

# There to Help 2

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PROGRESS TOWARDS ENSURING PROVISION OF APPROPRIATE ADULTS FOR  
VULNERABLE ADULTS DETAINED OR INTERVIEWED BY POLICE

*CHRIS BATH*

# Background

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- **2014:** Home Secretary: “lack of AA provision for adult suspects”, commissions research
- **2015:** *There to Help* report considers data from 2012/13 and 2013/14; finds issues with identification of AA need and AA provision
- **2019:** New report provide update for 2017/18; progress and baseline for evaluating partnership agreement and changes to PACE Code C

# Method

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- Data from 43 territorial police forces, plus BTP
  - How many adult authorised detentions? / how many needed AA?
  - How many adult voluntary interview? / how many needed AA?
- Data from Liaison and Diversion (L&D)
  - How many L&D patients actually had an AA?
- Survey of AA providers
  - Areas covered, hours, funding, AA types, call outs, contract types?

# Results

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RECORDED AA NEED (POLICE DATA)

# PACE Code vulnerability (2017)

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- A police officer **suspects** the person **may**:
  1. have **any disorder** or **disability** of mind (as per MHA 1983); or
  2. because of their mental **state** or **capacity**, they **may** not understand the significance of what is said, of questions or of their replies. (Applies when there is '**any doubt**')

# Actual % of need is uncertain

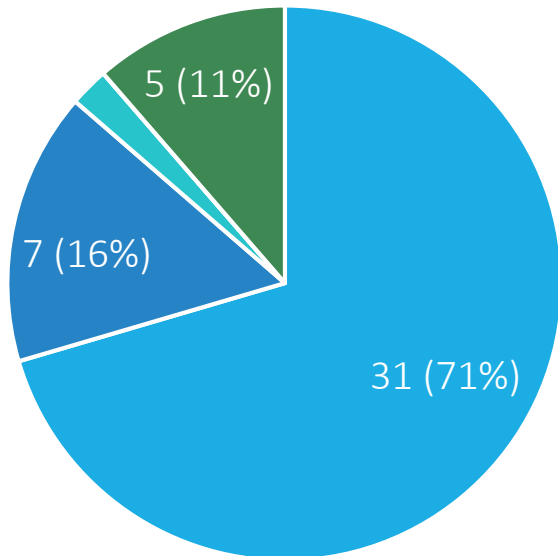
Research	Group description	Prevalence
Gudjonsson et al. (1993) <i>Royal Commission on Criminal Justice</i>	Problems which might interfere with their functioning or coping ability during police interviewing	35%
Scott et al. (2006)	Custody records containing evidence of possible mental illness or learning disability as judged by mental health nurses	12%
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%
(Rapley et al. 2011).	Custody records with some medical need (including mental / learning disability) excluding general medical needs and substance misuse	23.8%
McKinnon & Grubin (2013)	Adults in police custody having mental disorders including intellectual disability according to clinical interviews	38.7%



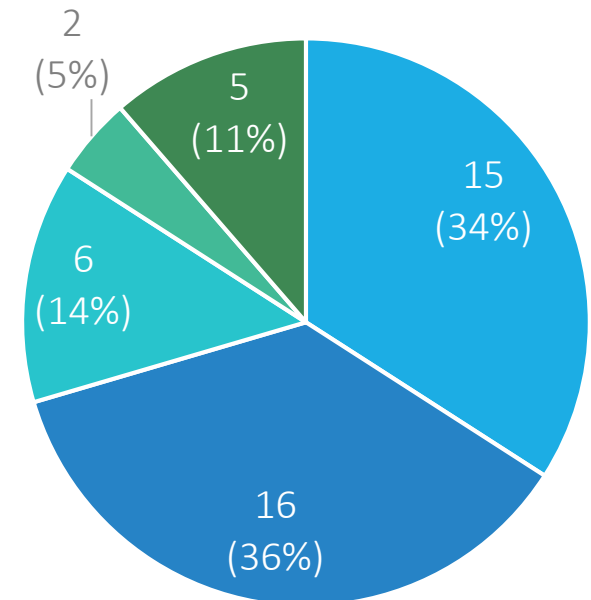
# Custody has better data

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## Custody



## Voluntary interviews

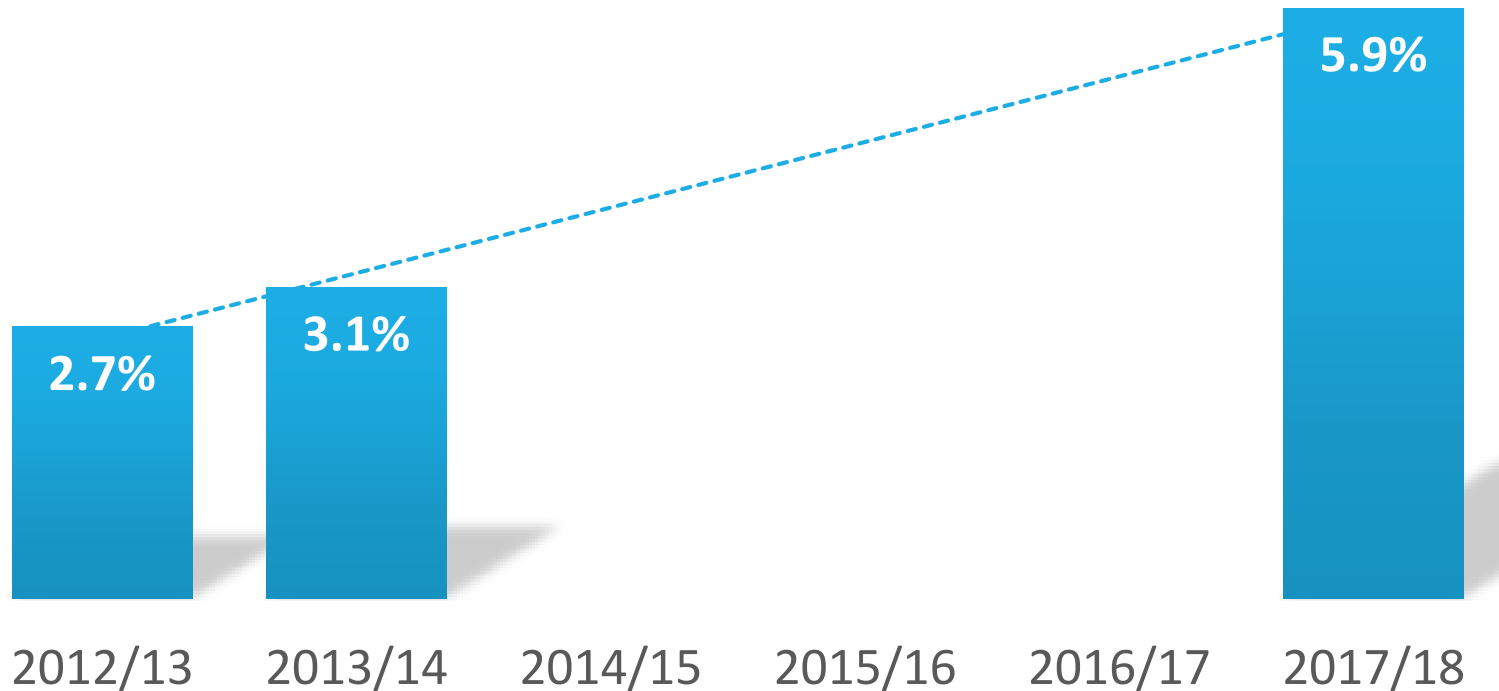


- Information provided
- Not provided (manual search)
- Not provided (not recorded)
- Not provided (technical issue)
- No response

