for AAs and greater professionalisation of the service – stating, for example:

> *AAs should be trained, equipped to provide the best service and have a degree of professionalisation; they can be volunteers, however, rather than professionals*

> *AAs need to be individuals that are trained, understand what the role of an AA is, are on-call, available and able to refer to other services*

5. Ensuring full provision

> *[AA provision for adults] is a gaping hole. No one owns it, no one scrutinises it, and nobody inspects it. It needs to change.* (Senior Stakeholder)

The primary and secondary research undertaken for this project has confirmed the need for AAs; stakeholders, professionals and practitioners involved in this project said that the role makes an important positive contribution. A number of barriers to achieving provision of AAs for all vulnerable adult suspects who need them have been identified. Full provision demands that any suspect's vulnerability and associated need for an AA are identified by the police. The police must then be ready to secure an AA, and have access to local services which can promptly supply individuals with the requisite knowledge and skills to fulfil the role.

5.1 A partnership approach

Ensuring full provision of AAs for adults requires a paradigm shift, recognising that health, social care and justice services share responsibility for this provision, even if local agencies approach it with different perspectives and are driven by different legislative requirements and policy goals. This partnership approach will ideally be underpinned by a cross ministerial commitment involving the Home Office, Ministry of Justice, Department of Health and Department for Communities and Local Government, alongside the Welsh Assembly Government for provision in Wales.

At the national level, a clear and shared vision would describe the cross ministerial commitment, which would be supported by relevant bodies including, for example, NAAN, the College of Policing, national policing leads, Local Government Association, NHS England, the judiciary and people with mental vulnerabilities. Suitable wording for the shared vision is as follows:

> *In the interests of individuals' welfare and of justice, all mentally vulnerable adults should have access to the timely support of a competent AA throughout any period of detention in police custody or the conduct of any voluntary interview.*

The following strategic objectives would help to realise the vision:

- To improve the recording and sharing of information regarding mental vulnerability amongst adults detained or otherwise questioned by police;
- To increase the identification of mental vulnerability and need for an AA amongst adults detained or otherwise questioned by police;
- To extend the availability of AAs;
- To improve the competency of AAs.

Recommendation 1: To develop a new approach at a national strategic level and a vision shared by relevant departmental bodies, agencies and organisations.

5.2 Strategic frameworks

The development of a new and discrete strategic framework for AA provision for adults, to sit alongside other frameworks, is unnecessary. Integration is more cost effective, and complements current approaches to partnership working. AA provision is as a critical and integral part of those wider justice, health and social care services focused on improving outcomes for vulnerable people, and should be regarded as such. Locating AA provision within existing strategic frameworks – including those relating to liaison and diversion, Health and

Wellbeing Boards and adult safeguarding – has the potential to save resources, reduce complexity, and promote a consistent and coherent approach to people with mental vulnerability. A number of existing frameworks have been identified which, potentially acting together, could provide an effective framework for AA provision.

Liaison and diversion

Liaison and diversion services work to ensure that individuals receive the support they need at each stage of the criminal justice process. The Bradley Report linked AA and liaison and diversion provision and there remains a strong rationale for placing AAs within the same framework, including:

- Alignment of purpose: both services support vulnerable individuals caught up in the criminal justice system;
- Scope of provision: both services encompass the full range of mental vulnerabilities
- Location: both services operate within police custody suites and liaison and diversion provides a link to courts, where need for support of the type offered by AAs has been identified
- Structure: liaison and diversion is an established programme with momentum, support, strong oversight and a route to mainstream funding from 2017.

Strategic alignment should not, however, be confused with the merging of AA with liaison and diversion services. AAs fulfil a criminal justice role that is, and must remain, distinct from the health role of liaison and diversion services. A conflict of interest is likely to arise if those responsible for health screening and assessment also take the role of the AA.

Health and Wellbeing Boards

Health and Wellbeing Boards are well-placed to assess the local need for, and support the inclusion of, AA provision in local commissioning plans. AA provision should be integrated with the preparation of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This would help ensure the sustainability of AA services at a local level.

Adult safeguarding

Safeguarding Adults Boards are statutory bodies bringing together local authorities, health and police to help and protect adults where there is reasonable cause to suspect they have needs for care and support and are at risk of abuse or neglect. They share their annual strategies and reports (which are drawn from those of their constituent agencies) with Health and Wellbeing Boards. Statutory guidance for the Care Act 2014 highlights the AA role in relation to safeguarding but this could be given greater clarity. Subject to this clarity, Safeguarding Adults Boards could provide an accountability framework for local AA partnerships.

Whole place / community budgets

As per the Troubled Families programme, whole place/community budgets offer a person-centred approach to public services. This approach identifies fragmented, reactive and acute services; focuses on outcomes over organisational responsibilities; is user focused; and pools or aligns resources to maximise both available funds and provision. The approach relies on access to funding for the up-front costs of transformation but not more money overall. A relevant example is the Better Care Fund which has made £3.8 billion available to be deployed locally on health and social care through pooled budget arrangements.

Transforming Care

The Transforming Care programme, which arose out of the abuse at Winterbourne View hospital, has been committed to by a wide range of partners including police, adult social services and health. The Transforming Care and Commissioning Steering Group has recognised how 'fundamentally important' the concerns set out in the Bradley Report are to its agenda and encouraged the Government to respond to the recommendations in the recent report 'The Bradley Report five years on' which included the need for improvements in AA provision and clarity on their funding.

Regulation and inspection

Consideration should be given to including AAs within the regulatory framework of the Health and Care Professions Council which has been made responsible for 'regulating health, psychological and social work professionals' and is being accorded powers to set up voluntary registers for unregulated professions or related professions. In addition, consideration should be given to responsibility for the inspection of AA services – for example the potential role of the Care Quality Commission.

Wales

Health and social care is devolved to the Welsh Assembly Government. Hence, for example, liaison and diversion services in England are distinct from criminal justice liaison services in Wales. However, the suggested approach can readily be adapted for AA provision in Wales.

Recommendation 2: To locate AA provision within existing strategic frameworks, of which the preferred option is to incorporate AA services within the liaison and diversion framework

5.3 Implementing the new approach

Realising full AA provision for vulnerable adult suspects will demand a series of reforms and actions relating to: police identification of need; recording and data-sharing; legislation; the PACE Codes of Practice; commissioning; and the development and implementation of national standards. The resource implications of the proposed changes should also be examined and addressed.

Commissioning

A clear and consistent commissioning framework for AA provision is required. Recent reforms integrating health and social care and focusing on outcomes over organisational boundaries have removed a historical barrier to progress: namely, that AA commissioning does not easily 'sit' with a single organisation. It is proposed here that AA provision be incorporated within the liaison and diversion framework, with commissioning to be co-ordinated and informed by Health and Wellbeing Boards and Safeguarding Adults Boards. This would provide a local platform for criminal justice, health and social care services to share data regarding the prevalence and nature of needs, which in turn would inform strategy development and commissioning. It also provides a multi-agency framework for accountability in terms of provision and use of services.

Recommendation 3: Establish AA provision within a clear and consistent national framework for local co-commissioning, with commissioning co-ordinated and informed by Health and Wellbeing Boards and Safeguarding Adults Boards

National standards

It is important that decision-making on the specifics of service delivery are made at the local level involving partner agencies and those who use the service. However, commissioning and oversight of AA provision should be supported by an enhanced set of national standards. Key elements of these national standards would include:

- AA provision is swiftly and easily available in all areas of England and Wales via organised schemes, operating in alignment with liaison and diversion services 24-hours and 7 day per week, with a mix of operating times and out-of-hours arrangements based on local need
- Whether paid or voluntary, all AAs have appropriate support, have completed accredited training, operate within a framework of continual professional development, and are competent and confident to act
- In addition to the AA, subject to the wishes of a mentally vulnerable adult, police and AA services should facilitate the involvement of a family member or friend to provide moral support and provide information about the individual's support needs.
- Continuity of support when a mentally vulnerable adult moves from one part of the criminal justice process to another.

Recommendation 4: To develop enhanced national standards to provide national support for local commissioning

Recording and data-sharing

There is an urgent need for improvement in police recording practices with respect to mentally vulnerable people who are detained or interviewed as voluntary attenders. At a minimum, consistent records should be kept on the numbers of individuals identified as vulnerable; for whom an AA was required; for whom an AA was secured; who were bailed due to the lack of an AA; and the background or status of the AA. The data should be shared with local partners and should inform Joint Strategic Needs Assessments and commissioning plans. The data should also be used to inform internal improvement plans, made available to HMIC to support transparency and accountability and be available for the purpose of monitoring AA provision.

Recommendation 5: To ensure consistent police record keeping on vulnerable suspects, identification of need for AAs, the securing of AAs, and where they came from

Identification of need

Effective AA provision depends on the capacity and preparedness of the police to first recognise possible vulnerabilities in police suspects and their need for an AA. Due to the low threshold in PACE Code C, police do not need to identify or diagnose conditions. Rather, they need to be able to recognise information or behaviour that gives them a *suspicion* that a person *may* be mentally vulnerable. To that end, simple screening questions should be integrated into all police custody risk assessments, which are themselves already recognised by custody officers as a critical tool. Training on vulnerability, the role of an AA and how to secure one, should be required for all custody officers. Custody officers should be aware that the responsibility for identifying possible need lies with them (with support provided, as necessary, by health and social care partners) and there is no discretion as regards securing an AA once the threshold in Code C is met. This requirement is not negated by practical constraints, the convenience of the police or solicitors, or indeed the wishes of the suspect themselves.

Recommendation 6: To integrate simple screening questions in all police custody risk assessments and ensure all custody officers have received training on vulnerability and AAs

Review of PACE Codes of Practice

The Home Office should undertake a review of the Codes of Practice with the purpose of clarifying and simplifying their provisions relating to AAs. The labyrinthine nature of the current provisions permits them to be purposefully misinterpreted, simply ignored or, more typically, genuinely misunderstood.

> *I think at the moment some bits of the [PACE] guidance are open to interpretation...The guidance needs to be clear....It shouldn't be that different forces in the country interpret the guidance in their own way. (Senior stakeholder)*
>
> *It's about applying the Codes in the way they were intended. (Senior stakeholder)*

Consideration should be given to replacing them with the simple principle that all mentally vulnerable individuals have the right to be supported by an AA throughout their periods of detention or questioning by police. Limited exceptions to this, on practical grounds, could be introduced; for example, where the collection of evidence is time critical such as a breathalyser test.

Recommendation 7: To amend the PACE Codes of Practice to clarify and simplify provisions on AAs

Legislative change

Government should give consideration to amending the PACE Act 1984 to establish an explicit statutory duty on police officers to *secure* an AA for all mentally vulnerable adults – thereby aligning the Act with the Codes of Practice, and removing any ambiguity about whether AA provision for vulnerable adults is a requirement or matter of guidance. This would also help to achieve consistency in provision for children and for vulnerable adults in police custody. References in the Act to 'mentally handicapped persons' should be amended to bring it into line with the Mental Health Act 1983 and the PACE Code of Practice. As highlighted in section 3.1 above, evidence obtained in the absence of and AA represents a significant risk to justice. The corollary of the Court of Appeal's increasingly variable approach to accepting of such evidence (Paper C) is that there is no clear and consistent message to custody sergeants. This should be considered in a future review of PACE 1984.

Recommendation 8: To consider amending PACE 1984 to establish an explicit statutory duty on police officers to secure an AA for all mentally vulnerable adults; and to bring greater consistency to the approach of courts on the admissibility of evidence obtained in the absence of an AA

A statutory duty to ensure *provision* was a strong, consistent and uncontroversial theme across all stakeholders: it would be consistent with the PACE requirement on police to secure an AA, and with the statutory duty on YOTs to ensure provision for children. It would make explicit the Government's intention (implied in the Codes) that services for adults must have the same consistency of provision as those for children. As a new requirement, it would represent a new burden with associated costs for central government. However, the 'burden' is not entirely new as some of the costs are already currently being met by local authorities, health and police (see section 5.4 below and Paper H for cost estimates).

There is currently no legislative barrier to ensuring provision for all vulnerable adults. Both street triage and the liaison & diversion programmes have made significant progress without it. Legislative change is therefore recommended but should not be a pre-requisite for progress.

Recommendation 9: To consider establishing a statutory duty to ensure provision of an AA when requested by police, to create parity with children's AA services

Investment

An alternative to immediate statutory provision is to invest in encouraging funding at the local level from mainstream budgets through strategic investment.

The alignment of AAs within the liaison and diversion framework could be supported with programme funding. This would enable preparation for the mainstreaming of budgets in 2017. This approach has been taken successfully by the Department of Health both for liaison and diversion and for street triage, the latter of which is now operational in parts of 36 police forces. Funding could be managed by a collaborative led by the liaison and diversion programme (NHS England), and including NAAN and, it is suggested, the Local Government Association. This transformation funding would be used to develop services, test approaches to delivery and commissioning across differing geographies and demographics, evaluate best practice and shape a core model. Evaluation would include analysis of outcomes and develop estimates of costs savings, enabling 'invest to save' business cases to be promoted to local commissioners.

The objective would be for funding would be mainstreamed alongside liaison and diversion from 2017, subject to HM Treasury approval. Alternatively, clinical commissioning groups could be asked to expand the commissioning of AA services for adults. This could be achieved either through enhancement of the £30m support fund to the Crisis Care Concordat or the £60m police custody health care budget as it is transferred to the Department for Health.

Police budgets are a potential source of funds contributing to the upfront costs of transformation, as improved provision of AAs will generate efficiency savings in custody. Measures would be required to avoid any additional funding being substituted for existing spending.

A budget of £3m-£5m per year is proposed, for a minimum period of two years.

Recommendation 10: Provide short-term programme funding of £3m to £5m per year to support the inclusion of AA provision within mainstream budgets. This could be to 2017 (subject to integration into the liaison and diversion framework and HM Treasury approval) or longer if required.

5.4 The cost of full provision

Full provision through organised schemes

Estimates of the cost of full provision are provided in Table 1. There are significant challenges in calculating the costs of provision, not least the limitations of the quality and quantity of data currently available (see Paper H). Key assumptions include: -

- All AA provision is via trained individuals from organised schemes with a high use of volunteers. Family members and friends may be engaged in the process in addition
- Mentally vulnerable adults are supported fully throughout the custody process, as described by the PACE Codes of Practice (not simply for the interview).
- AAs are provided both for all detentions and for all voluntary interviews
- A call out cost of £69.75 is used (average cost for schemes using volunteers and able to meet demand), which is below the current average rate (£80.79) and compares favourably with the estimated cost of and AA call out when delivered by a social worker (£375).
- The upper bound of estimates of need (22% of adults) is unlikely to be achieved in the medium term, rendering estimates of cost irrelevant at this stage.

ID rate	ID rate description	National cost (£)	Cost per force area (£)	Cost per local authority (£)
3.12%	Current rate	5,574,789	129,646	32,039
4.90%	Current rate where there are AA services	8,766,099	203,863	50,380
11.00%	Actual need (lower bound)	19,678,999	457,651	113,098

Table 1: Estimated annual costs of full AA provision across England and Wales

Continued use of untrained individuals as AAs

If statutory provision were established without a requirement to use the locally trained and provided AAs, costs would likely be marginally lower. This is estimated to be in the region of a very conservative 10% reduction, resulting in an average annual cost, at an 11% ID rate, of £17.7 million (national) or £102,000 per local authority (see Paper H).

This is based on an assessment that 90% of AA call outs would be serviced by AA schemes. If reliable AA schemes were available, the police would be highly likely to use them, in line with the existing instructions to police that trained/experienced individuals are likely to be more satisfactory than family members (PACE Code C, paragraph 1D). Unlike children, mentally vulnerable adults are often estranged from their families. Their friends may not always be appropriate for the AA role.

Estimated savings do not factor in consideration of the appropriateness or effectiveness of a mentally vulnerable adult's family member or friend, or any future savings to be gained through high quality, consistent AA services. Consideration of savings should be considered in the context of wider efforts to bring quality and consistency to care and support services to people who are mentally vulnerable.

Existing spending

Existing spending on dedicated schemes is estimated to be in the region of £3m per year and is provided mainly by local authorities (66%), police or police and crime commissioners (24%) and clinical commissioning groups (6%). However, this excludes existing spending on local authority social workers acting as AAs within their core role which, though low in volume, could be significant in cost.

Introduction

Adults with mental ill health, learning disabilities and other mental vulnerabilities, face significant disadvantage in the criminal justice system (CJS). They are at increased risk of providing information which is inaccurate, unreliable or misleading (Gudjonsson, 2010). When asked about their experience of the CJS, they typically report they did not understand what was happening to them or why, that they felt alone, they did not know whom to turn to for support and that they were uncertain about what to say or do (Hyun et al., 2014). Further, more than a third of people who died in police custody in 2013/14, and two-thirds of people who took their lives within two days of being released, were reported to have had mental health concerns (Home Affairs Committee, 2015).

This review of the literature provides an overview of the prevalence and identification of mental disorders[1] and mental vulnerabilities[2] in police custody; the factors that influence custody sergeant decision-making on whether to call-out an AA; the commissioning of AA services and considers longstanding debates about who is best fit to serve as an AA. The review concludes drawing on the views of people with mental vulnerabilities who have recently experienced detention in police custody, as laid out in the recent HMIC thematic inspection on the welfare of vulnerable people in custody (HMIC, 2015).

Prevalence of mental disorders and mental vulnerability in police custody

Research evidence suggests that the prevalence of mental disorders and mental vulnerability is significantly higher within the criminal justice system than within the general population (see Tables 1 and 2).

Table 1: Prevalence of mental ill health and other mental vulnerability in the general population

Prevalence of mental ill health and other mental vulnerability in the general population		
Research	**Finding**	**%**
ONS (2001)	At any one time, British adults experiencing at least one diagnosable mental health problem.	17%
O'Brien (2006)	Learning disabilities (UK)	2–3%
Emerson et al. (2010)	Learning disabilities (England) *Equates to 1.2 million of which 75% are adults*	2.3%
British Dyslexia Association	Severe dyslexia (UK)	4%
Brugha et al (2009; 2012)	Autistic spectrum disorders in men/women (UK)	2%/0.3%

[1] Mental disorder means any disorder or disability of the mind (Mental Health Act 1983)
[2] A detained person is mentally vulnerable if, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies (PACE Code C 1G)

Table 2: Prevalence of mental ill health and other mental vulnerabilities in the criminal justice system

Prevalence of mental ill health and other mental vulnerabilities in the criminal justice system		
Research	**Finding**	**%**
Brooker et al. (2012)	People under probation supervision who have a current mental illness	39%
Singleton et al. (1998)	Remand prisoners who have a diagnosis of personality disorder	78%
Loucks (2007)	People who offend who have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.	20-30%
McBrien et al.(2003)	People diagnosed with learning disabilities who have experienced some contact with the criminal justice system	10%
Brugha et al (2012)	Prevalence of autism in prisons.	5-40%

Further, they are more likely to be drawn into the system, more likely to be arrested for minor offences, less likely to be granted bail and spend longer periods in police custody (Cummins, 2007; Hartford et al., 2005). The Bradley Report (2009) found that the estimated number of mentally disordered suspects passing through police stations varied widely between 2% and 20%. Other studies (see Table 3) looking at mental health and learning disabilities in police custody have found prevalence rates between 12% and 39%, with an average of 27% (Gudjonsson et al., 1993; Scott et al., 2006; McKinnon & Grubin, 2013; 2014). These figures coincide with the recent evidence submitted to the Home Affairs Committee, in which the police estimated that 20[3]-40%[4] of people passing through police custody have a mental health issue, whilst noting that the multiple definitions available left police unclear as to what to count.

A number of studies have suggested that the rate of AA need is slightly lower than the overall prevalence of mental health and learning disabilities at between 11% and 22% (Rapley et al 2011; McKinnon & Grubin 2013; Brown et al., 1992; Gudjonsson et al., 1993). However, the Police and Criminal Evidence Act 1984 Code of Practice C (PACE Code C) requires an AA for all adults for whom there is *suspicion* that they may be mentally disordered or mentally vulnerable and therefore demand for AAs may be higher than the need assessed by clinicians and academics (Home Office 2014).

[3] Home Affairs Committee, Oral evidence: Policing and mental health, HC 202, Tuesday 2 September 2014
[4] Home Affairs Committee, Oral evidence: Policing and mental health, HC 202 Tuesday 28 October 2014

Table 3: Mental health & mental vulnerability in police custody

Studies considering prevalence of mental disorders and mental vulnerabilities		
Research	**Finding**	**%**
Gudjonsson et al. (1993)	Problems which might interfere with their functioning or coping ability during police interviewing	35%
Scott et al. (2006)	Custody records containing evidence of possible mental illness or learning disability as judged by mental health nurses	12%
(Rapley et al. 2011).	Custody records with some medical need (either physical or mental, including learning disability) / excluding general medical needs and substance misuse	47%/ 23.8%
McKinnon & Grubin (2013)	Adults in police custody having mental disorders including intellectual disability according to clinical interviews	38.7%
McKinnon & Grubin (2014)	Adults in police custody with psychosis, major depression, intellectual disabilities and people who lacked capacity to consent.	25.6%
Studies considering prevalence of mental disorders / mental health only		
Robertson et al. (1996)	'Obvious' serious mental illness in police custody including cases of schizophrenia, affective disorders, brain damage and solvent abuse induced psychosis	1.4%
Shaw et al (1999)	Serious psychiatric disorder among those held in custody overnight appearing at Magistrates Court.	6·57%
Payne-James, (2010)	Those found to have an active mental health diagnosis amongst a cohort who had been referred by custody officers to an FME	18%
Young et al. (2013)	Current symptoms of Attention Deficit Hyperactivity Disorder (ADHD) / Conduct Disorder	23.5% / 76.3%
Studies considering prevalence of learning disabilities and difficulties in custody		
Holland et al. (2002)	Learning disabilities (study of existing research)	0.5% to 9%
Scott et al. (2006)	Definite or possible learning disability	1%[5]
Gudjonsson et al. (1993)	Intellectual disabilities / below the reading age of 9 / mental handicap.	8.6% / 6% / 3%
Young et al. (2013)	Intellectual disabilities	6.7%

[5] Community Mental Health Nurses screened 9014 custody records for evidence of mental ill health of learning disability. 1089 records (12%) screened positive. Of these 95 were judge on interview to have a possible or definite learning disability. This is 8.7% of those screened or 1.05% of the total records screened.

