Mental health and fair trial

A Report by JUSTICE

Chair of the Committee
Sir David Latham

Established in 1957 by a group of leading jurists, JUSTICE is an all-party law reform and human rights organisation working to strengthen the justice system – administrative, civil and criminal – in the United Kingdom. We are a membership organisation, composed largely of legal professionals, ranging from law students to the senior judiciary.

Our vision is of fair, accessible and efficient legal processes, in which the individual's rights are protected, and which reflect the country's international reputation for upholding and promoting the rule of law. To this end:

- We carry out research and analysis to generate, develop and evaluate ideas for law reform, drawing on the experience and insights of our members.
- We intervene in superior domestic and international courts, sharing our legal research, analysis and arguments to promote strong and effective judgments.
- We promote a better understanding of the fair administration of justice among political decision-makers and public servants.
- We bring people together to discuss critical issues relating to the justice system, and to provide a thoughtful legal framework to inform policy debate.

59 Carter Lane, London EC4V 5AQ
www.justice.org.uk

THE WORKING PARTY

Sir David Latham (Chair)

Jodie Blackstock (rapporteur)

John Briant

Insp Michael Brown OBE

Anthony Burton CBE

Zoë Chapman (rapporteur)

Professor Nigel Eastman

Julia Krish

Dr Eileen Vizard

Jan Jones, Registered Intermediary

HHJ Sean Enright

Natasha Lloyd-Owen

Carolyn Taylor

Dr Kulvinder Manik

Jennifer McDermott

Kris Venkatasami, Deputy Chief Crown Prosecutor

Please note that the views expressed in this report are those of the Working Party members alone, and do not reflect the views of the organisations or institutions to which they belong.

CONTENTS

EXECUTIVE SUMMARY

The prevalence of people with mental health conditions and learning disabilities within our criminal justice system is a longstanding concern. Though overrepresented in police custody and prison, these individuals are not always identified, nor is the system designed with them in mind. From first contact with the police through to disposal, there remain fundamental problems with our response to mental health. If these are not addressed, the fair trial rights of many defendants may be undermined.

The Working Party adopted a broad definition of "vulnerability." Our recommendations apply to persons of all ages who can be considered to have any impairment that may have caused them to commit potentially criminal conduct, and/or which may affect their ability to effectively participate in the criminal justice process. This includes neurological as well as psychiatric conditions, which may fluctuate over time. These conditions make people vulnerable to criminal justice processes and require appropriate consideration.

The broad, overarching theme of this report is that vulnerable people must be properly identified and given such support and reasonable adjustments as will enable effective participation in their defence or, if appropriate, not be prosecuted. Those diverted from prosecution or prison should receive suitable and effective treatment to ensure that they remain outside of the criminal justice system. The recommendations in our report reflect this goal.

The report contains 52 recommendations across the following aspects of the criminal justice process:

1. The investigative stage
2. Decision as to charge or prosecution
3. Pre-trial and trial hearings
4. Legal capacity tests
5. Disposal and sentencing

The investigative stage

The Working Party was concerned that mental health experts, not police officers, should be identifying vulnerability and that those so identified should have access to proper support. Other recommendations in this chapter include:

- Joint working between police and mental health professionals should be made available nationwide to correctly identify vulnerable suspects and relieve pressures on police time. Arresting officers should be assisted by a "street triage" scheme. Every police force area should also have a mental health lead to liaise with local health services.
- Liaison and Diversion (L&D) practitioners should screen every suspect who comes into custody rather than leaving identification of vulnerability to custody officers. L&D practitioners should assess fitness for interview and recommend reasonable adjustments for suspects.
- Appropriate adults should be re-named. Volunteers should be properly trained and comprehensively available.
- Mandatory legal representation should be given to suspects identified as vulnerable.
- The MoJ Registered Intermediary Scheme must provide intermediaries for defendants and ideally they should be embedded in the police station on a duty scheme basis.

Decision as to charge or prosecution

The Working Party felt that the public interest element of a charging decision requires a better evaluation of vulnerability. As such, cases where vulnerability is an issue should be flagged, which will be easier with the introduction of the Common Platform. Other recommendations in this chapter include:

- A specialist prosecutor who has received mental health awareness training should be created for each Crown Prosecution Service area and this prosecutor must make the charging decision in cases of vulnerability, assisted by up-to-date guidance.
- Detailed consideration should be given to the establishment of a mental health diversion panel to assist specialist prosecutors once the evidential threshold has been passed on whether diversion to a suitable support programme would be an appropriate outcome for the case.

Pre-trial and trial stage

Trial processes can be bewildering and incomprehensible for those with mental ill-health and learning disabilities. Recommendations here include:

- Where a defendant is vulnerable, online and virtual procedures are inappropriate and in court hearings will be necessary.
- Magistrates' courts, youth courts and the Crown Court should have a dedicated mental health judge with enhanced case management powers and with responsibility for a case progression protocol.
- Intermediaries should be embedded in courts through a duty scheme. A regulatory body with training obligations should be established.

Legal capacity tests

The Law Commission has written extensively on the reform of three legal capacity tests: fitness to plead, insanity and diminished responsibility. We largely adopt their recommendations.

- We agree with the Law Commission that there should be a capacity based test of fitness to plead and fitness to stand trial, placed on a statutory footing and available in all courts.
- We also agree with the Law Commission that the insanity defence should be amended to a defence of 'not criminally responsible by reason of a recognised medical condition' available in all courts.
- Further review is needed of the available defences where mental capacity is in issue, for example taking into account the difference between *substantial* and *total* lack of capacity.

Disposal and sentencing

As with the investigative stage, some recommendations in this chapter concern better cooperation – for example, information sharing about the offender and the offence must be shared with the Mental Health Tribunal in relevant cases, to enable appropriate decisions on discharge to be made. Other recommendations include:

- We agree with the Law Commission that the range of disposals available where a defendant lacks capacity must be broadened. We are concerned about the powers that should be available on a breach of an order, a complex and difficult question where someone lacks capacity.
- Decisions on disposal and sentence of vulnerable people should ideally be reserved to the dedicated judge, but at a minimum to judges that have undertaken mental health training.
- A Sentencing Guideline on mental health and vulnerability should be created.

Fundamental to effective outcomes for those with mental health concerns is an integrated criminal justice and mental health sector, which can assess, treat and support those who need this. L&D has the potential to significantly improve our approach to mental health in the criminal justice system, and must be supported by effective and appropriate treatment programmes.

I. INTRODUCTION

For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.[1]

1.1 The problem presented by those with mental ill health and learning disabilities has bedevilled the legal systems of almost every country for centuries. To what extent does the law have to take into account a person's mental capacity, mental health, and mental development when determining the legal consequences of their actions; and to what extent should the system accommodate their ability to participate effectively and fairly in its procedures? We have been asked by JUSTICE to consider the way the criminal justice system in England[2] approaches these issues, in the context of upholding a person's right to a fair trial. The overriding principle that we have adopted is that both the law and its procedures should be designed to ensure that those who have any vulnerability by reason of their mental health or capacity do not suffer, discrimination, unfair criminalisation or unfair punishment, so far as possible within the limits of ensuring public safety.

The scale of the problem

1.2 Around one in four adults in the UK are diagnosed with a mental illness during their lifetime and many more will experience changes in their mental well-

[1] A report from the independent Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, (February 2016), available at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[2] Most of our recommendations are relevant to all four UK nations, but due to the distinct legal and medical jurisdictions we focus here on the practice in England.

being.[3] It is estimated that in England in 2015 there were 1,087,100 people with learning disabilities.[4] Nearly two million adults were in contact with specialist mental health and learning disability services at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all.[5]

1.3 The available evidence suggests that people in the criminal justice system are far more likely to suffer from mental health problems than the general population. Most of the statistics quoted in research and policy papers are based on a comprehensive study published in 1998, which estimated that 90% of the prison population had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence).[6] However, this was a broad definition and the data is now 20 years out of date.

1.4 More recent evidence is available but it is partial. For example, when prisoners are screened on arrival at prison, 23% report that they have had some prior contact with mental health services. This data is unlikely to be complete.[7] The National Institute for Health and Care Excellence states that an estimated 39% of people detained in police custody[8] and an estimated 29% of those serving community sentences,[9] have a mental health issue. Seven per cent of the prison population is thought to have a learning disability,[10] compared with 2% of the general population.[11] Specifically, NICE states that around 60% of prisoners

---

[3] National Audit Office, *Mental Health in Prisons*, HC 42, Session 2017-19, (29 June 2017), available at https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf p. 13.

[4] Public Health England, Learning Disabilities Observatory: People with learning disabilities in England 2015: Main report, (November 2016), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/613182/PWLDIE_2015_main_report_NB090517.pdf

[5] Mental Health Taskforce, *supra*, p. 8.

[6] N. Singleton *et al*, *Psychiatric morbidity among prisoners in England and Wales*, (ONS, 1998).

[7] National Audit Office, *supra*. p. 13.

[8] NICE, Mental health of adults in contact with the criminal justice system, NICE Guideline 66, (March 2017), available at https://www.nice.org.uk/guidance/ng66/evidence/full-guideline-pdf-4419120205, p. 17.

[9] *Ibid* p. 17.

[10] Prison Reform Trust, *Fair Access to Justice? Support for vulnerable defendants in the criminal courts*, (2012), p. 10, available at www.prisonreformtrust.org.uk/Portals/0/Documents/FairAccesstoJustice.pdf

[11] NICE Guideline 66 *supra*, p. 17.

have personality disorders, compared to 5% of the general population; 11% of those serving community sentences have psychotic disorders compared to 1% of the general population; and 76% of female and 40% of male remand prisoners have a common mental health disorder.[12] The National Appropriate Adult Network estimates that between 11-22% of arrested adults are mentally vulnerable and require the assistance of an appropriate adult, and on the data available, there appears to be a significant under identification of need amongst police forces.[13] Many children who offend have mental health, behavioural or learning difficulties, and often these conditions have gone undiagnosed. These problems can be at the root of a child's offending, and frequently are a barrier to engagement or progress in education.[14]

1.5 There is little up-to-date information concerning the number of people with mental health issues at each stage of the criminal justice system, and the range of their illnesses or disabilities. This has made being accurate about the scale of the problem in our work difficult. In March 2017 NICE recommended that research should be undertaken to determine the prevalence of mental health and associated social problems for those in contact with the criminal justice system. We agree. We consider that accurate reporting should be required of the police and courts on the number of people identified as having a vulnerability in the criminal justice system, what that vulnerability is and at what stage of the process. This would help services to respond accurately to the needs of these individuals.

---

[12] NICE Guideline 66 *supra*, p. 17. Although statistics are not routinely captured, it is thought that somewhere between 3.5–7% of prisoners are veterans, with strong evidence pointing towards complex mental health problems, such as PTSD, and dual diagnosis being a factor. The percentage rises to 13% of High Security and Category B prisoners, which indicates that veteran offending is more serious. As we have also recognised, improving mental health assessment and the training of individuals carrying out the assessment; increased data sharing; integrated mental health and criminal justice care pathways; and placing leadership with the NHS, could reduce veteran offending and imprisonment, Community Innovations Enterprise LLP, *From Gate to Gate: improving the mental health and criminal justice pathways for veterans and family members*, (2016), available at http://www.ciellp.com/wpress/wp-content/uploads/2016/09/From-Gate-to-Gate-8th-September-2016A.pdf)

[13] NAAN, *There to help: Ensuring provision of appropriate adults for mentally vulnerable adults detained or interviewed by police* (2015), available at http://www.appropriateadult.org.uk/images/pdf/2015_theretohelp.pdf

[14] C. Taylor, *Review of the Youth Justice System in England and Wales*, (MoJ, 2016), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577103/youth-justice-review-final-report.pdf p. 2. A 2005 study found 31% of 150 young offenders assessed had a mental health need. R. Harrington, et. al. *Mental health needs and effectiveness of provision for young offenders in custody and in the community* (Youth Justice Board for England and Wales, 2005), available at http://www.mac-uk.org/wped/wp-content/uploads/2013/03/Youth-Justice-Board-MentalHealthNeeds-of-Young-Offenders.pdf

1.6 The greater prevalence of mental ill health and learning disabilities of those in contact with the criminal justice system points to a failing to appropriately address their concerns by the public sector at large. Ultimately it suggests that vulnerable people are being criminalised rather than given the support and treatment that they need.

