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# Mental Health & Policing:

*A perspective from the  
'front-line' of police custody*

September 2016

West Midlands Police



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## **Introduction**

This small scale research study was carried out by Leeds Beckett University in collaboration with West Midlands Police, to explore how mental health issues impact on police custody suites. A significant number of people with mental illness will come into contact with the police on a daily basis, and Bradley (2009) proposed that, there needs to be improvements made to police training in mental health awareness and where appropriate, people with mental illness should be diverted to suitable services which meet their needs. Despite this, the Independent Commission on Mental Health and Policing (2013) noted cases where people have, “died or [have been] seriously injured following police contact, or [within] police custody” (p.6), and the findings from this review inform police conduct around the safety of detainees. The Crisis Care Concordant promotes partnerships between the police, health and social care to improve the experience of people in mental health crisis (Department of Health 2014a) and this has led to the provision in some areas, of ‘street triage’ teams, with a move to have psychiatric nurses based within police custody suites (Department of Health 2014b). These initiatives focus on reducing the use of Section 136 detentions under the Mental Health Act (1983), with the aim of improving the experience of people who find themselves in a mental health crisis (NHS England 2015). This research was a case study based in the West Midlands which explored the experience of custody support officers, detention and escort officers, triage workers, custody sergeants and inspectors, working with people with mental health difficulties. Although this study was located in the West Midlands the findings provide key insights into the tensions that exist when dealing with mental health difficulties within police custody, further research is required to inform practice.

## **Methodology**

This study utilised semi-structured interviews as a data collection tool as it allowed for some flexibility within a busy custody suite. Although originally the plan was to carry out the interviews face-to-face, this became difficult because participants had to return to custody at busy times. In order to provide more flexibility, it was agreed to do telephone interviews where the participant could contact the researcher at a convenient point within an allocated time slot. Participants were aware of the focus of the study and they had the option to see the questions before agreeing to be interviewed. The participants were provided with an information sheet and they then indicated if they were interested in participating in the study. Each participant (n=10) gave their consent to be interviewed and were given the opportunity to withdraw from the study at any point by emailing or telephoning the researcher prior to data analysis. The

interviews were recorded (with the permission of the participant) and then fully transcribed. The data was then coded using NVIVO software to perform a thematic analysis where a number of themes emerged - these were then subjected to theoretical triangulation by considering how they relate to other studies in this area. In order to maintain confidentiality, the participant's names or roles will not be identified.

## Research questions

1. What issues are there for the police service when dealing with mental health difficulties within police custody?
2. To what extent do custody staff and police officers feel equipped to deal with a range of mental health difficulties?
3. How are issues of 'vulnerability' and 'risk' dealt with within police custody?

## Findings

### Increased Police Involvement with Mental Health

The findings of this study support the supposition that although dealing with mental illness had always been part of the police role, over time this had increased for a number of reasons. Participants suggested that the recession had resulted in a decrease in health and social care services, leaving people uncertain where to get support when they were in crisis. All the participants were committed to improving the care of people experiencing mental health crisis, but they identified that in order to offer a good service they needed more training around mental health awareness.

*"...it's a massive challenge for the police to be able to deal with mental health because we are seen as a jack of all trades"*

*"We are finding that we are becoming more and more responsible for doing everyone's job really, you have to be a social worker, a counselor...when you see the people sometimes you ask why they actually ended up [in custody] especially when it's a mental health issue"*

Some participants made the suggestion that due to increasing poverty, homelessness and social exclusion, people frequently find themselves in custody because of low level crime. Furthermore, the participants proposed that people are increasingly calling the police when they are feeling low and suicidal because they know they will get a response.