Police identification of mental disorders and mental vulnerability

When vulnerable adults arrive at custody, they often do so with multiple and complex needs. It has been found that of the adults identified with either mental health, substance misuse or alcohol misuse issues, the majority, have more than one of these issues (Home Affairs Committee, 2015; Brooker et al., 2011).

Research suggests that current risk assessment processes regularly lead to an inaccurate picture of people's mental health needs and, in turn, failure to engage with AAs and mental health professionals (Adebowale, 2013; Shaw et al., 1999). It has been found that police risk assessments identify between 52% to 63% of those with mental health and learning disabilities (McKinnon & Grubin, 2013; 2014; Rapley et al, 2011); highlighting potential gaps in the identification of vulnerabilities picked up by the police. Research shows that the some conditions have lower identification rates. For example, psychosis was identified by police around 40% of the time (McKinnon & Grubin, 2013), and the identification of learning disabilities in police custody was around one sixth of the prevalence in the general population (Rapley et al., 2011). It has been reported that indicators such as poor reading and writing skills and attendance at specialist education services are not consistently recognised as potential indicators of learning disability (CJJI, 2013).

Studies (Hodgson, 1997; Jacobson, 2008; Young et al., 2013; CJJI, 2013) suggest that low identification rates are the result of:

- A lack of effective and systematic screening
- A lack of training for police
- Mentally vulnerable individuals often showing no visual or behaviour clues or greater signs of anxiety and stress than other people who are detained by police
- The influence of alcohol or drugs complicating assessment
- A disregard of self-reporting
- The failure to use historical information from police records to identify learning disabilities to the same extent as they are used for mental health
- Some people seeking to disguise it (while others may be happy to alert police to their condition or it may be apparent from other information provided)
- Computerised risk assessments based on standardised questions which may be less likely to identify intellectual disability than mental health, drugs and alcohol use and self-harm (McKinnon & Grubin, 2010).

Most BME communities are disproportionately represented in the criminal justice system, mental health care and learning disability inpatient care (ONS, 2011; Ministry of Justice, 2011, Centre for Mental Health, 2014) though they do not necessarily have a higher prevalence if mental ill health or learning disabilities (Nazroo and King, 2002). Cultural factors can reduce access to services such as the fear of stigma, the imperative to 'save face', maintain social status and moral reputation (Centre for Mental Health 2014).

Police requirement for AAs

Police and Criminal Evidence Act 1984 Code of Practice C (Home Office, 2014) states that if a custody officer has any doubt about the mental state or capacity of a detainee, that detainee should be treated as mentally vulnerable and this should prompt an Appropriate Adult (AA) call-out (see Paper I).

However, research suggests that despite police identification of mental vulnerabilities among suspects, AAs are only called in 54-63% of cases; highlighting a disjuncture between the identification of need and AA call-outs for adults with needs around mental health and learning disabilities (Medford et al, 2000; McKinnon & Grubin, 2014; CJJI, 2013). Studies have shown that whilst the police often recognise the extent of the mismatch, the use of AAs remains generally low (Leggett et al., 2007; Cummins, 2007). Consequently, the proportion of adults in custody for whom the police require an AA is very low. Findings range from 0.18% to 14% (Bean & Nemitz, 1994; Rapley & Sandberg 2011). However, it is interesting to note that the most recent studies found rates of 4.8% (McKinnon & Grubin, 2013) and 4.2% (Young et al., 2013) respectively, mirroring the 4.3% found by the Royal Commission on Criminal Justice more than 20 years ago (Gudjonsson et al., 1993).

Decision-making by custody officers

There are a wide range of factors that influence a custody sergeant's decision to call an AA. This includes the nature of the offence; the circumstances of the arrest, the presentation of the suspect; and wider pressures in the custody suite; in addition to a custody sergeant's continued reliance on their own interpersonal skills and experience (Cummins, 2007). Whilst screening questionnaires have been developed to help police identify vulnerabilities, this has not necessarily translated into commensurate AA call-outs (McKinnon & Grubin, 2014). In an evaluation of a volunteer scheme, Nemitz and Bean (1998) found that as trust between the AAs and police grew, the demand for the service increased. Other factors that enter the custody sergeant's decision-making equation on whether to call-out an AA are discussed below.

Training

Described as 'woefully inadequate' (The chair of the Police Federation cited in Dodds, 2014), the lack of training provided to custody sergeants on mental health, learning disabilities and other mental vulnerabilities is consistently reported to be inadequate and correlated with the under-use of AAs (Palmer, 1996; Cummins, 2007; Williams, 2000; CJJI, 2013).

Delegation of decision-making to healthcare professionals

PACE Code C states that 'Health care professionals should advise on the need for an appropriate adult to be present' (para. 5, Annex G of Code C) but that, 'Once the health care professional has provided that information, it is a matter for the custody officer to decide whether or not to allow the interview to go ahead and if the interview is to proceed, to determine what safeguards are needed' (para. 8, Annex G of Code C).

However, there is evidence to suggest that, rather than consulting with healthcare professionals (HCPs) regarding the need for an AA, custody officers often delegate their legal responsibility to HCPs to make the decision on whether an AA is required (Phillip and Brown, 1998; Medford et al, 2000; Williams, 2000; McKinnon et al, 2010). This is perhaps unsurprising given custody officer's likely perception of their relative levels of training. Indeed, there is some evidence to suggest that forensic physicians (commonly referred to as forensic medical examiners or FMEs) or healthcare professionals (HCPs) are more likely suggest an AA call-out (Rapley et al., 2011). However, recently, the current training, management and capability of forensic physicians to recognise when an AA is required have come under scrutiny (Adebowale, 2013; CJJI, 2013). Typically GPs, there is no requirement for them to have psychiatric or learning disability training. Previous research has found them: to be poorly informed on PACE Code C the thresholds and requirements; to ignore suggestibility and the differing contexts of a doctor's examination and a police interview (Norfolk, 1996); and to confuse and conflate decisions over fitness to interview with the requirement for an AA (Robertson, 1993; Williams, 2000).

Assessments have been increasingly undertaken by specialist nurses. Some have little or no training in relation to learning difficulties, such as access to AAs (CJJI, 2013). It was found that in one force visited by inspectors, none of the ten detainees with identified learning disabilities received an AA, even though, many had been medically assessed (CJJI, 2013).

Researchers have suggested that HCP staff do not focus sufficiently on psychological or mental health symptoms and recommended improved knowledge and awareness (Young et al., 2013; McKinnon & Grubin, 2014). It is also notable that the design of computerised risk assessments can actively discourage genuine consultation around the need for an AA, by forcing medical professionals to respond only 'yes' or 'no'. Jacobson (2008) recommended PACE Code C be amended to make explicit that an AA is mandatory whenever a custody officer has sufficient concerns about a suspect's mental state or capacity to request a health professional's assessment of fitness for detention and/or interview. This is logically consistent since an AA is already required whenever a custody officer has a suspicion.

Availability of AAs

Research consistently highlights the difficulties in some areas with the availability of AAs, with local social services emergency duty teams responding only if they had no higher priorities (Durcan et al 2014). This has a direct impact on operational decisions, causes delays in investigations and leads to mentally vulnerable people being detained for longer than is necessary, including overnight, and in an environment which is unhelpful to their mental state (Home Office, 2008; CJJI, 2013). In a survey of police forces, most commented that the poor level of service provision was due to a lack of statutory responsibility for vulnerable adults (Perks, 2010). Notably, Norfolk (1996) found a statistically significant association between those FMEs who said police put pressure on them not to recommend an AA and areas where the police have difficulty in finding AA.

Early research indicated difficulty finding AAs in around half of areas and problems securing timely attendance due to the lack of an equivalent of the custodial duty solicitor scheme (Royal Commission on Criminal Justice, 1993; Norfolk, 1996; Hodgson, 1997; Signy, 1997; Littlechild, 1998[i]). On average, it is reported that an vulnerable adult spends over 4.5 hours in custody prior to the AA's arrival, with some waiting more than 20 hours (Medford et al, 2000).

The 2002 PACE Review found that the chaotic and unstructured provision of AAs lead to avoidable delays in custody and recommended national policy and full national guidance. Further research led to recommendations for adequate funding, statutory provision of adult services, training for police and the overhaul of 'fractured and dislocated' community-based mental health services (Pritchard, 2006; Cummins, 2007). Although researchers noted that there are many AA schemes serving adults in existence that operate effectively, some long-established, providing extensive coverage and well-integrated with other local services (Jacobson, 2008) the subsequent PACE Review concluded that, "There are [still] difficulties in some areas around availability and attendance of appropriate adults at police stations" (Home Office, 2008 p.30). A recent HM Inspectorate report suggests there are still significant issues with the availability of AAs in some areas and that, "Custody sergeants said appropriate adults were not always available to assist with cases" with only two of six forces reporting AAs are available day or night (CJJI, 2013 p.5).

Commissioning AA services

It has been recommended that there should be a statutory provision for vulnerable adult suspects, equivalent to that for children, and that the necessary funding is ring-fenced whether the duty lies with local authorities or health (Pritchard 2006; Jacobson, 2008; Perks 2010; PRT, 2011). A PACE Review proposal to place the statutory duty on police forces was rejected in consultation responses, due to concerns over conflict of interest and perceived independence and suggesting it should lie with local authorities (Home Office, 2010).

While local approaches have been identified as a good model, concerns have been raised about the 'patchy and of variable quality' of development, the lack of evaluation of training courses and the ease with which they could be undermined by poor selection and training or dominated by ideologies that are more concerned with securing treatment than protecting rights (Bean & Nemitz 1997; 2001). In response to these risks, the PACE Review consultation showed broad support for local agreements with social services, voluntary schemes, and companies but also a national approach supporting recruitment and retention, communications, learning the lessons and monitoring and accountability (Home Office, 2007; 2010).

The recent report 'The Bradley Report five years on' provided an independent review of progress against the Bradley Report's recommendations. It noted the lack of statutory responsibility and recommended clarification of the funding arrangements and access to AA provision in any facility where a vulnerable person is likely to be interviewed (Durcan et al 2014). Sir Stephen Bubb's review of progress on the (post-Winterbourne View) Transforming Care agenda emphasised the need for a Government response to these recommendations,

explicitly recognising how 'fundamentally important' the issues were to its agenda - transforming care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services (Bubb 2014). In 2015, in response to the Bubb review, NHS England, the Department of Health, the Local Government Association, the Association of Directors of Adult Social Care, the Care Quality Commission and Health Education England published a commitment to strengthen the Transforming Care delivery programme by creating a new delivery board, as well as reinforcing the need to respond to those same recommendations[6].

Who makes an appropriate AA?

Whilst PACE 1984 guidelines identify who should take on the role of AA for children, for adults, this is left to the Codes of Practice (see Paper B). The literature outlines the relative efficacy of different types of AA, including the use of family members, social workers and volunteers.

(i) Family members

The literature highlights that the use of family members as AAs for children is fraught with difficulty. Problems with the use of parents as AAs for children include; a misunderstanding of the AA role, the threat of physical violence towards their child, pressure on their child to confess, aggression towards police and their involvement in ongoing family conflicts (Dixon et al, 1990; Brown et al, 1992; Evans, 1993; Littlechild, 1995; Bean, 1997; Bucke and Brown, 1997; Pierpoint, 2006). However, it is not clear to what extent these issues are present for family members acting for vulnerable adults.

Studies suggest that the AA role is too complex for the short explanation that a busy custody officer can deliver to an untrained person and a small amount of information about the role can render a person less effective than if they had none (Williams, 2000; Nemitz & Bean, 2001; Dhami and Garcia-Retamero, 2014). The 2008 PACE review proposal to limit the role to trained individuals while encouraging parents and carers to attend was strongly supported in consultation responses subject to 'significant resource and capacity implications' (Home Office, 2008; 2010) and is supported by research (Littlechild 1995, Pierpoint 1999, 2000a, 2000b, 2006). The view of the Inspectorates is that, "If the Appropriate Adult system is to be fit for purpose, it must be staffed by workers/ volunteers who have received appropriate training" (CJJI, 2013 p.20).

(ii) Social workers

Issues with the use of social workers as AAs are well documented (Kay and Quao, 1987, Dixon, 1990; Brown, 1997; Hodgson, 1997; Williams, 2000; Pierpoint, 2001; White, 2002). These include the perception of them as 'instruments of control or punishment' by vulnerable suspects, their tendencies towards elements of crime control, and the fact that they are more co-operative towards the police than parents. It has been questioned whether social workers' training, experience and codes of ethics suits them to the role, with confidentiality being

[6] http://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf

a key area of conflict of interest (Thomas, 1995; Williams, 2000; Pierpoint, 2001). Case law has held that those in a position of authority over a client are inappropriate (Hodgson, 1997). Perhaps the most critical issue that the unit cost of a social worker outside London is £159 per hour of face-to-face contact or £226 of qualifications are included (Curtis, 2013)[ii] meaning that many individual custody episodes would cost over £1000.

(iii) Volunteers

Prior to the enactment of a statutory duty to ensure AA provision for children, the government proposed the use of volunteers as a response to limited availability (Home Office, 1995) and to save money by reducing the time spent by social workers (Audit Commission, 1996).

Though efficiency had been the only consideration, later evaluations proved positive at least on the basis that volunteers arrived more quickly than social workers, reducing the time spent in custody (Bean and Nemitz 1997; Nemitz and Bean, 1998; Revolving Doors Agency, 1996; Pierpoint, 2008). Volunteers were able to act without conflict of interest or emotional attachment. Whilst volunteers did not always contribute enough, the quality of contributions was superior to parents or social workers. However, effectiveness was found to be contingent on good selection and preparation, improved training and monitoring practices, and effective regulation and guidance (Pierpoint 2000a; Pierpoint, 2001). There is an absence in the literature considering the relative efficacy of people paid to be a dedicated AA, whether sessional or otherwise.

Insights from people who have used AA services

The thematic joint inspection on vulnerable people in custody (CJJI, 2015) commissioned research into views on AAs of people who had used their services. It found that:

- Children are always provided with an AA but vulnerable adults are not.
- People sometimes decline an AA to get out of custody faster, something that can be a matter of regret. This should be addressed to protect the rights and welfare of vulnerable detainees.
- Some people value having an AA whom they know and trust, while others felt inhibited talking openly and honestly with a parent/carer present.
- Some who had a parent/carer as their AA understood the role to be entirely passive. If a parent/carer acts, it is better if they have good knowledge of custody and criminal justice.
- No people who used an AA service recalled meeting their AA earlier than shortly before the interview.
- Where AAs take a long time to arrive it delays the custody process.
- AAs make a positive difference to the custody experience and outcome. They provide support during interviews (people feel more relaxed and can understand and communicate better), protect rights (more able to exercise their rights), and promote fairness (unprofessional conduct and inaccurate information is challenged)
- People who had used AAs said *all* detainees should have one to ensure welfare and rights in custody.

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Police and Criminal Evidence Act 1984 (PACE)

The PACE system is divided into the Act itself, the Codes of Practice which are not law and the Notes for Guidance which are technically not part of the Codes[1]. The Act contains no provisions relating to AAs for vulnerable adults.

Section 63B (Testing for presence of Class A drugs) defines who may act as AA for a juvenile[2] and requires that an AA be present in relation to testing juveniles for Class A drugs .

Section s.66 and 67 (Codes of Practice) require the Secretary of State to issue codes of practice and make revisions by statutory instrument subject to consultation and approval of Parliament. Codes are admissible in evidence and shall be taken into account by courts and tribunals where relevant.

Section 76 (Confessions) (2)(b) requires courts to exclude from evidence a confession that was made in consequence of anything said or done likely to make it unreliable, unless the prosecution can prove beyond reasonable doubt that it was not. This includes the omission of an AA when one was required *(see R vs Gill* [2004] in Paper C).

Section 78 (Exclusion of unfair evidence) (1) enables courts to refuse evidence that was obtained in circumstances that mean it would have such an adverse effect on fairness that they ought not to admit. Courts have excluded evidence and quashed convictions under this section due to the absence of an AA (Paper C).

Section 77 (Confessions by mentally handicapped persons) directs courts to have special caution before convicting where a case depends on a confession by someone "in a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning" when an independent person was not present. Courts have struck out evidence on this basis. Independent AAs satisfy this requirement.

PACE Codes of Practice

All information relating to AAs for vulnerable adults is contained in the PACE Codes and is spread across Codes C, D, E, F and H[3]. Though the Codes are not are law, in combination with PACE 1984 s.76-78 they have legal status and practical effect in case law and if they are not followed then courts may refuse to admit evidence and may quash convictions (see Paper C). This applies to their Notes for Guidance, despite the statement within the Codes that they are not part of them[4].

The Codes set out the AAs purpose and powers, who may act, the thresholds defining when one is required, the actions police must take and the circumstances and procedures for which one must be present (see Paper I). These rules apply so far as is possible, to 'voluntary attenders' who are interviewed under caution without arrest).[5]

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[1] Zander (2012). If the PACE Codes Are Not Law, Why Do They Have to Be Followed? *Criminal Law and Justice Weekly* http://www.criminallawandjustice.co.uk/features/If-PACE-Codes-Are-Not-Law-Why-Do-They-Have-Be-Followed

[2] Section 63B(10)(a) defines eligibility as parents, representatives of care organisations, local authority social workers or, failing those, anyone over 18 with the exception of those employed by the police. As currently enacted, a juvenile is aged under 17 years. However, the Criminal Justice and Courts Act 2015 will amend this to under 18 years.

[3] Code C: detention, treatment, questioning and identification; Code D (identification, fingerprints, and parades); Code E and F (audio and visual recording interviews); of persons by police officers (or Code H for Terrorism Act 2000 cases).

[4] Zander (2012). If the PACE Codes Are Not Law, Why Do They Have to Be Followed? *Criminal Law and Justice Weekly* http://www.criminallawandjustice.co.uk/features/If-PACE-Codes-Are-Not-Law-Why-Do-They-Have-Be-Followed

[5] Although the Codes focus on detention, their requirements apply, so far as is possible, to voluntary attenders (interviewed without arrest but under caution regarding suspected involvement in an offence). This includes determining whether they require an AA under Code C 3.5(c)(ii)). (Code C 3.21)

The Crime and Disorder Act 1998

Provisions relating to AAs

Sections 38 and 39 place a statutory duty on local authorities (via Youth Offending Teams) to ensure provision of persons to act as AAs for all children and young persons in their area, "to safeguard the interests of detained or questioned by police officers" – the only definition of AAs in legislation.

Sections 66ZA and 66B assign additional AA responsibilities beyond those in PACE. AAs must be present in relation to youth cautions and youth conditional cautions. The associated Code of Practice[6] notes that as 17 year olds are excluded from this support[7] "the authorised person must also bear in mind the provisions of PACE Code C concerning mentally disordered or mentally vulnerable offenders and the use of an appropriate adult" and "ensure that an appropriate adult is present…where there is reason to doubt the capacity or ability…to fully understand the nature and requirements of a youth conditional caution."

Community Safety Partnerships

Section 17 requires local authorities to have due regard to the need to, and do all it can to, prevent crime and disorder, re-offending and the misuse of drugs, alcohol and other substances. All policies, strategies, plans and budgets must therefore be considered with the potential contribution to the above.

Sections 5 to 7 form the basis for CSPs including local authorities, police and clinical commissioning groups (CCGs) as statutory partners, require the implementation of joint strategies as per section 17 and provide reports to the Secretary of State.

The Human Rights Act 1998 (HRA 1998)

Article 2 (Right to life) imposes an obligation to protect individuals in state detention whose life is at risk, including from suicide. This includes a duty to put in place appropriate systems designed to protect lives. According to the ECHR (2015)[8], in relation to police detention, this includes but is not limited to: -

- Freedom from abuse, bullying, threats, disrespectful treatment and neglect
- Freedom from unlawful restraint
- An effective risk assessment by a qualified practitioner as soon as practicable and timely access to medical and mental health treatment
- Access to support, plus information and advice in an appropriate format on how to access it

Article 6 (right to a fair trial) sets out a number of minimum rights. This includes being informed in a way a person understands and in detail, the nature of the accusation against them. Case law has held that Article 6 applies to suspects interrogated in police custody, with obvious implications for people with a mental vulnerability.

Article 8 (right to private and family life) has been interpreted broadly by courts and in includes what is, in effect, a proportionality balancing test between the right and interference with it by a public authority (such as the police) in accordance with the law. Areas such as police fingerprinting and photography, for which AAs should be present, may come under this Article.

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[6] Code of Practice for Youth Conditional Cautions Crime & Disorder Act 1998 (as amended by the Criminal Justice & Immigration Act 2008 and the Legal Aid, Sentencing and Punishment of Offenders Act 2012)
[7] The Criminal Justice & Courts Act 2015 will amend this to all children under 18
[8] Equality & Human Rights Commission (2015) Preventing Deaths in Detention of Adults with Mental Health Conditions. London: EHRC

Article 14 (discrimination) requires rights under all articles to be afforded without unjustifiable discrimination between groups, including people who are disabled.