1.7 In 2009 Lord Bradley reported following his review of mental health in the criminal justice system.[15] The review followed a series of reports over many years to attempt to address this problem. The Reed Report[16] recommended a properly resourced court assessment and diversion scheme as early as 1992 and subsequent focus on the mental health of prisoners enabled the NHS to become engaged with addressing prisoner needs.[17] The Bradley Report made key recommendations for the integration of criminal justice and mental health services, starting from identification in children and young people in educational establishments, through to NHS commissioned healthcare in police custody, training for all professionals in the criminal justice system on mental health and learning disabilities, increased availability and use of mental health treatment requirements, and a greatly improved approach in prison. The recommendation that has achieved the most success is the liaison and diversion programme that is currently being rolled out by NHS England in police custody and the courts.[18]

If we are not to repeat the mistakes of the past few years, as exemplified by the rather uncoordinated approach to the implementation of liaison and diversion services, it will be vital to ensure that there is a clear, visible, national focus on this agenda that transcends all the traditional governmental and organisational boundaries. My review has been a starting point for this, by providing an independent focus for discussion on many of the issues in relation to mental

---

[15] The Bradley Report, *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, April 2009, available at http://webarchive.nationalarchives.gov.uk/20130123195930/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

[16] The Reed Report, *Review of health and social services for mentally disordered offenders and others requiring similar services*, (Department of Health and Home Office, 1992).

[17] Such as: HM Inspectorate of Prisons, *Patient or Prisoner?* (1996); Department of Health, *The future organisation of prison healthcare*, (1999); HM Inspectorate of Prisons, *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs* (2007); The Corston Report: *A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system* (Home Office, 2007).

[18] An executive summary of Lord Bradley's recommendations is available here http://webarchive.nationalarchives.gov.uk/20130123195930/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

health, learning disabilities and offending, and generating an enthusiasm and momentum among stakeholders to drive this agenda forward.[19]

1.8 However, eight years on, there are still significant problems with the way mental health is identified and approached across all public services including the criminal justice system. Healthcare and local authority services must take their share of the responsibility for dealing with vulnerable members of the public who are experiencing mental health crisis. Just as resource issues are a root cause of the current problems, they are also the stumbling blocks for any proposed reforms. The schemes referenced in this report offer examples of how this effort is already underway, and are encouraging. This approach needs to be part of a nationwide effort, underpinned by national standards and targets, to avoid the postcode lottery that people currently find themselves in.

1.9 The NHS Five Year Forward View recognises this and aims to improve physical and mental health care,[20] and the Mental Health Taskforce to NHS England Five Year Forward View for Mental Health sets out recommendations to achieve parity of esteem between mental and physical health.[21] The Taskforce recommends that Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.[22] The recommendations have been accepted by NHS England, which recognises that the aim to improve mental health and wellbeing cannot solely be achieved by the NHS, but must be delivered in partnership with other local organisations including local government, housing, education, employment and the voluntary sector.[23]

1.10 Increased NHS funding is necessary to enable it to provide the resources needed to properly support vulnerable individuals. Yet increased NHS resources would result in major savings for the Police, courts and prisons. Although hard to quantify, the Liaison and Diversion (L&D) Full Business Case to Treasury

---

[19] The Bradley Report *supra* p 124.

[20] NHS, *Five Year Forward View* (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[21] *Ibid*.

[22] *Ibid*, p 35.

[23] NHS England, *Implementing the Five Year Forward View for Mental Health*, available at https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

identifies potential savings,[24] which could be extremely significant.[25] If these savings are then utilised correctly in the criminal justice system, we consider that all the recommendations we make in this report are entirely achievable. Significant additional funding has now been committed to enable L&D to be realised.[26]

Definition

1.11 In this report we aim to include all persons, of all ages, who can be considered to have a mental or physical impairment of any kind that may have caused them to commit potentially criminal conduct, and/or which may affect their capacity to effectively participate in the criminal justice process, i.e. to follow the process and make decisions about their defence. This includes mental ill health and learning disability as well as recognising the somewhat artificial divide between neurological (physical) and psychiatric (mental) conditions (for example: stroke, dementia, Parkinson's, deafness, muteness compared to anxiety, personality disorder or schizophrenia), both of which can lead to cognitive, and therefore mental capacity, impairment. It also includes the many cases in which there will be overlap between these conditions, and the dual diagnosis of mental health concerns and chronic substance misuse. Mental health vulnerabilities can be missed because of the lack of awareness that they are frequently associated with learning disability and Autistic Spectrum Disorder. One vulnerability does not exclude the other. In fact, co-occurrence of several disorders at the same time is the norm with complex cases. This is particularly important to understand when assessing children and young people, whose developmental immaturity causes difficulty for the identification of underlying mental health conditions. Another important aspect to consider is that these conditions can fluctuate and

[24] The Case applies the assumption that there will be further development of the wider integrated health and justice pathways, which will enable criminal justice system providers to utilise information gleaned through the provision of earlier information regarding an individual's mental health. For example, diversion through a non-court disposal could result in non-cashable savings of between £1,150 and £2,050 per case (taking into account court and CPS costs), and a possible non-cashable saving of £5,800 where a six month prison sentence (of which three months would be served) is replaced by a community order with a treatment requirement to address the underlying health issues.

[25] Given that there were 1,528,880 receipts into the Magistrates' court in 2016, and assuming an average saving of £2,000 per diverted case, if 10% of receipts had been diverted, £3.5m would have been saved across the criminal justice system; were this 20% of receipts, £6.1m would have been saved; and were this 30% of receipts, £9.1m would have been saved. Reduction in the use of psychiatric reports where L&D services can provide this function will save further court time and expert costs.

[26] NHS England, *supra*.

be exacerbated by contact with the criminal justice system, requiring continued assessment.[27]

1.12 The Mental Health Act 1983 uses the term 'mental disorder', defining it as "any disorder or disability of the mind."[28] The Mental Capacity Act 2005 focusses on activities rather than conditions, and states that "a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."[29] Special measures are available for witnesses pursuant to the Youth Justice and Criminal Evidence Act 1999, s. 16 where a person suffers from mental disorder or otherwise has a significant impairment of intelligence and social functioning. None of these terms is useful in finding a sufficiently broad definition.

1.13 However, the Police and Criminal Evidence Act 1984 (PACE) Codes of Practice and Criminal Procedure Rules adopt the phrase "vulnerable' to refer to the same range of features that we intend to include. While some are concerned that to use the term "vulnerable" diminishes the agency of the individuals involved, "vulnerable", allows us to include under its umbrella, all those persons who require support when they come into contact with the criminal justice system. Without such support, they are vulnerable to being swept along in processes they do not understand, and vulnerable to succumbing to pressures within the system, that those without such vulnerabilities may not. Moreover, L&D services have adopted the term, which indicates that its meaning is understood across all healthcare and criminal justice agencies. We therefore adopt the term throughout this report.

International obligations

1.14 In drafting this report we have been mindful of the UK's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD), to which it

---

[27] For example, "someone who has manic depression may have a temporary manic phase which causes them to lack capacity to make financial decisions, leading them to get into debt even though at other times they are perfectly able to manage their money. A person with a psychotic illness may have delusions that affect their capacity to make decisions at certain times but disappear at others. Temporary factors may also affect someone's ability to make decisions. Examples include acute illness, severe pain, the effect of medication, or distress after a death or shock": see Department for Constitutional Affairs, Mental Capacity Act 2005: Code of Practice, (TSO, 2007), paras 4.26- 4.30 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

[28] Mental Health Act 1983, section 1(2).

[29] Mental Capacity Act 2005, section 2(1).

is a party, and the first General Comment of the CRPD Committee, on the article 12 CRPD right to equal recognition before the law.[30] The General Comment has revealed a tension between two international human rights approaches. The Committee advocates a human rights model to ensure equality before the law for people with disabilities. This departs in some significant ways from the methods adopted to prevent violation of the right to a fair trial in many jurisdictions, including the UK, pursuant to article 6 of the European Convention on Human Rights (ECHR). We are concerned that, although the aims of the Committee – to ensure no one is treated discriminatorily in any setting merely due to a physical or 'psychosocial' disability – are laudable, the general guidance in some important respects fundamentally conflicts with the justifications underpinning the criminal justice process.

1.15 There are a number of key places where these conflicts arise:

- The Committee specifically rejects the premise that perceived or actual deficits in mental capacity justify the denial of legal capacity, as well as the use of discriminatory labels such as "unsoundness of mind" to accomplish the same end. Likewise, an expert meeting held in 2015 concluded that the concept of fitness to plead is itself discriminatory and should be eliminated,[31] as article 13 CRPD requires that states ensure effective access to justice for persons with disabilities.[32]
- The Committee argues for supported decision-making, including providing information in a more understandable format or the designation of trusted support persons to assist suspect/defendants in exercising their legal capacity. Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual and decisions must be made on their behalf, they should be made while keeping the "best interpretation of their will and preferences" in mind, as opposed to substituting the "best interests" of the person. The expert meeting recognised that there is a lack of practical guidance for how supported decision-making and the "best interpretation" standard should be implemented. In discussions with the Human Rights and

[30] UN Committee on the Rights of Persons with Disabilities, 'General Comment No. 1' (11 April 2014) UN Doc CRPD/C/GC/1 [13]. The CRPD further requires that state parties ensure effective access to justice through the provision of appropriate procedural accommodations in articles 12(3) and 13.

[31] OHCHR, 'Expert meeting on deprivation of liberty of persons with disabilities: Background note' (9 September 2015).

[32] The expert meeting recommended the development of impairment-neutral defences, but did not provide any examples or guidance on how those could be developed. It is also unclear whether the goal would still be to exempt persons with impairments from criminal responsibility, or to better incorporate them into the existing system.

Disability Advisor to the OHCHR, when we suggested the gap between the aspirations of this goal and practice, it was clarified that any determination on the will and preferences of a person must be an "informed, deductive decision."

- The Committee rejects detention and diversion without criminal conviction as arbitrary and discriminatory. The expert meeting recognised the primary functions of criminal justice systems as being to repair the victim and society as a whole and deterring future crimes. However, the International Criminal Court, the UN Mechanism for International Criminal Tribunals, and the UN General Assembly's Standard Minimum Rules for the Treatment of Prisoners and for Non-custodial Measures[33] also recognise the importance of rehabilitation and incapacitation. While some of the Committee's recommendations make sense in civil matters, by its nature, the criminal justice system is compulsory and coercive.
- Although the Human Rights and Disability Advisor considered that it might be possible under the Convention to accept that in some cases diversion to a hospital or community treatment may be necessary, the criminal justice system should review the progress of the treatment, thereby maintaining a criminal justice response.

1.16 We recognise the observations of the Committee, the expert's meeting and the Human Rights and Disability Advisor that in many cases, with appropriate support, people should be able to fully take part in proceedings irrespective of their disability and that every effort should be made to ensure a person's equal access to justice and fair participation in their trial. We also accept that consent to treatment is essential, should be fully explained and supported, and every effort should be made to determine and follow the will and preferences of the person.

1.17 However, it seems to us that the Committee has not fully considered the realities of the criminal justice process, where prosecution must be justified in the public interest, taking into account the capacity and culpability of the suspected offender. Without considering this fundamental justification for coercion of the person by the State, nor the scenarios in which the General Comment would operate in practice, it is difficult to see how these requirements can or should be complied with in every case.

1.18 We find it inconceivable that, applying human rights principles, it would be acceptable to try someone who has no insight into the legal wrong they are alleged

[33] UN General Assembly, *United Nations Standard Minimum Rules for Non-Custodial Measures (The Tokyo Rules) : resolution / adopted by the General Assembly*, 2 April 1991, A/RES/45/110 available at http://www.ohchr.org/Documents/ProfessionalInterest/tokyorules.pdf

to have committed and no ability to instruct their legal team on the circumstances of the offence or the evidence against them. Struggling with the same issue, the Law Commission took the view that fitness to plead proceedings could continue, subject to adequate safeguards, the defendant's will being respected wherever possible, and any restrictions on liberty applying for the shortest time possible. In these circumstances it did not consider that the procedure would necessarily be incompatible with the CRPD.[34]

1.19 Therefore, where the current approach of the CRPD Committee would create results that are perverse to what we consider to be the CRPD's intention, i.e. where we believe that the person would in fact be indirectly criminalised and discriminated against for having a disability, we must depart from its guidance. We believe that the approach used in this report meets the overarching aims of the CRPD.

Our approach

1.20 In this report we trace the criminal justice pathway from the point a suspect is approached by the police through arrest and police custody or voluntary interview, to charging decision, to trial, and disposal. We have not considered the effectiveness of imprisonment, hospital detention or community orders due to the already broad scope of our enquiry, and the fact that other organisations are better equipped to address these issues than we, as a volunteer working party, could ever hope to.[35]

1.21 The broad theme of our work has been to ensure that vulnerability is properly identified, and where identified, properly approached so that the person either receives reasonable adjustments to give them the capacity to effectively participate in their defence, or if appropriate, is not prosecuted. As Lord Bradley and others have identified, this requires the criminal justice and health systems to work together. Where a person is diverted from prosecution or prison, suitable and effective treatment and support must be available to ensure that the person remains outside of the criminal justice system. We make recommendations throughout the report to achieve these aims. A list of our recommendations is set out in the concluding chapter. The organisations and individuals that have assisted us in understanding the complexities of this area are acknowledged in the final chapter.