*“the emergency services are being called because it's quite an impulsive situation, or it maybe they've carried out impulsive acts of harm to themselves or carrying out risky behavior, but also I think it has increased because socially, in terms of their financial status and general day-to-day living now is certainly not easy”*

Custody was described by one participant as a 'safety net' for people who have not been able to get the support that they need, however all participants agreed that police custody is not the right place for someone with mental health concerns, unless they have committed a crime. In order to prevent this, the participants highlighted the importance of appropriate liaison and diversion arrangements being in place. Notwithstanding these measures, the participants noted that there are still high levels of vulnerable people detained in custody suites relating to criminal behavior. In spite of their commitment to provide a safe environment for the person(s) in custody (PIC), they expressed frustration that someone with clear signs of mental illness and a desire to hurt them self are often viewed as *not* needing a mental health assessment.

*“She'd always end up staying with us and we'd have to restrain her every time she was here, not because she wanted to hurt us, but [because] she really wanted to hurt herself”*

*“The cell was a bloodbath sometimes when she'd been in it”*

*“... it is quite distressing if you've got someone with severe mental health problems who obviously can't cope with being in a cell”*

There was a perception among several of the participants that some people who come in to custody have reached a crisis point and this was the root of their offending behaviour. This could be because a person who had been released from hospital was unable to get in touch with mental health services when they experienced a crisis. In these cases, the PIC would often report that they had stopped taking their medication, had been drinking or using drugs to self-medicate. The participants suggested that if someone had been able to intervene at an earlier point, the person could have been treated appropriately and spared from repeated visits to custody.

*“She had been in the mental health unit when she was about 12 ...she said that the medication she was on didn't do anything other than calm her down a little but they didn't stop her wanting to hurt herself...she came into custody regularly but [was] never ever subject to any mental health assessment, she always went through the system and went to court, which I just think was horrendous really...she wasn't somebody who needed criminalising...it was obviously her cry for help”*

Despite their concerns, it was clear from the findings that all the participants were committed to the safety and the well-being of PIC's, but they discussed the tensions that exist when caring for vulnerable people within the process. As outlined by Bradley (2009) the key to providing a safe environment is appropriate training, but the participants in this study suggested that what they currently receive is insufficient for the changing custody environment.

*“The training that frontline staff have is limited because we are taught about a wide number of areas and we are not specialists – it gives you a broad idea of mental health and the appropriate legislation...I don't feel that it's good enough”*

*“the training we're given around mental health is very limited and so you really just using your own personal skills to address these major issues. They are very complex issues as well”*

Some participants identified more specific areas where they wanted training, this included guidance on the use of restraint with vulnerable people. All of the participants were keen to do 'the right thing', ensuring the care for detainees is of the highest standard. In order to do this, they recognised the need for additional training around suicide and self-harm. The participants noted that they currently have allocated training time each month, but there was a sense that these days were not always used to their full potential.

### Identifying Vulnerability

All the participants were aware of mental health and vulnerability within the custody suite, with some suggesting that nine out of ten people who come into custody will have some sort of mental health difficulty. There was an acknowledgement that this can range from mild depression and anxiety, through to severe psychiatric illness. Within the context of this discussion the participants identified a number of ways that they attempt to safeguard the PIC including, appointing of an appropriate adult, making medical referrals, and where necessary, the provision of a mental health assessment. Participants acknowledged that although positive steps to protect people from harm within custody have been taken, there continues to be some difficulties that include, identifying when a person is suffering from a mental illness, understanding how this illness relates to the offence and having robust processes that reliably assess the level of risk.

*“The biggest part of my role is doing that risk assessment we have to do when they come into custody...one of those questions is, do you suffer from any mental health problems, do you suffer with depression, and have you ever tried to self-harm or commit suicide”*

Participants raised concern that although everyone who is booked into custody are asked a set of questions to assess risk, the process relied heavily on the PIC being honest when answering. Despite asking the same set of questions to each PIC, their willingness to give comprehensive answers varies, impacting on the reliability of any risk assessment. Where a person has previously been in custody there could be some information on the police system that would suggest mental illness, self-harm or issues with drugs and alcohol problems. The participants in the study were concerned about the possibility of 'missing something' because while alcohol intoxication is easier to identify, the signs of mental illness or distress are not always as obvious.