The recent Equality and Human Rights Commission Inquiry published a Human Rights Framework for Adults in Detention and recommended its adoption and use as a practical tool in police custody (ECHR, 2015)[9].

The Equality Act 2010[10].

Sections 6 and 15: define disability as a physical or mental impairment, which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities; and prohibit unfavourable treatment that is not proportionate and legitimate where the disability was known or could reasonably have been.

Section 28 requires reasonable adjustments to be made to standard provisions, criteria, practices or physical features to avoid disadvantage. Reasonable steps must be taken to provide any 'auxiliary aid' without which a disabled person would be disadvantaged.

Section 149 establishes a proactive, public sector equality duty. Section 153 gives a Minister power to impose specific duties on specific public authorities following consultation with the Equality and Human Rights Commission.

The Mental Health Act 1983 (MHA 1983)

Section 1(2) states that 'mental disorder means any disorder or disability of the mind'. There are several hundred definitions of mental disorders alone (American Psychiatric Association, 2013)[11] but include Alzeimer's disease, autism, Down's syndrome, dementia, personality disorders, psychosis and schizophrenia. Learning disability (defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning') is included for most purposes in the Act and always where the 'disability is associated with abnormally aggressive or seriously irresponsible conduct'. The PACE Codes use this definition, while the PACE Act retains the term 'mentally handicapped'.

Section 130A establishes *Independent Mental Health Advocates (IMHA)* to provide advice and support around rights, options and in raising concerns about the care received for those in secure mental health detention, although they are not legal advisers. IMHAs are provided by various organisations and funded by a Department of Health Grant passed down to local authorities.

The Mental Capacity Act 2005

Section 1 sets out five underpinning principles: presumption of capacity; right for individuals to be supported to make their own decisions; right to make unwise decisions; best interests; and the least restrictive intervention.

Sections 35 and 36 establish Independent Mental Capacity Advocates (IMCAs) to safeguard people to whom authorities are seeking to apply safeguarding powers and enable the local authority to "make such arrangements as it considers reasonable" to ensure IMCA availability.

Most 'mentally vulnerable' adults will not lack capacity but will still require, and cannot refuse, an AA. Where AAs have doubts about capacity they request a professional MCA 2005 assessment.

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[9] ECHR (2015) Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission

[10] Principle 2 of the College of Policing's Authorised Professional Practice on investigative interviewing notes that Equality Act 2010 and the Human Rights Act 1998 must be complied with

[11] The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

The Health and Social Care Act 2012

This Act created a new commissioning framework for health and social care in England, creating local Clinical Commissioning Groups (CCG) and the NHS Commissioning Board. Health and Wellbeing Boards (HWB) must be established by local authorities, and produce a strategy which feeds into CCG planning. Their statutory membership includes each local CCG, directors of both child and adult social services and the local director of public health. This transformation and integration is supported by the £3.8 billion Better Care Fund (BCF), a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government. As part of the changes, the revised Health and Care Professions Council extended to "regulating health, psychological and social work professionals". The HCPC also regulates Speech & Language therapists and is being accorded powers to set up voluntary registers for unregulated professions or related professions.

The Care Act 2014 (England only)

The Act provides a new framework for safeguarding adults and significantly increases local authority responsibility for health and social care.

Section 1 (*Promoting wellbeing)* requires local authorities carrying out any care and support function, to promote a person's well-being, including mental health and emotional well-being; protection from abuse and neglect; social and economic well-being; personal dignity and their contribution to society. Critically, the Act does not specify the services which must be commissioned.

Section 6 (*Local Co-operation)* creates a duty of co-operation between a local authority and partners (police, probation, NHS, local authorities) in relation to adults with needs for care and support.

Section 43 and Schedule 2 (*Safeguarding Adults Boards)* require each local authority to establish a Safeguarding Adults Board (SAB) to help and protect adults where there is reasonable cause to suspect they have needs for care and support, are at risk of abuse or neglect, and are unable to protect themselves. Statutory members include CCGs and chiefs of police. Annual strategic plans and reports must be made and shared with the Chair of the local Health and Wellbeing Boards.

Section 67 (*Independent Advocacy Support:* requires that, local authorities must, when engaging with a person under the Act, arrange for an independent person to represent, support and facilitate their involvement. This applies when they would experience substantial difficulty in understanding, retaining, using or weighing relevant information or communicating their views.

Though the Act focuses on vulnerable people as victims, its statutory guidance states that, "Everyone is entitled to the protection of the law and access to justice." It also states that where a suspected abuser "has care and support needs and are unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an 'appropriate' adult if they are questioned by the police under the Police and Criminal Evidence Act 1984 (PACE)" (Department of Health, 2014)[12].

Social Services and Well-being (Wales) Act 2014

Alongside the Care Act in England, this Act establishes entirely separate social care legislation for England and Wales. Many of the principles and much of the wording are similar to the Care Act 2014. The duties to promote well-being, co-operate and share information are similar. Section 134 establishes Adult Safeguarding Boards,

[12] Care and Support Statutory Guidance, Issued under the Care Act 2014, Department of Health

though these will not necessarily be contiguous with local authority areas. Section 132 establishes a National Independent Safeguarding Board, supporting SABs and reporting on them to Ministers.

Autism Act 2009 (England)

The Act requires the Secretary of State to prepare and publish an autism strategy for meeting the needs of adults with autistic spectrum conditions by improving the provision of relevant services to such adults by local authorities, NHS bodies and NHS foundation trusts and to issue guidance to them to ensure implementation.

Under the strategy, 'Think Autism: Fulfilling and Rewarding Lives' (HM Government, 2014), priority challenge 13 is "If I break the law, I want the criminal justice system to think about autism and to know how to work well with other services". People with autism need access to support when suspected of committing a crime. The police should ensure they have access to expertise to support adults with autism.

The Department of Health is currently running a consultation on new statutory guidance. The draft guidance makes a number of relevant statements: -

- It applies to local authorities and health bodies working with justice system agencies
- Local authorities should ensure they are looking at the needs of their local autism population, including those who do not meet thresholds for care and support.
- Without "preventative support and safeguarding in line with the Care Act" people with autism can spiral into contact with the justice system.
- People with autism need access to support whether they are a victim, or witness, or are suspected of committing a crime.
- When people with autism come into contact with the criminal justice system it is often up to them, or their carer, to explain what having autism means. In some cases, it can positively change the way that police or courts view a situation.
- Police, probation services, courts and prisons should be supported so that they are aware of the communication challenges experienced by people with autism.
- The role local authorities, via Community Safety Partnerships (CSPs), is to bring agencies together to develop plans to support the Autism Strategy.
- The role of health bodies is to deliver on the Liaison & Diversion Programme to ensure people with autism are referred into services and diverted from offending, and to share information to enable more informed decisions about charging, case management and sentencing.

Local Authority Social Services Act 1970

Amongst others under Schedule 1, social services functions explicitly include: -

- the protection of the young in relation to criminal and summary proceedings (Children and Young Persons Act 1933 (c. 12) Part III)
- the welfare of persons who are blind, deaf, dumb or otherwise handicapped or are suffering from mental disorder (National Assistance Act 1948 (c. 29) sections 29 and 30)
- the welfare of mentally disordered persons (Mental Health Act 1959 section 8 and the Mental Health Act 1983 Parts II, III and VI)
- instructing an independent mental capacity advocate before providing accommodation for person lacking capacity (Mental Capacity Act 2005 section 39)

National Assistance Act (1948)

Section 1 states that a local authority may, with the approval of the Secretary of State, make arrangements for promoting the welfare of people aged eighteen or over who are blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

International Obligations

The UN Convention on the Rights of Persons with Disabilities was ratified by the UK in 2009. It has not been embedded into law but all UK government policies and practices must comply with the convention[13]. Article 13 requires effective and equal access to justice for people with disabilities in all legal proceedings, including at investigative and other preliminary stages and the promotion of appropriate training for police (amongst other professionals).

In 2003, the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). A National Preventive Mechanism is co-ordinated by HM Inspectorate of Prisons. The aim is to strengthen protection for people who are vulnerable by virtue of being deprived of their liberty.

[13] HM Government (2010) Creating a fairer and more equal society/ Available at https://www.gov.uk/government/policies/creating-a-fairer-and-more-equal-society/supporting-pages/united-nations-convention-on-the-rights-of-disabled-people (Updated August 2014) [Accessed 10/03/2015)

Paper C: Case Law Review

This paper provides a summary of the development of the Court of Appeal's approach to the exclusion of evidence obtained in the absence of an appropriate adult (AA).

In an early review of case law, Hodgson (1997) noted a lack of clarity in court decision and identified a shift towards a less robust interpretation by the Court of Appeal during the 1990s.

In *R v Dutton* [1988] [1] the Court of Appeal held that the trial judge had erred in allowing confession evidence to be put to the jury which had been gained from a 'mildly mentally handicapped suspect' (with an IQ of 60) in the absence of an AA. In cases such as *Morse and others* [1990] [2], *Cox* [1991][3], and *Kenny* [1993][4] the Appeal Court continued the approach that what should be considered was the actual mental condition of the suspect (not what the police believed it to be) and whether evidence had been obtained in consequence of anything likely to make it unreliable (the lack of an appropriate adult) rather than taking a view on its actual reliability. This approach implied that the absence of an AA would exclude evidence even if it was *prima facie* reliable.

However, in the case of *Lewis* [1996], attempts to argue that the defendant should have had an AA due to his low IQ were dismissed not on the objective basis of his intelligence but due to opinion that the presence of a solicitor was sufficient to ensure his rights were safeguarded. Hodgson (1997) saw this as, "a move from roundly condemning breaches of PACE and the Codes and upholding procedures put in place by Parliament, to taking account of other factors which might in some way mitigate the effects of the breach and so permit the court to admit the evidence subsequently obtained".

This more permissive approach was apparent when, in *DPP. vs Cornish* [1997][5], the Court of Appeal held that confessions could still be admissible even where an AA should have been present due to a learning disability. It stated that a court should consider the nature of the interview, including who was present, and assess what effect the lack of an AA had made with regard to PACE s.76(2)(b)[6].

Similarly, in *R v. Law-Thompson* [1997][7] an appellant with 'autistic psychopathy' and Asperger syndrome, had given a confession during an interview without an AA. The Court of Appeal felt there was no basis for believing the confession was unreliable and did not find it should have been excluded under PACE s.78.

[1] R v. Dutton (unreported case no. 4627.G1/87 (http://apt.rcpsych.org/content/14/5/369)
[2] Morse and others [1991] Crim.L.R. 195; Everett [1988] Crim.L.R. 826.
[3] [1991] Crim.L.R. 276.
[4] [1994] Crim. L.R. 284; Times, July 27, 1993; Independent, August 16, 1993; CA (Crim Div); 16 July 1993
[5] The Times, 27 January
[6] Gudjonsson G. H. (2003) The Psychology of Interrogations and Confessions: A Handbook
[7] R v Law-Thompson (Howard James) [1997] Crim. L.R. 674)

Failure to inform appropriate adults of their role may lead to confessions being excluded, or to miscarriages of justice (see *R v. Palmer* in Legal Action, September 1991, p. 21). However, in *H and M v. DPP* ({1998} Crim L.R. 653), the Court of Appeal held that a failure by the police to inform 'W' that he was the appropriate adult, and to provide the information required under para. 11.16, was a technical breach. However, it produced no substantial unfairness to the appellants. Each interview was conducted in the presence of W. However, he was never told that he was the appropriate adult and was unaware of the term, but he was told that he was there to support the juveniles. The court felt this was sufficient information[8].

In *R. v. Aspinall* [1999][9], the Recorder had allowed interview evidence obtained without an AA from a man with a history of schizophrenia that was stabilized by medication. The Recorder's view was that this was acceptable because, though the police were aware of his diagnosis, the suspect was lucid at the time and did not exhibit any acute symptoms of schizophrenia or other mental health problems. However, the Court of Appeal overturned this decision, stating that the correct question to ask was not whether a condition meant an AA wasn't needed but whether the admission of the evidence would have such an adverse effect upon fairness that it should be excluded[10].

R v. Ali [1999] concerned a man with an IQ between 66 and 72. The trial judge excluded some interview evidence on the basis that he was 'mentally handicapped' and an AA could have intervened to establish that he understood the need to avoid boasting and exaggeration. Though he was still convicted, this was quashed by the Court of Appeal, which stated that although some of his evidence was sensible and reliable, his admissions and assertions were obviously exaggerated and likely to be unreliable (Ventress et al., 2008).[11]

In *R vs Gill* [2004] a man who was mentally vulnerable (due to low intelligence) had been convicted on the basis of a confession was made without an AA present. However, the Court of Appeal disallowed the appeal stating that the absence of an AA did not mean the confession was automatically excluded; each case must be taken on its own merits. In its deliberations, the Court said that the words 'anything said or done' in PACE s.76(2)(b) are wide enough to include interviewing a mentally vulnerable suspect without an AA. However, it went on to say that, while in some cases it may be material to consider whether a Code breach occurred, if the police are not aware of the person's relevant condition, it is the consequent loss of protection that should have been provided that is relevant. Citing *R. v Aspinall* the Court stated that the correct approach was to consider what had been lost as a result of the absence of an appropriate adult at the time of the confession. In this case, the Court

[8] Williams, J. (2000) The inappropriate adult. *Journal of Social Welfare and Family Law*. 22(1):43-57

[9] [1999] 2 Cr. App. R. 115; (1999) 49 B.M.L.R. 82; [1999] Crim. L.R. 741; (1999) 96(7) L.S.G. 35; Times, February 4, 1999; CA (Crim Div); 29 January 1999

10 Olubokan,J. (2008). The vulnerable adult in police custody: lessons learned from the case of R v Paul James Aspinall. *Medicine, Science and the Law*, Vol. 48. No. 3

[11] Michael A. Ventress , Keith J. B. Rix , John H. Kent. Keeping PACE: fitness to be interviewed by the police http://apt.rcpsych.org/content/14/5/369

decided the judge had been entitled, and correct, to conclude that the presence of an appropriate adult would not have affected the man's evidence.

In *R vs Wilding* [2010][12], the Court of Appeal overturned the trial judge's decision to include confession evidence from a vulnerable adult who had not had an AA and quashed his conviction. It accepted that the trial court had been entitled to take its own experience into account in undertaking an enquiry as to the reliability of the evidence. However, citing *R vs Gill*, it 'cautiously and with respect' concluded the trial judge should have considered the whether an AA would have made any difference, and whether their absence rendered the admission unreliable, rather than having regard to how well the interview was conducted (as had happened in *DPP vs Cornish*). The Court of Appeal concluded on the basis of expert evidence that Wilding was within the definition of mentally vulnerable in Code C and that an AA might have secured legal advice, which might in turn have led to him making no admission.

In *R. v Brown* [2011][13] the Court of Appeal refused an appeal based on the fact that, post-conviction, a clinical psychiatrist had later determined that Mr Brown, who had not had an AA, had an extremely low IQ of 58 (only 0.3% of people have an IQ that low). In explaining its decision, the Court made the following points.

a) Mr Brown refused assistance for people with learning difficulties or disabilities when asked by police whether he need it.
b) Analysis of the interview transcripts concluded that Mr Brown had no apparent difficulty in concentrating, apparently had no major problems with understanding the questions, and gave reasonably clear and comprehensible answers
c) The type of support and advice offered by an AA would have been unlikely to make any impact on the interview because an expert[14] assessed Mr Brown as a confident, assertive and strong-willed man and that his language comprehension was better than suggested by his IQ.
d) Citing *R v Law-Thompson* [1997], the absence of an AA where a solicitor was present was unlikely in itself to justify the exclusion of an interview.
e) The jury had had a good opportunity to come to its own assessment of how bright Mr Brown was.

A number of drink-driving cases such as *R. (on the application of DPP) v BE* [2002], *R. (on the application of DPP) v Preston* [2003] and *Stanesby v DPP* [2012] have allowed evidence obtained not in the presence of an AA. In such cases the Court of Appeal has been consistent in disallowing appeals based on the absence of an AA for breath or blood based alcohol tests because they are time critical. This is the case even though it has been accepted that rights and procedures may not have been understood.

[12] R. v W Court of Appeal (Criminal Division) 05 November 2010 - [2010] EWCA Crim 2799 http://www.bailii.org/ew/cases/EWCA/Crim/2010/2799.html
[13] [2011] EWCA Crim 1606 - http://www.bailii.org/ew/cases/EWCA/Crim/2011/1606.html
[14] Professor Gisli Gudjonsson

Police Data

To gain an understanding about the national picture of AA need and provision a request was sent to the 43 police forces asking for the following data for the year 2012/13 and the year 2013/14:

- The total number of adults arrested by the police
- The total number of adult arrestees for whom an AA was requested
- The total number of adult arrestees for whom an AA was secured
- The proportion of AAs for adult arrestees supplied by dedicated AA schemes

Twenty-three forces replied representing approximately 60% of adult arrests in England and Wales[1]. The data presented in this paper relates to 721,048 (2012/13) and 704,652 (2013/14) adult custody records searched.

Data quality

Forces experienced considerable difficulty in supplying data on the number of AAs requested and secured; in part due to problems with data recording and in part due to the problems with data retrieval. A number of forces also provided caveats about the reliability of their data. No force was able to provide data on the proportion of AAs coming from different sources (e.g. AA service, relative, friend).

Several approaches were adopted to identify both the number of AAs required and secured. To identify AAs required, some forces had to conduct a 'free text' search of the custody system, some searched for a record of self-identification or identification through the risk assessment at booking in and others searched a 'vulnerable adult' marker on the custody system (though this is not a guarantee that an AA was requested). To identify the number of adults secured, some forces checked for a record of an AA being present for rights and entitlements, some looked for the presence of AA information in the 'contact details' screen and others asked their local AA scheme to provide data on AAs supplied. One force said that they were unable to identify the number of custody episodes where an AA was requested/secured because the method of retrieval included multiple AA call outs for a single custody episode. As a result, there were anomalies in the data, which variously may underestimate the number of AAs requested and secured or overestimate the number of AA-supported custody episodes.

Identification of need

The average rate of identification in 2013/14 was 3.1% (Table 1). This is lower than that found by recent (London-specific) studies (4.2%-4.8%) and the Royal Commission in 1993 (4.3%). This rate suggests approximately 36,500 adults per year are currently identified by the police as requiring an AA[2].

[1] Home Office (2014), Police powers and procedures England and Wales 2012 to 2013. London: Home Office

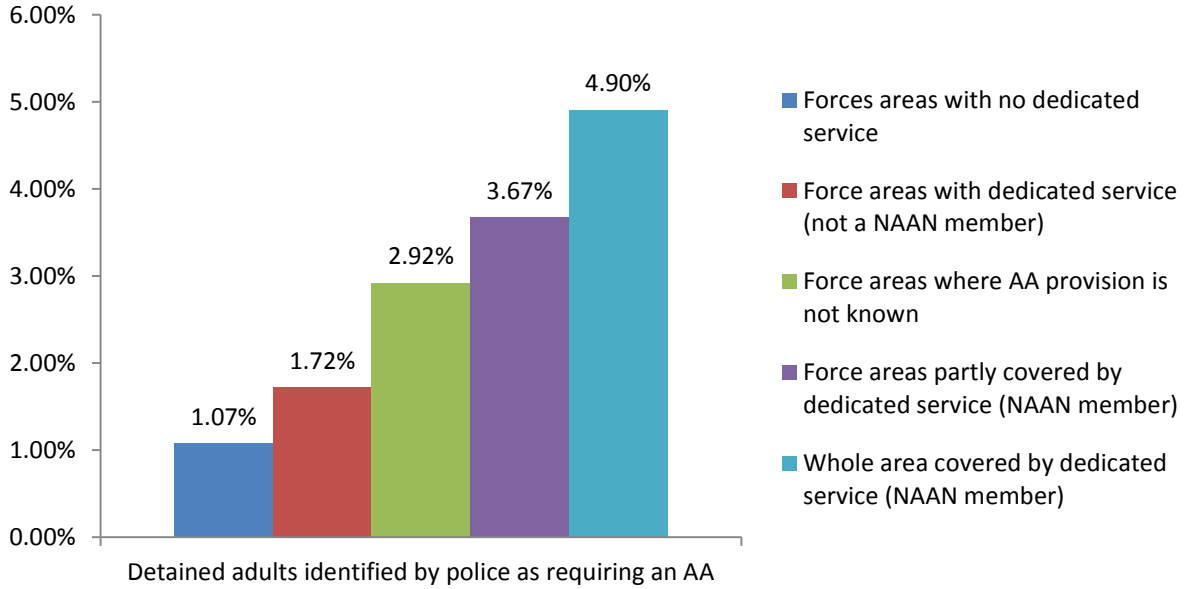
[2] Responding Forces made up 60.19% of the 944,242 arrests of adults for notifiable offences in 2012/13. The national estimate for AA need identified = respondents' AA required divided by 0.6019 = 36,483

Table 1: The average rate of identification

	2012/13	2013/14
Total adult detentions (23 Forces)	721048	704652
Identified need for AAs[3]	19619	21958
Identified need for AAs (%)	2.7	3.1

In 2013/14 the percentage of adults, from the 23 forces in the sample, who were identified as requiring an AA ranged from 0.5% to 9.2%. The two forces reporting 0.5% reported that their systems were poor and this was likely to be an underestimate. Chart 1 below provides an illustration of the correlation between the rate at which the police identify the need for an AA and the AA provision on which they rely. Interestingly, forces that have access to a NAAN registered scheme were the most likely to identify the need for an AA.