---

[34] Law Commission, Unfitness to Plead (Law Com No 364, 2016) para 3.176.

[35] See for example the Prison Reform Trust's work on mental health care in prisons, available at http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth

Views of people in the criminal justice system

1.22 Another important issue that the UN Committee on the Rights of Persons with Disabilities identifies is that the participation of people with disabilities in the reform of laws that will have a particular impact on their lives is necessary for the legitimacy of the reforms. The Mental Health Taskforce spoke to 20,000 people in developing its recommendations to NHS England and the L&D operating model requires services to involve "service users" in their governance processes.[36]

1.23 While for this report we have not spoken directly with vulnerable individuals, we have made every effort to consider their experiences in our work, through conversations with those that represent their views and provide support services. Throughout the report we refer to examples from our own cases and other sources of suspect, defendant and offender views on their experiences that have informed our recommendations. One of our members is also a legal expert with personal experience of mental health problems.

[36] Offender Health Collaborative, *Liaison and Diversion Manager and Practitioner Resources: Service User Involvement*, (August 2015), available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-06.pdf

II. THE INVESTIGATIVE STAGE

I was driving at a roundabout and had a milkshake in my hand. A police car indicated to me to stop… I told the police I had Asperger syndrome and asked if I could get a friend [to] help me… explain myself, but they did not seem to understand the condition and I was told that I couldn't… I became very nervous and tried to get away… When they tried to put the handcuffs on me… I felt anxious and so the situation worsened. They shoved me into a van. I felt so scared that I [bit] an officer… [M]y friend tried to explain my disability but the police didn't understand… When the [the doctor] arrived they didn't have any knowledge of Asperger syndrome either. I felt I was being treated as if I were mad… I was allowed home, but… [t]he situation was very unclear and no one has explained it to me. Helena[37]

A policing intervention

2.1 Cuts to healthcare services nationwide mean that the Police are very often relied on to fill gaps in mental health service provision, acting as first responders when it comes to individuals experiencing mental health crisis, even where there is no suggestion of criminality.[38] The sheer volume of calls and call-outs[39] to the Police (and other emergency services) from vulnerable people places enormous time and resource pressures on the police service when it is experiencing funding cuts,[40] and places vulnerable people at risk of criminalisation and denial of the medical attention they require.[41]

---

[37] The National Autistic Society, *Autism: a guide for criminal justice professionals* (2011), p.11.

[38] Section 136(1) Mental Health Act 1983 grants the Police the power to detain a person they find in a public place if they appear to be suffering from mental disorder and to be in immediate need of care or control, and if it is necessary in the interests of that person or for the protection of others, to take them to a "place of safety" within the meaning of section 135.

[39] Commander Christine Jones, who was until recently the National Police Chiefs' Council lead for Mental Health, informed us that in 2015/16 the Metropolitan Police Service (the Met) logged approximately 100,000 adult individuals as vulnerable applying the 'ABCDE' test – the vulnerability assessment framework used by first responders - who could not then be directed to suitable services because they did not exist. In fact, local authorities will not even accept this information in relation to adults, only children, again, as a result of cuts to funding.

[40] In 2010, there was an 18% reduction in the budget for police. This has resulted in a fall in police officers from 144,353 in 2009, to 122,859 in 2016, A. Travis, 'Simple numbers tell story of police cuts under Theresa May', *The Guardian*, (5 June 17). Additionally, budgets are not being increased to match inflation, leading to claims by the Met that by 2021, it will face a cut in real terms of £400m, BBC, 'Reality Check: is the Met Police facing £400m in cuts?' (21 June 2017). See also the "Cuts Have Consequences" campaign adopted by a number of police federations, https://www.metfed.org.uk/cuts-have-consequences

[41] The total number of uses of section 136 has changed from year to year, but the general trend of uses of police cells has been a significant reduction. (see 'Use of Section 136 of the Mental Health Act 1983

2.2 In 2015, Her Majesty's Chief Inspector of Constabulary (HMIC) conducted a review of the welfare of vulnerable people in police custody,[42] including a review of first point of contact and diversion. Inspectors found clear evidence that custody could have been avoided for a number of vulnerable adults and children had other services been available to support them. Some were in custody because they were a risk to themselves, not because they had committed a crime, which had a detrimental impact on their health and wellbeing. In the six police forces inspected, although there were staff who demonstrated an understanding of the needs of vulnerable people and tried to respond appropriately, time limitations on call handlers (because of the volume of calls received) and the lack of access to information from other agencies such as healthcare services meant that police officers were often responding to vulnerable individuals and making arrest decisions with little background knowledge of the individual's medical history.[43]

2.3 Moreover, for many, the *only* way of potentially accessing mental health services is via the Police.[44] This means that vulnerable people are often obliged to come into contact with the criminal justice system. In some areas of the country, this is something of a gamble. For anyone who does not meet the threshold for detention in a place of safety, the remaining option is custody. In these cases, diversion from first point of contact is vital.[45]

---

in 2015-16 (England and Wales)', available at http://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf

[42] HMIC, *The welfare of vulnerable people in police custody*, (March 2015), available at http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/the-welfare-of-vulnerable-people-in-police-custody.pdf

[43] *Ibid*, p.18.

[44] As is well known, some people deliberately commit offences in order to attract the attention of the Police, in the hope that they will be diverted to a medical care environment. We were given the example of a woman in Hereford who damaged the window of a Co-op supermarket in order to get arrested and then be referred to mental health services. However, she was assessed in custody as not needing to be sectioned and so was prosecuted and incurred a £1000 fine. No mental health care was provided.

[45] A significant proportion of detainees in police cells need not be there, but have been arrested due to mental health concerns rather than alleged offending. This is highlighted in the report of the Right Hon. Dame Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*, January 2017 (published 30 October 2017), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

The Policing and Crime Act 2017 seeks to address this problem by removing the designation of a police cell as a place of safety for children through the insertion of new section 136A into the Mental Health Act 1983. This is a positive step. However, the Act regrettably leaves it to the Secretary of State to create the same provision as regards adults. The Act does limit the use of police custody as a place of safety,

2.4 At the heart of this problem is the fact that too often, vulnerability is mistaken for violence that requires a policing response, rather than a health intervention, even where crime is not in issue.[46] While the appetite for improving mental healthcare provision is growing, there is much to be done, and more recent changes by government have actually made matters worse. Last year, the Mental Health Taskforce found that the mental health strategy implemented by the Coalition government in 2011 has led to "inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives." This was due to challenges with system-wide implementation and an increase in the number of people using mental health services.[47] The report notes that "[m]ental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds" and urges "equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond".[48]

2.5 The focus of this Working Party is how mental health is treated once criminal activity is suspected. Nevertheless, investment in treating crisis with a medical rather than policing response will free up vital policing resources to ensure that crime is appropriately responded to in cases where mental health is a factor.

Identifying mental health needs in suspects of crime

2.6 When a crime is reported to the police and they attend a place where a suspect is located, officers have to exercise their professional judgment as to the appropriate response. This may be difficult where vulnerability is a feature. Police officers should not be required to make assessments as to whether a suspect is vulnerable in the absence of assistance from a qualified clinical professional or prior

---

and guidance has been published to assist officers on how to apply the legislation, see Department of Health, Home Office, *Guidance for the implementation of changes to police powers and places of safety provisions in the Mental Health Act 1983*, October 2017, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656025/Guidance_on_Police_Powers.PDF

[46] *The Five Year Forward View for Mental Health*, *supra*.

[47] *Ibid*, p.4. In 2016, 120 people took their own lives, which is the highest number on record. The number of self-harm incidents, at 40,161, was also the highest on record. Between 2012 and 2014, 70% of those who took their own lives had been identified as having mental health needs, National Audit Office, Mental Health in Prisons, Her Majesty's Prison & Probation Service, NHS England and Public Health England, 29 June 2017, pp.4 and 5, available at: https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf

[48] *Ibid*, p.5.

knowledge of the mental condition of the suspect.[49] The key to appropriate decision making at the scene as we describe hereafter is the ability of officers to access appropriate clinical advice.

2.7 A significant obstacle to the identification of vulnerability by the Police is the lack of information-sharing between the Police and the NHS and, furthermore, between one NHS area and another.[50] Moreover, healthcare in the criminal justice system is increasingly provided by the private sector, creating additional information-sharing barriers.[51] The 2015 HMIC review found that, where available, joint working arrangements with mental health services were successfully diverting people with vulnerabilities away from custody by offering them advice and support. However, in many cases, the responding police officer had no option other than to detain or make an arrest because of a lack of suitable services. On other occasions, this was used as a mechanism to get people the help they needed.[52]

A multi-agency approach

2.8 A number of initiatives have been put in place around the country with the aim of correctly identifying vulnerability in suspects of crime at the street level (in most

[49] Dr Jenny Holmes, the Mental Health Lead for the Faculty of Forensic and Legal Medicine of the Royal College of Physicians, explained that the major problem in her view is that under resourced mental health services are driving demand towards the Police. The widely held belief that the Police need more training misses the real issue. Police officers cannot be trained to be psychiatrists or mental health nurses. They should not be expected to make clinical judgements and there is a blurring of boundaries between health and policing which does not serve vulnerable people well.

[50] Authorised clinical record access is possible through a number of national IT platforms, once the patient and his/her available records are appropriately identified. However, digital GP records and mental health records are usually separate entities. Both should be able to be made readily available in the suspect's/patient's own locality when clinical IT platforms in the CJS-setting match the wider region's IT platforms. Where the suspect is detained out of region, and IT platforms do not match, current clinical records will be more difficult to access. In these circumstances appropriate access will require more investigation and liaising with clinical authorities. It is possible to access information from other NHS areas. For instance, if someone registers as a temporary patient away from their usual area, doctors would require that person to grant them a certain amount of access to their records so that they can treat them safely.

[51] Healthcare for detainees is currently commissioned by police forces. There was a proposal last year that responsibility be taken over by the NHS but this has since been withdrawn for reasons that are unexplained. This means that there is no national body currently responsible for commissioning services and standards, see for example J. Rozenberg, 'False economy on custody,' *Law Gazette*, 16 May 2016, available at https://www.lawgazette.co.uk/analysis/comment-and-opinion/false-economy-on-custody/5055251.article although quality of care is reviewed by the Care Quality Commission

[52] HMIC, *supra*, p.18.

examples, this can be characterised as 'street triage'), as well as relieving the pressure placed on police time and resources by the sheer volume of vulnerable individuals they come into contact with. These schemes offer opportunities to ensure that those individuals are referred to health services where necessary and, where appropriate, not criminalised for their vulnerability. Examples of these are the mental health pathway developed in Cambridgeshire, Leicestershire, and the West Midlands, as well as the sanctuary rooms run by the charity MIND in Cambridgeshire and Peterborough. We provide examples if these in Annex 1.

2.9 What is common to all of these initiatives is that the Police and local NHS commissioners (and in some cases, third sector organisations) are working together to respond to vulnerable individuals, recognising the need to provide a medical response in order to break the cycle of crisis, arrest, and either release with no action taken, or prosecution, which is liable to escalate into offending, or more serious offending behaviour if left unchecked. The schemes are all characterised by effective information-sharing between health services and the Police.[53] A key feature of the schemes is that suitably-trained clinicians are providing immediate advice to police officers, either from the force control room or on the street with the officers, allowing the officers to make medically-informed legal decisions in relation to the suspected criminality of individuals they deal with.[54]

2.10 The significance of this assistance should not be underestimated. Inappropriate policing decisions can put both members of the public and the police officer at risk. A vulnerable person may be subjected to wrongful detention and ill-treatment and the officer may experience an IPCC investigation, which can put their career on hold for years, and may lead to disciplinary action. Inappropriate decisions may also lead to unnecessary criminalisation of individuals who are

[53] For example, in Cambridgeshire, nurses provide First Response cover seven days a week, 24 hours a day, Cambridgeshire and Peterborough NHS Foundation Trust, 'Help in a mental crisis', available at: http://www.cpft.nhs.uk/about-us/mental-health-crisis.htm These initiatives demonstrate that it is possible to undertake effective information-sharing and remain Data Protection Act 1998 compliant. The Data Protection Act permits information to be shared with a police officer in connection with his or her statutory duties.