*"What's really scary about that is, sometimes you have people in custody with no background information on them and they'll say no [when asked about their mental health], not at all, nothing."*

*"...then you get a doctor in and the doctor does a little digging with their GP and actually they could have an extensive mental health background, they're not necessarily going to disclose that to you when standing in front of you at the custody block"*

Participants at all levels discussed the need for continuous assessment of risk and acknowledged that it is an important role for all custody staff. The PIC would be initially placed on a risk level, ranging from one to four and this would be updated as and when things changed. Participants described their concern that these levels of risk can quickly escalate within custody, especially where a PIC is in mental distress.

*"When she first came we didn't realise how severe she was, so we just were on a camera watch on a level three. But we quickly learned that if she was in custody she had to be on a one-to-one...on a level four"*

Participants explained that levels one and two identified the frequency of the custody checks, level three requires constant surveillance using CCTV and level four requires the position of officers at the door of the cell. There was clear evidence that the custody support workers and the detention and escort officers review the level of risk continuously. They described how they did this by engaging the PIC in conversation while they were providing them with food and drink, and when carrying out their scheduled checks. The custody support workers and the detention and escort officers reported that if their interactions with the PIC raised concern about the person's state of mind, this would be fed back to the custody sergeant immediately. The level of risk is calculated individually and as a collective, and the participants noted that when a number of PIC's require level three and four care, this can result in the closure of custody to ensure the safety of staff and PIC's.



*“We’ve got 17 cells here, we only need two people with mental health issues, we might only be able to have seven people in the cells, we might have 10 empty cells, because if you think about it, if you got someone who potentially wants to kill themselves or self-harm and you’re the sergeant trying to keep the lid on that as well as the other prisoners, then you can’t be compliant with PACE and keep [them] safe”*

Participants suggested that just coming into the custody is oppressive and therefore any mental illness is likely to be exacerbated. In some instances, the participants had been involved in constant supervision that required them to sit in the doorway of the cell. The participants reflected on occasions when they sat in the doorway and were able to support the PIC’s emotional well-being, but they also recalled occasions where the PIC had become very distressed to the point where it was necessary to use restraint. Clearly the role of the custody sergeant is critical in the assessment of risk, but again the issue of training was identified as a concern.

*“The custody sergeant is making a lot of decisions without much training, we know what we see and but the nature of somebody who is suffering from paranoid schizophrenia in a mental health crisis... they could be anybody from Ralph Moat down to someone that is experiencing some distress...we don't really get any training in that”*

As well as ensuring that the custody environment is safe, the custody sergeant is required to assess that the PIC understands the process in custody, and is able to make their own decisions about legal representation. This requires an assessment of a persons ‘capacity’ under the Mental Capacity Act (2005) but the findings suggest that there can be a lack of clarity about the distinction between this, and assessing if a person is a ‘vulnerable adult’.

*“It is one of those phrases that tend to get thrown about a room but no one can really pin it down”*

*“In my experiences whether a person has or does not have capacity is difficult to assess...they are doing it retrospectively...assessing and saying that this person does or does not have capacity...nobody in the police knows”*

The participants were aware of the need to assess ‘capacity’ but as the quote above shows, some were unclear of the purpose. However, most of the participants were aware that the assessment of capacity needs to be specific to the current situation and focused on the PICs detention in custody. All of the participants discussed the requirement to provide someone with an ‘appropriate adult’ if they were deemed to be vulnerable, but there was a lack of clarity

about who has the responsibility for identifying the need, and some confusion about the role of an 'appropriate adult' within custody.

*"...the healthcare professional [will] flag up that they will need an appropriate adult"*

*"...it depends on how much they need an appropriate adult...they just need to give them some reassurance that we are not doing anything that we shouldn't do"*

*"...the appropriate adult is treated as a parent or a social worker, so if they want some time to explain something to them in the cell, then we do it"*

*"We need to consider if they understand what's happening and somebody needs to decide if we need appropriate adult to make sure that no harm comes to them."*

Despite this, participants stated that they were aware of how to access an 'appropriate adult' by using either a voluntary scheme that ensures people are vetted before they can enter custody, or in the case of young people, via social care or youth offending. During the interviews some participants raised the concern that it is not always possible to locate an 'appropriate adult' because although they have a list of contacts, this does not guarantee that someone is available, and willing to come in.