Chart 1: The effect of AA service provision on police identification of need



London

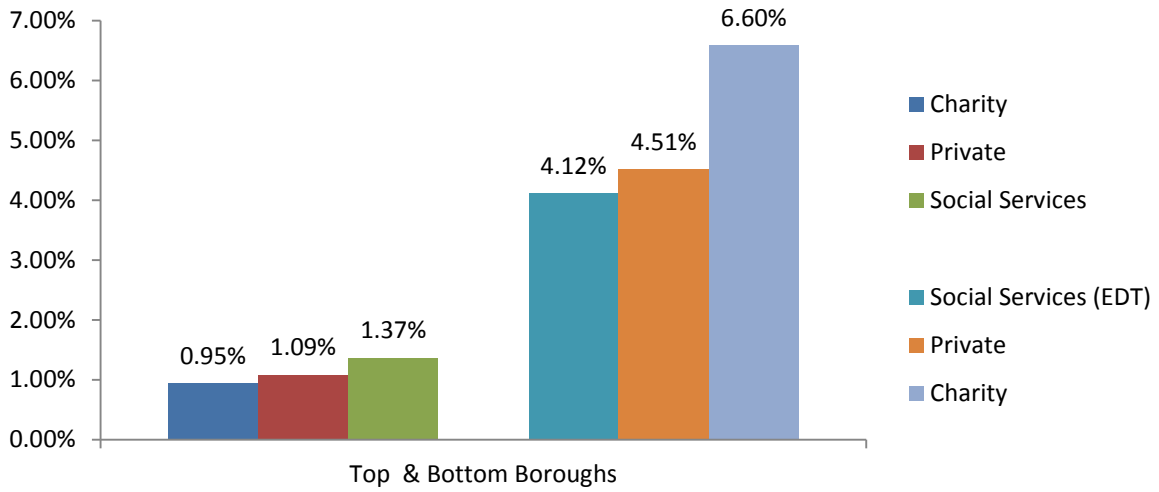
The Metropolitan Police alone accounted for 30% of the custody records searched and 23% of identification of AA need. The complexity of policing and local authority relationships across London is unparalleled in England and Wales, and this is reflected in AA commissioning and provision in the capital. Of the 33 areas[4], 30 provided data on AA provision; of these 11 boroughs have AAs provided by the private sector, seven by the public sector, six by a charity, two by a Youth Offending Team (YOT) and the remainder by an unknown provider.

[3] To mitigate against data issues, for each Force response we took the larger of either 'AAs required' or 'AAs secured'. Therefore this sum does not necessarily equate to AAs actually secured.

[4] 32 London Boroughs (covered by the Metropolitan Police) and the City of London (which has a separate police force)

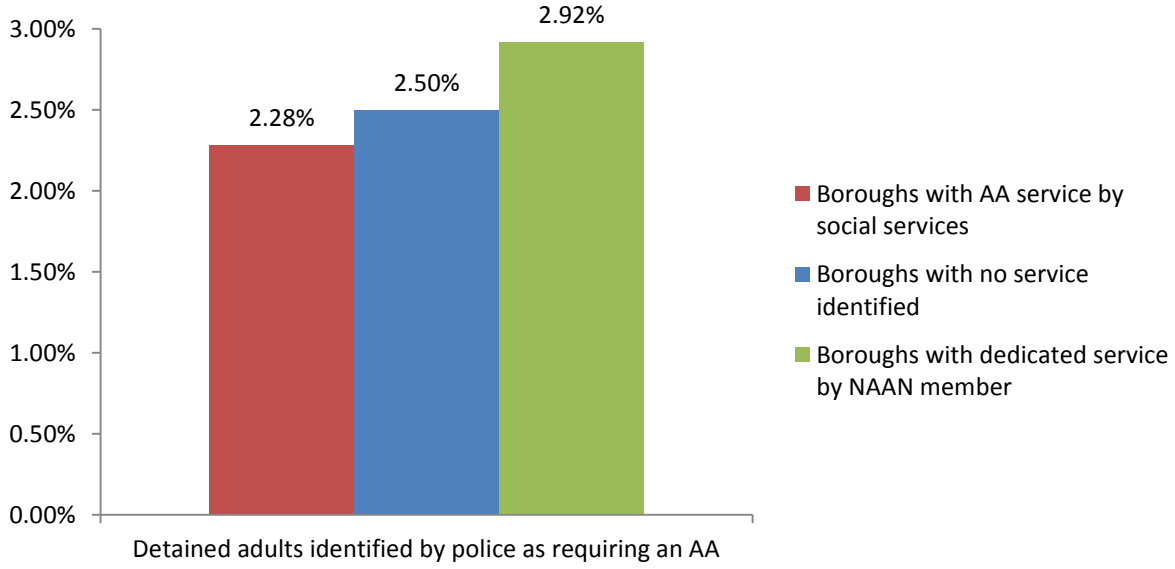
There was no evidence to suggest that the AA provider's sector made a signficiant difference to the rate at which police identified the need for an AA. The local authority areas with the lowest and highest rate relied on each sector equally. Chart 2 below illustrates the percentage of adults identified by the police who required an AA.

Chart 2: Percentage of adults identified by police as requiring an AA



Interestingly, the six boroughs with the highest identification rates all had dedicated AA services provided by NAAN members. Whilst areas with a dedicated service tended to have slightly higher rates, it was by no means a guarantee of high rates as illustrated by Chart 3.

Chart 3: Effect of AA service provision on police identification of need



To improve our understanding of the drivers of higher identification rates, we examined the commissioning in two boroughs where dedicated AA services are provided by the same NAAN member organisation but where rates are very different. The results are shown in Table 3 below and suggest that the nature of commissioning may significantly affect the rate at which police identify the need for an AA.

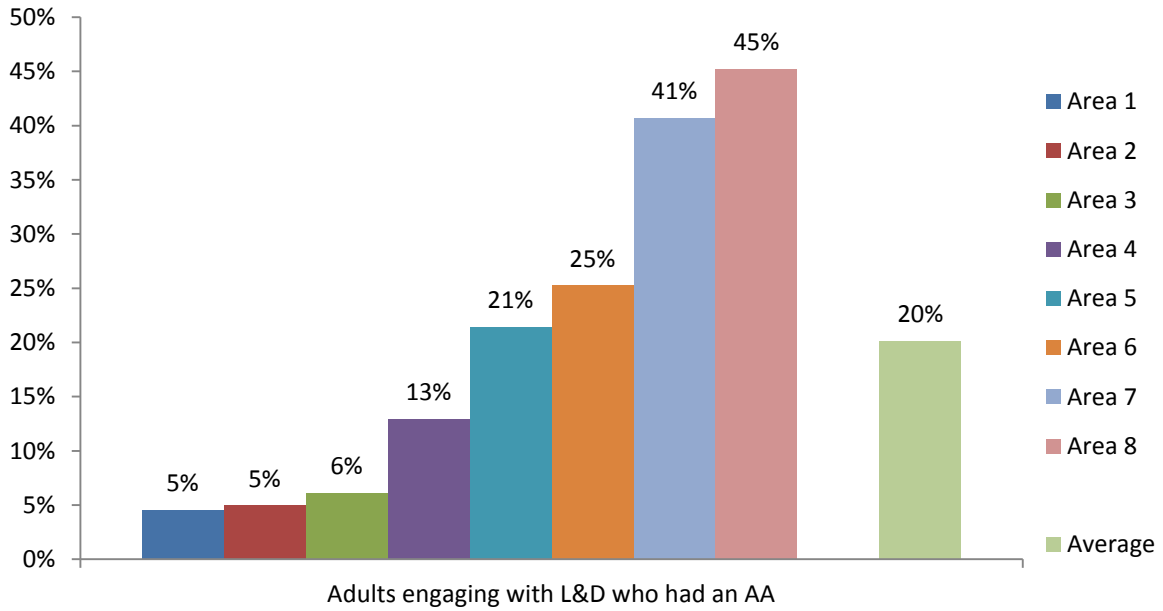
Table 3: The effect of commissioning on AA call out rates

	Borough A	Borough B
AA rate	2.2% (below average)	4.5% (above average)
Commissioner	Social services	Social services
Hours of operation	Monday to Friday 9am and 5pm	7 days per week 24 hours per day
Eligibility	Adults who live within the borough	All adults
Custody officer requests for AA	Must go via social services who consider and pass on requests to the provider	Direct to AA provider

Liaison and Diversion Data

Since 1st September 2014, the national liaison and diversion programme has been collecting data on the provision of AAs to individuals who are referred to, and engage with, the service. Liaison and diversion (L&D) involves the screening, assessment and referral of people with mental vulnerabilities including mental health and learning disabilities. Of the 11 operational sites, three had not collected data on AAs. The percentage of adults engaging with L&D who had received an AA varied considerably from five per cent to 45 per cent, the average was 20 percent, as illustrated in Chart 3.

Chart 4: Percentage of adults engaging with L&D who had an AA, by area (1st Sept - 31st Dec 2014)



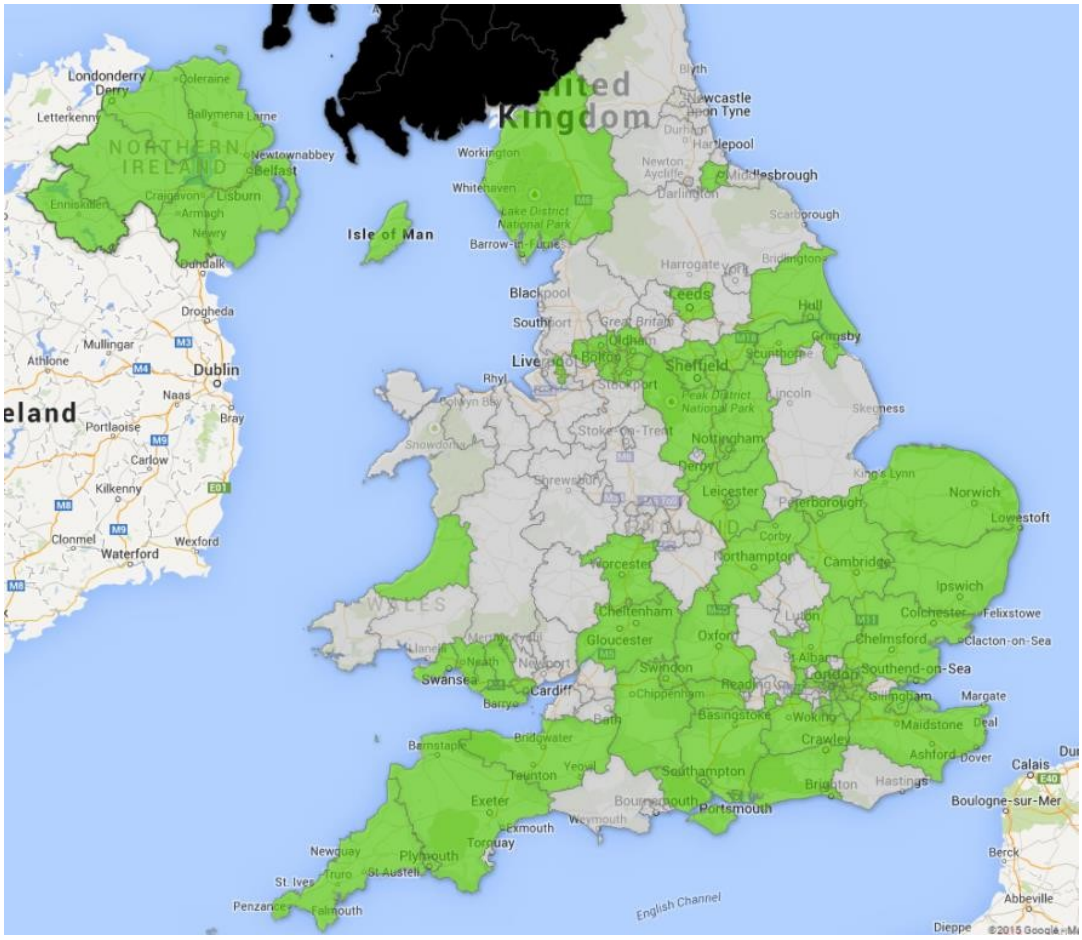
It was not possible to make comparisons with police data on the percentage detained adults for whom an AA is requested or secured. The liaison and diversion programme does not currently collect data on the proportion of detained adults who are referred to liaison and diversion services by custody staff.

NAAN Survey Data

The NAAN survey request received 38 responses from organisations currently providing appropriate adult (AA) services for vulnerable adults in England and Wales (78% of the relevant NAAN members)[5]. Unless otherwise specified, statements and figures relate to responses from England and Wales only and percentages are out of 38 responses.

Geography

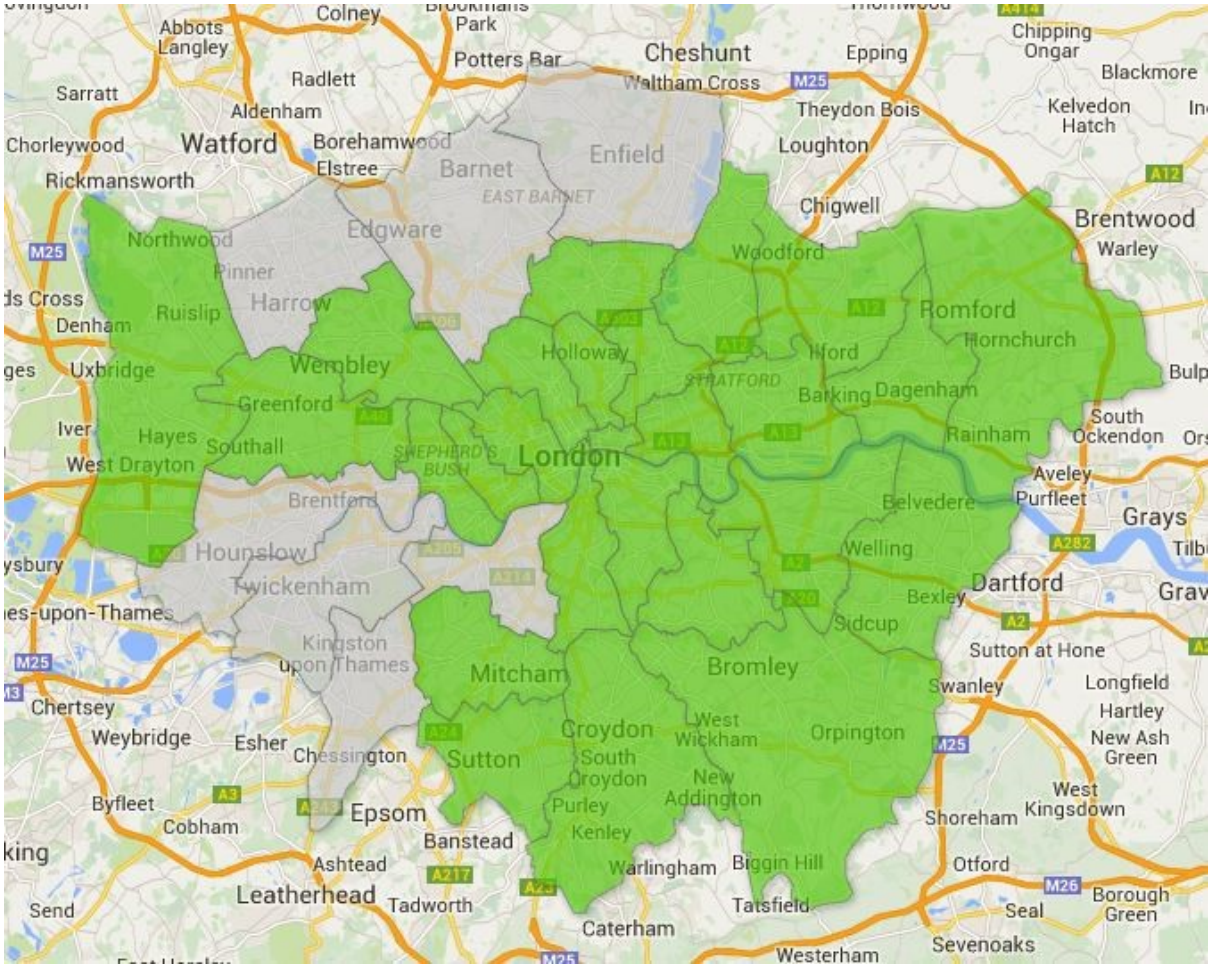
Eighty-seven percent of respondents said they covered all adults in a specific geographical area (one or more local authority) while eight per cent only provided AAs for their own clients.



Map 1: Adult AA service coverage by NAAN members (including non-respondents)

Seventy three per cent of schemes covered a single local authority, whilst 27% covered between two and six. One provider only covered adults with mental health issues and one said that eligibility varied across the contracts they held. One provider covered approximately 20 local authority areas (of which 14 were in London).

[5] A response was also received from the Northern Ireland AA Service, which is run by a charity providing a single service covering all of Northern Ireland.



Map 2: London Adult AA service coverage by NAAN members (including non-respondents) in the period covered by police data (2013 to 2014)

Service locations

Seventy-one per cent of providers said they provided services from one to five police stations, while 21% worked in six to 12 police stations. One provider covered interviews on its own premises and one was currently setting up a service. One provider covered almost 100 police stations. The average (excluding the large provider) was 4 police stations per provider.

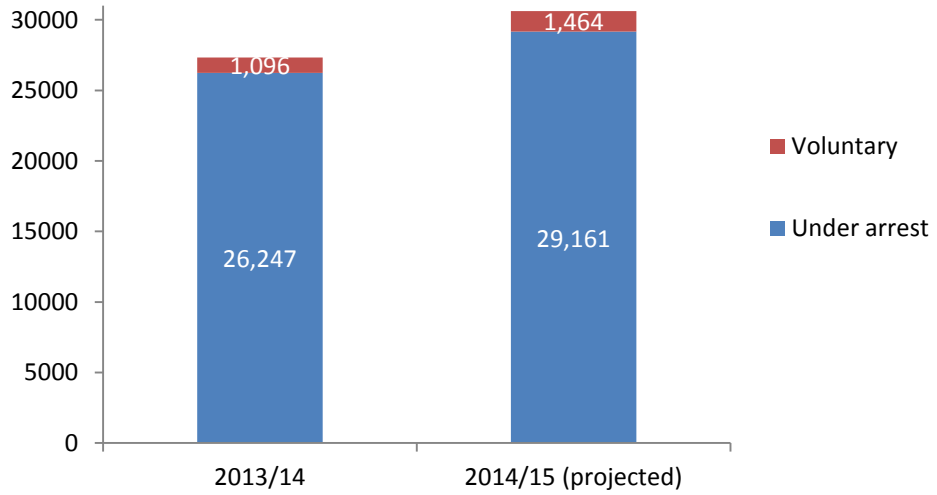
Half of respondents said they also covered prisons. Other locations covered included: young offender institutions (24%); Department for Work and Pension offices (18%); airports, ports and borders (11%); various secure mental health settings (8%)[6], agreed local authority buildings (3%). Eight per cent said they would attend any venue at which a voluntary interview was conducted. Services also reported that they provided AAs for PACE interviews conducted with the RSPCA[7], British Transport Police and Trading Standards, as well as for non-PACE age assessments of suspected illegal immigrants conducted by the UK Border Agency.

[6] Psychiatric hospitals, local psychiatric units (including forensic), Low Secure Units, secure mental health units
[7] Royal Society for the Protection of Cruelty to Animals

Call out volumes

Thirty-three respondents provided call out data including for custody and voluntary interviews for (a) the financial year to 2013/2014 and (b) the three quarters from April to December 2014. The latter was used to project volumes for 2014/15, as illustrated in column two in Chart 5 below.

Chart 5: Annual AA call out volumes in England and Wales



Call out volumes for 2014/15 are predicted to be 12% higher than the previous year, reaching 30,625. This is despite the police arresting around 10% fewer adults for notifiable offences in 2012/13 than the previous year (Home Office, 2014)[8], and police data provided to this study suggesting the use of custody reduced by around 2.3%. There are two possible explanations; there has been an increase in the proportion of adults being supported by an AA and/or an increase in the number of call outs per custody detention.

Provider sector

A variety of types of AA provider responded to the survey including: charities (20); youth offending teams (10); private AA companies (2); a private psychological counselling company (1); a local authority emergency duty team (1); a police and crime commissioner (1); a community safety team (1); a psychiatric hospital (1); and a social enterprise formed from local NHS mental health services (1). Over three-quarters of respondents stated that their service provided AAs for both children and mentally vulnerable adults.

[8] Home Office (2014), Police powers and procedures England and Wales 2012 to 2013. London: Home Office

Provider size

The number of call outs (per year) to police stations reported by AA providers varied considerably. Of the 33 respondents call outs ranged from three to over 10,000, with an average of 828. The six largest providers were responsible for more than two thirds of all AA call outs, whilst the seven smallest provided under one per cent. Chart 6 below illustrates the number of AA providers by the total annual call out and Chart 7 shows the proportion of total call outs by provider size.