# Custody identification rates up

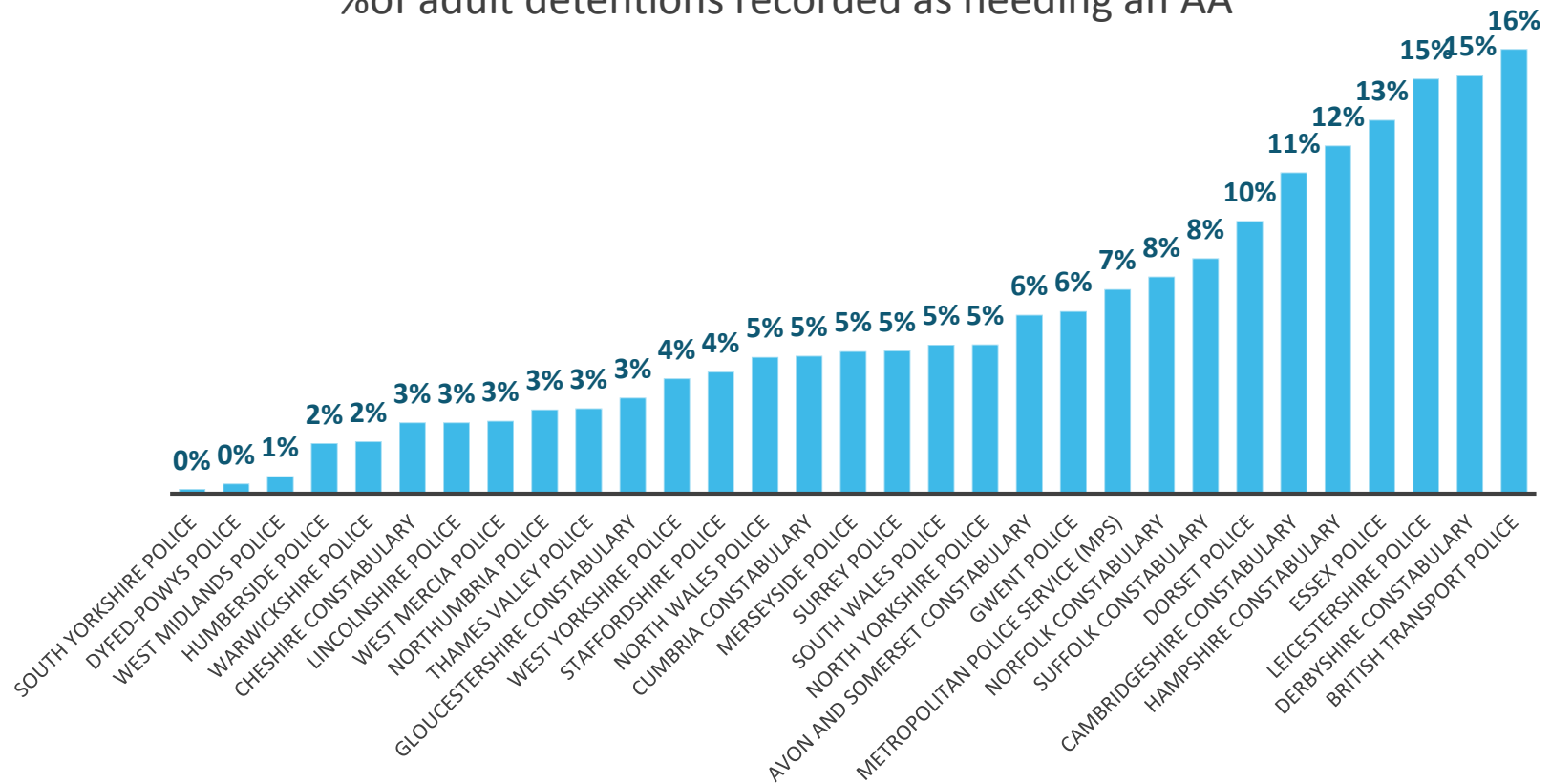
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Proportion of adult detentions recorded as needing AA

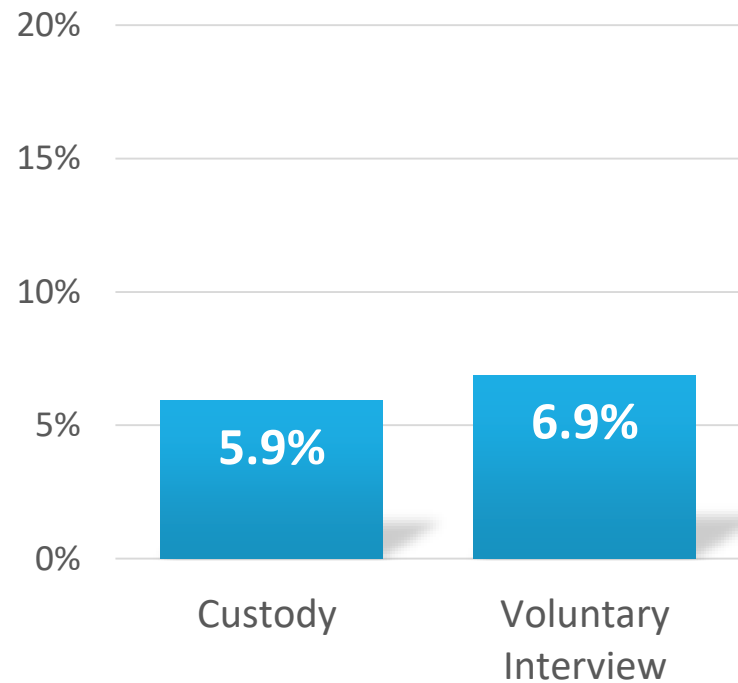
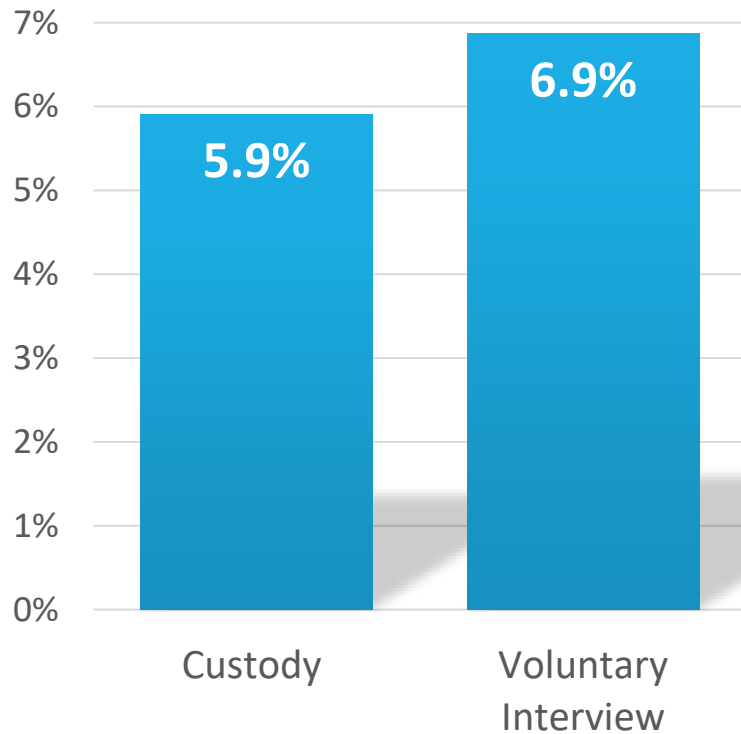


# But rates in custody variable

% of adult detentions recorded as needing an AA



# Higher in voluntary interviews

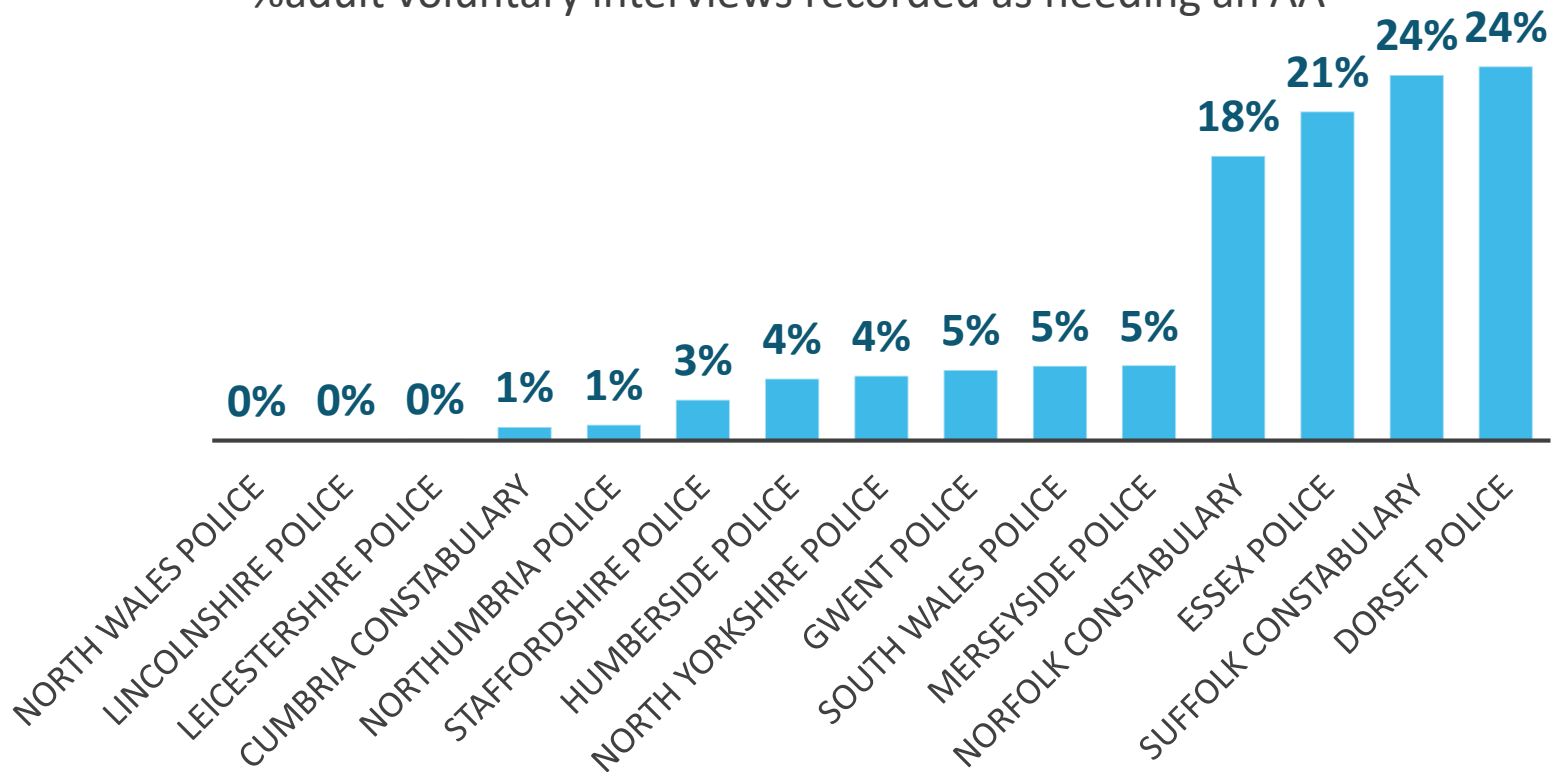


% of adult authorised detentions / voluntary interviews in which need for AA was recorded (2017/18)