*"...they quite often live in some sort of supported accommodation and they have got protocols and pathways to deal with that person"*

There was a shared view amongst the participants that where possible, when a vulnerable adult arrives in custody, attempts should be made to find someone who knows the person well to act as their 'appropriate adult'. They suggested that this is more reassuring for the PIC but noted that this is not always possible unless someone is living in supported housing, or is known to other services. There was a recognition that everyone needs to ensure that the PIC is dealt with in an appropriate manner, and that they are fully informed of the custody process.

*"...we had a detainee with schizophrenia who had assaulted someone in his supported housing...because he was mentally vulnerable, he needed an appropriate adult to make sure he understood what's going on...we could not access an appropriate adult so we had to bail him without having an appropriate adult with him"*

*"I couldn't wait any longer because he had been sectioned so I had no choice...I thought that it was the best thing to do, sometimes you have to just default back into what is the best thing to do...in this situation I felt that in these circumstances we should not wait"*

The frustration expressed above was mirrored in the interviews with other participants who suggested that waiting for an appropriate adult can increase concern about the PIC's emotional needs while in custody. Other comments suggested that the delay in locating the appropriate adult impacts on the criminal justice process, including the PACE 'clock'.

One participant proposed that there can be a tension when dealing with a serious crime, because although they understand the need for an appropriate adult, they also need to collect evidence and samples as soon as possible. From the findings there was a suggestion that at very busy times the ability to access an appropriate adult was a source of frustration, but despite this there was an agreement from all the participants that the provision of an 'appropriate adult' was essential.

Another interesting area where vulnerability was discussed was the point at which someone is released from custody, especially when their arrest and subsequent charge is likely to have a huge impact on their life.

*"We still have a duty of care for the next 24 hours after release so although they might say that they are not suicidal – the people that are quiet and don't cause you any problem [are] probably the most likely to go out and do it"*

An example of this was where a lorry driver was charged with drink driving and the impact for them could mean the loss of their job.

*"We do what we call pre-release care plan. At an extreme someone who has downloaded pornography or charged with some sort of sexual offence with a child and hasn't been remanded in custody, our care plan would involve some sort of safeguarding for them so they don't take their own life or self-harm. That's one extreme"*

*"...we have found recently that female drink drivers are the biggest danger... Unfortunately, someone did get bailed with drink-driving and she did take her own life. I wasn't directly involved with that but obviously when that came round it really opened my eyes"*

Participants identified what they described as 'loopholes' within legislation whereby if a PIC is being released without charge, it is not possible to detain the person for their own safety.

*"We end up having to bail people who are vulnerable...even if I know that they're going to commit suicide and all I can do is get a release care plan in place for them. So I effectively have to kick somebody out of the custody cell knowing that they are going to kill them self because I can't detain them under Section 136 because they are already in a place of safety"*

Participants discussed vulnerability on release and described how a pre-release care plan can be used because even in cases where the PIC does not have a mental illness, they can still pose a risk of suicide on release. From the findings it was clear that all levels of custody staff were committed to the care of vulnerable people within custody but they agree that where possible people should be diverted away from the criminal justice system where appropriate.

### Liaison & Diversion

There was agreement from most of the participants that if someone is known to mental health services, they should be diverted from the criminal justice process for low level crime. They all agreed that custody is not the right place for somebody that is vulnerable as the environment can have high noise levels, with people banging on their cell door and shouting for hours. They explained how this type of environment can lead to increased anxiety and a worsening of a mental health crisis, with the result that the PIC's mental state is likely to deteriorate.