[54] A Six Month Review of the Integrated Mental Health Team (IMHT) Pilot in Cambridgeshire sought to measure the efficacy of the scheme. Officers taking part in focus groups for the review reported that, while their identification skills had not improved, their confidence in responding to vulnerable individuals had improved considerably. For many, this was because they had access to the nurses' experience, knowledge, advice and guidance. Public Contact staff also commented that an improved level of understanding as a result of access to the IMHT nurses had enabled them to interact with callers better and to realise that they "are ill rather than a nuisance". Those we spoke to when we visited the Force Control Room a number of months later conveyed a similar message. See, Cambridgeshire Continuous Improvement Team, IMHT Pilot, 'Six Month Review (April 1st – September 30th 2016), (Cambridgeshire Constabulary, December 2016), p.14.

in need of better support. For minor offences a medical treatment approach may be the appropriate outcome.[55] The complainant of the crime would need to be informed that this approach is being taken, but we consider that often they would see this as an appropriate response.[56]

2.11 A decision to take no further action should be logged by officers as a 'diversion' for recording purposes. Such cooperation schemes should not be an ad hoc creation of dedicated professionals at a local level, but be available comprehensively and permanently across the country.

2.12 If an officer decides to investigate a suspected offence further, the use of a mental health street triage process can also ensure that a vulnerable suspect is not unnecessarily arrested and detained in custody, which may aggravate their condition.[57] With this advice from the first responder community mental health team, officers will be in a better position to consider a voluntary attendance at the police station or other location for interview, known as a Caution+3, or further assessment of whether even this is appropriate. It might be that an assessment of fitness for interview could be carried out at the suspect's home rather than custody and that reasonable adjustments to help the suspect through the interview process could also be organised ahead. These steps would prevent an overnight stay in a police cell while professionals are found to carry out any relevant assessments.

2.13 If a voluntary interview is pursued, it is important that all the safeguards that we set out below are available to the suspect in the same way as if they were under arrest.[58] The voluntary process must be organised to ensure that this is possible.

---

[55] There is evidence that diversion improves mental health and various international sources show that reoffending either reduces as a result, or that there is no negative impact on reoffending, see M. Parsonage *et al*, *Diversion: A better way for criminal justice and mental health*, (Sainsbury Centre for Mental Health, 2009), at 21-22, available at http://www.ohrn.nhs.uk/resource/policy/DiversionSCMH.pdf

[56] SmartJustice (an alliance of organisations then based at the Prison Reform Trust), in partnership with Victim Support, published the results of a survey undertaken in 2006/7 which asked victims how they thought the criminal justice system should deal with people who commit non-violent crimes. The findings challenged many preconceived views that victims always want penalties to take the form of imprisonment. Instead, it demonstrated that they support a range of measures that they believe are more effective in stopping further offending. The survey showed that seven out of ten victims wanted to see more treatment programmes in the community for offenders suffering from mental health problems, and substance addiction, to tackle the causes of non-violent crime, the Bradley Report, p. 8

[57] Arrest must be necessary pursuant to s. 24(4) PACE.

[58] PACE Code C, para 3.12 sets out that these same safeguards apply and proposed amendments to the Code currently being consulted upon would reinforce this, see Draft Revised Code C, 25th October 2017, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654530/2017_CodeC-ToC_tracked_-17-10-18_GOVUK__2_.docx

This is particularly important when alleged offences occur in a hospital setting, where interviews are always voluntary, yet the identification of vulnerability is not followed with the support of an appropriate adult, legal representative or other assessment of the suspect's needs.

Custody

2.14 If police officers decide that it is necessary to arrest someone and take them into custody, it is the responsibility of the custody sergeant to conclude, with or without the advice of an Appropriate Healthcare Professional (AHCP)[59], or a Liaison and Diversion assessment, that the individual is "vulnerable" and therefore in need of further support through the custody process.

2.15 The Police and Criminal Evidence Act 1984 Codes of Practice set out the procedures for police to follow. Code C addresses the custodial setting.[60] Paragraph 1.4 and Annex E, require any officer who has suspicion or is told in good faith that a person may be mentally disordered[61] or is otherwise mentally vulnerable[62] or mentally incapable of understanding the significance of questions put to them or their replies, to treat the person as such under the Code.[63] This includes people with learning disabilities or difficulties. The consequence of this is that a suspect must receive the support of an appropriate adult.

---

[59] This term replaces the previous term "Forensic Medical Examiner." Note 9A to Code C defines a "healthcare professional" as a "clinically qualified person working within the scope of practice as determined by their relevant statutory body. Whether a healthcare professional is 'appropriate' depends on the circumstances of the duties they carry out at the time."

[60] PACE Code C (Revised Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers) available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/364707/PaceCodeC2014.pdf

[61] 'Mental disorder' is defined in the Mental Health Act 1983, section 1(2) as 'any disorder or disability of mind.'

[62] Note for guidance 1G to Code C explains that 'Mentally vulnerable' 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.

[63] An amendment to this definition is currently being consulted on that would place the focus on the capacity of the person rather than the medical condition and redefine throughout the Code "a vulnerable adult" as opposed to someone who "may be mentally disordered or otherwise mentally vulnerable." Although this aim is laudable, the test focusses on the level of understanding and possible confusion of the person, which is going to be incredibly difficult for the officer to determine in practice without the assistance we recommend below, see Draft Revised Code C, 25 October 2017, *supra*.

2.16 A detained person who appears to have a 'mental disorder' must receive appropriate clinical attention as soon as is reasonably practicable, even if the detainee makes no request for medical attention, pursuant to Code C, paragraph 9.5. Medical assessments must be carried out by an AHCP.[64] Annex G sets out general guidance for the assessment of whether a detainee is fit for interview.

2.17 There are a number of problems with this process. Firstly, the identification of mental disorder or vulnerability may be too complex for officers to make. Secondly, the health care professional assigned to conduct the assessment of vulnerability may not be appropriately qualified to do so.[65] Thirdly, the facilities and support services provided where vulnerability is identified are inadequate. Fourthly, these provisions only have to be applied by the officer "in the absence of any clear evidence to dispel" the suspicion of mental disorder or mental vulnerability.

Custody officers' identification of vulnerability

2.18 We are concerned, therefore, that the current process of identifying vulnerable suspects is ineffective. The onus is placed on police officers to identify vulnerability whilst operating under the time pressures of the custody environment.[66] Although the College of Policing has developed national standards for identifying

[64] See also College of Policing, Authorised Professional Practice, at http://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/mental-ill-health-and-learning-disabilities/#vulnerability-assessment

[65] There is no requirement for AHCPs to have psychiatric or learning disability training. This may explain why, in one force visited by inspectors, none of the ten detainees who had learning disabilities and had been medically assessed received an Appropriate Adult, Criminal Justice Joint Inspection, *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system - phase 1 from arrest to sentence*, (London: HM Inspectorate of Probation, 2014), p.18.

[66] Police officers interviewed by NAAN on the difficulties involved in identifying vulnerability for its *There to Help Report* were clear:

"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…" (p3).

vulnerability, training of police officers still requires development.[67] At a time of cuts across public services, there is insufficient police resource to enable all officers to undertake additional, comprehensive training. In any event, as we set out above, no amount of training can provide officers with clinical proficiency, nor should it attempt to.

2.19 Combined with this, many if not most detainees have a range of vulnerabilities – such as anxiety, depression, personality disorders, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder. We understand from the police officers we have taken evidence from that, despite the Code C guidance, many of these illnesses are not considered to require additional support or assessment.[68] This is also borne out by research.[69] Yet these conditions could well affect the ability of the suspect to exercise their rights of defence and engage with police questioning, or be aggravated by detention.

2.20 Members of our Working Party who regularly represent people in police custody have expressed concerns about the police interpretation of the phrase "in the absence of any clear evidence to dispel" the suspicion that a suspect is suffering from mental disorder or is otherwise mentally vulnerable. For example, where a suspect has not had an AA on a previous occasion, this has been assumed to mean

[67] We understand that the College of Policing has produced five training packages, ranging from street identification to senior officer training. The training requires a minimum of two days. While some forces have taken this on, such as the British Transport Police, others have not.

[68] We are told that whether vulnerability is identified will depend on the custody officer's assessment of the 'need' for an Appropriate Adult, based on how the suspect is behaving at the time. Exceptions to this are if the suspect is a juvenile or, per Met policy, has schizophrenia, pursuant to the case of *R v Aspinall* [1999] 2 Cr. App. R. 115, though the case makes clear that if a custody sergeant is told that a suspect is vulnerable because of a "mental disorder" of *any kind* they must be provided with an appropriate adult, even where that suspect seems to be coping with the present situation.

[69] R. Dehaghani, 'He's Just Not That Vulnerable: Exploring the Implementation of the Appropriate Adult Safeguard in Police Custody,' Howard Journal of Crime and Justice, Vol 55, Issue 4 (2016), pp 396-413. Following several months of observation, Dehaghani concluded that "a significant number of suspects brought into custody could be considered mentally vulnerable or mentally disordered. However [Custody Officers] did not always implement the safeguard where the suspect had been identified as such" (p.8). She considered that this was because they "seem to view certain conditions as being less worthy of attracting the safeguard than others" (p.9); the biggest concern for custody officers was whether the suspect was behaving "normally" and "presented well" (p.10), leading to the belief that someone is not vulnernable who is, for example, schizophrenic, but on medication. Dehaghani concluded that the police appear to be focussing mainly on mental vulnerability and ignoring mental disorder as a distinct category under PACE Code C, para 1.4, casting doubt on their compliance with Code C (p.11).

there is no requirement on the current occasion.[70] In fact, we are informed by a member of the PACE Strategy Board that the phrase was intended to make the presence of an AA more likely, not less. We consider that our recommendations below will go some way to resolving this problem. However, it seems to us that this phrase ought to be removed from the Code since it is reducing access to support.

2.21 It appears to us that the Code C guidance is a blunt tool without additional diagnostic support to indicate what the actual needs of the suspect are at this stage.[71] The Bradley Report recommended better identification and assessment during the screening process at the police station, to ensure rapid access to treatment and to ensure that detainees are dealt with appropriately earlier on.[72] Five years later, the House of Commons Home Affairs Select Committee report *Policing and Mental Health*[73] recommended improved training for frontline staff, particularly custody sergeants, on identifying vulnerability. The Report also recognised that police officers need to be able to get advice from mental health professionals to inform the decision, and that such information needs to be available at all times.[74]

2.22 We considered whether a solution to this problem would be better diagnostic tools for custody officers and looked at some of the tests already available and being developed to "sieve" for vulnerability. Such a test would need to be wide enough so as not to exclude anyone who has participation or comprehension difficulties, and must also provide clear instructions and a sufficient level of incentivisation to the police to ensure that it is utilised. However, in order to make this in any way a useful test, we consider that it would be too long or too complicated for an officer to administer.[75]

---

[70] This was stated by an officer interviewed in C. Bath & others, *There to Help*, (National Appropriate Adult Network, 2015), available at http://www.appropriateadult.org.uk/images/pdf/2015_theretohelp_complete.pdf: "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," (p.3).

[71] Also observed by Dehaghani, *supra*.

[72] The Bradley Report, *supra* p.41.

[73] Home Affairs Committee, *Policing and Mental Health*, Eleventh Report of Session 2014-15, (TSO, 3 February 2015), available at https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

[74] *Ibid*, p.28.

[75] Screening has been tested and reviewed by academics: For example, Dr Iain McKinnon of Newcastle University worked with the Met, in developing a health screening tool for adults, designed to identify certain physical and mental disorders (specifically psychosis, major depression and intellectual disability). Detection rates by officers of suspects with these conditions were 93%; 75% and 83% respectively.

2.23 Useful assistance would be derived from a street triage scheme of the kind considered above. This would enable arresting officers to arrive at custody with helpful and relevant information to inform that process. Just as with identification by First Response, in our view, custody officers should not be required to make clinical decisions, and increased clinical training is therefore not appropriate. What is required is support and information about recognising vulnerability, how to interact with the vulnerable person,[76] and where to source appropriate support for that person. The support must also be readily available when officers request it.

Liaison and diversion

2.24 Lord Bradley recommended that custody should be as much a healthcare environment as a criminal justice one.[77] Indeed, since custody often constitutes the first occasion on which an individual has the opportunity to have their mental health assessed, suitably trained professionals should be available in custody to assess and where possible, meet those needs, and ultimately to ensure that Police decisions take those needs into account.

2.25 The L&D National Model (the National Model) was formulated as a result of Lord Bradley's recommendations. L&D services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders.[78] The term 'liaison' refers to connecting criminal justice services with health and social care services, and the term 'diversion' indicates referrals into health and other services. This may involve diverting individuals out of the criminal justice system altogether or diverting them from a custodial to a non-custodial sentence. The National Model aims to have 75% coverage of L&D services across police stations, magistrates' courts and Crown Courts by

---

However, the numbers who received AAs or were referred to a HCP were markedly smaller at 54%/89%; 11%/89% and 50%/33% respectively, which indicated that custody officers may be continuing to exercise their discretion in the cases where they believe an AA is either not required or not readily available, I. McKinnon and D. Grubin, 'Evidence-Based Risk Assessment Screening in Police Custody: The HELP-PC Study in London, UK,' Policing: A Journal of Policy and Practice 2014, 8(2), 174-182, available at http://eprint.ncl.ac.uk/file_store/production/197587/E8AEFC0B-A30D-4F04-9EAB-71B06ED5FCCC.pdf

[76] Some people may carry an autism recognition card, which is the size of a business card and indicates and explains their condition, see National Autistic Society, *Autism: a guide for criminal justice professionals*, *supra*. Officers should be aware of this possibility and ask a suspect if they have one.