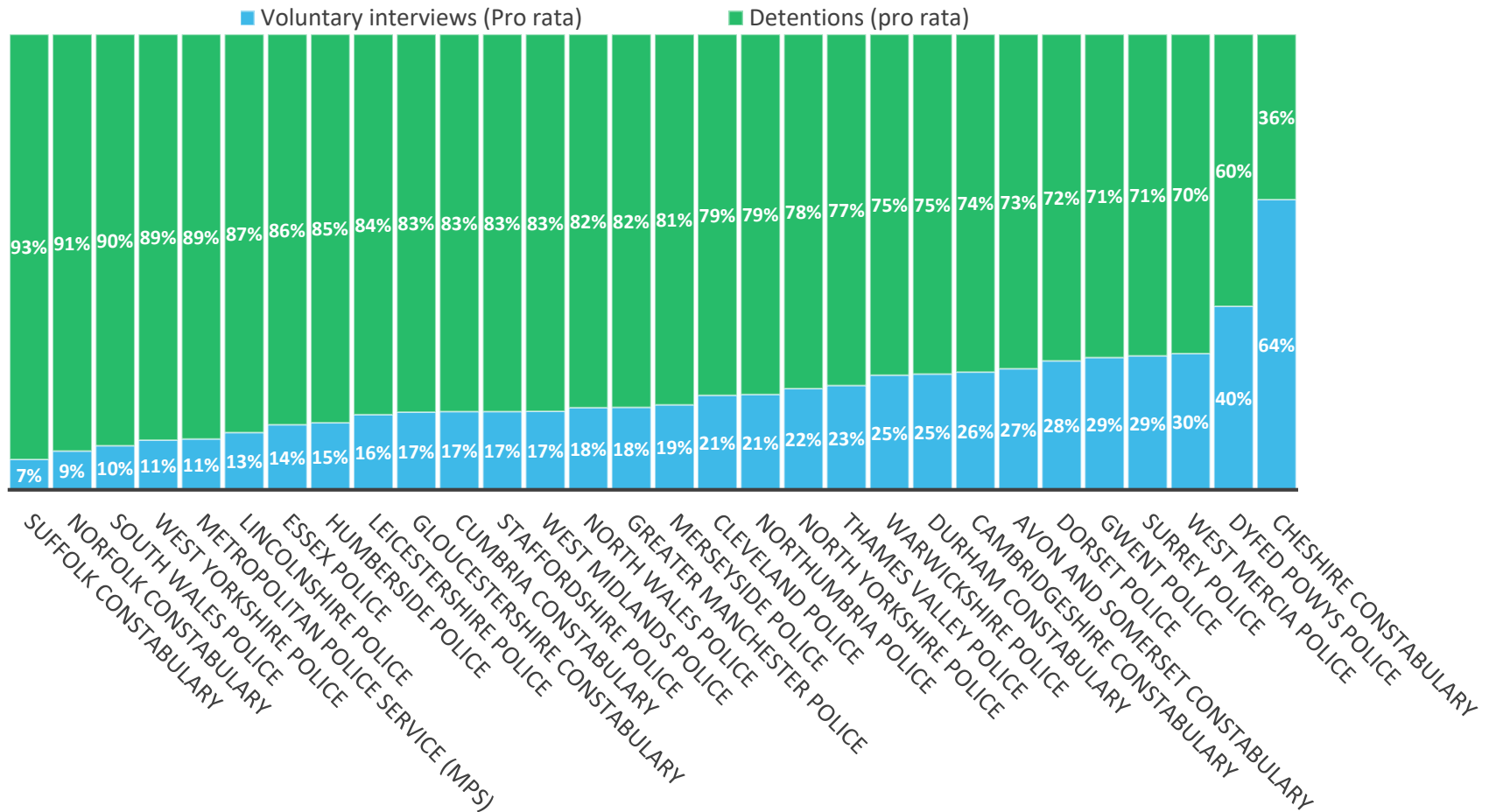
# Variable in voluntary interview

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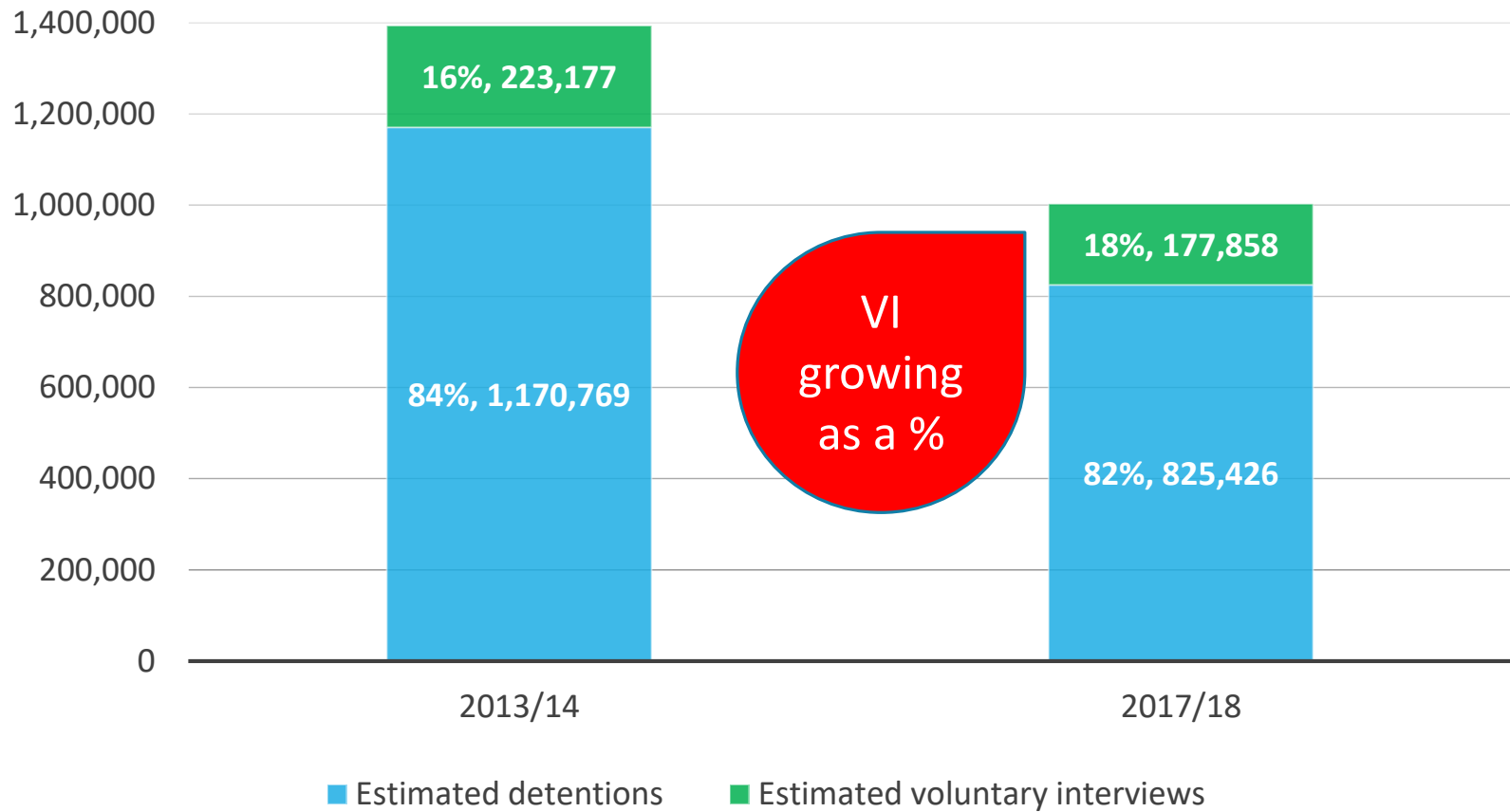
%adult voluntary interviews recorded as needing an AA