*"I think that they need to go to somewhere that is more like a homely environment. They should not be in the same place as is typical criminals that have shop lifted in order to finance a drug habit"*

Although there was the suggestion that custody was not the right place for someone with a mental illness, there was also the recognition that the offence needed to be dealt with. The participants noted the importance of considering the seriousness of the offence that has been committed, alongside any assessment of the level of learning difficulty or mental illness. Where a person in mental health crisis is detained, the participants all noted the importance of getting a detailed mental health assessment.

*"We go straight to the medical health professional services that we have to use in custody... we will go straight to them, and be guided by them really"*

*"If somebody is mentally unwell and [has] a learning disability we'd probably look to deal with it in the least restrictive way, it could be they'll pay for the damage out of the benefits or they will apologise"*

*"...all we can do is rely on other medical professionals for support to say if they need to be sectioned or go through the criminal justice system"*

Where a PIC is assessed as needing a mental health service the participants noted that they would not be interviewed until they were deemed to be fit. Where there is a low level crime, there are attempts to look for a community resolution. There was acknowledgement that when

the crime committed was of a serious nature, decisions needed to be made about how to proceed.

*“The grey area comes when an offence has been committed. Some people may have had mental health difficulties for a number of years but still commit offences. I believe that these offences should not be ignored and custody should be considered based on risk. If the offence is a serious one, then I would use custody to both deal with the criminal but also mental health aspect”*

*“Depend on how unwell a person is, we did try to deal with the crime first, if somebody is acutely unwell then we would need to deal with the illness first – we all understand how the different professions operate”*

Where there are concerns about a mental illness the participants were all aware of the process that they would go through in order to get a mental health assessment as a basis for their planning. Despite this there were a number of tensions that existed and participants reported that a PIC could wait a number of hours to be seen by a mental health practitioner.

*“...we would call healthcare professionals and we would be waiting however long for a nurse who says they need a mental health assessment, so you're waiting for a doctor to come out and for him to say yes I do believe they're suffering with a mental health illness [so] we will then need to turn the crisis team out”*

*“If he had a family member there or somebody who was close to him than the nearest relative is entitled to call up for a mental health assessment, but again in my experience it is almost like a battle for them to do it – it depends who is on the other end of the phone. They feel like they have to justify the world to get somebody out to assess somebody”*

The participants noted that any delay in getting a mental health assessment impacts on the criminal justice process by reducing the time they have to conduct their enquiries. They explained how they are only able to detain someone for twenty-four hours and by the time they get confirmation that the person can be interviewed, they might only have four hours left on the PACE 'clock'. During the interviews a number of participants explained that there was even greater difficulty getting a mental health assessment if the person has been drinking or taking drugs. They understood the reason for this, but they noted that this increases the time the person would remain in custody.

*“[Having] the nurses in custody... I think it’s a wonderful idea if I’m honest because quite often the doctors who are in custody might not be as well versed in mental health as the CPN...psychiatric nurses deal with mentally ill people all day every day, and again they have access to all the records, the systems, they are familiar with all the treatments and pathways so I think it will reduce the amount of unnecessary mental health assessment in custody”*

The participants also discussed the provision of a psychiatric nurses based in custody and suggested that this would improve the experience of people with mental health difficulties. The main improvement that they identified was a reduction in the time waiting for a mental health assessment.

*“It will provide people who have got concerns about their mental health [will] actually be speaking to the right person - they are going to be referred to the right pathway – I think it’s a positive thing to have the nurses in custody, as much as we try to avoid people who have got mental illness being placed in custody I think we are sort of overwhelmed with it at the minute, so having an expert in that environment is only a good thing”*

Having a mental health nurse in custody who has the capability and capacity to speak to all the PIC’s was viewed as ideal because it would provide someone who would listen to their concerns. There was also a suggestion that through this process people can be referred by the nurse to appropriate services, including drug and alcohol programs.