Chart 6: Number of AA providers by annual call out volume

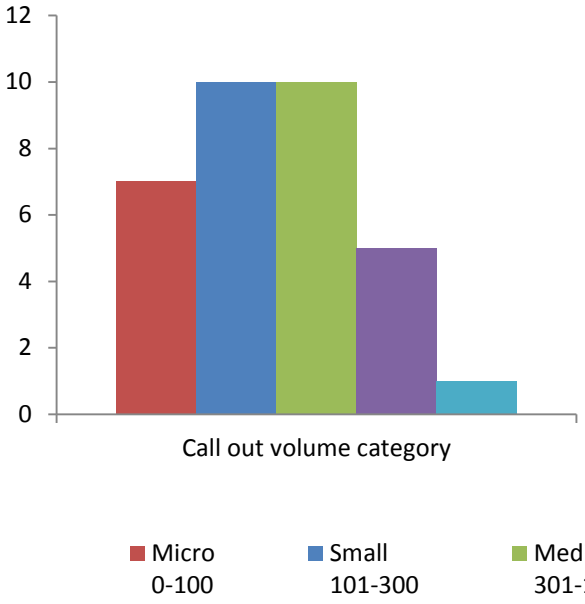
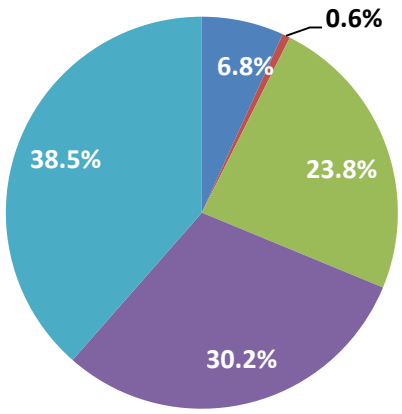


Chart 7: Proportion of total call outs by provider size



Staffing

Thirty-five respondents reported a total workforce of 1,320 people. Of these almost three-quarters were volunteers, just under a quarter were sessional staff, and just under five per cent were paid employee posts. Providers reported that paid staff spent a total of 1,243 hours per week on co-ordination. This implies efficient management, with 22 call outs achieved per hour of co-ordination. The average team size was 38 people (range from two to 184). The average annual number of call outs per team member was 15 (range from one to 57).

Capacity

Fifty-seven per cent of respondents said that they were generally able to respond promptly to a request within their current resources. While 11.4% said they had some spare capacity, just over a third said they were either 'sometimes' or 'often' unable to respond to the level of demand.

Commissioning

In 2013/14, almost nine in every ten call outs were commissioned under contract, based on either a fixed annual price or cost per use. Table 4 below provides data on the percentage of call outs in 2013/14 which were commissioned under a fixed price contract or similar agreement alongside the funding arrangements for all other call-outs.

Table 4: Commissioning and funding arrangements

	Providers	Number of call outs	% of annual call outs
Commissioned under a fixed price contract or other agreement	15 *(14 charities)*	10,480	38.3
Commissioned under contract with charges per hour or call out[9]	3	13,052	47.7
Spot purchase / Provided ad-hoc with charges per hour or call out	2	1,039	8.1
Funded by own organisation/authority (public sector)	9	2,217	3.8
Unfunded / funded by own organisation (charity or private company	6	517	1.9
TOTAL	**36**	**27343**	

The inequity of arrangements across the country was a leading theme, as was the urgency of the need to clarify accountability and ensure sufficiency. There were concerns about the current reliance in some areas on the goodwill of charities, some (but not all) of whom were well intentioned but poorly trained.

Most respondents thought AA commissioning, provision and oversight should be a shared responsibility between local government (78%), health authorities (31%), Police and Crime Commissioners (36%) and local partnerships such as safeguarding adults board (22%), with a partner agency commissioned to deliver the service. Respondents noted positive experiences of integrated health and social care commissioning teams and drew a link with liaison and diversion teams. Several concerns were raised about the responsibility sitting with Police and Crime Commissioners because AA provision is unlikely to be a community priority and it would be a conflict of interest with their role of inspecting custody. A quarter of respondents said that the responsibility should sit with national government, thus ensuring a clear national mandate unable to be diluted by local interpretation.

While direct delivery by adult social services was not viewed as a realistic option, there was a strong view that commissioning should be focused through local authorities. As AA services provided or commissioned by YOTs are well established, it was proposed that local authorities could negotiate with their own YOTs as to how best to

[9] This category includes all call outs by the single largest provider who delivers under various contract models but mostly under a pay per call out model with a fixed upper budget.

deliver AA services while minimising cost. Though it was made clear that these should be local decisions, combined services (children and adults) were seen by some to be desirable and workable. For one YOT scheme, extending existing service to adults via an service level agreement (SLA) and additional funding was relatively simple as it was ultimately 'coming from the same council pot'.

Respondents eschewed the idea of national or regional services, strongly supporting local (64%) or force area services (22%). In addition to cost benefits, localism was viewed as having qualitative benefits. One respondent stressed that local knowledge and needs must not be overlooked. Another noted that the development of local relationships with custody staff based on trust and positive links with local organisations and services ultimately benefitted vulnerable adults. These would not be replicated without the closeness of services to custody.

Eligibility criteria

Respondents said contracts should be based upon broad eligibility criteria that are inclusive of all mentally vulnerable people irrespective of their condition, home postcode or use of other services. They should enable provision both in custody and for voluntary interviews elsewhere if it is in a person's best interests. This would reduce complexity, result in shorter detention times and reduce overall costs.

The need for value for money

Respondents were aware that the commissioning landscape was changing. There was a recognition that value for money needed to be demonstrated and that a shift is required from activity based measures to an outcome focus. Respondents noted that even commissioners who already understood and valued the AA role increasingly needing to evidence their value. In part this was due to the increasing involvement of Clinical Commissioning Groups (CCGs), who are relatively new to the criminal justice system. It was said that greater sophistication was needed when gathering feedback and measuring outcomes if a reliable evidence base was to be established.

Funding

Twenty-three respondents provided a breakdown of their funding arrangements. Adult social services funded the most schemes, supporting 16 schemes and funding more than half of the call outs, as illustrated in Chart 8 below.

In total, the police funded six of the 23 schemes and around one fifth of call outs. YOTs were also reported to part fund adult schemes. This arises due to the high proportion of combined schemes in the sample and the methodological challenges of apportioning costs in a combined adult/child AA service. Chart 9 provides a breakdown of the percentage of AA call outs by funding source.

Thirty-five respondents provided information on the stability of their funding, of these over half (60%, representing 20,000 call outs per year) said their funding was at risk. If funding was available, 83% of providers stated that they would consider expanding the geographical coverage of their areas

Chart 8: Number of services receiving funds from each source

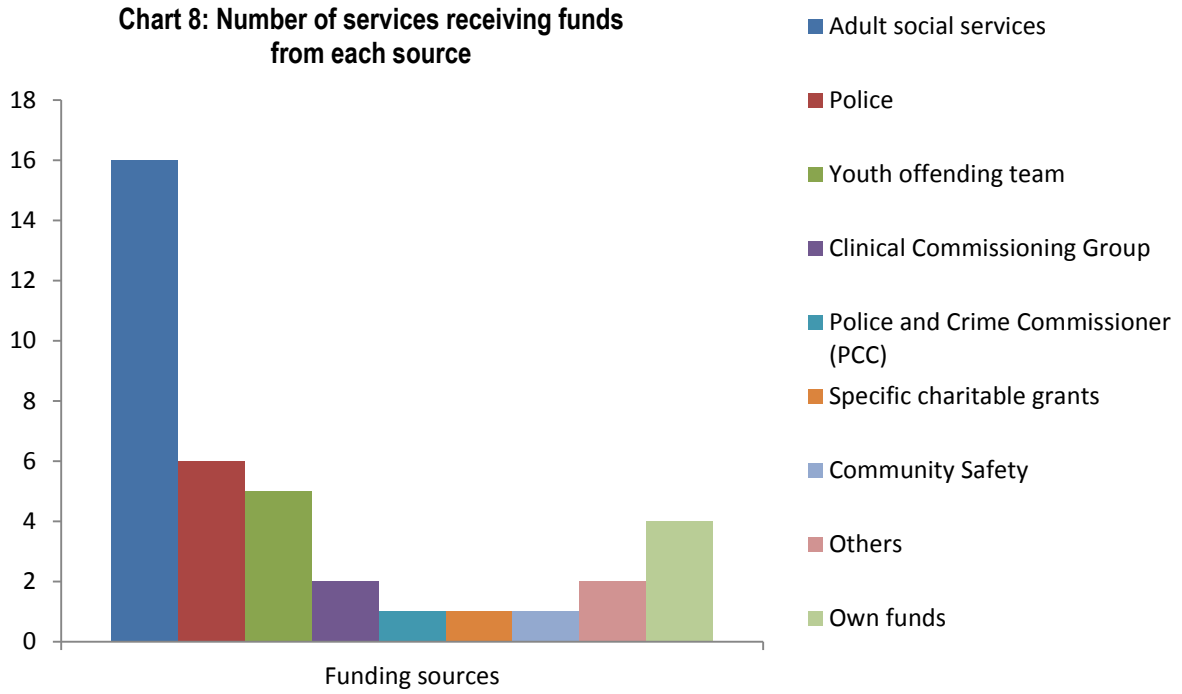


Chart 9: Percentage of AA call outs by funding source

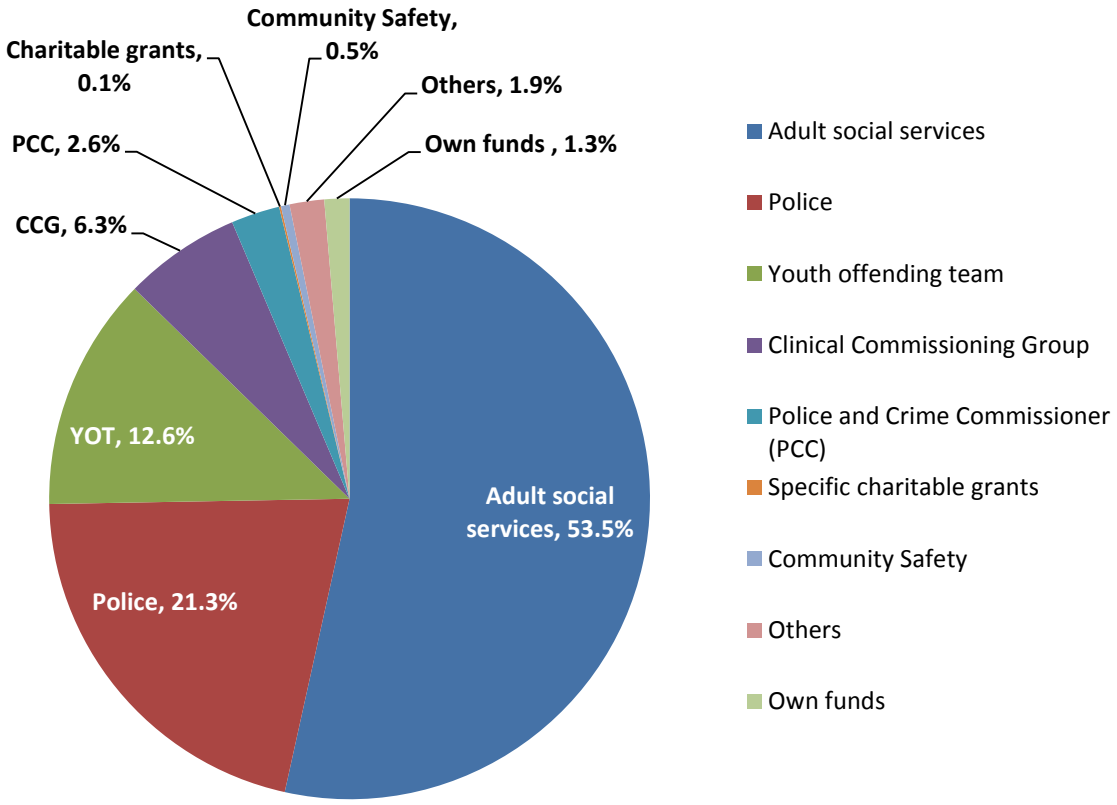


Chart 10a: Respondents stating AAs are likely to be present (high)

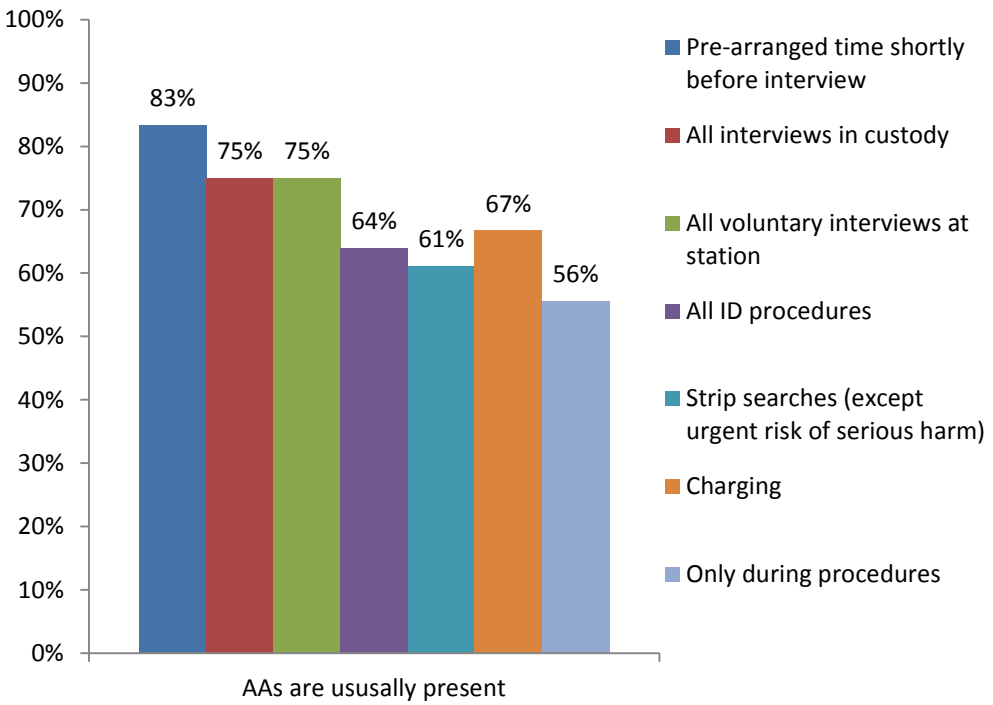
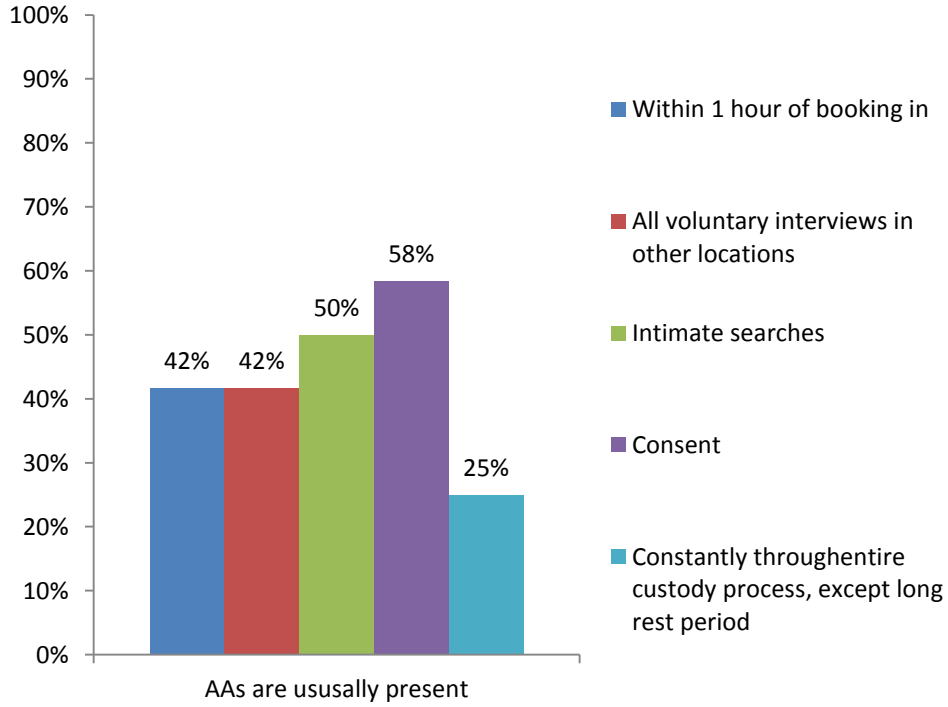


Chart 10b: Respondents stating AAs are likely to be present (low)



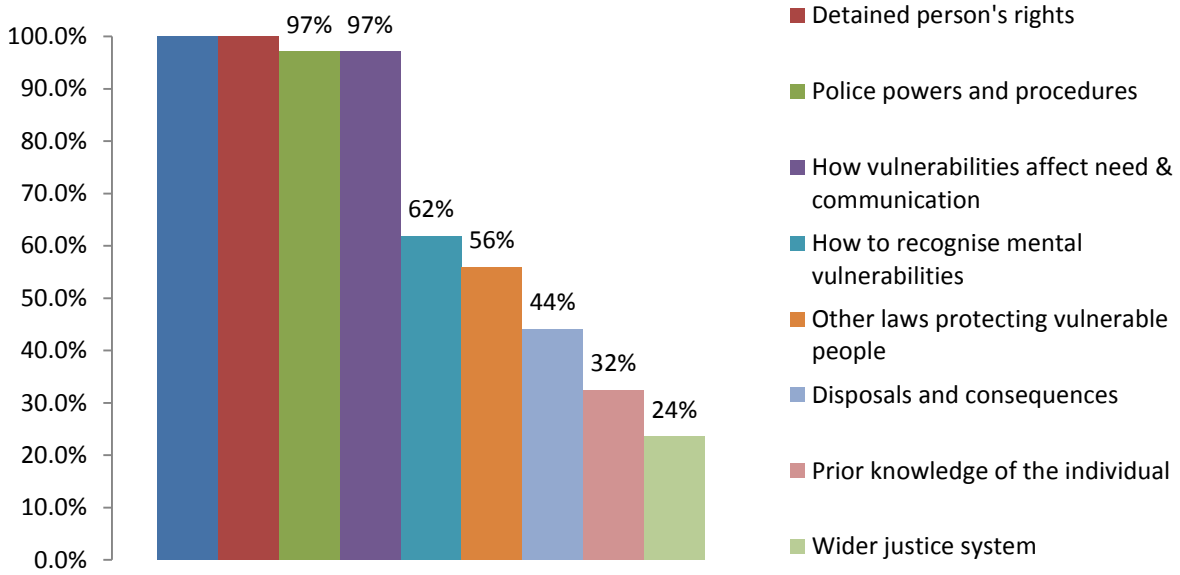
Use of AAs

Respondents were asked to say when their AAs were usually present. The results suggest that some AA requirements in the PACE Codes are adhered to more than others. Vulnerable people in custody appear unlikely to have support until shortly before interview, which leave a scarce amount of time to establish a detainee's needs or develop rapport. Many respondents reported that AAs were rarely present for strip or intimate searches. AAs are usually only present for the duration of specific procedures rather than throughout a vulnerable person's time in custody, Charts 10a and 10b illustrate respondents' views on the procedures for which an AA is usually present.

AAs skills and experience

Thirty-four respondents provided views on the knowledge (Chart 11) and skills required to be an effective AA. Knowledge about rights, powers and procedures were rated as 'necessary' by almost all respondents, along with understanding how mental disorders and mental vulnerabilities might affect a person's understanding, communication and welfare needs. This contrasted with prior knowledge of the individual (32%) and of the wider criminal justice system (24%). Respondents also noted the importance of an understanding of: safeguarding; the remit of other professionals at the station; local support services; and recording and following up on any concerns.

Chart 11: Respondents' views and rating of the necessary knowledge to be an effective AA



In terms of skills, being a skilled communicator (100%), maintaining boundaries (97%) and providing support (91%) were all viewed as essential. Respondents also viewed assertiveness, tenacity, patience, empathy, confidentiality, being non-judgemental and knowing when to ask for support as important skills for a confident and competent AA..

Mandatory training

Respondents were keen for mandatory national standards and *'a degree'* of regulation over training to be introduced. Several respondents also said that there needed to be clarification on the definition of vulnerability, and of the AA role in PACE with minimum training requirements introduced to ensure equality of outcome across the country.

Demand for AA services

Several respondents noted that there had been an increasing demand for their service. Reasons identified included increased efforts by the police to address concerns about mental vulnerability in custody and increasing appreciation and understanding of the AA role. Interestingly, one area where an AA scheme was established and reported a positive relationship with the police, said officers tended to call upon the services of an AA with greater frequency than in neighbouring areas where the custody population was similar but a less established scheme was in place.

Respondents were clear that a disinvestment in adult social care and mental health services by successive governments coupled with an increase in the number of adults being detained by the police - who would be better dealt with in another setting - had placed additional demands on existing AA services.

Some respondents said that one of the key drivers of demand was the increase in multiple call outs per custodial episode (e.g. booking in, interview and disposal). Delays in processing arrestees tend to increase the need for multiple call outs as additional visits were often seen as preferable to sitting and waiting. At times, however, this resulted in a vulnerable adult being supported by more than one AA for one custodial episode. Understandably, AA providers reported that delays in processing frequently had a negative impact on vulnerable adults.

Identification of need

Respondents reported that the extent to which custody officers fulfilled their duties varied considerably. Providers were clear that there is unmet need in custody but that the number of mentally vulnerable adults who are not supported by an AA is unknown. Respondents thought identification of vulnerability was hampered by the lack of training provided to custody officers. It was said that *'if a client does not seem to be too bad they [police] push them through the station'.* One particular provider reported that custody staff are open about their inconsistency in providing AAs, citing the case of a 'prolific shoplifter' who was provided with an AA on some occasions but on other occasions one was not requested '*so they could get him charged and into court.'* Respondents believed that the expansion of liaison and diversion services will undoubtedly help the police, by increasing understanding and assisting in the identification of vulnerable adults. The expansion of liaison and diversion was not however, viewed as a panacea to improving the custodial experience of vulnerable adults as it would not address those situations where police officers chose not to address a person's vulnerabilities.