# Custody/VI split varies by force



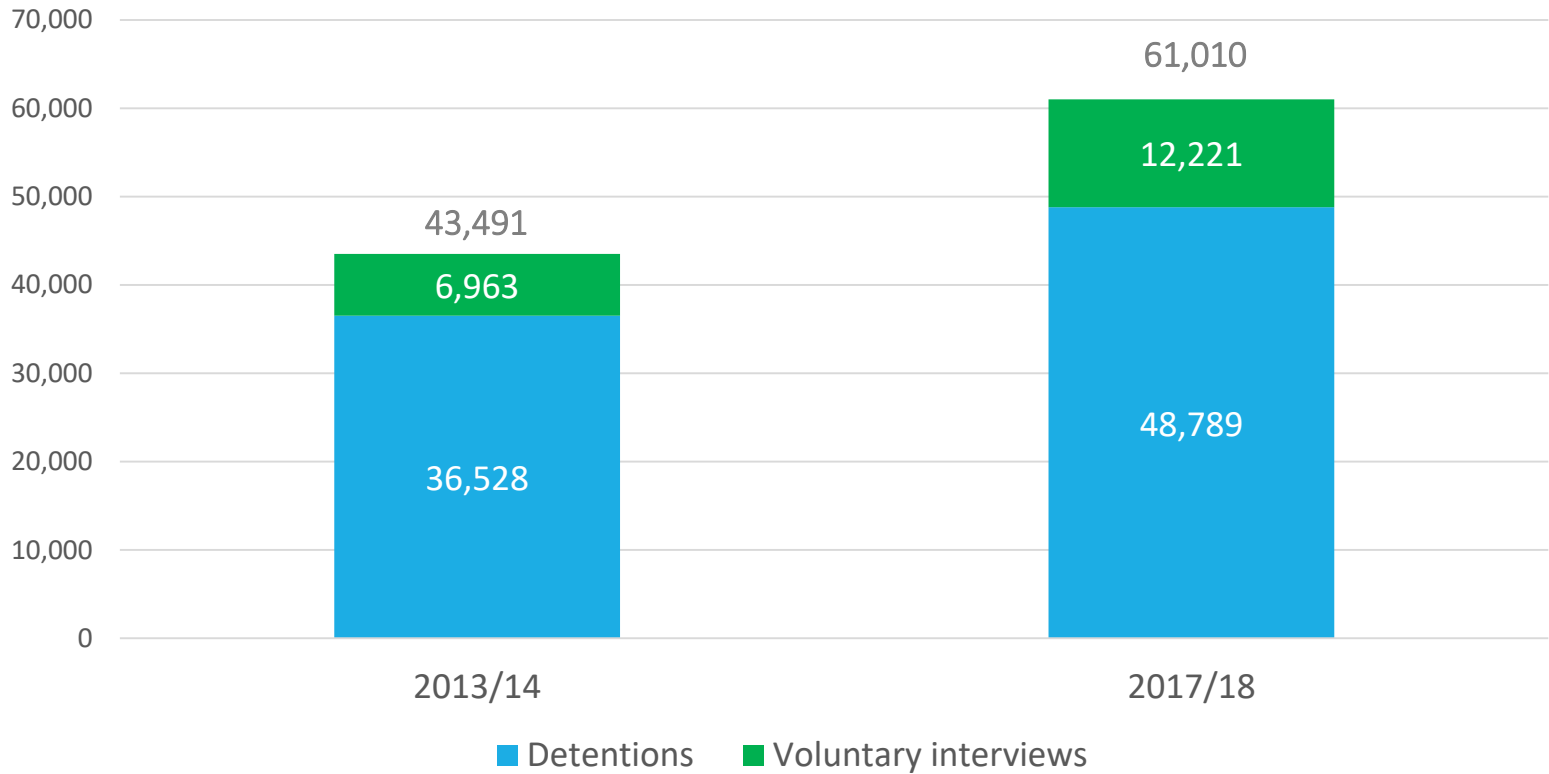
# Fewer detentions & interviews



# Demand volume up due to ID

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Estimated volume of demand for AAs

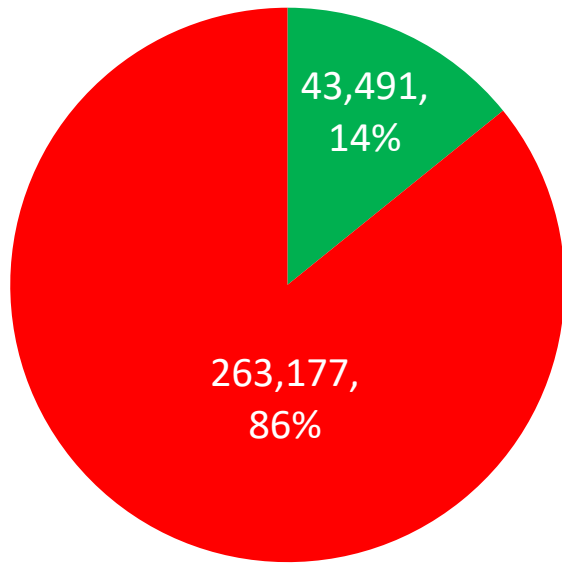




# Unrecorded demand (@22%)

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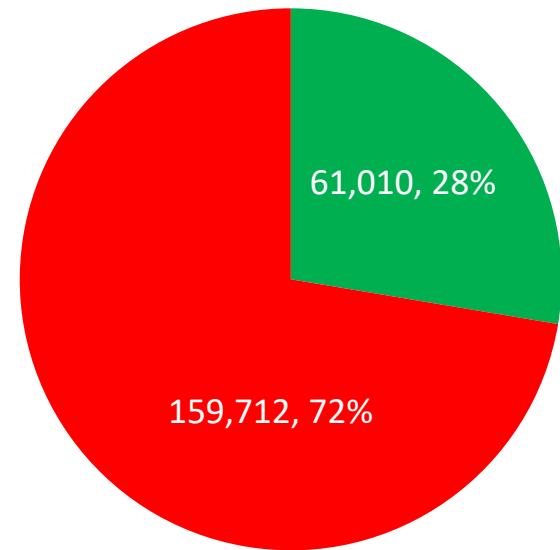
Demand for AAs  
2013/14



- Recorded need
- Unrecorded need

Assumes  
actual rate  
of need of  
22%

Demand for AAs  
2017/18

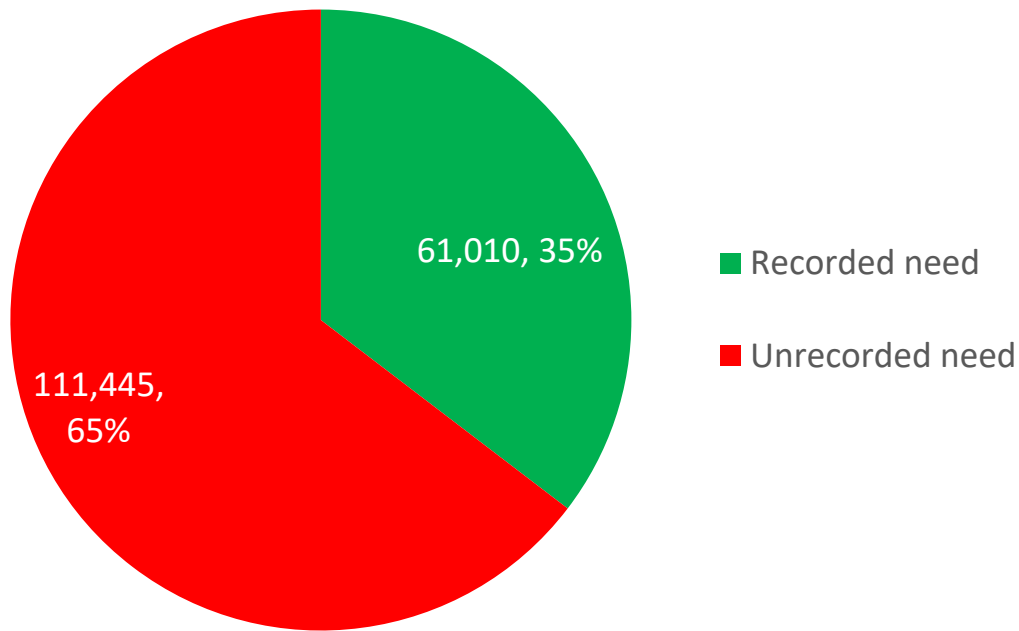


- Recorded need
- Unrecorded need

# Unrecorded demand (forces)

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Demand for AAs 2017/18



AA safeguard would have been applied to over **111,000** more detentions and interviews if all forces had recorded need at the same level as those with the highest rates.

# Results

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RECORDED AA USE (L&D DATA)

# L&D Vulnerability

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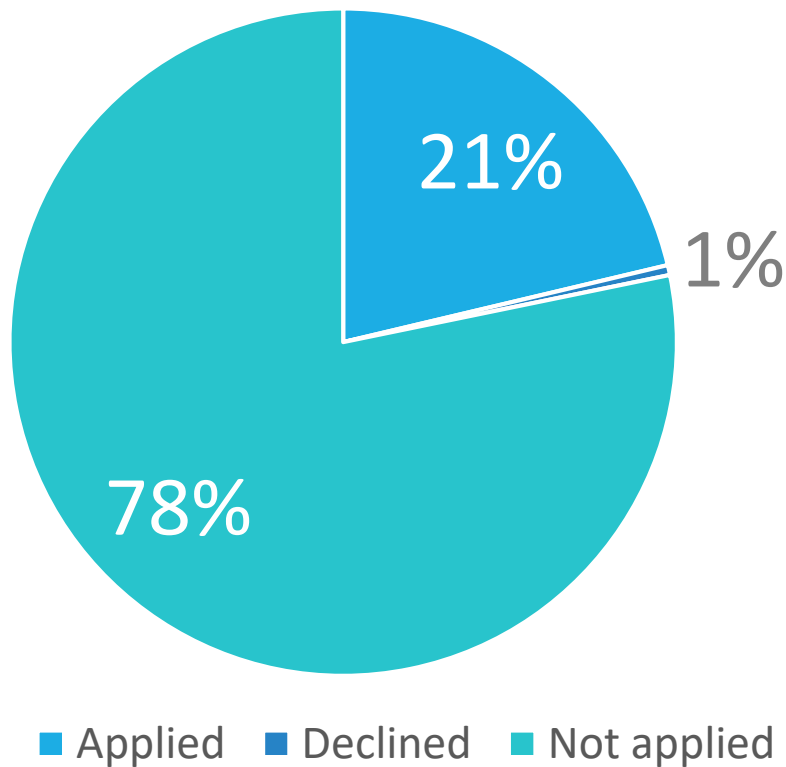
“The service will address the conditions detailed, but not be limited, to those tabulated in the following non-exhaustive list:

- Mental health
- Learning disabilities
- Autistic spectrum
- Substance misuse
- Physical health
- Personality disorder
- Acquired brain injury
- Safeguarding issues.”