*“it’s very difficult because no-one will touch anybody who’s under the influence of drugs, the doctors won’t, social services won’t, so that sits fairly and squarely with us until they’ve got to the point where they’re no longer under the influence...they have to be in a position to be fit before anyone will do any assessment with them”*

*“...it puts us in a difficult position but what I have found is that it’s frustrating if someone has dual diagnosis, they are actually an alcoholic but as well as that they are mentally unwell. Mental health services generally won’t go near them so then it’s like ‘who picks that up’ ...what happens with that person then?”*

Participants were committed to improving the experience of people who are having a mental health crisis and they noted that in the past there had been a lack of knowledge and understanding in this area of policing. One participant suggested that when there is a need for police intervention because of the risk someone poses to them self, there needs to be a commitment to avoid custody and to reduce the stigma that people can experience. At the time of the data collection there was provision of a ‘triage team’ that worked out of two local custody suites which included a police officer, a paramedic and a psychiatric nurse. Some of the participants worked in the ‘triage team’ and could identify many of the benefits of this approach, but they also identified that some tensions still exist. In particular, they noted that

when people have been drinking or taking drugs, it is not possible for the nurse to do a mental health assessment.

*“The challenge that we face as a triage car is that if we go out to somebody who is intoxicated it limits our nurse’s ability to assess them”*

*“If mental health services are washing their hands of them and saying that it is alcohol... well it might be, but alcohol services aren’t going to be open at two o’clock in the morning and who do I refer to, what happens to them?”*

The participants who worked in the triage team described how they can be left with limited options when they attend a scene where a person is posing a risk to them self or to others, *and* they are intoxicated. They suggested that it is not appropriate to take someone in this position to accident and emergency department because this could worsen their mental state, and if the person was violent, it could put others at risk.

*“...it seems like, almost an excuse to avoid dealing with somebody, to avoid treating somebody’s symptoms because they are intoxicated, so it is frustrating and it does provide barriers”*

*“Custody is not a safe environment so then you’re forced to take somebody to A&E where you’ve got genuine sick people, who don’t need to be seeing somebody acting violently, coming in with police officers and all the rest of it”*

In these circumstances they would detain a person under Section 136 of the Mental Health Act (1983) and take them to a ‘place of safety’ in a local psychiatric hospital. The participants noted how this impacts on resource because it requires one or two police officers to stay with the patient until they were fit to be assessed. Similar concerns were raised about the need for police officers to sit with the person who is causing a breach of the peace in accident and emergency, stretching a resource that is already depleted. This frustration was increased when dealing with a person who is well-known to mental health services and is now presenting with psychosis because despite the history of mental illness, they can not be assessed if they are intoxicated. In these circumstances there was a feeling that the police were being left in a difficult situation because another service was refusing to accept responsibility for that person.

Despite these tensions the findings of this study suggest that police custody was rarely being used as a ‘place of safety’ within the West Midlands, and there was a real recognition that police custody was not somewhere that should be used for this purpose. Participants suggested that when they attend a scene and the person is clearly mentally unwell they would utilise mental health legislation, to ensure that the person was taken to a ‘place of safety’ suite rather than the accident and emergency department. The provision of street triage teams,

alongside a commitment to dealing with people in mental health crisis sensitively, had also minimized the unnecessary use of police custody.

*“They know that patients may have had a bad experience with police officers in the past for whatever reason, they always try to offer a new experience by explaining what we need to do to keep them and others safe...we do it in the most dignified way that we can”*

Despite these best efforts, there was a recognition that when taken to a ‘place of safety’ the patient can still be very distressed and if the crisis escalates, restraint is often necessary. In these cases, the police would be required to provide the resource to keep the person safe until a full assessment is carried out.

*“it is normally outside of working hours, so they [the hospital] would be on night-time skeleton staff, and they would then have to invoke certain procedures by getting the crisis team out, the consultant psychiatrists to section them or to admit them, and that would take a long time in terms of paperwork and procedures, so my officers would still be there for four, five or six hours”*

*“I can imagine that if you’re mentally unwell it adds to your distress and having an intervention from a police officer when it should really be a mental health professional”*

One participant involved in the street triage team noted how they had started to build good working relationships with local mental health services, ensuring that any intervention is appropriate to reduce the need for unnecessary admissions.