Statutory provision

A recurring theme from respondents was the lack of a statutory duty to ensure provision of AAs for mentally vulnerable adults. The need is therefore '*overlooked and not treated seriously'* and as a result, '*vulnerable people are being let down'.* One provider noted that half the requests for AAs in their combined service were for vulnerable adults. This particular provider thought the current situation was an *'injustice'* and that AA provision for adults should be on a statutory footing. Another provider remarked that, *'Everybody wants the service but nobody want to pay for it'.*

Extending services up to court

Some respondents said that vulnerable adults were treated unfairly because they lost all support if during an investigation they switched from being a suspect to a witness and whenever they progressed to being a defendant at court. One respondent noted that if services were extended through to the court stage, cost savings would be available to mitigate the cost because mentally vulnerable people often fail to attend court appearances, generating costs in rearrangements and the creation and execution of warrants.

Remote provision

The delivery of AA services remotely for some elements of the process was also a matter of concern, with respondents feeling that physical presence was critical to understanding and supporting a vulnerable person's needs.

Data sharing

The sharing of relevant and proportionate data must be improved between social care, health and mental health, both to ensure that AAs are well informed before attending and to ensure that information captured by them is fed back, allowing vulnerable adults to benefit from additional support.

Costs

Respondents were asked how much their service costs to deliver. This was combined with call out figures to arrive at an average 'unit cost' per AA call out. Reliable figures were obtained for 26 AA services, totalling around 25,000 call outs per year (2013/14). The average unit cost ranged widely from £13.34 to £750, with an average of £80.79. In comparison, the absolute unit cost of a social worker (including on costs, overheads and ongoing training but excluding qualification costs) would be approximately four times higher at around £375[10] (see Charts 12 and 13).

Chart 12:Respondents by unit cost

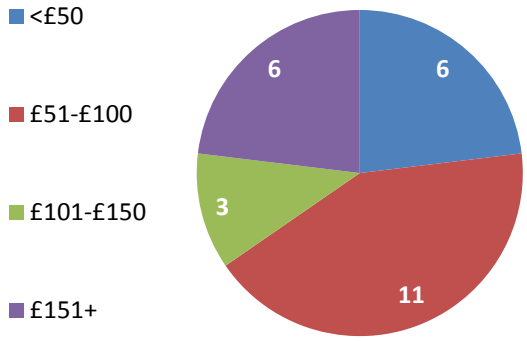


Chart 13: Unit costs of dedicated AA vs social worker

[10] Curtis (2013) Unit costs of Health and Social Care 2013. Kent: Personal Services Research Unit. This report calculated that the average cost of face-to-face social work was £128 per hour or £171 per hour in London. Based on an average callout time of 2.5 hours at £150 per hour the unit cost per call out is £375

Variations in unit costs were identified based on: the use of volunteers; the sector of the provider; whether the service combined with children's AA services and whether the scheme said they had spare capacity. Average unit costs are detailed in the four charts (Charts 14-17) below.

Chart 14: The use of volunteers and costs

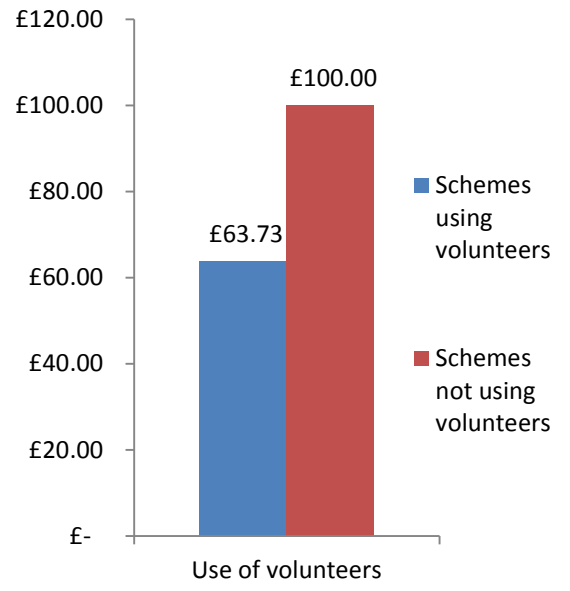


Chart 15: Type of service and costs

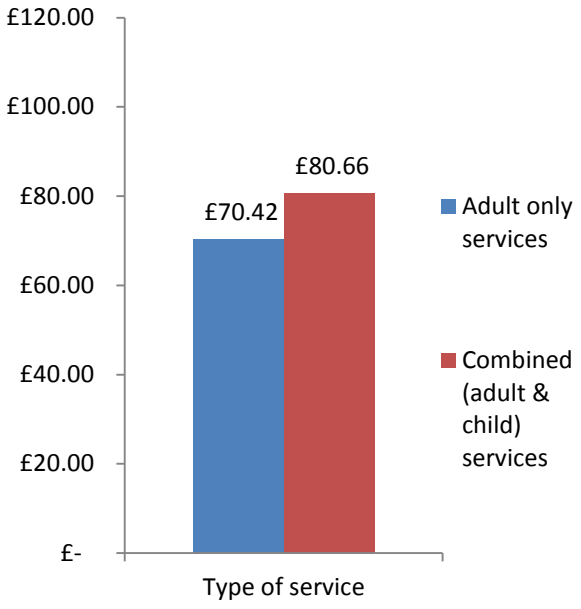


Chart 16: Sector provider and cost

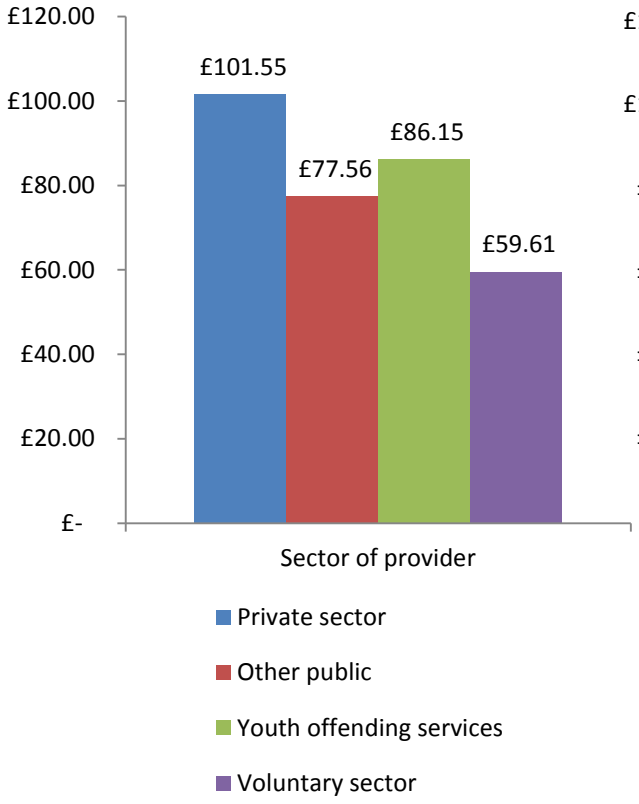
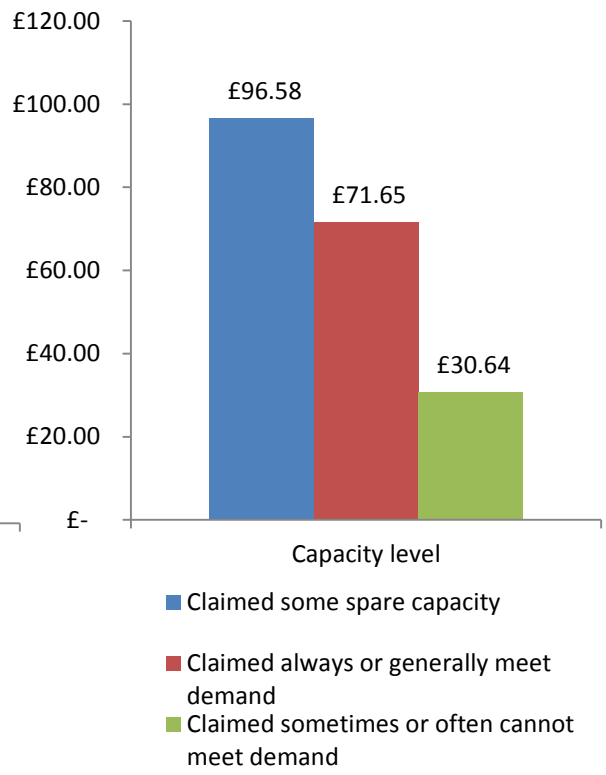


Chart 17: Capacity level and cost



Lower unit costs tended to be found amongst schemes using volunteers, those provided by the voluntary sector and those which served adults only. It is interesting to note that all the adult only schemes were only provided by organisations which offered a wider range of advocacy and support services. In addition to combining with children's AA services, this offers another method to spread the fixed overheads of an AA scheme.

Unsurprisingly, respondents who said that they had spare capacity to deliver more call outs within existing budgets, had a higher than average unit cost. Private sector providers made up the vast majority of those with spare capacity and the sector's higher unit cost should be seen in this light. However, claims of spare capacity from any provider should be viewed alongside the evidence that the survey showed AAs are not present for all custody procedures as required by the PACE Codes of Practice.

Paper E: Results - survey of custody sergeants

Introduction

This section of the report explores the views and experiences of custody sergeants working in custody suites, involved in processing vulnerable adults that need an appropriate adult. The findings presented here are based on a web-based survey of custody sergeants from one police force[1]. In total 64 custody sergeants undertook the survey, of which fifty completed the survey[2].

Identification and assessment of vulnerability

Almost all (58) custody sergeants (n=60) stated that they have dealt with adults whom they have identified, or who have identified themselves, as vulnerable. A range of issues were said to be taken into account by custody sergeants when assessing vulnerability and when considering whether to provide an AA. This included (ranked based on number of responses): a suspect's ability to understand the purpose of the custodial process; ability to understand and respond to the questions asked during a PACE interview by investigating officers; ability to understand and respond to the general questions when being booked in; ability to understand what being charged, bailed or cautioned means; and ability to understand their rights (access to a free solicitor, phone calls, sleep etc.). 'Other' considerations about whether to provide an AA included, if the suspect was known (via previous custody records or disclosed by the suspect themselves) as having a mental health issue; the suspect's presentation and behaviour in custody; following a risk assessment; consultation with an FME (forensic medical examiner or forensic physician) and the age of the suspect.

A minority (6) of custody sergeants (n=55) indicated that they would accept a detainee's self-assessment of vulnerability at face value. Just under two-thirds stated that a) they would accept but ask the opinion of a medical professional (34), and b) accept but seek to verify by accessing previous custody records to see if an AA has been requested and supplied (32). Almost half stated that they would accept but seek to verify through a series of force-approved questions (24); under a third would accept but seek to verify (with consent) by contacting a relative or close friend (17); rarely accept at face value and always carry out own independent assessment (12); and accept but seek to verify (with consent) by contacting local AA scheme staff (7).

> *Will always err on the side of caution and will look to verify using medical professional, (FME or Mental Health Liaison Nurse) and previous custody history*
>
> *Any vulnerability at all - if you are questioning if they need an appropriate adult, they probably do*

[1] Five police forces were invited to take part in the survey. However, only one force participated. The web-based survey ran for a three weeks between Feb-March 2015.

[2] 14 respondents dropped out of the survey at different points between questions 3 and 19. A further 42 respondents dropped out at questions 1-2, and there were 60 views of the front page which were not taken further. Nil responses are excluded from the analysis. The total number of responses for each question is variable as not all respondents answered all questions.

Training

The survey asked respondents what training is provided to custody sergeants to assist them to identify vulnerable adult suspects. Almost a third (15) of the custody sergeants who responded to this question (n=55) reported that 'no training is provided'. This was in contrast to the remainder of the sample (40) who had received training and stated that training was provided in the following ways:

Training provided	**No. mentions**
On the job training	26
Training as part of custody sergeant training	19
E-Learning	7
Training as part of the sergeant's training/exam	4
In-house training provided by professional AA service providers	1
'Other'	10
Total	67*

*Includes a number of multiple responses from 40 respondents.

'Other' responses referred to the limited training provided to custody sergeants to assist the identification of vulnerable adult suspects. A few custody sergeants cited a vague recollection of some one-off training or training provided as part of a custody refresher course. Some mentioned the need for more focussed training around the identification of mental health issues specifically. Other custody sergeants were of the opinion that they were provided with 'training' on-the-ground, given their first-hand experience and years in service dealing with suspects.

> *Part of custody training but not much and needs to be more especially in regard to mental health issues*
>
> *Recently had* [name of course] *training, most of it was pointless as we knew what they were saying from years of experience dealing with people*
>
> *There has been a training input as part of the PDD training programme in the last year about vulnerable adults / learning difficulties but not provided to my knowledge by the AA scheme itself.*

All custody sergeants (n=54) stated that their force provided them with a risk assessment template for use when booking in detainees. The majority (44) of custody sergeants reported that the risk assessment template is 'good' for managing/identifying vulnerability. The remaining ten respondents felt that the Risk Assessment template did not contain any or enough information on identifying vulnerability.

Over half of the custody sergeants (n=54) stated that they had not been provided with the College of Policing (CoP) Authorised Professional Practice (APP) guidance on detention and custody. Six had been provided with the guidance and over a third were unsure if they had received it. Of the six who had been provided with the CoP

guidance, all stated that they had read it. Two of these six said they found the guidance useful for dealing with vulnerable adults; a further two found it useful in some situations; and one said it was not useful. (One did not comment on the usefulness of the guide).

Custody sergeants (n=37)[3] were asked about what (other than individual force and CoP APP guidance) would help the police to identify vulnerability. With the exception of a minority of custody sergeants (4) who reported that the identification of vulnerability was not problematic and one who was unsure, other custody sergeants were able to suggest ways to improve the way police identify vulnerability. Echoing the findings from our stakeholder interviews, over a third (13) stated that there was need for more or better quality training and just under a quarter of the sample suggested the need for more information sharing from other agencies/services (e.g. through databases of information on vulnerability) (8). Other suggestions put forward by custody sergeants to help police identify vulnerability included more availability of medical staff (6); more experience (3); input from other experts in custody suites (3); and more time available to police to make decisions (1).

Access and availability of AAs

Custody sergeants (n=51) were asked in what proportion of cases AAs are obtained for adult suspects identified as vulnerable. The majority stated that AAs were obtained in 'all' (15) or 'almost all' (25) cases where suspects were identified as vulnerable. A smaller number of custody sergeants reported that AAs were secured in 'more than half' (7); 'around half' (2); 'less than half' (1); and 'rarely' (1).

Just under a half (n=53) of the custody sergeants explained that the main reasons for *not* securing AAs for adult suspects who have been identified as vulnerable related a) to AAs being requested but not available and b) AAs were difficult to obtain at weekends and at night (6pm-9am).

> *AA service will not come out after midnight. Need 24hr coverage so that vulnerable adults can be dealt with expeditiously*

The limited availability of AAs when requested and provision of out-of-hours AA services were also concerns raised by all the stakeholders we interviewed. Further reasons provided for not securing an AA included, when a suspect is bailed to return when an AA becomes available (16); time pressures (the custody clock) (12); a suspect does not want an AA (9); a suspect is de-arrested (5). 'Other' (10) reasons included: AAs are often not secured by custody sergeants; cases where charges or simple cautions were given in the presence of the suspect's solicitor; the suspect is being sectioned the Mental Health Act; and where criminal charges are dropped.

[3] The reported figures include a small number of multiple responses from 37 respondents.

The majority (36) of custody sergeants (n=52) stated that they had an approved AA scheme operating in their area. This contrasted with almost a quarter (12) who had a scheme in operation at certain times of the day and a minority (4) who did not have a dedicated scheme operating in their area.

According to the custody sergeants surveyed (n=37), the bulk of local AA services were provided by local authority or social services (15). The number of different providers of local AA services identified by custody sergeants is shown in the table below.

Provider	**No. mentions**
Local authority or social services	15
Dedicated AA scheme	10
Criminal justice charity	10
Mental health charity	3
Local volunteer service	1
Community Service Volunteer	1
Total	**40***

*Includes small number of multiple responses from 37 respondents.

Custody sergeants (n=52) were asked how easy it was to secure an AA when one is needed. Most (22) said that securing an AA was relatively easy. Others rated the ease of accessing an AA as follows: very easy (3); neither easy nor difficult (13); relatively difficult (9) and very difficult (5).

There are various stages cited by custody sergeants (n=51) at which an AA is usually present, during dealings with a vulnerable adult suspect. All but two custody sergeants reported that an AA is usually present for *all* interviews conducted in custody. A breakdown of the various stages at which an AA is usually present, is presented in the table below.

Stage	No. mentions
For all interviews in custody	49
For all identification procedures (fingerprints, photographs, identity parades)	34
For charging and related actions (disposals including cautions)	33
Whenever consent for procedures is sought or given	33
For strip searches (except where there is an urgent risk of serious harm)	24
For all voluntary interviews conducted at the police station	23
For intimate searches	20
When procedures are carried out, leaving during long breaks	13
For all voluntary interviews conducted in other locations (e.g. homes)	4
Throughout the entire custody process, except during a detained person's rest period	2
Total	**235***

*Includes a number of multiple responses from 51 respondents.

Custody sergeants were asked what they do when they are unable to secure an AA for a vulnerable adult suspect. Among the thirty-eight respondents who answered this question, only two 2 respondents stated that they have not faced the problem of being unable to secure an AA when one is needed. Around two-thirds (25) commented that they would bail the suspect or that bail would be considered in such instances. One respondent stated that the heightened risk of detaining a vulnerable adult in police custody places further pressure on custody staff and is central to decision-making when considering whether to bail a vulnerable adult suspect. Other responses are detailed below.

> *Wait or consider bail until AA is available*
>
> *All depends on the nature of the crime and time limit. If no AA available the likelihood is that bail will be considered. Again this makes imposing bail conditions difficult as an AA should be present.*
>
> *Best practise is to bail until [AA] is available.*

Ten custody sergeants stated that (at least in some circumstances) they would wait for an AA to be secured; for example:

> *If bail is not an option then a short period of detention until an AA attends may be necessary.*
>
> *Keep the detainee in Custody until an AA is available.*
>
> *Consider waiting until one might be available; with due regard for proportionality and custody time constraints.*

This contrasts with seven custody sergeants who said that they would consider proceeding without an AA, or attempt alternative approaches. Some of these approaches are summarised in the quotes below.

> *Consider range of available investigative disposals for subject, consider securing an AA by phone e.g. family member/relative etc. etc. to support/guide remotely.*
>
> *I would, in the first instance, re-assess the detainee and see whether an AA is still required. I may also try to speak to an AA (if it is a relative) over the phone and explain what we need to do in terms of processing the detainee (e.g. taking fingerprints/ photograph/ DNA) and seek their agreement for it to be done without him or her actually being present. I would not let a tape-recorded interview go ahead, however. Everything I would do would be with the best of intentions in order to get the job done even if not completely 'by the book'.*
>
> *Minimum try to ensure presence of solicitor…*

In addition, a minority (4) of respondents said that they would seek an AA from a variety of sources, for example, an AA recruited from partner agencies such as the fire service or a family member or friend.

To get a sense of the AAs called into custody, custody sergeants were asked what proportions of AAs who attend the custody suite are suspects' friends/family; from approved AA schemes; members of the public; or other professionals. Their responses are shown in the table below. As the table shows, AAs were largely described as being from approved AA schemes or suspects' friends/family members. However, it appears other professionals and members of the public and are regularly asked to 'fill in'.

What proportion of AAs are:	**All**	**Most**	**Some**	**Few**	**None**	**Total**
Friends/family members	1 (2%)	11 (22%)	34 (68%)	4 (8%)	0 (0%)	**50**
From approved AA schemes	1 (2%)	24 (48%)	19 (38%)	5 (10%)	1 (2%)	**50**
Members of the public	0 (0%)	1 (2%)	1 (2%)	19 (43%)	23 (52%)	**44**
Other professionals	0 (0%)	1 (2%)	4 (9%)	22 (50%)	17 (39%)	**44**

Custody sergeants (n=40) were asked how, overall, they think the provision of AAs for vulnerable adult suspects could be improved. The theme that emerged by far the most frequently (in 27 instances) was the need for greater supply of AA services; a finding that coincides with the views of all of the stakeholders we interviewed.

These comments focused, for example, on the importance of having 24-hour cover from AA services, or suggested that there should be AAs based in custody suites. These prevalent views are captured in the following quotes.

> *Having a 24 hour scheme would mean a lot more vulnerable detainees could be dealt with late evening or throughout the night as at the moment they stop between 0000 & 0900.*

> *By having a permanent AA available at busy custody suites like we are supposed to have permanent health care professionals. There is more than enough demand for the role and it would significantly reduce the amount of time vulnerable adults spend in custody.*

> *By simply incorporating an accredited company responsible for supplying paid private adults to act at short notice and at all hours. Similar to how the Duty Solicitors Scheme functions.*

Three respondents argued that demand for AAs should be decreased 'by not arresting vulnerable people', by providing the right to an AA under-17s only, or reducing the amount of time that AAs are required to spend in the custody suite, such that 'An AA should not have to be present for the taking of fingerprints/photo/DNA or any other administrative matters.'

Paper F: Results - stakeholder interviews

We interviewed a total of 13 stakeholders during the course of the study. Interviewees were selected for their knowledge of one or more of the following areas: custody procedures, mental health issues, and/or appropriate adult service provision. Stakeholders were from a variety of professions, including: policing, health, legal services, service commissioners and providers and a mental health/criminal justice expert.

The interview schedule was thematic; structuring our schedule in this way allowed us to gather information about a key set of themes from all interviewees whilst also allowing interviewees to bring their own experience and expertise to the interview. Themes covered in the interview included:

- views of the Police and Criminal Evidence Act (1984);
- the difficulties encountered by the police when identifying vulnerabilities in adult suspects;
- the barriers which exist to appropriate adult call out;
- the availability of appropriate adults;
- commissioning appropriate adult services;
- diverting vulnerable adults from the criminal justice process;
- gaps and/or shortcomings in current provision of appropriate adults for vulnerable adults; and
- ensuring the rights of vulnerable adults are fully protected whilst in custody

A couple of the early interviews served to orientate the research team to the issues, while those towards the end of the study served to test out themes and ideas which were emerging.