# L&D vulnerability ≠ AA

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Application of AAs to L&D patients



- L&D screen and assess people in police custody for mental vulnerability
- 69% of L&D patients had an identified mental health need

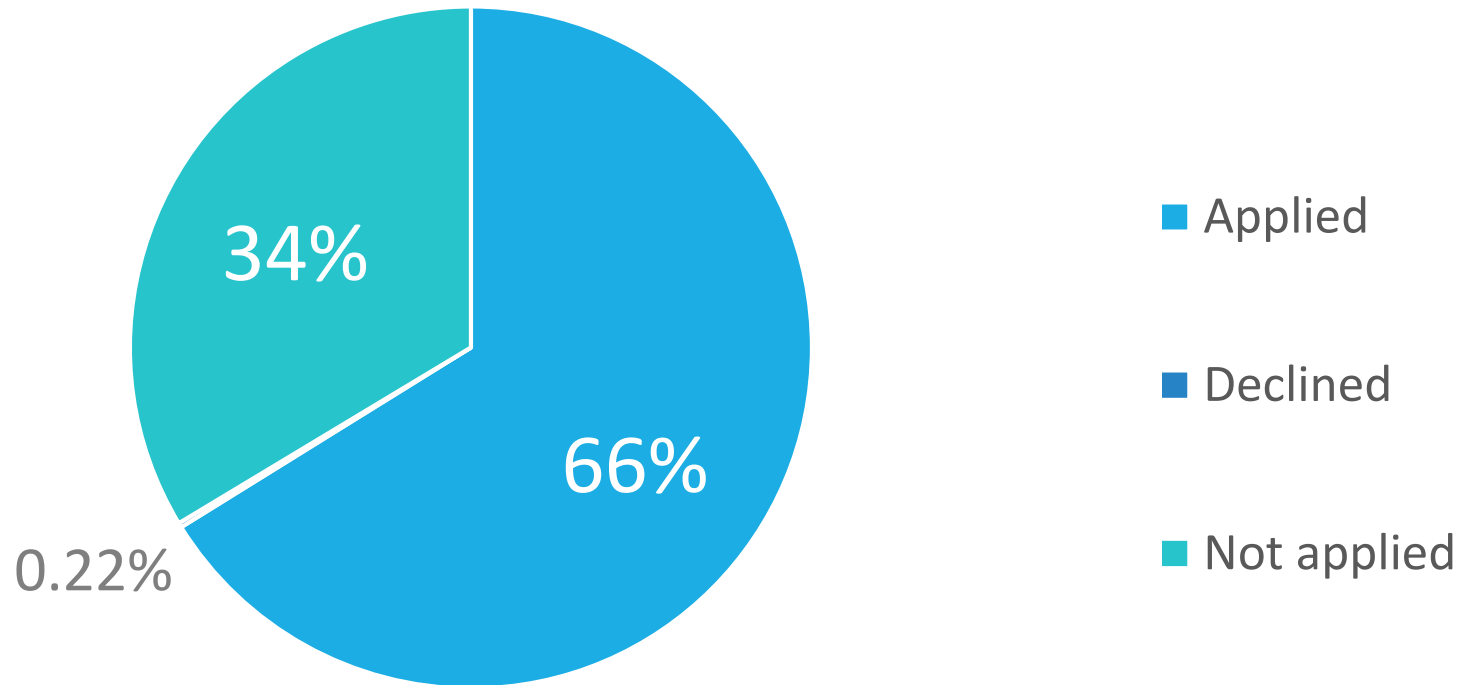
# AA use rates varied locally

<b>Full compliance with PACE Code C 2017</b>	<b>100%</b>	
Sussex	65%	50%
London (Wave 1)	47%	40%
Hampshire	47%	
Norfolk & Suffolk	36%	
Wiltshire	35%	
Avon & Somerset	31%	30%
Cleveland	29%	
Lancashire	28%	
London (Wave 2)	27%	
Northamptonshire	22%	20%
Middlesbrough	20%	
Devon & Cornwall	19%	
Leicestershire	18%	
Nottinghamshire	18%	
Dorset	16%	
Liverpool	16%	
Oxfordshire	14%	
Sheffield	13%	
Durham	13%	10%
Kent & Medway	8%	
Coventry	8%	
Rotherham & Doncaster	7%	
Northumbria	6%	
Black Country	5%	
Sunderland	4%	
South Essex	4%	
Wakefield	2%	
Surrey	1%	
Barnsley	0%	
<b>Average in England as a whole (mean)</b>	<b>21%</b>	
<b>Average across service areas (median)</b>	<b>16%</b>	

# Learning disability $\neq$ AA

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Application of AA safeguard to L&D patients with a learning disability



# Local use (learning disability)

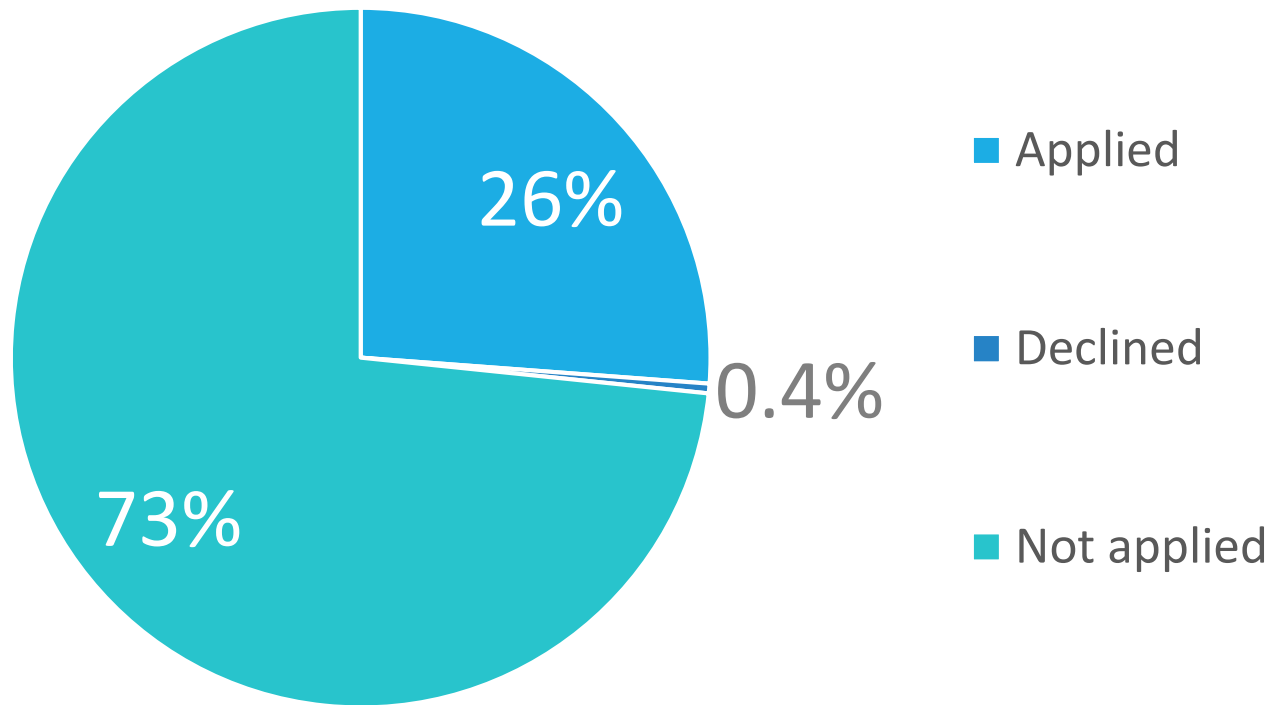
<b>Full compliance with PACE Code C 2017</b>	<b>100%</b>	
Northamptonshire	100%	100%
Sussex	92%	
Nottinghamshire	88%	
London (Wave 1)	86%	
Avon & Somerset	85%	
Devon & Cornwall	82%	
Lancashire	81%	
Middlesbrough	80%	80%
Norfolk & Suffolk	78%	
Hampshire	75%	
Dorset	75%	
Cleveland	73%	
Oxfordshire	67%	
Sheffield	67%	66%
Liverpool	63%	
Kent & Medway	63%	
Wiltshire	60%	
Sunderland	60%	
Leicestershire	56%	
Durham	50%	50%
Coventry	50%	
London (Wave 2)	46%	
Black Country	40%	
South Essex	32%	
Wakefield	20%	
Northumbria	14%	
Surrey	10%	10%
Barnsley	0%	
Rotherham & Doncaster	Unknown	
<b>Average in England as a whole (mean)</b>	<b>66%</b>	
<b>Average across service areas (median)</b>	<b>65%</b>	



# Mental disorder $\neq$ AA

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Application of AA safeguard to L&D patients  
with mental health needs



# Local use (mental health)

<b>Full compliance with PACE Code C 2017</b>	<b>100%</b>	
Sussex	72%	50%
Hampshire	49%	
London (Wave 1)	49%	
Norfolk & Suffolk	44%	
Northamptonshire	40%	40%
Wiltshire	37%	
Cleveland	36%	
Avon & Somerset	34%	
Lancashire	32%	
London (Wave 2)	31%	30%
Middlesbrough	29%	
Liverpool	26%	
Rotherham & Doncaster	25%	
Leicestershire	24%	
Devon & Cornwall	21%	20%
Dorset	19%	
Durham	18%	
Sheffield	17%	
Nottinghamshire	17%	
Oxfordshire	15%	
Coventry	11%	10%
Kent & Medway	9%	
Northumbria	7%	
Sunderland	5%	
Black Country	5%	
South Essex	5%	
Wakefield	2%	
Surrey	1%	
Barnsley	0%	
<b>Average in England as a whole (mean)</b>	<b>26%</b>	
<b>Average across service areas (median)</b>	<b>21%</b>	