*“We act as a bit of a bridge between all the services really, to strengthen alliances, to make the working in partnership which we endlessly talk about to make it easier...if I called up mental health team to find out information on a patient...they would be reluctant to give it to me - now if I ring up and want to know about a patient it’s not a problem, they just provide the information straightaway”*

This level of partnership working represented a significant change linked to the ability of the triage team nurse being able to assess the patient and liaise with community mental health teams, or home treatment teams where appropriate. Other participants recalled times when they needed to attend incidents where someone was having a mental health crisis and felt that they did not have the skills and knowledge to deal with the situation. Having a triage team available to respond to this type of incident was viewed positively because having a police officer, a paramedic and a psychiatric nurse working together, meant that they could deal effectively in the person’s best interest.



*“By virtue of having the CPN [Community Psychiatric Nurse in the team] they're able to get access to the patient's mental health history, if they have ever been known to services, what services they've had in the past, any diagnosis, any medications that they're on”*

*“As a team we're able to go in, armed with all that information and to discuss [this] with the patient and they [CPN] are able to refer back in”*

*“I have learned so much from being here [the triage team] and because I am so interested every time we go to something new or I hear of something new there's an opportunity for learning with the CPN”*

The participants noted that although they can only use Section 136 of the Mental Health Act (1983) in a public place, they are still able to offer a service to people in their own home, by liaising with mental health services to identify appropriate support.

## Conclusions

This study demonstrates how the participants understood their role in supporting people that were experiencing a mental health crisis. There was a clear agreement that when there is a need for a 'place of safety', it should not be in police custody. With the provision of street triage teams and a commitment to work in partnership with mental health services, West Midlands Police were ensuring that people in crisis were taken to an appropriate hospital setting. Despite this, the level of mental illness within society means that custody staff will still be required to care for detainees who are experiencing mental illness. In addition, the changes to mental health services, and the reduction in community support, means that some people get involved in low level crime that could have been prevented with early intervention from health and social care services. This is also the case when people are released from prison without appropriate support.

Clearly the needs of detainees in police custody are complex and participants in this study expressed concern about managing risk and vulnerability within the custody environment. With this in mind, it is important to highlight the concerns raised by the participants about the need for appropriate training. It would appear that custody staff would be willing to undertake further training and some discussed wanting opportunities to learn together when working alongside other professionals on the triage team. Participants identified that mental health awareness was not something that can be simply 'taught', it has to be experienced. There was a suggestion that this type of learning would lay a foundation for a more holistic approach when dealing with people in mental health crisis. In the interviews there was a recognition that

providing appropriate training in mental health was a difficult task, because of the complex nature of mental illness and vulnerability, but there was agreement that training needs included mental health awareness, signs and symptoms of mental illness and appropriate support for vulnerable PIC's. In addition, the participants suggested that there could be a 'mental health champion' in each custody suite, who could have additional training and would disseminate mental health updates to others.

While acknowledging that each person brought into custody will be assessed by the custody sergeant, there was concern that people do not always acknowledge a history of mental illness, self-harm, drug or alcohol addictions when asked. It was reassuring to note that although the first risk assessment is carried out by the custody sergeant, the custody staff continually assess risk and report any concerns that they have. From the findings it is clear that the assessment of risk is a critical role that is carried out by detention and escort/custody support officers, therefore further training could be very beneficial. West Midlands Police have shown a commitment to dealing with mental health needs positively but the findings would suggest that they are still experiencing some difficulty getting timely access to 'appropriate adults' and mental health assessments. It would be interesting to see if the planned move to larger custody suites can improve access to these two crucial areas of support. Further research could be carried out with a larger sample to identify current training needs, evaluate current mental health practice and any new mental health initiatives. By taking a strategic approach to mental health in custody, West Midlands Police Service have gone some way to avoid inappropriate detention and ensure the safety and well-being of vulnerable PIC's.

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