The Police and Criminal Evidence Act (1984)

The Police and Criminal Evidence Act 1984 (PACE) sets out the powers at the disposal of the police to tackle crime In addition to the Act are the accompanying Codes of Practice (Codes), which police officers must take into consideration and refer to when carrying out various procedures associated with their work. The aim of PACE and its Codes is to strike the right balance between the powers of the police and the rights and freedoms of the public, maintaining that balance is a central element of PACE. As part of the interview we asked stakeholders for their views on the adequacy of PACE and the associated Codes in safeguarding the rights of vulnerable adults whilst in custody. Interviewees were fairly divided in their opinions; some believed the Act was comprehensive despite it being over 30 years old, while others believed it needed to be reviewed and updated. Difficulties highlighted by interviewees included the Codes of Practice not being a statutory requirement, the inaccessibility (e.g. the availability in custody of copies of the Codes in formats which are accessible to detainees with impaired vision, learning disabilities and in languages other than English) and lack of clarity of both the Act and the accompanying Codes, as highlighted by the interviewees below:

> *PACE is adequate, it's how it's adhered to - its application - that needs to be looked at. How do officers interpret the guidelines and codes, what is their understanding of Code G, who is monitoring whether the codes are being adhered to? That is what we need to look at.*

> *PACE is very comprehensive, although I think at times it's quite inaccessible. Given detainees have the right to consult PACE and to read the Code of Practice I think that's pretty much a token gesture because it's written in legal speak, it's full of language that's not particularly familiar... PACE could be much clearer about when an appropriate adult is required at different stages because when I meet people nationally appropriate adults seem to be going in at different stages* [in the custody process] *across the country.*

> *PACE was written over 26 years ago: it's completely inadequate. Mental Capacity Act has arrived, alongside other new legislation but PACE stays the same. In essence where you have Liaison and Diversion PACE will be adequate because the additional experts will be on hand to assist. Where there is no Liaison and Diversion, PACE will remain inadequate*

Views about whether and how to revise the existing Codes were varied. A number of interviewees suggested that the provision of appropriate adults for vulnerable adults should be a statutory requirement; others believed the Codes needed greater clarity, others suggested that there needed to be an information leaflet available to AAs which spelt out in a 'clear unambiguous' way the AA role in relation to other professionals in the custody area; whilst others suggested that officers should receive additional training to assist them in carrying out their responsibilities, as illustrated below:

> *I think at the moment some bits of the* [PACE] *guidance are open to interpretation ...The guidance needs to be clear....It shouldn't be that different forces in the country interpret the guidance in their own way.*

> *It's about applying the Codes in the way they were intended. Changing legislation always takes time. [We] should look to change the way AA provision is provided rather than changing the Codes.*

Identifying vulnerability

The recently published HMIC report 'The welfare of vulnerable people in custody'[1] highlighted the detrimental impact custody can have on vulnerable adults and how quite often it is the wrong approach to take. Custody staff (both police and civilian) were, however, reported as demonstrating "an understanding of the needs of vulnerable people and tried to respond appropriately (pg 18)". In addition the report found that:

> *It was noticeable that police officers and staff were highly dependent on their own experiences and personal judgements when identifying and responding to vulnerable people, rather than being able to refer to official training or guidance.*
>
> (HMIC 2015: 18)

[1] HM Inspectorate of Constabulary (2015) The welfare of vulnerable people in custody. London: HMIC

A number of our interviewees reported similar views to those reported by HMIC; many highlighted the difficulties custody staff face in identifying vulnerability, a difficulty which is sometimes exacerbated by the frenetic nature of a custody suite and the time pressures that are placed on police officers to adhere to the requirements of PACE. Other interviewees suggested that whilst there is no statutory requirement for vulnerable adults to be supported by an AA this can sometimes lead to custody staff overlooking a vulnerable suspect's need for an AA. Interviewees' thoughts on the difficulties of identifying vulnerability are highlighted below:

> *The decision as to whether somebody needs an AA lies with the custody officer. So the custody officer presumably is expected to have a good knowledge of psychiatry, of learning disabilities, of vulnerability generally, and of course...what the role of the AA is there to legislate against and the simple fact is, they don't have either of those*

> *Many vulnerabilities are difficult to appreciate straight away; many are hidden from the police. Where there are other professionals in custody this can be overcome but it is still difficult & no amount of training will improve some of the identification.*

> *The police do not have the skills to identify vulnerability at all. ... Coupled with this is the unwillingness to identify vulnerability. Why would you add a five hour delay to your enquiry just to help a prisoner, that's what you are asking a police officer to do. You take them off the street for five hours, they are late home because someone is just borderline, do they or don't they need an AA? If they get the chance they will say: no, they're fine. That is why the statistics are so low. As a police officer I've done interviews without an AA when the person has not wanted one but has needed one*

> *The concept of who is and isn't vulnerable is a big issue for custody sergeants... There is always an area of doubt: who should or shouldn't have an AA? It's complicated; mental capacity can vary, today I need one tomorrow I don't. It is completely unrealistic to ask custody sergeants to be mental health experts…. Some vulnerabilities are subtle and difficult to spot. There's also a lack of information for officers on the street, if you call through on the radio, you will never be told a suspect needs an AA: this isn't seen as essential information. People are judged on their last visit to custody: it's assumed they don't need an AA if they didn't have one when last in custody*

Improving the identification of vulnerability as early in the police process as possible and providing the support needed were seen as important elements of improving the custodial processes for vulnerable adults. Interviewees were unanimous in their view that the current police response is inconsistent and very much a 'postcode lottery' for detainees. The introduction of liaison and diversion services was welcomed and viewed as a positive step forward to achieving a better police response for vulnerable adults. Providing the police with additional experts to work with was also viewed as one of the benefits of liaison and diversion. In areas where custody staff and operational officers work alongside mental health nurses, interviewees were positive about the benefits of this arrangement, in particular the opportunity for both to actively engage in a knowledge transfer process. Other suggestions put forward by interviewees included: providing the police with a standardised assessment tool, greater information-sharing between agencies (both in terms of shared *systems* and *willingness* to share) targeted training for custody staff (both civilian staff and police officers) and joint training with triage nurses.

To improve identification we need experts in custody as well as out with officers; in [area] there are mental health nurses in custody and a triage car. Liaison and diversion staff providing a level of expertise will also improve identification. Officers see the same people come through time & time again ... They want someone else there (in custody or on the street) who can give them a view.

There needs to be an exploration of the influences on custody staff decision making. How do custody staff/arresting officers identify vulnerabilities through the risk assessment process and thereby the need for AA services? There needs to be greater use of mental health nurses and other professionals in custody. Use health risk assessment tools or a vulnerability assessment framework developed.

The introduction of schemes for vulnerable adults to carry cards identifying their vulnerabilities could help – such schemes have been successfully introduced for certain vulnerabilities in some parts of the country

Whilst appreciating the difficulties the police face in identifying vulnerabilities in adult suspects, several interviewees suggested that the situation is compounded by the non-confidential, open-plan layout of custody, which may prevent vulnerable adult suspects from disclosing their vulnerabilities in public. It was argued that, to improve identification the design of the custody environment should be re-thought or private spaces more readily available and offered.

Barriers to AA call-outs once vulnerabilities are identified

Once a detainee has been identified as vulnerable, one of the key difficulties is securing the services of an AA. An AA must be over the age of 18 and be able to support the detainee during/throughout the custodial process. The Home Office Guidance (2011)[2] states that the role of an AA is to:

- "support, advise and assist the detainee
- ensure that the police act fairly and respect the rights of the detainee
- help communication between the detainee, the police and others"

Procedures which should involve the presence of an AA include:

- the detainee being informed of his/her rights
- cautioning
- a recorded PACE interview
- charging and related actions

Other procedures which may require an AA include: being present for fingerprinting, DNA swabbing, ID parades and searches (strip and intimate). Current provision of AA schemes is patchy. Where there is no coverage the police rely on volunteer AAs, relatives or members of the public. All of our interviewees sympathised with the predicament many custody sergeants find themselves in; far too frequently a detainee will be identified as vulnerable and the police are unable to locate an AA. The problem of AA availability is further exacerbated by the

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117682/appropriate-adults-guide.pdf

timing requirements of the PACE clock[3], and the day and time of an arrest. It was mentioned to us on several occasions that finding an appropriate AA at 3am on a Sunday morning in many areas of the country is "a nightmare for custody sergeants". This situation either leads to detainees being bailed to another day and time, being kept in until an AA can be found or being processed without an AA present.

In addition to the lack of universal custody coverage by AA schemes, interviewees also raised concern about the appropriateness of some AAs. Interviewees were divided about whether family members should be AAs, whilst interviewees recognised the importance of the emotional support a relative can provide they also thought that remaining objective proved difficult for many family members. The lack of training provided to relatives, members of the public and some volunteers was viewed as problematic by our stakeholder interviewees:

> *Provision is patchy across the country, in some areas it's particularly good, especially those areas where there are dedicated AA schemes; in other areas the police have few resources to pull on, bar family members who may or may not be appropriate*
>
> *There are very few people who are qualified or trained to deal with people with learning disabilities or autism around the criminal justice system.*
>
> *There are not enough AAs. It's much better where there are* [dedicated] *AA services; otherwise the police have to rely on relatives, which can be problematic. Training is important, which is more difficult if it's a relative. AAs should be trained, equipped to provide the best service and have a degree of professionalisation, they can be volunteers, however, rather than professionals.*
>
> [there is] *inconsistent commissioning of AA services across the country and therefore AAs are not always available. There is a difficulty with using members of the public as AAs because they are not trained. In* [particular area*] AAs receive training, are shadowed and properly accredited. In* [particular area] *there is a rota of volunteers provided to the police and they are contacted directly during working hours, but no out-of-hours provision*.

Interviewees were unequivocal in their view that AA provision needed to be provided by trained volunteers/professionals, some interviewees thought the current AA services should extend their coverage across England and Wales to all 43 forces and that there should be more than one service covering each force area. Others believed that AA provision should – in the future - be brought under the umbrella of liaison and Diversion schemes. Other interviewees suggested creating a comprehensive list of volunteers in each force area who can be called upon on specific days at specified times of the day.

> *There should be a paid pool of individuals that are available across all police forces and targeted at particular times of day and night. Often we rely on call-outs and/or volunteers. I'm not saying we shouldn't have a voluntary network but I actually think we should have a core requirement and coverage in all police forces and all local authority areas.*
>
> *AAs need to be individuals that are trained, understand what the role of an AA is, are on-call, available and able to refer to other services. Provision needs to be throughout the criminal justice system not just at the*

[3] Once a detainee has been booked into custody the PACE clock starts to tick. The police are legally allowed to hold an individual for 24 hours before a disposal decision has to be taken. If the police wish to detain a suspect for longer they must request an extension. In the first instance from a police officer of Superintendent rank and thereafter from a Magistrate. The longest period a person can be held in custody without being charged or bailed is 72 hours.

point of arrest. There needs to be an AA whilst a vulnerable adult is in the police station, court, probation etc. The service should probably be mental health led.

AA schemes should be brought under umbrella of liaison and diversion. There's a huge benefit to be had of having a coherent approach to people's vulnerabilities. Liaison and diversion is principally about mental health, but now it's accepted that all of someone's needs should be recognised: e.g. drugs and alcohol and other issues. It's a false economy to just deal with the first presenting issue rather than provide wrap-around services to support those who have found themselves in the criminal justice system.

Commissioning and governance of AA services

Stakeholder interviewees tended to view the commissioning and governance of AA services as a shared responsibility. There was general agreement amongst interviewees that delivering AA services should be through a partnership, comprising of health, police and social services. Most interviewees believed that AA provision should not be the responsibility of the police or the PCCs, as highlighted below:

The provision of AA services is essentially a safeguarding issue. Local Authorities need to understand and recognise this. It should be multi-agency led, with mental health as lead. Partners must include: health, police and voluntary/statutory mental health services. Adult safeguarding boards should widen their remit to inspect AAs and provide guidance on best practice.

The current commissioning of AA services was seen as inconsistent; in some areas AA services were paid for by the PCC in other areas the Local Authority, in a number of areas provision was provided by voluntary agencies and paid for by a partnership, which often consisted of health, police and social services. In some areas the commissioning teams are integrated and sit within the remit of health and social care. Most interviewees were of the view that Adult Safeguarding Boards should be the lead agency in reviewing and deciding upon the level of need and the governance arrangements. Clinical Commissioning Groups (CCGs) were generally viewed as the best agency to commission AA services at a local level. The following insights reflect our stakeholder views regarding the commissioning of AA services:

It's very complicated and messy at the moment because all issues are separately funded: there are several funding streams and haphazard provision because AA provision is not statutory

Personally, I don't think it sits just with adult social services. I think the safeguarding board should oversee AAs for vulnerable adults, I think that would be very helpful. It then positions it in people's everyday practice around safeguarding.

I think commissioning AA services sitting with the Local Authority has been a very positive thing ... Our funding is becoming more complicated. As well as adult social care contributing to our funding, CCG now have a big input. Our commissioning team is integrated and sits with health and social care, which seems to work really well. Our local safeguarding board has oversight of the service... I'm not overly confident about that sitting with the PCC, my kind of impressions of the PCC is very much responding to what local communities say ...and I am not convinced that the rights of vulnerable detainees is going to be high on people's agendas

> *Ideally AAs should become part of liaison and diversion, with Treasury funding liaison and diversion through mainstream funding.* [Till 2017 liaison and diversion will be funded as Department of Health project.] *With mainstream budgets you can start to provide wrap around services. Post 2017 the aim should be for AA services to 'piggy back' onto liaison and diversion because the money will come through NHS England, the National Commissioning Board should be the lead, with partnerships to include police, PCCs, Local Authorities, social care, housing and education. Commissioning at a local level should be through Health and Well-Being Boards with a strategic body that holds the money for CCGs. This way there will be less reliance on voluntary services having to provide services like AAs.*

Some interviewees acknowledged that historically the relationship between health professionals and police managers - at a strategic level - had lacked a partnership approach. In part this was due to the remit of the two organisations being diametrically opposed and in part due to the funding, oversight and accountability arrangements of the two organisations; as illustrated by the interviewee below:

> *The relationship between health and policing has always been problematic (mainly at a strategic level).There's been a lack of police presence on Health and Wellbeing Boards and the incredibly complicated accountability arrangements make it even more difficult. Who holds health services and their provision to account? It is really hard to unpick. They can say they have no mental health beds; if police say 'no' to a vulnerable adult in custody they then have to provide a guard at A and E, as if their mental health is a police problem.*

Stakeholder interviewees did, however, provide us with many examples which illustrated the benefits of the two services supporting one another both 'out on the street' and in custody. Many police forces now work alongside mental health nurses at an operational level, in custody and in the control room. One of the benefits of co-ordinating responses and maximizing capacity is the ability to provide detainees with the means to link with other (more appropriate) services for their needs. Ultimately our interviewees agreed that whilst vulnerable adults often found themselves in custody they also were known to the police as victims. There was unanimous agreement amongst our interviewees that custody for vulnerable adults was only really appropriate for a small number of cases. The shared view of interviewees was that the more the police work with and refer to other services the less likely vulnerable adults will be to keep returning to the custody suite.

> *There must be joined-up thinking between liaison and diversion, street triage, victim services (most offenders with mental health problems are also victims) and AA services. These four services need to be under the same umbrella and funded in the same way. Mental health agencies and the police do not link up and work well together; there is a huge tension. There is a real need for community advocates to help bridge that gap. There is a data disconnect and a professional disconnect.*

> *We've always worked with what is now the liaison and diversion service. For as long as I can remember we've had mental health workers based in custody suites and at court and I think AAs have a very positive role to play with them* [liaison and diversion]

> *AAs should be part of liaison and diversion services, and street triage should be rolled out nationally. The latter will assist police to identify vulnerable individuals and to make decisions based on a number of facts - the offence, vulnerability of the individual, services available, and the likely criminal justice outcome.*

> *How difficult would it be to make AA schemes part of liaison and diversion? Not a problem in terms of guidance, if there is a policy agreement. It is about piggy backing onto a current programme. If over time there needs to be a legislative change it becomes inevitable and not controversial because it is happening on the ground: you are merely tidying up what is current practice. The impact on the public of the police and health working together is phenomenal*.

Diverting vulnerable people away from the criminal justice system

> *During the course of our inspections it was clear that custody could have been avoided for a number of vulnerable adults and children, had other action been taken by police officers, or other services been available to support these individuals (HMIC, 2015 pg. 22)*[4]

The view expressed by HMIC was shared by our interviewees. One concern raised by a small number of respondents, however, related to the availability of appropriate service to refer people to. Local services must be available otherwise there is little point in attempting to break the custody cycle.

> *Diversion should be the aim, the one thing we know about the CJS is that it doesn't work. We lock up the same people, we put them through the same process, they go into prison they leave prison, they go back in. Land D, triage nurses etc. are all good news. We need early intervention, at the first point of contact.*

> *Diversion away from the CJS should be the goal. The police have options at the point of arrest and should explore these. They need to apply the necessity and proportionality test far more than they do. For me it's all about turning off the demand tap for AA services. We should not be at a place where there are more vulnerable people in custody with corresponding increased demand for the safeguard/support services that AAs are a part of. If Human Rights principles and policing priorities were aligned in practice there should be a corresponding reduction in vulnerable people being arrested for minor offences, that might be dealt with lawfully in other ways.*

> *We have too many vulnerable adults who end up in the custody suites when they should never be there at all. What we really should be doing is looking at preventing people from being in the custodial setting...we should be looking at strong alternatives*

One final comment made by a number of interviewees was the need for commissioners and service providers to view police custody as one part of a process. Concentrating on custody alone was viewed as short sighted and not in the best interests of vulnerable adults; vulnerable adults should be supported at every point in the criminal justice system. As highlighted below.

> *AAs should be part of the process and not seen in a silo. An AA should flow with the system to whichever part of the system a vulnerable person goes - be it prison, courts or into services. It's about individual case management. AAs should be provided wherever they are needed in the CJS; not just for the police element of the service.*

[4] HM Inspectorate of Constabulary (2015) The welfare of vulnerable people in custody. London: HMIC

A discussion was held with members of the Working for Justice group, run by KeyRing and supported by the Prison Reform Trust. Members of the group have learning disabilities, and one member has autism. At some point in their lives all of the group have found themselves in the Criminal Justice System as suspects, defendants, offenders and/or prisoners. The discussion was based on, but not restricted to, a number of key themes.

Understanding the AA role

While there was a general understanding that the role of the AA was to 'help', this was essentially limited to support with communication in interviews. The AAs purpose was viewed as helping detained people to understand the questions being put to them by the police. Members of the group said:

- *'They are there to help me when the questions were difficult'*
- *'To help stop misunderstandings'*
- *'To help with communication'*
- *'So you don't incriminate [yourself]'.*

Experience of support

Four of the six had not received help from an AA. Of the two that had, one group member said:

- *'They helped to explain the questions.'*

Who should be an AA?

Relatives and friends

Service users were asked about the advantages and disadvantages of having a relative or friend as their AA. Moral support was by far the strongest reason for having someone they knew. One group member said:

- *'My mam was there; she made sure they asked the right questions.'*

A number of downsides were expressed, the most significant being that they would not know what the role involved or 'how to behave'. However, the issue of potentially complex relationships between people with support needs and their family members was also of importance to the group. There was agreement that there were risks inherent in having previously fallen out with a family member who might then be called or agree to act as your AA. Group members said:

- *'What if you don't have a good relationship with them?'*
- *'Some people don't want them to know what's going on.'*
- *'What if there are torn loyalties?'*
- *'They might be judgmental. They are not independent.'*
- *'It shouldn't be a family member but it should be someone who knows you.'*

Trained professionals

All those taking part felt people should be trained to be an AA. Independence, confidentiality and a non-judgmental approach were seen to be important attributes of a successful AA. Group members felt that training should cover what help and support should be offered by an AA. Group members said:

- *If they just sit there they won't be much good. They won't know how to help you'*
- *'So they know what to say and how to direct you'*
- *'They need to know confidential things'*
- *'They should be an independent person and they should be non-judgemental.'*

Personal choice

The group thought that everyone with a learning disability should have an AA. However, the issue of personal choice was an important theme.

Under PACE Code C, it is a matter for the police alone to decide whether an AA is required. On this basis the AA is a safeguard for the police, mitigating the risk that evidence (for example a confession) will be ruled inadmissible at court. However, there was a strong view amongst group members that it should be the choice of the individual as to whether or not they had an AA.

The group also discussed previous poor experiences, either with relatives (see issues above) or professional workers (whom they did not think were effective or, for whatever reason, they found them hard to get along with). In this context, group members felt they should be able to exercise a degree of choice on who would be acting as their AA, potentially being able to turn down one person in favour of another.

Demand side

How many adults are detained or interviewed as voluntary attenders by police in England & Wales each year?

- Figures on detentions are not centrally collected and published.
- The forces which responded to our data request detained 704,652 adults in 2013/14.
- Published Home Office statistics show that the responding forces made up 568,312 (60.19%) of the 944,242 notifiable arrests in England & Wales in 2012/13.
- Assuming that the responding forces made up the same proportion of national detentions as notifiable arrests, the total number of adult detentions per year is estimated to be 1,170,769
- Figures on interviews by voluntary attendance are not centrally collected and published.
- HMIC found that across 3 forces there were 57,170 detentions and 10,898 (a ratio of 5.25:1)
- Based on custody throughput of 1,170,769, voluntary attendance is estimated at 223,177
- The combined total estimate is therefore 1,393,946 or approximately 1.4m per year

How many of these adults require an AA?