[77] The Bradley Report, *supra*.

[78] See NHS England website https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/about/

April 2018. It is currently at around 68% coverage and is fully funded until 2021. L&D services are expected to help reduce reoffending, reduce unnecessary use of police and court time, and ensure that health matters are dealt with by healthcare professionals.[79]

2.26 The National Model seeks to provide twenty-four hour, seven days a week provision. To achieve this some L&D practitioners will be embedded in custody suites and others available for a larger geographical area. It consists of a mix of operating times and out-of-hours arrangements, including links to existing services and provision. L&D is intended to be available at all points of the adult and youth justice pathway and respond to a wide range of health issues and vulnerabilities. L&D practitioners assess referred people during custody or court appearances and provide immediate recommendations on the needs of the person, produce assessment reports that can be made available to criminal justice professionals, and contact a broad range of services to try to put treatment and other needs in place.

2.27 While we have been focussing on L&D's role in ensuring that vulnerable people receive support in custody, L&D also has an important role to play in safeguarding the agency of a person who appears to meet the Code C definition of vulnerability but is not in fact vulnerable and does not require the assistance of an AA.[80]

2.28 L&D services located in police stations receive a list of those arrested and are made aware by custody staff of particular detainees who might benefit from the service. Some practitioners also describe walking around the cells and talking to detainees to identify those potentially at risk. Assessment is conducted using a range of standardised diagnostic tools and can be described as holistic. L&D

---

[79] NHS England, Liaison and Diversion, Standard Service Specification 2016 (draft); NHS England, Liaison and Diversion Operating Model 2013/14, available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/ld-op-mod-1314.pdf

[80] Factored into custody officers' decisions about whether someone is vulnerable are considerations around the length of time that it can take to obtain an AA, and the suspect's own insistence that they do not require one (often also motivated by an awareness of how much longer they will be required to remain in custody whilst an AA is sourced). A custody sergeant told us that "if anyone who suffers from anxiety and depression needs to have an AA, someone will need to provide serious funding for the provision of appropriate adult services as probably 80% of detainees have some sort of MH issue. Even if they weren't arrested, but were interviewed outside of custody, the officer would still need to get an AA for the interview." A particular problem we are aware of is that, when confronted with someone with a serious vulnerability such as schizophrenia, particularly in a hospital setting, officers may assume that the person lacks capacity to form the mental element of the potential offence concerned, and will therefore decide not to arrest. The label of mental illness may therefore also prevent an assessment of actual capacity. An L&D practitioner can make an accurate assessment as to the capacity and needs of the individual.

practitioners can be mental health trained nurses, social workers or psychologists. Sometimes L&D practitioners will seek to arrange assessment by a specialist practitioner – either someone within the L&D team, or a practitioner from another agency. The wide range of vulnerabilities covered by the National Model means that L&D services need to work with a considerable number of agencies, building contacts so that they can act as an advocate for the person to receive the necessary support.

> Screening seeks to develop an understanding of how any mental vulnerability or learning disability might interfere with the person's ability to navigate the system independently and participate effectively. It is less about diagnosis and more about how the person's vulnerability manifests itself in relation to the situation. This could include something as relatively innocuous as noting that someone is diabetic but doesn't have their insulin with them. The recommendation in that case could be that they are bailed to get it, or that insulin is prescribed and provided before the interview takes place. Or, it could be that someone has taken medicine that doesn't kick in for several hours, in which case, the recommendation would be that the interview is postponed. Information from an L&D practitioner

2.29 L&D is not yet fully operational across the country and will take time to reach its potential. There are signs that L&D integration is contributing to greater awareness of vulnerability in custody,[81] which is promising. However, a key difficulty with accessing the service is that it still requires a referral from the custody officer, which demands an initial identification of need to be made. We think that the service ought to be more ambitious and screen everyone who comes into custody. We are aware that some L&D practitioners are doing this in one London team and in Greater Manchester. This ensures that the accurate identification of vulnerability is not left to a custody officer to assess, but is carried out by a medical professional. While this may require more service provision, it will ensure that no one who needs assistance is missed and provides the ideal solution to the problem of officers having to carry out clinical assessments.

---

[81] The most recent evaluation found that increased numbers of people with vulnerabilities were identified in custody; L&D practitioners were viewed as a valuable source for information and expertise; they were described as providing "reassurance" to custody staff, "sharing responsibility" for assessment and decision-making about difficult cases and providing a "second opinion" on key decisions regarding the risk that a detainee posed to themselves (or others); There was evidence that information from the L&D service had informed police charging and remand decisions in some instances; L&D was perceived to lead to more efficient processing of detainees in police custody in some cases, Rand Europe, University of Warwick Medical School and Applied Research in Community Safety, 'Evaluation of the Offender Liaison and Diversion Trial Schemes', (Rand Corporation, 2016), available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1283/RAND_RR1283.pdf pp. 76 and 77.

2.30 Another difficulty is that PACE Code C requires the decision as to whether a person is fit for interview to be taken by an AHCP. However, as indicated above, this is often a privately contracted nurse who will not have mental health training and may incorrectly assess that the suspect is fit. It can be distressing and confusing for the suspect to have to be assessed by two practitioners, especially if they come to different decisions. Since a commitment has been made for L&D services to be available across the country, it would seem sensible for the decision as to whether a person is fit for interview, and what reasonable adjustments might be needed to enable them to participate, should be taken by an L&D practitioner if there is a mental health concern, and an AHCP for a physical condition. In any case, the assessment should apply mandatory minimum standards set by the Faculty of Forensic and Legal Medicine.[82]

2.31 A further difficulty is ensuring that where a suspect is to be voluntarily interviewed, they get to see an L&D practitioner, because the service is organised around custody. In most cases of vulnerability, a voluntary interview will be more appropriate than custody. The service should be available to all suspects, irrespective of whether they are detained or attending voluntarily.[83] Following a street triage which identifies vulnerability concerns, an L&D assessment could be undertaken ahead of interview and in a location away from the police station (including the suspect's home), which would identify which services are required for interview. This would ensure that all relevant practitioners are present for the appointment without the need to incur delay or detention of the suspect.

Responding to mental health needs in custody

2.32 Once vulnerability is identified, PACE Code C places two requirements on the custody officer – to obtain the support of an appropriate adult (AA) and to obtain a clinical assessment. In our view this is insufficient and we set out below the additional assistance services that we believe are required. The L&D practitioner will be key to ensuring that the custody officer knows that these services are necessary.[84]

---

[82] FFLM and BMA Medical Ethics Department, *Health Care of detainees in police stations, standards of care* (2009), available at https://www.fflm.ac.uk/wp-content/uploads/documentstore/1236269117.pdf

[83] Identified by the Rand Evaluation. We understand that L&D assessments are starting to take place in other venues, such as NHS centres, for this reason.

[84] Research commissioned for *There to Help*, *supra*, found that in eight sites over a three month period during 2014, an average of only 20% of the people engaged with L&D received the assistance of an AA. Although it is not known whether, following the L&D assessment, an AA was in fact required (i.e. whether the person met the Code C vulnerability test), nor whether L&D recommended to custody officers that an AA be sourced, the access to an AA across the sites ranged from 5-45%, which indicates that certainly

2.33 We also observe that although suspects must be given a notice of their rights and entitlements, the Code does not require an "easy read" version for vulnerable suspects.[85] Easy read has been developed to help people with language difficulties understand information more easily, using short, simple sentences and pictures, lowering the 'readability level'. Little research has been carried out to understand whether it is an effective strategy, with that research giving mixed results, [86] although more research is being conducted. [87] This may explain the small range of easy read documents available in the justice system, and the lack of requirement to provide them. However, we consider that simple, written and pictorial information is likely to help clarify the process better than nothing at all.[88]

Appropriate adults

2.34 AAs provide advice, support and assistance to vulnerable suspects in police custody and for voluntary interviews. The aim of AAs is to ensure fair treatment and effective participation in investigative procedures, including in interviews. This is intended to provide assurance to courts, mitigating the risk of inadmissible

---

some AA entitlement was missed, see NAAN, There to Help, Paper D: Results – police, AA schemes and liaison & diversion, (2015), available at http://www.appropriateadult.org.uk/images/pdf/2015_D_results_police_AA_LandD.pdf It is therefore important that L&D practitioners are trained in the PACE Codes and safeguards that suspects are entitled to while in police custody or being voluntarily interviewed.

[85] PACE Para 3.3A says that this should be provided to all suspects, if available.

[86] See Inkle Comms, 'Claims Easy Read Works – a closer look', (2015), available at: http://www.inklecomms.co.uk/claims-easy-read-works-closer-look/

[87] See J. Hughes, 'Comparing understanding of Health related knowledge following Easy Read alone or Easy Read with additional support in adults with intellectual disabilities', 2015, available at: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/easy-read-and-health-related-knowledge/ and S. Buell, 'The Easy Read Project. Participation in healthcare: an investigation into the accessibility value of health-based literature for people with poor literacy skills associated with intellectual disability', (2014), available at: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/the-easy-read-project-version-1/

[88] Keyring has been working to improve the use of easy read documents in the criminal justice system, see http://www.keyring.org/cjs/easy-read It records that the use of an easy read application form to the CCRC has resulted in a significant surge in applications from vulnerable groups, and helped prisoners access services. The pre-March 2014 easy read notice of rights and entitlements is available here http://webarchive.nationalarchives.gov.uk/20130505075839/https://www.gov.uk/government/publications/notice-of-rights-and-entitlements-easy-read An updated version is not currently available online. Some forces have developed their own, with photographs, and in consultation with "service users" see http://www.keyring.org/uploaded_files/1127/images/Going%20to%20the%20Police%20Station%20in%20Stroud%20-%20Gloucestershire%20Police%20and%202gether%20%282%29.pdf

evidence and miscarriages of justice. Although this is a neutral outcome, given its supportive and protective nature, it is also a partisan role.

2.35 AAs can be a relative, guardian or other person responsible for the suspect's care or custody, someone experienced in dealing with vulnerable people or if none of these are available, some other responsible adult aged 18 or over. There are some exceptions, including police employees.[89] Note 1D to Code C advises that, in the case of people who are 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 that the person's preference should be respected.

2.36 In practice, if no family member is available, police often call upon a locally organised AA scheme, many (but not all) of which operate using volunteers. The National Appropriate Adult Network ("NAAN") sets suggested national standards and publishes a national training pack.[90] While membership is not mandatory, around 90 organisations are members, representing provision in over 120 local authority areas. However, as there is no statutory duty to provide AAs for vulnerable adults, there are significant gaps and variations in provision. Where there is no such dedicated provision, in certain areas or at certain times, police rely on the limited availability of social workers and may even seek assistance from untrained members of the public. Waiting times for AAs also vary widely as a result and can be many hours.

2.37 There is no regulation of AAs, no statutory body responsible for ensuring that vulnerable suspects are supported by AAs, nor is there a legal duty on Local Authorities to ensure provision of AAs for vulnerable adults (as there is for child suspects).[91] NAAN recommends that AAs undergo a minimum of 20 hours training before beginning work, which should be provided by local schemes.[92] However, training is not compulsory, with many AAs being family members who receive no training and who are simply (at most) given some

[89] Code C, Paragraph 1.7(b).

[90] NAAN works primarily with AA scheme leaders to help them to develop their AA's knowledge and skills and overall scheme quality. The benefits of joining include: access to a National Training Pack; free professional development days; expert advice in delivering AA provision; access to the Research Hub; and access to iKAAN (an online knowledgebase for trained AAs). National Appropriate Adult Network, 'Membership,' available at: http://appropriateadult.org.uk/index.php/about-us/membership

[91] There is a duty to provide AAs for children via their Youth Offending Team (YOT) per the Crime and Disorder Act 1998, section 38.