# AA use by mental disorder

Diagnosis	% with AA	% of cases	% of MH cases
Acquired brain injury	57%	0.3%	0.4%
Organic disorder	56%	0.3%	0.4%
Dementia	54%	0.2%	0.3%
Schizophrenia or other delusional order	51%	11.9%	17.7%
Bipolar affective disorder	44%	3.2%	4.8%
Attention deficit disorder	39%	2.2%	3.3%
Personality disorder	30%	9.1%	13.5%
Unknown MH Need	25%	3.7%	5.5%
Eating disorder	24%	0.2%	0.2%
Anxiety/phobia/panic disorder/OCD/PTSD	19%	7.6%	11.3%
Depressive illness	15%	24.1%	35.9%
Adjustment disorder/reaction	7%	4.5%	6.7%

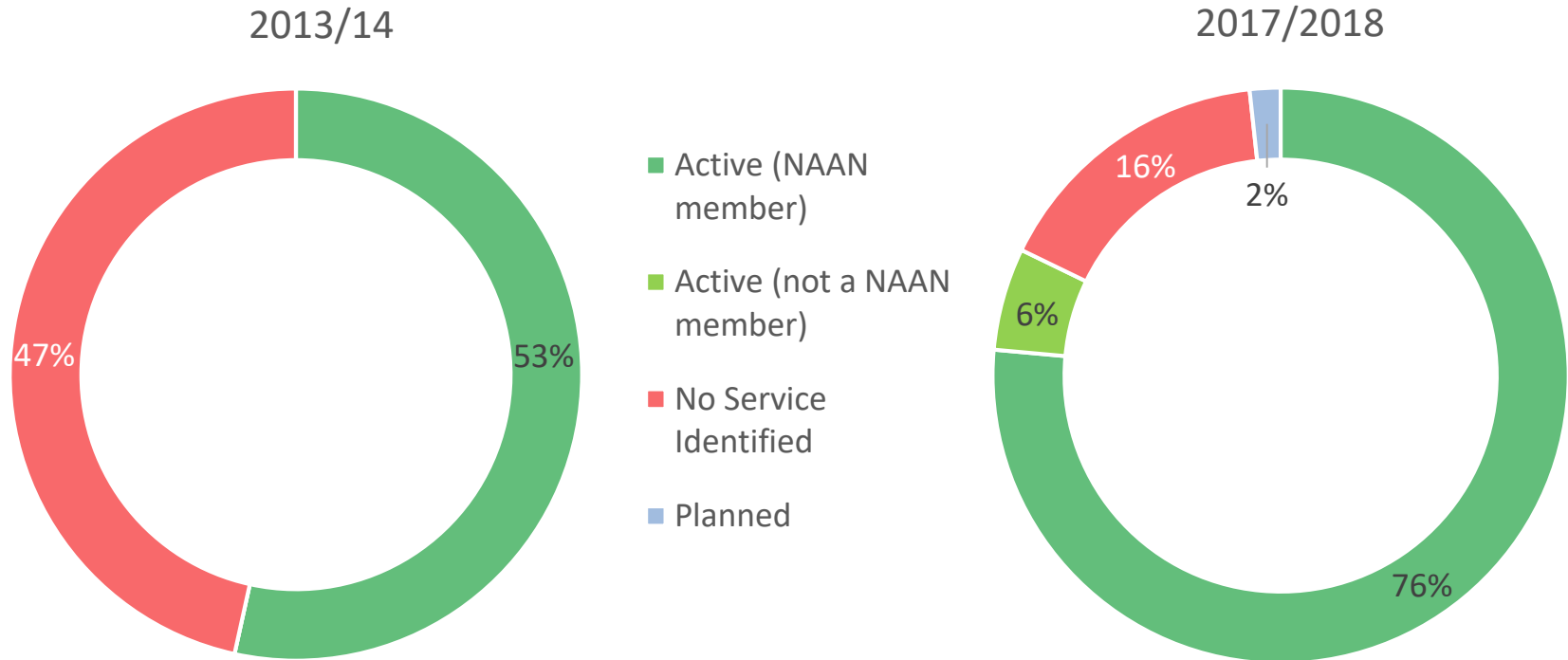
# Results

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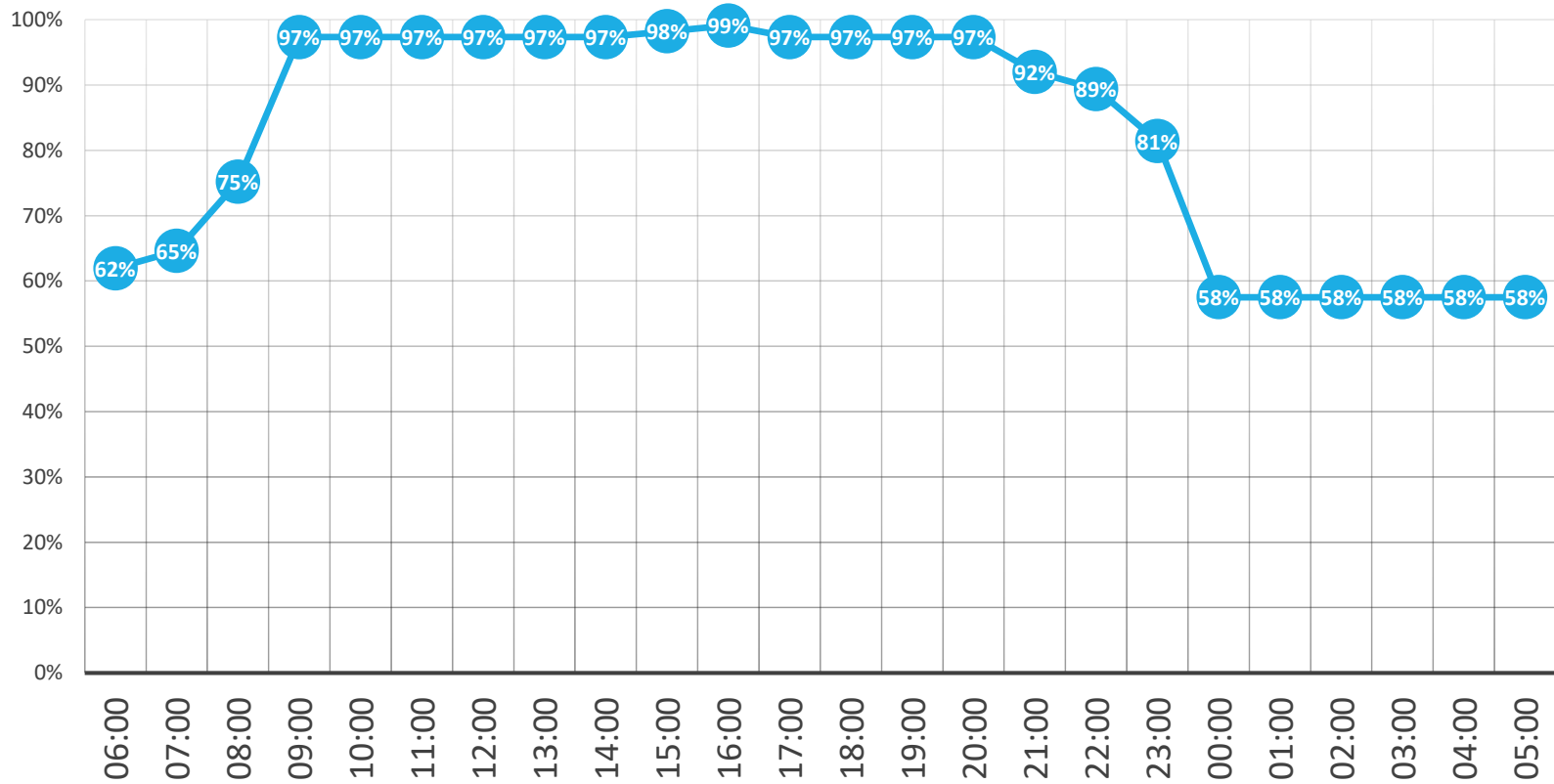
AA PROVISION (SCHEME DATA)

# AA schemes cover more areas

Local authority areas by status of AA scheme for adults



# Operating hours are improving



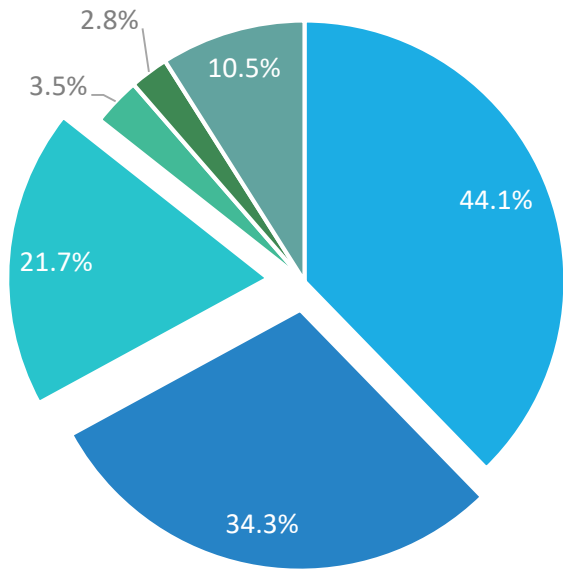
# ...but there are still gaps.