- Based on the data supplied by police forces, the current average rate at which police are requiring an AA is approximately 3.12% and equates to 43,437 'episodes'
- Based on from forces and AA schemes, the average rate at which police forces that are covered by NAAN member schemes are requiring an AA is approximately 4.90% and equates to 68,303 episodes
- Based on the academic literature, the actual rate of need is between 11% and 22%. This equates to between 153,334 and 306,668 episodes

How many AA call outs are generated by one episode?

- Voluntary interviews can be considered to require a single AA call out
- The situation in custody is more complicated. There are a number of distinct phases (booking in, identification, interview, charge and disposal) for which an AA should be present. There can be a significant gap between booking in and interview, and again between interview and charge. This will vary depending on the complexity of the case, the extent to which police choose to expedite the investigation, the availability of police resources, the need for rest periods and the length of delay while the Crown Prosecution Service make a charging decision.
- Depending on the service being provided to the vulnerable adult, a single 'custody episode' could typically generate between one and three call outs.

Supply Side: What is the cost of an AA?

- Based on data provided by AA service providers responding to the online survey, the average cost of an AA call out is £80.79. However, the average cost when provided by a scheme that is able to meet current demand and uses volunteers is £69.75. These numbers are based on the total annual cost of service divided by the number of call outs achieved.
- These call out rates are based on current service designs and demand requirements. That means that do not take account of potential changes in the way police or the Crown Prosecution Service conduct their operations. Critically, they are based on AA services being delivered in a small number of fixed locations (custody suites). Many services do not currently cover voluntary interviews outside police stations. If they were expected to attend significant volumes of voluntary interviews at home addresses, service design would require transformation.
- While these estimates can be used to directly calculate the cost of supporting a voluntary interview, they clearly underestimate the cost of supporting a custodial episode
- The precise number of required call outs per custody episode is not known, though we can be confident that it is between two and three
- Even if the precise number was known, it would not necessarily be accurate to multiply the unit cost of a call out by that number. If all growth was assumed to be delivered by new schemes, costs may be directly proportional. For example, if a scheme using volunteers delivers 2,000 calls per year for £100,000 and a new scheme is established on the same basis, the total costs would be £200,000 for 4,000 calls per year.
- However, this is not necessarily the case if growth is assumed to come in part from expansion of existing schemes. If a scheme is delivered by paid staff and commissioning on a per call out basis then costs would rise proportionately. However this ignores the potential for greater efficiency of the service and negotiation by the commissioner as volumes grow. If a scheme is volunteer-delivered, the most substantial costs (staff responsible for co-ordination) are relatively fixed, while the variable costs are more minor (volunteer recruitment, training and expenses). However, once volume increases beyond a certain point, additional co-ordination/administration staff will of course be required. Costs are therefore not directly proportional when expanding existing schemes. For example, if a scheme using volunteers which delivered 2,000 calls per year for £100,000 increased to 4,000 calls per year, it would not cost an extra £100,000 per year.
- In the case of custody episodes, a reasonable multiplier is therefore required. This can either be applied to the unit cost of a call out (to give the unit cost of a detention episode) or applied to the number of detentions (to give the number of call outs). The effect is the same.

Calculation of costs of full national provision

The calculations in the following tables assume that:-

- The average call out unit cost is £69.75. This substantially below the average rate of £80.79 and the very common rate of £100 and the rate in Northern Ireland where a single service exists across the province using paid charity staff. This reflects an expectation that service delivery will be achieved according to the most cost efficient model in all areas. If commissioners and suppliers are not able reduce overall costs from their current level, the total costs would be higher.
- The number of detentions and voluntary interviews by police remains static at the level of 2013/14. In fact, custody numbers appear to be reducing but the data are not available to judge to what extent they are being substituted for voluntary interviews. If custody numbers continue to fall, for instance due to better use of PACE Code G and other initiatives designed to keep mentally vulnerable people out of custody, the total costs would reduce.
- A multiplying factor of two is used in relation to custody, reflecting an expectation that services will provide full support through custody episodes. This may be achieved either by staying throughout or through multiple call outs depending on individual circumstances and needs. There is insufficient data to accurately judge the accuracy of this assumption.
- There are 174 local authorities[1] and 43 police forces
-

Rates of identified need

The calculations in the tables are based on various rates of identification of need for an AA amongst adults:

  - 3.12% (the current average stated rate)
  - 4.9% (the current average rate for forces covered by dedicated schemes who are also members of NAAN)
  - 11% (representing a low estimate of actual need according to the literature)
  - 22% (representing a high estimate of actual need according to the literature)

Cost efficiency compared to use of social workers

The calculations also include estimated costs assuming that all call outs were delivered by social workers rather than dedicated schemes. The Unit Costs of Health and Social Care 2013 report calculated that the average cost of face-to-face social work was £128 per hour or £171 per hour in London. This excludes the cost of a social worker's qualifications. Based on an average rate of £150 and a callout time of 2.5 hours, the cost of a social worker providing the AA service is estimated to be £375.

Type of AA

In light of this project's findings and recommendations, Tables 1a and 1b assume that all AAs are trained and provided by organised schemes and involvement by family members or friends is in addition. Tables 2a and 2b estimate the costs if it continues that anyone can be an AA irrespective of training. It is estimated that 90% of call outs for adults would still delivered by schemes because Code C (1D) prioritises trained/experienced individuals over family members and if reliable AA schemes were available the police would be highly likely to use them. These comparative costs do not take account of relative effectiveness of each type of AA and future savings to be gained through high quality, consistent AA services.

[1] This figure includes county councils, unitary authorities, London boroughs, metropolitan boroughs and Welsh unitary authorities. It does not include district councils.

Paper H: Analysis of costs

Calculations

National total annual voluntary interviews	223,177
National total annual police detentions/custody episodes	1,170,769
Estimated call outs per detention	2
Proportion served by AA schemes (rather than family etc)	100%
Unit cost per call out by a dedicated scheme (£)	£69.75
Unit cost per call out by a social worker (£)	£375

Table 1a

ID rate	Voluntary interview call outs	Custody call outs	Total episodes	Total call outs
3.12%	6,955	72,966	43,437	79,920
4.90%	10,936	114,735	68,303	125,671
11.00%	24,549	257,569	153,334	282,119
22.00%	49,099	515,138	306,668	564,237

ID rate	Voluntary interview cost (£)	Custody cost (£)	Total costs by social workers (£)	Total cost by dedicated scheme (£)
3.12%	485,109	5,089,680	29,970,119	5,574,789
4.90%	762,811	8,003,288	47,126,638	8,766,099
11.00%	1,712,433	17,966,565	105,794,493	19,678,999
22.00%	3,424,867	35,933,131	211,588,986	39,357,997

ID rate	Avg. call outs per Force	Avg. costs per Force by social workers (£)	Avg. cost per Force by dedicated scheme (£)
3.12%	1,859	696,980	129,646
4.90%	2,923	1,095,968	203,863
11.00%	6,561	2,460,337	457,651
22.00%	13,122	4,920,674	915,302

ID rate	Avg. call outs per local authority	Avg. cost per local authority by social workers (£)	Avg. cost per local authority by dedicated scheme (£)
3.12%	459	172,242	32,039
4.90%	722	270,843	50,380
11.00%	1,621	608,014	113,098
22.00%	3,243	1,216,029	226,195

Table 1b

Paper H: Analysis of costs

Calculations

National total annual voluntary interviews	223,177
National total annual police detentions/custody episodes	1,170,769
Estimated call outs per detention	2
Proportion served by AA schemes (rather than family etc)	90%
Unit cost per call out by a dedicated scheme (£)	69.75
Unit cost per call out by a social worker (£)	375

Table 2b

ID rate	Voluntary interview call outs	Custody call outs	Total episodes	Total call outs
3.12%	6,259	65,669	39,094	71,928
4.90%	9,842	103,262	61,473	113,104
11.00%	22,095	231,812	138,001	253,907
22.00%	44,189	463,624	276,001	507,814

ID rate	Voluntary interview cost (£)	Custody cost (£)	Total costs by social workers (£)	Total cost by dedicated scheme (£)
3.12%	£436,598	£4,580,712	£26,973,107	£5,017,310
4.90%	£686,530	£7,202,959	£42,413,974	£7,889,489
11.00%	£1,541,190	£16,169,909	£95,215,044	£17,711,099
22.00%	£3,082,380	£32,339,818	£190,430,087	£35,422,198

ID rate	Avg. call outs per Force	Avg. costs per Force by social workers (£)	Avg. cost per Force by dedicated scheme (£)
3.12%	£1,673	£627,282	£116,682
4.90%	£2,630	£986,371	£183,476
11.00%	£5,905	£2,214,303	£411,886
22.00%	£11,810	£4,428,607	£823,772

ID rate	Avg. call outs per local authority	Avg. cost per local authority by social workers (£)	Avg. cost per local authority by dedicated scheme (£)
3.12%	413	155,018	28,835
4.90%	650	243,758	45,342
11.00%	1,459	547,213	101,788
22.00%	2,918	1,094,426	203,576

Table 2b

Estimating the existing national expenditure on AAs for mentally vulnerable adults

- The survey of providers identified confirmed spending of £2,032,000 per year. This related to coverage for 56 local authority areas (including 200 police stations)
- The survey also found provision in a further 16 local authority areas (including 31 police stations) where spending totals were not provided.
- Based on the NAAN membership database, a further 8 local authority areas are covered by providers that did not respond to the survey
- Assuming the same average level of spending, the estimated total spend for the above areas is £2,902,857
- The survey also found 4 organisations which covered only their own clients or only clients with certain conditions. Accurately total costs were not provided but are estimated to be below £30,000 per year.
- During the research we identified two police forces which are covered by organised schemes which were not within the NAAN network
- Although it is possible to identify the proportion of local authorities or population covered by this spending, it is not possible to extrapolate this to provide a reliable estimate of existing national spending.
- Organised commissioned schemes are highly likely to be known to NAAN and have been included in the scheme. Therefore it is likely that a high proportion of areas for which no scheme has been identified do not have such a scheme. Extrapolating as mentioned above would therefore significantly overestimate the total national spend
- Areas which use social workers to deliver AA services as part of their core role have not been picked up by this survey. If in the remaining 94 (174 minus 80) local authority areas, social workers are delivering the average number of call outs per area (459) for an average of 2.5 hours per call out, the cost would be over £16m per annum.
- It is not clear to what extent social workers are being in practice. The police survey suggests that it does occur in some areas (though time delays make it unsatisfactory). As shown by the calculations above, even a low use of social workers by local authorities would generate very significant spending. In some areas, internal, non-commissioned services may be hiding significant existing spending by local authorities. In other areas there may actually be no provision in effect. It must be remembered that there is no specific statutory duty on social workers to fulfil this role.

Paper I: The AA role according to the PACE Codes

The purpose of an AA

Police are required to explain that the purpose of the AA's presence is to:

- advise the person interviewed;
- observe whether the interview is being conducted properly and fairly; and
- facilitate communication

This is similar to, though not as expansive as Home Office Guidance which states:

- To support, advise and assist the detained person, particularly while they are being questioned.
- To observe whether the police are acting properly, fairly and with respect for the rights of the detained person. And to tell them if you think they are not.
- To assist with communication between the detained person and the police.
- To ensure that the detained person understands their rights and that you have a role in protecting their rights

The nature of the AA

Eligibility to be an AA

Under Code C 1.7(b), a vulnerable adult's AA may be: -

a) a relative, guardian or other person responsible for their care or custody;
b) someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police;
c) failing these, a responsible adult aged 18 or over (Home Office, 2014)[1]

The Codes state that, "In the case of people who are mentally disordered or otherwise mentally vulnerable, it may be more satisfactory if the appropriate adult is someone experienced or trained in their care rather than a relative lacking such qualifications. But if the detainee prefers a relative to a better qualified stranger or objects to a particular person their wishes should, if practicable, be respected."

The AA role may not be filled by: police or their employees; solicitors and independent custody visitors at the police station in those capacities; suspects, victims, witnesses and anyone otherwise involved in the investigation; or anyone who has received admissions prior to acting as the AA (Home Office, 2014)[2]

[1] Revised code of practice for the detention, treatment and questioning of persons by police officers, Police and Criminal Evidence Act 1984, (PACE) – Code C, May 2014 paragraph 1.7(b)
[2] Revised code of practice for the detention, treatment and questioning of persons by police officers, Police and Criminal Evidence Act 1984, (PACE) – Code C, May 2014 paragraphs 1B, 1C, 1F, 1.7(a)(iii) and (b)(iii)

Who an AA is required for

Under the PACE Codes, an AA is required for a person that is 'mentally disordered' or otherwise mentally vulnerable who is detained by police. The same requirements apply, so far as is possible, to people interviewed without arrest but under caution regarding suspected involvement in an offence (voluntary attenders)[3].

Definition of mentally disordered

'Mental disorder' is defined as per the Mental Health Act 1983[4] (see Paper B).[5]

Definition of mentally vulnerable

'Mentally vulnerable' is a broader term and applies to any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies.[6]

There is no requirement for a diagnosis or for a state or level of capacity to be long-standing or permanent. The choice of the word 'may' (versus for example 'is likely to') means there is no requirement on custody officers to determine the likelihood of a suspect not understanding. The test relates not just to understanding what is actually happening but to understanding its *significance*. This applies equally to *questions* put to them by police, *what is said* by other parties such as solicitors and their own *replies*.

In this document, the phase 'mentally vulnerable adult' is used to describe all those who require an AA.

Actions on arrival at the police station

Determining vulnerability

As part of their initial actions, the custody officer must determine whether a person requires an appropriate adult.[7]

The police must treat a person, of any age, as mentally disordered or mentally vulnerable if they have any suspicion or are told in good faith that they are, unless there is clear evidence to dispel that suspicion[8]. The notes for guidance in Code C expand this stating that, "If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, or mentally incapable of understanding the significance of questions or their replies that person shall be treated as mentally disordered or otherwise mentally vulnerable for the purposes of this Code"[9].

[3] Code C 3.21
[4] Code C 3.15
[5] Mental Health Act 1983 s.1(2A) to (4)
[6] Code C 1G
[7] C 3.5(c)(i)
[8] PACE Code C 1.4
[9] PACE Code C Annex E 1

The Codes state that there is no requirement for an appropriate adult to be present if a person is detained under section 136 of the Mental Health Act 1983 for assessment. There is some debate amongst police officers as to whether this means an AA is still required for the booking in procedure though the Home Office asserts that it does not. This may arise in part from the fact that this provision is included only in the Notes for Guidance appended to Annex E (in Code C).

Informing an AA

If the custody officer authorises the detention of a person who is mentally vulnerable or appears to be suffering from a mental disorder, the custody officer must *as soon as practicable* inform the appropriate adult of the grounds for detention and the person's whereabouts, and ask the adult to come to the police station to see them. This must be done *without delay* even where there is an authorised delay in notifying arrest or allowing access to legal advice.[10] However, it is not a breach of the Code if the delay is justifiable, reasonable steps are taken to prevent unnecessary delay and the custody record shows any delays and the reasons why they occurred.

Clinical needs

If they appear to be suffering from a mental disorder, the custody officer must ensure they receive appropriate clinical attention, making sure all relevant information which might assist in the treatment of the detainee's condition is made available to the responsible healthcare professional[11].

Rights and entitlements etc.

The custody officer must provide the detained person with a written notice (including Easy Read) of the person's rights and entitlements including their right to free legal advice. They must explain it and give them opportunity to read it. The reasons for arrest and the grounds for detention must also be explained. The custody officer must inform the person that AA duties include advice and assistance and they can consult privately, ask whether the person would like legal advice and/or someone informed of their detention.[12]

If the AA is already at the station, the above must be complied with in their presence. If they are not yet present, the above must be repeated in their presence *when they arrive*[13]. Although no specific time frame is given for the repetition, a custody officer must perform the functions of the Code as soon as is practicable[14].

[10] Code C 3.15, Annex B: B1, Annex E:3
[11] Code C 9.4, Annex E:5
[12] Code C 3.1, 3.2(b)(i),3.2A, 3.3A, 3.17,3.18), Annex E:3
[13] PACE Code C 3.17
[14] PACE Code C 1.1

Access to information

AAs must be allowed to inspect the whole of the detainee's custody record as soon as possible and at any time on request while in detention, and have a copy of it up to 12 months after release[15]. They are also allowed to consult with the detained person privately[16]. The AA is allowed access to the content of any risk assessment if not to do so would put them at risk[17].

Legal advice & legal privilege

AAs are allowed to request legal advice on the person's behalf if they consider it in their best interest. It remains the right of the person to choose not to use the legal advisor once they arrived at the station[18].

On receiving a request for legal advice from the detained person (or the AA on behalf of that person), the police must act without delay[19] to secure the provision of legal advice. Police must inform the detained person as soon as the legal advisor arrives at the station, even if an interview is in progress and/or they have previously declined legal advice, and take an interview break if the detained person wishes to speak to them[20].

AAs do not have legal privilege and it is the decision of the individual, in consultation with their legal advisor, to decide whether the AA is present in any legal consultation[21].

Procedures

Identification, testing and searches

Code D (Identification of persons by police officers) states that if any procedure in the Code requires information to be given to or sought from a mentally vulnerable adult, an AA must be present. Confusingly, it also states that if the AA is not present when the information is first given or sought, the procedure must be repeated when they arrive. This, albeit pragmatic, addendum has the unfortunate potential effect of negating the safeguard[22]. What is clear is that any procedure involving the *participation* of a mentally vulnerable adult must take place in the presence of the AA[23]. Procedures might include physical or video identity parades, photographs, foot wear impressions, body samples for DNA, evidential searches and examinations for marks etc., and fingerprinting. Wherever consent is required for ID procedures it will only be valid if given in the presence of an AA[24].

[15] Code C 2.4, 2.4A, 2.5
[16] Code C 3.18
[17] Code C 3.8A
[18] Code C 3.19, 6.5, 6.5A, Annex E: 4 , Annex E: E1
[19] Subject to the rules in Code C/H Annex B, whereby police can delay allowing access to legal advice.
[20] Code C 3.19, 6.5, 6.5A, 6.6(d)(v), 6.15,
[21] Code C 1E
[22] Code D 2.14
[23] Code D 2.15
[24] Code C 2.12

Strip searches and intimate searches

The presence of an AA is required for strip searches, unless it is an urgent case where there is risk of serious harm to the detainee or others[25]. The AA should be of the same sex as the person unless they specifically request an AA of the opposite sex[26]. The presence of an AA is also required for intimate searches[27] including informing of authority and grounds for the search and any required requests for and giving of consent[28]. The AA should be of the same sex as the person for an intimate search, unless; the person requests someone of the opposite sex who is readily available, or they state in the presence of the appropriate adult that they do not want one present.[29]

X-Ray and Ultrasound

Although an AA must be present for the informing of the authority and grounds and seeking and giving of consent for an x-ray or ultrasound, there is no requirement that they are present when one is carried out[30].

Interviews

A mentally vulnerable person must not be interviewed, or asked to provide or sign a written statement under caution or record of interview, without an AA. There a number of strict exceptions to this, covering the need for interviews that need to be conducted urgently to avoid serious damage to the investigative process or harm to others. In custody, the authorisation of an officer of Superintendent rank is required. [31]. An AA must be present for the caution given by police before questions are put to them as well as any special warnings.[32] The AA may read and sign the interview record or any written statement taken down during the interview[33].

Documents and translations

The AA must be present when police ask the person whether they wish to waive their right to written translations of essential documents; necessary relevant information under Code C Annex M is provided; the reminder about their right to legal advice is made; and when consent to waive is given[34]. The AA should be allowed to make representations that a document that is not listed in the table of essential documents is essential and that a translation should be provided.[35]

[25] Code C Annex A: 11(c), Annex E: 12
[26] Code C Annex A: 5, 11(b), Annex E: 12
[27] under PACE 1984 s.55 (a search which consists of the physical examination of a person's body orifices other than the mouth)
[28] Code C 1M(d)(i), Annex A: 2A, 2B, 5
[29] Code C Annex A: 5, Annex E: 12
[30] Code C Annex K: 2 and 3
[31] Code C 12.3, 11.1 or 11.18 to 11.20
[32] Code C 10.11A, 10.12, Annex E:7
[33] Code C 11.12
[34] Code C Annex M: 7(a) and (b)
[35] Code C Annex M: 8

Class A drug testing

An AA is required for the taking of a sample for Class A drug testing (and associated requests, warnings and information) only for those who have not attained the age of 17. An AA is not required for vulnerable adults for this procedure.

Reviews

Police should make reasonable efforts to give the AA sufficient notice to make themselves available in person or by phone/electronic means to make representations whenever detention is reviewed [36]. They should be consulted and their views considered before detention beyond 24 hours is authorised[37].

Charging and related actions (when there is sufficient evidence for a prosecution)

The custody officer must make reasonable efforts to give the AA sufficient notice of the time the decision (charge etc.) is to be implemented so that they can be present[38]. However, there is no legal power by which police can detain a person solely to wait for an appropriate adult. If the AA is not, or cannot be, present at that time, the person should be bailed under PACE 1984 s.37(7)(b) to return when they can be present (unless the Custody Officer determines that the absence of the AA makes the person unsuitable for bail for this purpose). The AA should be given a copy of the notice of particulars of charge at the point of charge or when they arrive[39].

[36] Code C 15.3(c), 15CA. Representations can be made in person or remotely (Code C 153B), however specific additional consideration must be given to the benefits of carrying out reviews in person if the detained person is suspected of being mentally vulnerable (Code C 15.3C(b)).
[37] Code C 15.2A(c)
[38] PACE Code C 16C
[39] Code C 16.3