[92] Although state funding is available, the lack of a statutory duty for trained AA schemes means that local funding is hugely variable and many schemes do not have the resources to deliver the required training.

brief guidance by the custody officer before they commence their duties.[93] This lack of (uniform) training can lead to varied levels of support and outcomes for vulnerable suspects.[94]

2.38 AAs are given broad responsibility under the PACE Codes. PACE Code C sets out that a vulnerable person must not be interviewed by the Police, or asked to provide or sign a written statement, in the absence of an AA, with some exceptions relating to the need for an urgent interview.[95] In interview, the AA is required to advise the interviewee, observe whether or not the interview is being conducted properly and fairly, and facilitate communication with the interviewee.[96] Outside of interview, the AA's role includes being present for the explanation of rights and entitlements, making representations to the custody officer about the need for continuing detention where detention is under review;[97] being present when the custody officer charges the suspect[98] or when the suspect is strip searched,[99] or identification procedures such as taking fingerprints and DNA swabs.[100] A vulnerable suspect has a right to consult privately with their AA at any time.[101]

2.39 The breadth of this role raises concerns for us.[102] As the Code describes the role, it includes making representations about important procedural safeguards for suspects at a time that is critical for whether criminal proceedings are commenced against them. Understanding whether an interview is being conducted properly and fairly, whether continued detention is necessary and whether there is evidence

---

[93] *There to Help* (2015), *supra*, p. 12.

[94] The senior stakeholders of the *There to Help* project largely supported mandatory training for all AAs for this reason (*There to Help*, *supra*, p.12).

[95] Para 11.15.

[96] Para 11.17.

[97] Para 15.3.

[98] Paras 16.1-16.4A.

[99] Annex A paragraphs 1(c) and 5.

[100] Code D, paras 2.3, 2.14.

[101] Code C, para 3.18.

[102] The Royal Commission on Criminal Justice raised a similar concern in 1993: "It seems to us that a more systematic approach is needed to the question of which people are suitable for being called upon to serve as appropriate adults and the training that they should receive." The Commission agreed with others that there should be a comprehensive review of the role, functions, qualifications and training, Runciman, Cmnd 2263 (London: HMSO, 1993) pp 42-44, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271971/2263.pdf

upon which to charge, requires legal knowledge and experience. Relying on AAs to carry out these activities, which relate to the exercise of the suspect's defence, risks denying vulnerable suspects the procedural protections they require. In order for AAs to properly safeguard the suspect's rights, they must understand the significance of the police procedures that are being conducted. This is highly unlikely unless they are properly trained.

2.40 Trained AAs tell us that they advise suspects to request legal assistance, and some won't take up the role unless there is a legal representative there as well. Code C, paragraph 6.5A gives the AA the power to request a legal representative on the suspect's behalf.[103] However, we consider that it is inadequate to leave this to the discretion and ability of the AA when such a broad range of people can carry out this role.

2.41 Equally, making representations about the length of detention may require clinical knowledge and an understanding of when certain conditions are unsuitable for vulnerable people. Specialist knowledge and experience are also necessary when facilitating communication for some vulnerable suspects. Without the right knowledge and facilitation skills, certain cues or signs may be missed, and chances for effective participation in a suspect's defence lost.

2.42 The length of training that AAs receive – if they receive any training – is insufficient to provide them with the knowledge and experience to appropriately protect vulnerable suspects on these issues. Vulnerable suspects require trained professionals who are well versed in these fields to make representations of the kind the PACE Codes envisage. Anything less risks vulnerable suspects' rights being violated. Yet PACE only provides for the assistance of an AA and no other professional support.

2.43 This is further compounded by AAs not being afforded the equivalent of legal privilege, which creates communication obstacles between the AA and the suspect, hindering the proper function of the broad role the AA currently has. AAs must therefore be subject to privileged communications.

2.44 PACE Code C appears to have been drafted in such a way as to rely on AAs to fill in the gaps in protection for vulnerable suspects that the system does not make

[103] Research on suspects held in police custody in 1997 revealed that although AAs contribute little to the police interview in terms of verbal interactions, their mere presence during the police interview has three important effects. First, in the case of adults, but not juveniles, it increases the likelihood that a legal representative will be present. Second, it appears to be associated with less interrogative pressure in interview. Third, in the presence of an AA, the legal representative takes on a more active role, S. Medford, G. Gudjonsson, J. Pearse, 'The efficacy of the appropriate adult safeguard during police interviewing,' Legal and Criminological Psychology, Vol 8, issue 2, (2003), pp 253-266.

provision for. The AA is therefore no substitute for proper professional support but has the potential to provide a helpful welfare, support and informal advisory service. We consider that in order for the AA role to provide effective support in all cases, there must be investment in a nationwide scheme and appropriate training for volunteers, and we agree with NAAN's recommendations in this regard.[104] Following the publication of *There to Help*, the Home Office established a Working Group on Vulnerable People. The group has considered statutory provision and some analysis of costs has been undertaken. In the short term, the Home Office has developed a voluntary 'partnership agreement' for local areas to adopt in order to fill current gaps in AA provision. Policing Minister Nick Hurd MP has recently written to all police and crime commissioners and directors of adult social care in England and Wales to introduce this agreement. In parallel NAAN plans to publish national guidance for those responsible for developing or commissioning AA provision in their area.[105]

2.45 Suitably trained AAs know how to assist suspects within the confines of their role and speak up for suspects who they consider are being treated unfairly. An accurately defined role in PACE and Code C will assist AAs to carry out what is a very valuable welfare and support role.[106] The AA also plays a crucial role in ensuring that legal representation and intermediary services are made available, and trained AAs should be highlighting their concerns to L&D practitioners and custody officers to make sure these services are provided.

Fred, who had been diagnosed with bi-polar affective disorder, was arrested and taken to custody where he waived his right to legal advice. Having spent time with him, a trained AA established this was because, in his depressed state, he found it difficult to make decisions and was not sure he was worth the effort. When the AA explained more, Fred requested a legal representative who was

[104] Family members or carers may be best placed to effectively support a vulnerable suspect and custody officers should continue to request their assistance in the first instance.

[105] The working group is also supporting work led by the National Police Chief's Council (NPCC) to develop a more effective and efficient risk assessment tool for use in custody. An NPCC working group is also working on issues associated with voluntary interviews, including the risk assessment, the involvement of L&D and AAs.

[106] The Home Office is consulting on amendments to the Code which would introduce a clearer definition of the AA's role as one to "safeguard the rights, entitlements and welfare of juveniles and vulnerable adults" in connection with the operation of the Code. In particular, to "support, advise and assist when a suspect is given or asked to provide information or participate in any procedure; observe whether police are acting properly, assist with communication and help understand rights and entitlements. This would make the obligations that we set out above better delineated from legal and clinical professionals, but there are still duties here that we consider to be professional roles, which should not fall to AAs to protect, see Draft Code C, *supra*, proposed new para 1.7A.

then present for the interview. However, when the police later sought consent for an identity procedure, the legal representative was in another interview. Fred seemed tentative in his consent and was unsure of the legal advice he had been given. The AA intervened to ensure the decision was postponed until his legal representative was available.[107]

2.46 Finally, we believe that the title, "Appropriate Adult" is entirely meaningless, if not patronising. It suggests that the suspect themself is not an appropriate adult, which is demeaning and discriminatory. We consider that in order to better delineate their role, and for suspects and police officers to understand their role, the title should be changed. We suggest to Approved Support and Welfare Assistant.

Legal representation

2.47 Navigating the custodial process is difficult enough for a fully able suspect, especially deciding whether to exercise the right to remain silent.[108] This can be incredibly hard to understand for people with vulnerabilities. Neither PACE nor its Codes require legal assistance for a vulnerable suspect. Instead, paragraph 6A of Code C gives the suspect's AA the power to request the presence of a legal representative for them. This applies where the individual has declined legal assistance and the AA considers it to be in the person's best interests.

2.48 In our view, the provision of legal representation for vulnerable suspects prior to, during and after interview for procedures that affect the suspect's rights should be mandatory. Indeed, it seems remarkable that a vulnerable person is considered capable of waiving their right to legal assistance.[109] The Scottish Government has recognised this concern[110] and the Criminal Procedure (Scotland) Act 2016 provides for mandatory legal representation for children and vulnerable adults. We recommend that equivalent provision be made in England and Wales.

---

[107] Anonymised case study from NAAN.

[108] See our joint empirical research J. Blackstock *et al*. *Inside Police Custody* (Intersentia, 2014) and also M. McConville and J. Hodgson, Royal Commission, *Custodial Legal Advice and the Right to Silence*, Royal Commission on Criminal Justice, Research Study No. 16 (HMSO, 1993).

[109] The European Court of Human Rights has indicated that waiver of the right to legal assistance by certain vulnerable groups may not be made voluntarily and knowingly, in breach of their article 6 ECHR right to a fair trial: *Pishchalnikov v Russia* [2009] ECHR App. No. 7025/04 (First Section, 24 September 2009).

[110] Following The Carloway Review, *Report and Recommendations* (2011), available at http://www.gov.scot/Resource/Doc/925/0122808.pdf and The Bonomy Review, *The Post-Corroboration Safeguards Review* (Final Report: April 2015), http://www.gov.scot/Resource/0047/00475400.pdf

2.49 This will undoubtedly require further provision of legal services. However, if street triage and L&D services are properly administered, and the question of whether it is in fact appropriate to interview a vulnerable person at all is properly addressed, we do not consider that significantly greater numbers of legal representatives will be required. Likewise we do not envisage a longer period in custody for these suspects than would otherwise occur. Legal representatives already operate a 24-hour duty scheme and are contractually expected to be available at the police station within 45 minutes in most circumstances.[111] Suspects would usually have to wait at least this long to be interviewed.

2.50 Once a legal representative has arrived, our experience is that suspects are unlikely to refuse their assistance. If they do, it should be borne in mind that the legal representative has been called because the individual is vulnerable, their legal rights are in need of protection and the representative should remain in order to ensure that the correct procedural safeguards are adhered to.

2.51 A fundamental concern for legal representatives is that custody officers currently refuse access to the records of their clients' medical assessments on the basis that this is personal and non-disclosable information. We do not believe this to be correct as the legal representative is in a professional relationship with the suspect at this stage, to which the information is entirely relevant.[112] The denial of access is problematic because without this information, legal representatives are not fully appraised of their client's physical and mental health. This impacts upon their ability to ensure an effective defence of their client. The L&D practitioner should be in a position to provide this information to legal representatives. However, our members and their colleagues are yet to interact with L&D practitioners in custody, nor see their assessments. L&D practitioners must also ensure that they update legal representatives about suspects' medical conditions and vulnerability.

[111] Legal Aid Agency, 2017 Standard Crime Contract Specification (February 2017), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/596286/2017-scc-specification.pdf

[112] PACE Code C, para 9.16 requires that if a healthcare professional does not record their clinical findings in the custody record, the record must show where they are recorded and that information which is necessary to custody staff to ensure the effective ongoing care and well-being of the detainee must be recorded openly in the custody record. However, information is frequently not recorded and AHCPs take their notes away from the police station with them.

Intermediaries

2.52 Intermediaries are experienced professionals with specific expertise in assessing and facilitating communication.[113] Although initially devised as a special measure for vulnerable witnesses when giving evidence,[114] their use has been extended to assisting in the taking of witness statements and assisting suspects and defendants. As their purpose is to facilitate communication, rather than protect the vulnerable person, their role is an independent and impartial one. In our view, their expertise should be considered an asset which could properly be used as a supplement to the AA, particularly where a person in custody is resistant to advice of his or her lawyer.

2.53 Intermediaries can pick up communication difficulties that are missed by other professionals. AAs, police and legal representatives may miss the warning signs because those with communication difficulties often devise coping mechanisms that allow them to conceal their difficulty by, for example, using stock answers. This could involve vulnerable suspects saying "I don't know" or "no comment" without really understanding what that means. One example given to us by intermediaries involved a suspect who said "I will have to look into that" as their stock answer. Their difficulties were not picked up initially by police officers or the solicitor, but the Intermediary was able to demonstrate significant impairments in the person's comprehension.

> A suspect with autism did not say anything during police detention for 19 hours. It was a case concerning terrorism and he had never been away from home. The suspect was undiagnosed at the time although one doctor had put 'query Asperger's' in the log. He did not think he needed a solicitor. An intermediary was contacted and when they looked at the record of taped interview, saw painful, long sentences from the interviewing officers. The suspect had used a stock phrase, acquiescing, in response. Without the intermediary's knowledge of autistic suspects using stock phrases, this would not have been identified. Example provided to us by an intermediary.

2.54 Early facilitated communication can also assist a suspect to understand the offence and make admissions, if they choose to and if appropriate in the circumstances. This can avoid a trial entirely. Another example given to us by

[113] In 2015, three-quarters were speech and language therapists, about 8% were teachers and the rest were from professions that included psychology, occupational therapy, nursing, social work and sign language interpretation, J. Plotnikoff and R. Woolfson, *Intermediaries in the criminal justice system: improving communication for vulnerable witnesses and defendants*, (Policy Press, 2015), pp. 17-18.

[114] Pursuant to the Youth Justice and Criminal Evidence Act 1999.

an intermediary is where a barrister repeatedly tried to explain to their client that there was DNA evidence against him, and the client simply kept saying he was innocent. The intermediary intervened and said "the police found bits of your body in her pants." The defendant then pleaded guilty.

