New NICE QS: mental health of adults in contact with the CJS

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NICE have issued a new quality standard (QS163, February 2018) for the management of the mental health of adults in contact with the criminal justice system (CJS). The QS focuses solely on the early part of the care pathway for individuals who need to access psychiatric care at the point of, or, after police arrest. This is a significant point of entry for many people with mental health problems, whose help-seeking behaviour is often disguised.

The NICE quality standard[1], consisting of four quality statements, follows a series of high-profile reports and articles since the Reed Report in 1992,[2] which have outlined key elements of safe practice for the recognition of mental health problems and importance of diversion into mental health care for mentally disordered offenders. The Bradley Report[3] clearly identified the point of arrest into police custody as a 'critical and under-resourced' stage of the offender pathway. One of his 82 recommendations was that all police custody suites should have access to liaison and diversion services, with better joint working between custody sergeants, their teams and mental health services. In 2014, a follow-up report, *The Bradley Report Five Years On*, highlighted the importance of training for everyone involved in the assessment of individuals who have just been arrested.[3]

We know that the initial period custody is a high-risk time; there are many challenges with the custody process, particularly in the management of a disturbed or psychotic individual who may or may not be intoxicated. According to the British charity, Inquest, 1649 people have died in police custody in the UK since 1990.[4] Figures from the Independent Office for Police Conduct, (formerly the Police Complaints Commission), which also collects these statistics, confirm that there have been on average 16 deaths each year in police custody between 2008/09 and 2015/16; around half of these are judged to have mental health problems. In response to this, Dame Elish Angiolini's Report into Deaths in Custody published in 2017, but commissioned two years previously by then Home Secretary, Theresa May, contains 110 recommendations for improving the way that the police manage vulnerable people at the point of arrest.[5] One recommendation was that police cells should not be used to transport or hold those detained under mental health powers unless in exceptional cases, and that detention in police cells of those believed to have mental health issues should be phased out completely. The NICE QS seems to accept that this sort of change will be a lengthy process and that procedures can be put in place in the interim, to keep people in custody safe and minimise any potential unnecessary harm. A second significant report into Deaths in Custody looking at international trends in this contentious issue was also published last year.[6]

The quality standards

NICE was set up to help to regulate the healthcare professions; but these quality standards are not just for doctors. They take the form of four quality statements, which describe what should be done by arresting officers and professionals who see people in custody in order to reduce a risk of anxiety, self-harm or aggression, and how incidents should be recorded. Each quality statement acknowledges that it will reach 'different audiences' and that professionals in mental health services need to work closely with professionals in all aspects of the criminal justice system (the police, the courts, probation, prison, commissioners, local authorities, and NHS England). We all know that this is a good idea, but it is challenging. The process of finding the right person to talk to about any particular problem, or any particular individual in an organisation that is not yours can be bewildering; having established roles in organisations for liaison and for an 'outward face' remains a challenge for institutions.

Quality statement 1 asks that police officers recognise features of mental health problems in people who are suspected of committing an offence and know how to respond to them. They should maintain safe boundaries, use respectful language and minimise the need for restraint by deploying de-escalation techniques. There should be transparency about training provided for police officers to achieve this, both initially and through updates that

have a clear audit trail. The need for transparency in the arrest and custody processes is a theme throughout the guidelines. This need has perhaps been answered partially by the adoption of the use of police body-worn cameras, which have shown a promising impact on reducing police complaints.[7] This strong emphasis on accountability perhaps stems from a growing public distrust relating to police legitimacy, and the rise in complaints against police across the majority of forces in the UK.[8] Training for police officers to use non-contact and appropriate communication styles with disturbed individuals is clearly available, but like the introduction of body-worn cameras, is probably not consistent or mandatory across all 44 police forces; implementing this sort of consistent training will require a significant resource and culture change.

In recent years, mental health services have developed enormously in terms of incident recognition and reporting. Incidents are defined as self-harm and assaults by detainees and data gathered about aggressive behaviour and the interventions used. Quality statement 1 also demands that a similar system of incident reporting is developed for custody suites. This has particular implications for the culture and infrastructure of police stations: in healthcare settings, there remains significant practitioner variation in what constitutes aggressive behaviour that should be reported and recorded.

Quality statement 2 simply states that adults in contact with the police who have a 'suspected mental health problem' are referred for a 'comprehensive assessment'. There are potential problems with the meaning of both those terms. The document defines 'suspected mental health problems' as including, but not limited to, a 'reported history of mental health problems, including self-harm or suicidal thoughts' and 'changes in behaviour…which may indicate the onset of, or changes to, mental health problems'. This would potentially be straightforward to assess if an individual is well known to a particular group of professionals, or if collateral history can be obtained, If, however, such information is not available, the ambiguity in 'suspected' may result in under- or over-referring to mental health liaison services.

Some detail is put into what 'comprehensive' means. Comprehensive assessments are time-consuming and require access to background reports of offending and psychiatric histories, which may or may not be available in police stations or out of hours. A balance will need to be struck between the time available for making such an assessment versus the resources that can be readily accessed. As the document rightly specifies, equality and diversity considerations are important. For example, individuals with cognitive impairment or learning disability should be provided with appropriate information, and information should be in a format to suit individuals' needs and preferences, including using interpreters and advocates. Although many police stations now have mental health liaison nurses, or specially trained mental health officers in custody suites, who can help with identifying mental health problems and referral pathways, such provision may not be available at all times or always covered during leave and holiday periods.

Quality statement 3 calls 'evidence of local arrangements for mental health care plans to include an agreed process for the plan to be shared…' This may sound straightforward but in practice achieving the right balance between the amount of information that may be regarded as confidential to the individual, and that which needs to be shared for risk purposes, can be contentious. In this context, an 'agreed process' will potentially require a significant amount of negotiation between involved agencies over what can, and should, be shared. The guidelines add that plans are developed in collaboration with the individual. Whilst this approach is ideal, there is no acknowledgment that people in crisis may not consent to such information being shared, particularly if it relates to sensitive issues such as mental health and offending.

Quality statement 4 requires a commitment to safe risk management plans during transfers out of custody to hospital, court or prisons. By incorporating this statement, the guidelines implicitly acknowledge that times of transfer are times of potential heightened risk, but they state only that 'people are not placed in transport, holding areas, cells or in accommodation in the community until the plan has been reviewed'. It would be helpful if the guidelines gave some indication of what such reviews might entail, as per the additional guidance given regarding mental health assessments in quality statement 2.

Conclusion

The publication of NICE Guidelines for the Mental Health of Adults in contact with the criminal justice system is timely. They come in answer to two important government documents dealing with the problem of deaths in custody. They provide a sensible

outline of how people in police custody could be managed safely, calling for multiagency working, better training of police, thorough mental health assessments, clear pathways for diversion, sharing of care-planning information, and safe transfers. Collaboration between different organisations, particularly those such as healthcare and the criminal justice system, which have separate, and perhaps competing, remits are fraught with potential difficulties. The guidelines would perhaps benefit from additional focus on the details of inter-agency working.

Little in these guidelines is new; they follow a raft of documents published since 1992 saying almost the same thing. They are not based on research evidence, but they are based on what we know clinically about safe practice. The true challenge is not knowing what to do, but how to implement safe systems for managing individuals with mental health problems who come into contact with the criminal justice system.

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Declaration of interests

No conflicts of interest were declared

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