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- 31 (18%) local authority areas had no AA service
- 16% of people lived in an area with no AA service
- 4 (9%) forces have no AA service, 9 (21%) partial

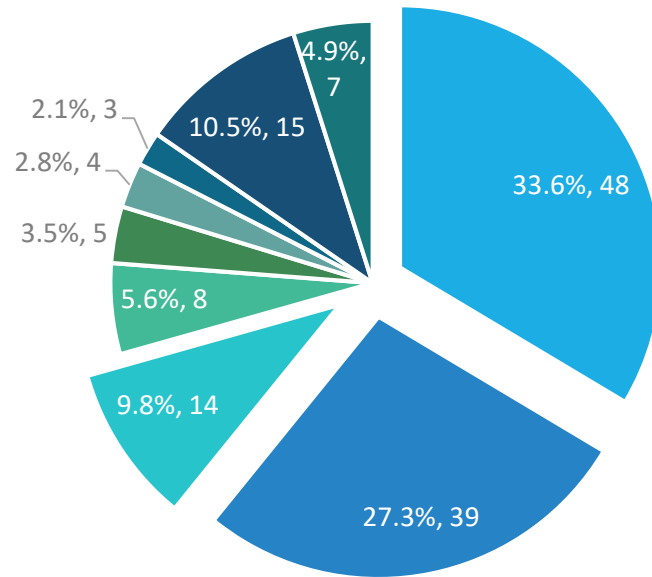
# 'Policing' is most common funder

% of local authorities in which each organisation is a funder



- Local authority involved
- PCC involved
- Police involved
- YOT involved
- NHS involved
- Unknown

% of local authorities by funding arrangement



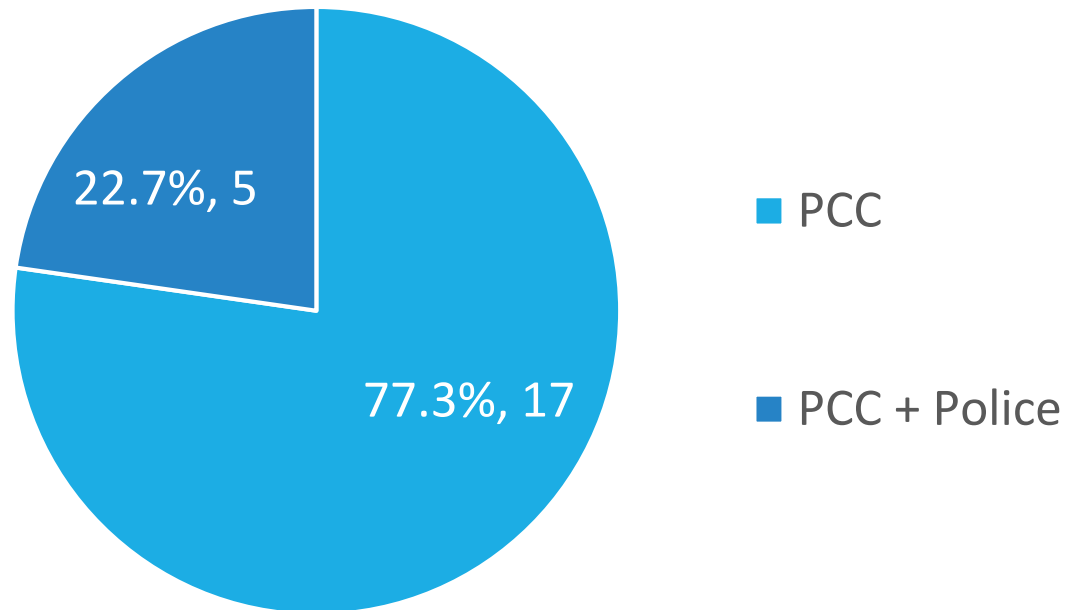
- Local Authority alone
- PCC alone
- Police alone
- Local Authority + Police
- PCC + Police
- Youth Offending Team (alone)
- Local Authority + PCC + Police
- Unknown
- Other arrangement



# Policing funds 100% in Wales

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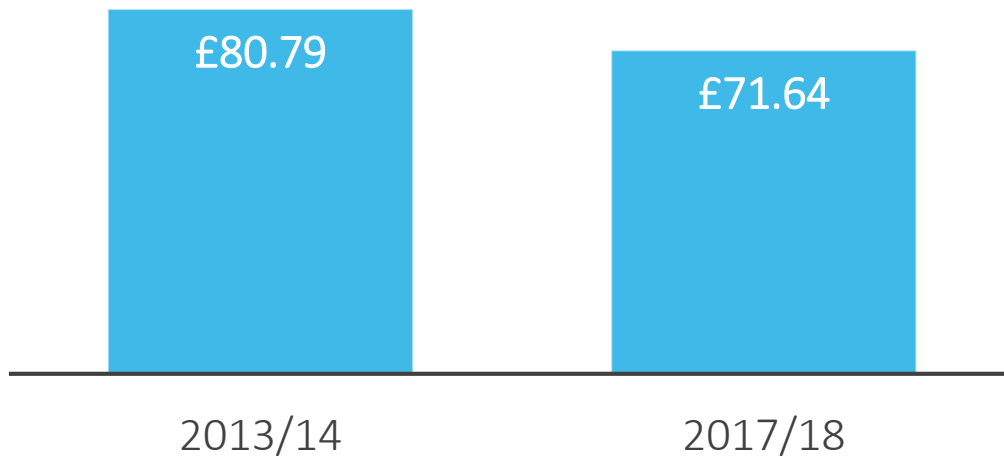
Welsh local authority areas with adult AA provision,  
by funding arrangement



# Funding per call out is down...

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Funding per AA call out



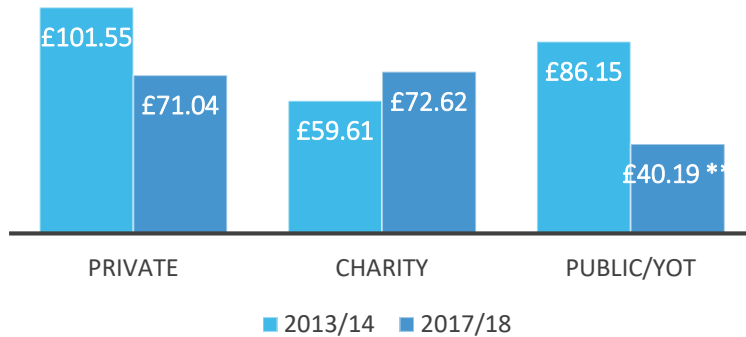
11%  
reduction

Average of  
4p per  
head of  
population

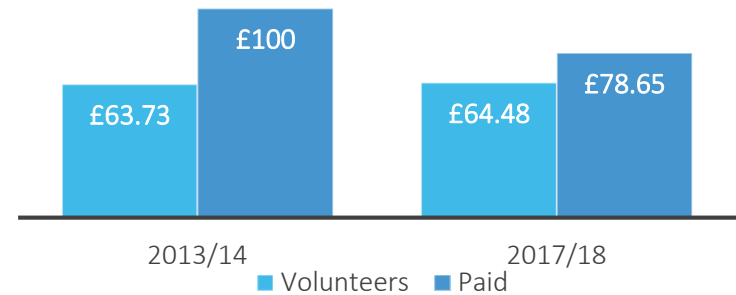
\*One scheme was largely unused by police despite funding it significantly. Removing this reduces average funding to £65.08.  
 \*\* Public/YOT data taken from very small sample and public sector providers have difficulty identifying overhead costs.

# Funding is standardising

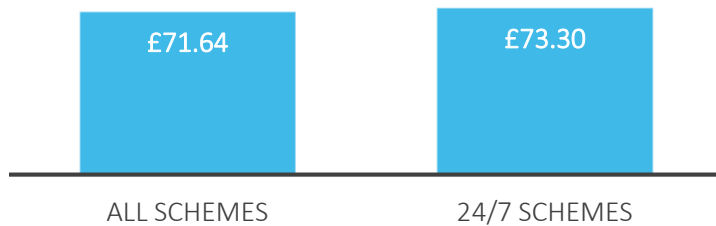
Funding per call out by provider sector



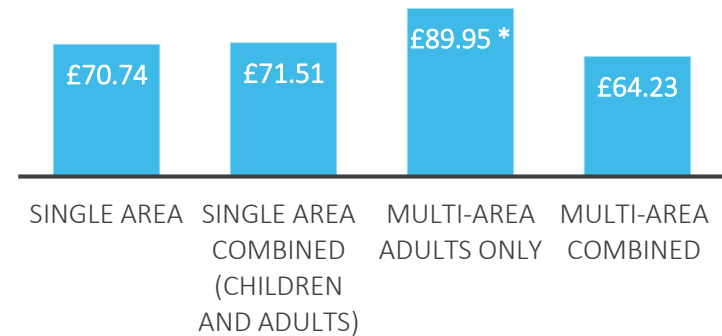
Funding per call out by AA type



Funding per call out by operating hours



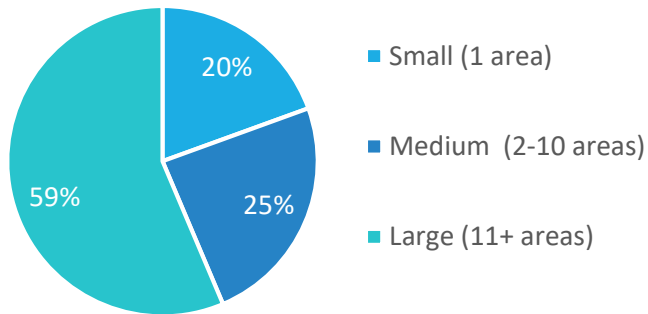
Funding per call out by contract type



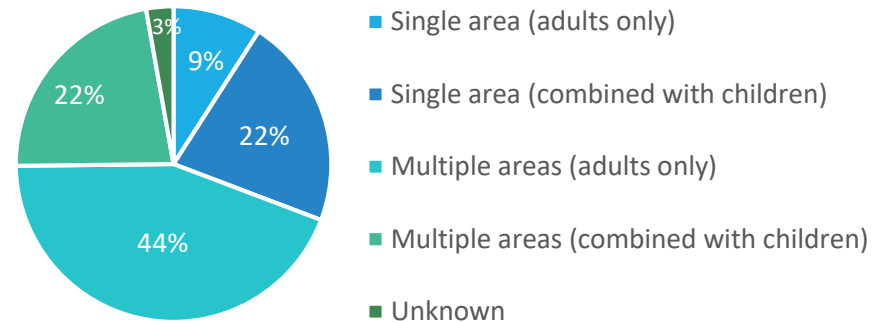
# % of areas with a service by...