2.55 Their intervention can also assist with ensuring proceedings are fair. Intermediaries are often presented at court with police transcripts where it is plain that the suspect did not understand what was going on. Once an intermediary can properly facilitate the person's communication, they may say something very different. This can create a contradictory account to that given in the police interview, resulting in the defendant being challenged in court for inconsistency. This may impact on how credible the jury finds their defence.

2.56 There is no statutory right to an intermediary for vulnerable defendants and detainees. The Ministry of Justice has a Registered Intermediary Scheme, for vulnerable witnesses. However, the scheme, pursuant to the Youth Justice and Criminal Evidence Act 1999 (YJCEA), specifically excludes defendants.[115] Its Matching Service also only applies to witnesses.[116] Moreover, PACE and Code C do not make any provision for intermediaries. In practice, those who work with defendants as intermediaries are either already registered in respect of witness work and willing to take on defendants as well, or else professionals who work exclusively with defendants – normally employees of Communicourt or Triangle.[117] However, this means that intermediaries working with suspects and defendants are entirely unregulated. A lack of regulation can lead to varied training and quality, which may be detrimental to suspects.[118]

---

[115] Section 16(1) YJCEA 1999.

[116] In September 2011, the Witness Intermediary Service decided to no longer assist with intermediaries for defendants. This was due to the high volume of requests to assist witnesses. Since then, the matching service has only provided registered intermediaries for defendants when obliged to do so as a consequence of litigation: In *OP v Secretary of State for Justice* [2014] EWHC 1944 (Admin), the Court held that the withholding of access from vulnerable defendants to the Witness Intermediary Service, and to professionally regulated Registered Intermediaries acting in that capacity for their testimony, breached equality of arms with Crown witnesses under Article 6 ECHR.

[117] Communicourt and Triangle and two privately run companies who provide intermediaries. They receive referrals and match the suspect or defendant to one of the intermediaries they employ. They train their intermediaries in-house.

[118] It should be noted that all Registered Intermediaries are required to adhere to the Code of Ethics and Code of Practice found in the MoJ, Registered Intermediary Procedural Guidance Manual 2015, available at https://www.theadvocatesgateway.org/images/procedures/registered-intermediary-procedural-guidance-manual.pdf A departure from any of the guidance could lead to a formal complaint, which is reviewed by the Quality Assurance Board, and the Registered Intermediary could be removed from the register. Communicourt also has a Code of Practice and Ethics and a complaints policy.

2.57 Intermediaries are hardly ever requested for suspects. In 2016 it was estimated that well over a thousand defendants were referred to Communicourt, Triangle and Intermediaries for Justice,[119] compared with just *nineteen* known referrals on behalf of suspects.[120] The large gap between intermediary requests for defendants and suspects is troubling. It seems to us likely that, should an individual require an intermediary for trial, they will almost certainly require an intermediary when the police are investigating whether to charge them.[121]

2.58 There are a number of possible reasons for the lack of uptake in custody. The primary reason is that police and legal representatives fail to identify the need for communication assistance and are unaware that intermediaries are available or where to source them. With an L&D assessment of all suspects, this can be negated and the value of an intermediary identified.

2.59 Secondly, a needs assessment must be carried out by the intermediary, which can vary in length from half an hour to two hours,[122] depending on the suspect and the degree of communication difficulties they present. The uncertainty surrounding the length of the assessment does not sit well with detention time limits. However, where the need for an intermediary is identified, the suspect can be released to return for interview once the intermediary assessment has taken place. This is a clear example of where the new PACE provisions on release under investigation should apply.

2.60 Thirdly, the number of intermediaries is small and they must be paid for.[123] There are not enough to respond to the demand for witness communication, l*et al*one suspects and defendants. A concerted effort must be made to retain

---

[119] Intermediaries for Justice is the professional body for intermediaries who work in the justice systems of England, Wales and Northern Ireland. In addition, it acts as a conduit, matching end user and intermediary. It is up to the end user and intermediary to decide if they have the right skills to assist with a particular suspect or defendant. It is not a regulatory or training body.

[120] These figures are approximate because some defendants were referred to more than one agency at the same time. In addition, some intermediaries may be approached directly by solicitors or police.

[121] This is acknowledged in Northern Ireland where the Registered Intermediary Scheme applies to witnesses, suspects and defendants, and operates successfully in the police station , see Department of Justice website https://www.justice-ni.gov.uk/articles/northern-ireland-registered-intermediary-scheme

[122] In very rare cases it could take longer, but often vulnerable people cannot manage much more than an hour.

[123] At the end of 2014, there were 98 intermediaries on the register and an 86% increase in the number of intermediary requests over the previous 12 months (J. Plotnikoff and R. Woolfson, *supra*, p 17). We understand that there are now around 170 registered intermediaries.

and train more intermediaries.[124] Currently, solicitors must cover the costs of the intermediary whilst they wait for approval for the costs of the intermediary assessments and other pre-trial work by the Legal Aid Agency. This cost risk makes many solicitors, who already struggle with small margins under their legal aid contracts, reluctant to request intermediaries even if they are aware of their benefit.[125]

2.61 A simple solution to many of these problems would be for the Ministry of Justice Registered Intermediary Scheme to extend to suspects and defendants. Indeed, this was the conclusion of the Bradley Report. For reasons that seem entirely unclear and in breach of equality duties in the Equality Act 2010 and article 14 UNCRPD, this has still not happened. We also consider that the ideal situation would be for intermediaries to be embedded in the police station, on a duty scheme basis, so that they can provide immediate assistance. This would reduce the disincentives to access their services, delay and cost of sourcing a practitioner.

2.62 The benefits of having an expert in communication assist vulnerable suspects at the police station seem obvious. By ensuring proper communication, intermediaries allow vulnerable suspects to be fully understood and investigated, leading to less delay, costs, and risks to the fairness of their trial later down the line. We return to this issue in **Chapter IV**.

2.63 The proper identification of vulnerability should therefore provide access to legal representation and AA assistance in every case. Some suspects may also need communication to be facilitated by an intermediary. This may result in a number of additional people being present to safeguard the evidential stages of the process, compared to an AA who should be present throughout detention. However, we believe that this is necessary to ensure effective participation of the suspect in their defence and reasonable adjustments to their disabilities are made.

Police and NHS leads

2.64 In order to ensure these services function effectively at the police station, we consider it essential that each force area has a mental health lead who can liaise with the local clinical commissioning group, mental health services and police staff to identify service needs and best practice. This is happening in the West Midlands, through its Mental Health Commission. The Commission has

[124] We are told that training has been organised that will enable more registered intermediaries by the end of the year and we welcome this move.

[125] J. Plotnikoff and R. Woolfson, *supra*, p 256.

an ambitious plan for training police officers and staff across the public sector in mental first aid (i.e. being aware of possible symptoms and how to react to them), individual plans for offenders with mental health needs and increased early intervention and prevention with vulnerable people.[126]

Amendments to PACE

2.65 In order to give effect to our recommendations, the PACE Codes will require amendment and we recommend that provision is made for the use and role of L&D Services, mandatory legal provision and intermediaries in the Code, as well as that legal representatives be entitled to receive medical information concerning their clients. We also think that the Codes should require a dedicated part of the custody record for recording AHCP and L&D assessments. Given the significant impact vulnerability can have, PACE itself ought to contain a definition of vulnerability and the obligations upon the Police when this is present. Likewise, PACE should be amended to indicate that L&D screening, mandatory legal assistance, Approved Support and Welfare Assistant and intermediary must all be provided.

Training

2.66 The decision whether to seek the assessment of a mental health professional will still necessitate an initial street identification by a police officer as to whether a suspect maybe vulnerable.[127] Likewise, police officers are often required to interact with vulnerable people, suspects or otherwise. Some guidance and training is therefore needed, but this must stop short of trying to turn police officers into clinicians. Resources are already available, but officers are not always aware of them or, if they are, how to use them. The College of Policing materials mentioned above are one example[128] and force areas have their own materials. A particularly helpful guide we have come across is Together for Mental Wellbeing's *A common sense approach to working with defendants and offenders with mental health problems*.[129] This guide is designed for all criminal

[126] See Annex 1.

[127] The decision whether or not to arrest a vulnerable individual for a suspected offence will come down to the officer's understanding of how that person's vulnerability interacts with their capacity to have committed the alleged offence.

[128] As is the National Autistic Society, *Autism: a guide for criminal justice professionals*, *supra*.

[129] Updated 2015, available at http://www.together-uk.org/uploads/acommonsenseapproach.pdf Linda Bryant, Director of Criminal Justice Services at Together and the guide's main author, informed us that,

justice professionals and offers clear, practical information to assist professionals in recognising signs of vulnerability, understanding how environmental pressures exacerbate this, and considering how to accommodate vulnerable people's experiences of the criminal justice system.

2.67 Nevertheless, we have found that the guide is not widely in circulation[130] nor were our members aware of it. It also does not mention the important role of intermediaries. We consider that the guide should be updated[131] and made available for reference in every custody suite, court centre, and hospital where criminal justice professionals are interacting with potentially vulnerable people. It should be incorporated into existing College of Policing vulnerability training, and custody, interview and sergeant training.[132] It could also be given to all new recruits who take part in training to become police station legal representatives or Approved Support and Welfare Assistants. Looking further along the criminal justice pathway, judges' and magistrates', magistrates' clerks' and other court staff training could involve familiarisation with the guide.[133]

2.68 All of these professionals need to have incorporated into their introductory training information about the role of other professionals: Approved Support and Welfare Assistants, legal representatives, intermediaries, so that the benefit of having them present and how to access them is made clear. Equally, L&D practitioners should receive guidance on how to engage with the legal process when giving their advice to the Police and courts, in order to tailor their advice for those purposes.

---

as various policy changes and strains on resources made it increasingly difficult for services to release employees for training with Together, they had to come up with a practical and pragmatic resource that criminal justice staff dealing with vulnerable people could refer to.

[130] Although it is available online (and also on the National Offender Management Service intranet), Together does not think that this is the easiest way to manage the material it contains. We agree. When it was first produced, hard copies were sent to the Met and probation services. Together prints copies and delivers them upon request, where resources allow.

[131] The contents will need to be kept under review and updated when necessary. If not by Together itself, this could be undertaken by NHS England or representatives from the bodies currently responsible for liaison and diversion services (of which Together is one).

[132] Training schemes should ensure that Together or other mental health service professionals are involved, since it is Together's extensive experience of working with criminal justice colleagues that informs the training they deliver and supports the delivery of the guide's contents.

[133] Responsibility for distribution of the published version of the booklet, as opposed to a print off from the website, will need to be adopted or shared by relevant agencies.

III. DECISION AS TO CHARGE AND PROSECUTION

Mr Brown was known to social services. Upon arrest he did not disclose his mild learning disability and was processed by the custody sergeant accordingly. Our L&D service is based at the police station. When I spotted Mr Brown being read his rights I raised my concerns. I carried out a screening and found out more about his previous involvement with relevant services, his difficulties and the fact that he felt in a "low mood" which was causing him challenging behaviour. As a result an appropriate adult came to accompany Mr Brown [and] the officers were advised on appropriate means of communication. Learning disability nurse[134]

Police charging decision

3.1 A custody officer may make a charging decision in respect of certain summary and either way offences.[135] In some police force areas this is done by a police evidence review officer (ERO) who then confirms with the custody officer that the suspect should be charged, and this will be done either prior to the suspect being released from custody or on a return date to the police station. Whether the decision is taken by the ERO or the custody officer, the Full Code Test[136] has to be satisfied. This requires there to be sufficient evidence to prosecute and a determination as to whether it would be in the public interest to prosecute.

3.2 A recent major disruption to this process is the introduction of the principle of release without bail, under what is termed "release under investigation" (RUI).[137] This policy has resulted in a significant reduction in release on bail with a 28 day police bail return date.[138] It can also result in a lengthy delay between arrest, charge and first appearance at court.[139] For any suspect and complainant of crime, this is causing greater uncertainty about whether a criminal charge will be

---

[134] Offender Health Collaborative, *Liaison and Diversion Manager and Practitioner Resources: Learning Disability*, (August 2015), p7, available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-05.pdf

[135] Pursuant to section 37 PACE and the Director's Guidance on Charging, (2013), available at https://www.cps.gov.uk/publications/directors_guidance/dpp_guidance_5.html

[136] CPS, Code for Crown Prosecutors, (January 2013), available at https://www.cps.gov.uk/publications/docs/code_2013_accessible_english.pdf

[137] S. 30A PACE.

[138] See 'National Police Chiefs Council response to new bail legislations', (23 September 2017), available at https://news.npcc.police.uk/releases/npcc-response-to-new-bail-legislations

[139] In addition the use of postal requisitions add to delay and in some cases the six month statutory time limit expiring on summary only offences.

brought. For vulnerable suspects this uncertainty confuses and exacerbates their situation in a way that was not considered by the legislators. We consider that in cases of vulnerability, there should be a charging decision within two weeks, with limited scope for extension.