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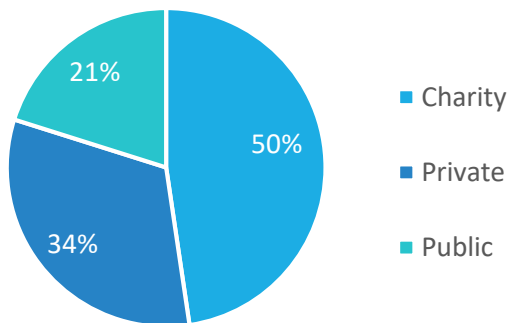
## Provider size



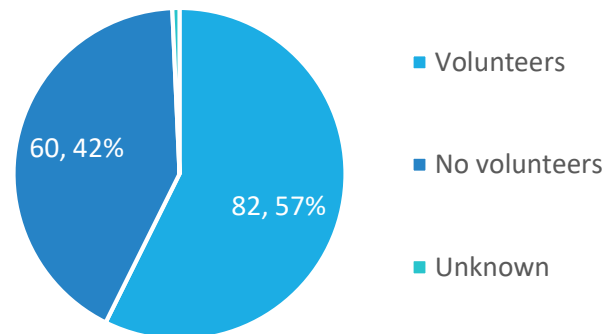
## Contract type



## Provider sector



## AA type



# Results

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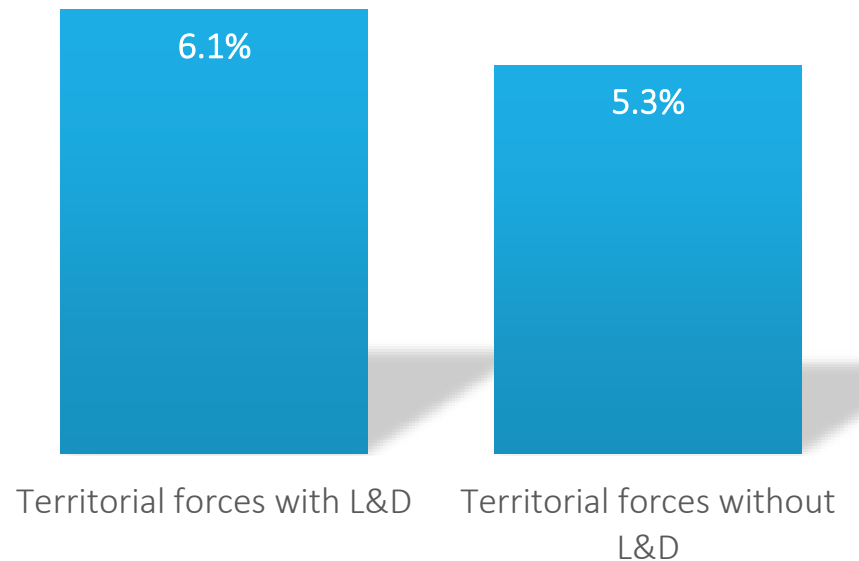
AA DEMAND (COMBINED DATA)

# Impact of Liaison & Diversion

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- L&D has no statistically significant impact on recorded rates of need for AAs

Chart: Average (mean) recorded need for AAs by presence of L&D (2017/18)

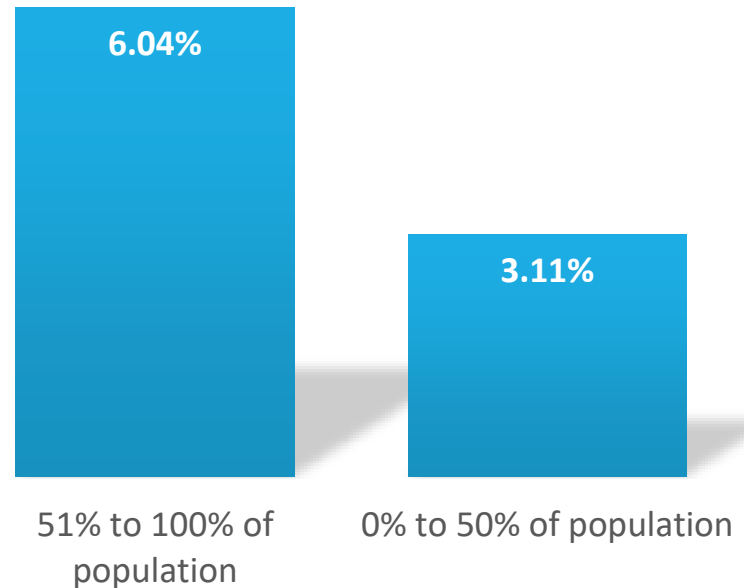


# Impact of AA service (custody)

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- Organised AA provision does have a statistically significant impact
- Half as likely where no provision

Chart: Average (mean) recorded need for AAs 2017/18 by AA provision population coverage

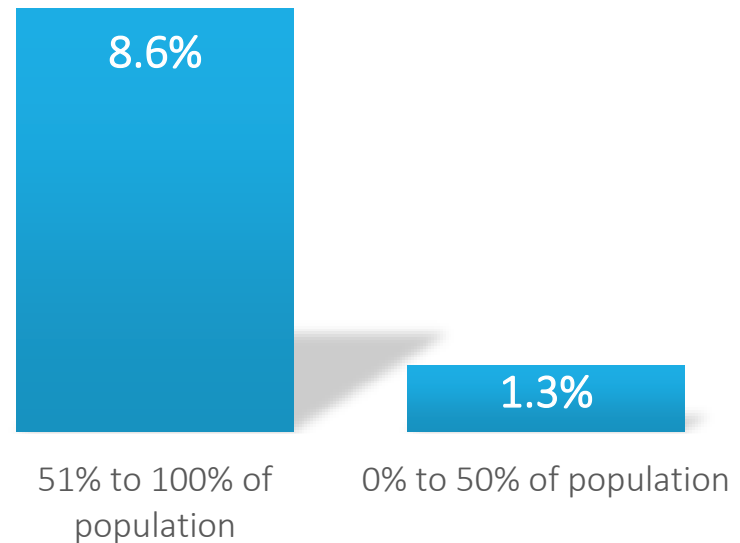


# Impact of AA service (VI)

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- Large apparent difference
- Low number of observations prevents statistical significance

Chart: Average (mean) recorded need for AAs  
Voluntary interviews (2017/18)





# Cost of 100% coverage...

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- At current volumes and Identification rates
- £71.64 per call out (avg. 4 hours)
- Additional **£530k-£575k** p.a. required
- If social workers currently meet one third of this demand = potential **saving of £130k**

# ...and improved identification.

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- £3.5m p.a. (at 11%)
- £7m p.a. based on highest rates currently being recorded by forces
- £10m p.a. (at 22%)
  
- Assumes schemes cover 85% of detention and 66% of voluntary interview need for adults.

# Recommendations

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ACHIEVING FURTHER PROGRESS

# Improve data

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1. Officers can quickly and simply record and retrieve reliable data on the need for, application of, and source of AAs; cross-referenced with equality data
2. Share data with Heads of Custody & Criminal Justice, OPCC, commissioners and providers.
3. NPCC could collate and share annually;
4. Share best practice

# Improve identification

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5. Develop evidence base for new definition
6. Evidence-based national screening tool for criminal justice risks
7. Increase awareness of criminal justice risks
8. L&D induction training on PACE vulnerability
9. L&D screening by L&D (not police) and done prior to voluntary interviews

# Improve provision

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10. Create funded statutory duty on local authorities to ensure provision;
11. Provide programme funding without a statutory duty under agreed framework
12. Hold AAs to account via health and social care inspectorates/regulators
13. Promote AA National Standards (2018)

# Questions

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QUESTIONS ARISING FROM THE RESEARCH

# Questions on recorded need

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- Why do recorded rates vary so much?
- Why might rates be higher in VI?
- Are forces with high rates of need in VI actively diverting vulnerable suspects from custody? At what stage? How?
- Why are some so different in custody vs VI?
- What is the 'right' rate of recorded need?
- What impact will Code C revisions have?
- Why is the custody/VI split so variable?



# Questions on AA use

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- Why is improved identification via L&D not impacting on AA call outs? Why do so few L&D patients get an AA?
- Why does it vary so much locally?
- Why are more prevalent disorders less likely to attract the AA safeguard?
- What is the basis (and consequence) of vulnerable suspects being given the power to 'decline' a procedural safeguard?

# Questions on AA provision

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- How sustainable is the recent growth in AA scheme coverage?
- How can necessary funding be secured for areas without AA provision?
- What are the implications of:
  - AAs being entirely / majority funded by police?
  - Market changes: More commissioning, Larger contract areas, larger providers, fewer volunteers, increasing standards/accountability