3.3 The public interest element of the decision to prosecute will require an evaluation of any vulnerability. One significant problem with the process is that there is no opportunity for the defence legal representative to make representations to the ERO, and rarely to the custody officer, as to whether it is appropriate to charge in the circumstances. It follows that the ERO will be dependent on the investigating officer for information with which to make this decision, and neither of them are likely to have considered the suspect's mental health.

3.4 If the custody officer or ERO decides to charge, or the case needs a Crown Prosecution Service (CPS) charging decision, the case file is passed to the CPS to review for prosecution against the Full Code Test. The CPS relies on the Police to provide accurate information about the suspect with no opportunity for this to be viewed by or on behalf of the suspect.

3.5 Currently, our enquiries suggest that very little, if any, information concerning the vulnerability of a suspect is passed with the file, despite this being required by HO Circular 12/95.[140] The circular requires police to:

a. Encourage professionals who may advocate a particular approach or disposal, to set out their views in writing or the police should summarise in the file any views expressed to them orally;

b. Include their views as to whether the suspect should be prosecuted;

c. Inform if the suspect has been seen by a psychiatrist, or arrangements have been made for assessment;

d. State on the file any informal conditions (such as treatment or residence) as part of bail arrangements;

e. Provide reliable, accurate and authoritative advice from outside agencies regarding factors in favour of bail or available placements.

3.6 In practice, vulnerability will only be apparent to a prosecutor from looking at the custody record answers concerning mental health and whether an AA was present.

[140] Available at http://www.cps.gov.uk/legal/assets/uploads/files/Home%20Office%20Circular%2012%2095.pdf

However, these are not provided as a matter of routine to the prosecution.[141] Even if they were, there will not be detailed information provided about the nature of the vulnerability that the suspect has, or whether this has any connection with the suspected offence. Often this will only be revealed at court, or if a defence solicitor writes to a prosecutor voicing their concerns. Where solicitors make such representations, they may not yet have any medical evidence to support their concerns and the prosecutor may have to request this evidence from them. This can either delay a case being resolved for many weeks, or it will continue to court regardless, with costs being incurred that could be avoided were the health of the suspect known.

3.7 Should our recommendations for the police station stage be followed – in particular, triage of all suspects by L&D officers; mandatory legal assistance; and intermediary assistance where necessary - there should be much more accurate information available concerning the appropriateness of charge for each suspect. This information should also be summarised in the MG3 (report to CPS for charging decision).

3.8 In these circumstances we consider that where vulnerability is shown to be a feature of the criminal conduct, the decision whether to charge is one that should be taken by a Crown Prosecutor in all cases. With fuller information available, the prosecutor will be in a much better position than the custody officer to decide if the suspect should be charged.

In a case where one of our members acted, the vulnerable suspect raised self-defence in interview but was later cautioned for the offence without his legal representative being present, having clearly misunderstood the implications.

Decision to prosecute

3.9 For this change to be effective a flag will need to be raised on the file to identify it as a vulnerability case. We understand that until the Common Platform[142] comes into operation, this will be difficult. However, when the Common Platform is

[141] The National File Standard does not require this, see https://www.cps.gov.uk/publications/directors_guidance/dpp_guidance_5_annex_c.pdf

[142] The CJS Common Platform will transform the criminal justice system for all users. It will replace the existing IT systems of HMCTS & CPS with a single system. A single central database will hold all the material (including multi-media) necessary to deal with cases from charge to trial quickly and efficiently. More information is available here https://insidehmcts.blog.gov.uk/2016/06/30/introduction-to-common-platform-programme/

complete, a flag can clearly appear on the landing page of each case in the system and remain visible for any criminal justice professional accessing the case.[143]

3.10 Secondly, such cases should go to a specialist prosecutor who has received mental health awareness training. We think this role is essential to ensure that prosecution decisions are correctly taken. Training should be made available to a prosecutor in each CPS area across the country, and must introduce them to the impact of vulnerability upon capacity to commit crime; the public interest test in this scenario; the need for medical assessment and suitable experts; the impact of Mental Health Act procedures upon the trial; the options available for diversion; and necessary adaptations to ensure that a trial is fair. This should be run with input from the Royal College of Psychiatrists, L&D, intermediaries and other relevant professionals.[144]

3.11 Thirdly, prosecutors will need information and evidence about vulnerability at the earliest opportunity in order to review the case in accordance with the Code for Crown Prosecutors and CPS guidance *Mentally Disordered Defendants* (the Guidance),[145] and to determine whether to charge. The Guidance is now old and needs to be urgently updated to reflect current practice and the role of L&D and intermediaries.[146] The Code articulates the balance to be struck between the public interest in diverting a suspect who has significant mental ill health from the CJS and other public interest factors in favour of prosecution, including the need to safeguard the public. If there is "significant evidence to establish that a suspect has a significant mental illness," a prosecution may not be appropriate "unless the offence is serious or there is a real possibility that it may be repeated."[147]

3.12 L&D professionals that we took evidence from assumed that their reports were passed on to both the CPS and defence representatives. However, none of our members, whether CPS or defence, have seen an L&D report in cases in which they have been concerned. In our view, the L&D assessment should be contained in a report that travels with the case file to the CPS, setting out the initial assessment and recommendations as to necessary support services and/or the appropriateness and nature of possible diversion.

---

[143] The CPS has agreed to take forward a flag on the Common Platform of this nature.

[144] The training programme for Mental Health Tribunal (formally the First-tier Tribunal – Health, Education and Social Care Chamber (Mental Health)) judges may provide useful content, see chapter 4.

[145] Available at http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/

[146] The CPS has held a workshop with relevant experts to consider this, prior to a wider public consultation exercise.

[147] Code for Crown Prosecutors, *supra* p. 8.

3.13 If these recommendations are followed, defence solicitors will have a better opportunity to make representations as to charge or diversion as they will know who the specialist CPS mental health prosecutor is.[148] With the initial report from L&D there should be sufficient information and advice to make a decision as to the need for further reports. If the suspect consents, the prosecutor should then be able to request the Police to source a psychiatric assessment, rather than waiting for the defence solicitor to obtain Legal Aid Agency approval.

3.14 The Guidance suggests that where a court has a scheme to facilitate the process of psychiatric assessment and the provision of constructive and coherent reports to the courts, the suspect should be referred to it for investigation and a report.[149] Where there is no such scheme, prosecutors must consider whether there is sufficient information upon which to base a decision whether to prosecute.

Diversion and public interest considerations

3.15 The Guidance states that where there is sufficient evidence to justify a prosecution, prosecutors should consider whether there is a suitable out of court disposal as an alternative to prosecution that is appropriate to the seriousness and consequences of the offending, and meets the aims of rehabilitation, reparation or punishment.

3.16 The Guidance makes clear that a prosecution must not be pursued solely to treat and manage a mental disorder or to provide a complete forensic history. The following factors should be taken into account:

a. The views of a mental health professional on the probable impact of a prosecution on the offender's health;

b. Any proposed treatment, the aim of that treatment and its potential impact on offending behaviour;

c. The likely impact of a prosecution on future offending. A prosecution may have the effect of confronting the offender with their behaviour and enable them to take responsibility for their actions. A prosecution may not be necessary where the risk of reoffending is low;

---

[148] If custody officers continue to charge, we think the same requirement should be placed on them through an amendment to PACE. This would replicate the duty in s. 42(6) PACE for a police superintendent to give an opportunity to make representations prior to extending detention. In practice, officers have to contact solicitors to attend for interview. Doing the same to inform them that a charging decision is proposed and to invite representations should not be onerous.

[149] Provision of psychiatric assessment varies across the country; some courts have full time assistance, others have one or two days per week. With the roll out of L&D services, the facilitation of this assessment should be improved, see chapter 5.

d. The risk of causing harm to others. A prosecution is more likely to be in the public interest where the risk of harm to others through reoffending is high;

e. Past offending history, especially where the offender has been diverted previously, and if so, whether his previous response to diversion is known;

f. The need for treatment and whether treatment is already being provided under the MHA either in hospital on a compulsory (ss.2 or 3) or informal (s.131) basis or under a community treatment order (s.17A);

g. The offender's current response to treatment and any history of engagement and response to treatment.

3.17 While we endorse this guidance, we are concerned that it does not give clear advice as to the appropriate decision where the evidence of lack of capacity suggests that there may be a need for a fitness to plead process. This may be required so that the Court can make a hospital order, see **Chapter V**.

3.18 Further, little detail is given about the nature of diversion. Diversion may mean diversion from prosecution, by way of a caution, or diversion from the CJS altogether. However, the Guidance does not set out the options for diversion. We entirely accept that there is no universal model for diversion and provision depends on local services. It would be helpful if the local services for each prosecution area were listed to help prosecutors determine what the appropriate alternatives might involve. Without this information, it may be difficult for prosecutors to satisfy themselves that it is not in the public interest to prosecute.

Caution and conditional caution

3.19 The Bradley Review identified that conditional cautions provide a good opportunity to appropriately respond to offenders with vulnerability.[150]

3.20 CPS guidance *Diverting offenders with mental health problems and/or learning disabilities within the National Conditional Cautioning Framework* 2010[151] indicates where cautioning may be suitable. A caution or conditional caution will not be appropriate if there is any doubt about the reliability of any admissions made or if the suspect's level of comprehension prevents him/her from understanding the significance of the caution or conditional caution and giving

[150] Lord Bradley considered that the effective use of conditional cautions should cut crime, improve health, reduce police and court workloads and free up prison places for serious and violent offenders, The Bradley Report, *supra*.

[151] Available at http://www.cps.gov.uk/legal/d_to_g/diverting_offenders_with_mental_health_problems_and_or_learning_disabilities_within_the_national_/

informed consent.[152] The guidance further states that if a caution/conditional caution seems to be in the public interest, information and advice should be sought from L&D or other reliable sources, and any suitable steps should be taken to enable a mentally disordered offender to understand the significance of the caution and give informed consent.[153] The conditions attached to a conditional caution may be reparative or rehabilitative, and may impose restrictions on any individual where these contribute to such objectives.

3.21 Where areas do not have provisions in place to provide the support for diversion for offenders with mental health problems and/or learning difficulties they are encouraged to engage with local health care trusts to establish links that will assist in prosecution decision-making with regards to these types of offenders. Again, links to local services that prosecutors can utilise should be provided in this guidance.

3.22 The difficulty is that these schemes are only available when a person has the capacity and/or is prepared to admit guilt. Where a caution is inappropriate, diversion can currently only be achieved by taking "no further action." In these circumstances, there is a lack of incentive for the suspect to address their mental health and the behaviour it may be causing. Moreover, there is currently no requirement on mental health services to provide the necessary support to prevent reoffending.[154] It is for precisely these reasons that prosecutors will be reluctant to discontinue the proceedings as they will want to know what support there will be in place for the suspect/defendant once the proceedings have been stopped.

---

[152] However, there is no definition of, or restriction on, the particular form of mental or psychological condition that may make an admission unreliable (*R v Walker* [1998] Crim L R 211).

[153] The Code of Practice for Conditional Cautions must be considered, pursuant to Part 3 of the Criminal Justice Act 2003.

[154] Clinical Commissioning Groups (CCGs) play a crucial role in the provision of mental health services in the community. However, CCGs are reluctant to accept responsibility for people leaving police custody or prison, or who are diverted from the criminal justice system. They consider this to be NHS England's responsibility, despite this not being the case. A real cause for concern is that community mental health services raised the threshold for entry two years ago and many people in the CJS struggle to meet the criteria, particularly in relation to learning disabilities: Centre for Mental Health, *Mental Health and Criminal Justice* (Centre for Mental Health, 2016), available at https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=83a8bfa6-678f-470e-9f49-de5c0769e752 concerns which were repeated to us by L&D practitioners and managers.

Mental Health Diversion Panel

3.23 We considered whether referring the consideration of available treatment in the community to a panel of local practitioners could assist the charging decision. The Panel would seek to agree a contract between the individual and the service providers for a programme of activities that would recognise the person's vulnerabilities and support their needs in order to avoid offending behaviour. If this were possible, the prosecutor could consider this a suitable alternative to prosecution. Unfortunately, because this would involve a contract, it would not avoid the problem created by the person who lacks capacity. However, there are some examples of this type of practice happening in the system already for other characteristics and at different stages, and for mental health in other jurisdictions. We set these out in Annex 2.

3.24 The Bradley Report recommended an approach that involved diversion at all stages of the CJS[155] and a diversion panel could provide assistance at the charging and sentencing stage. A diversion panel would consist of relevant local professionals, from, for example, mental health and social services, the police and crime commissioner's office, the youth offending team, housing, employment and other services where appropriate. There might be a core team that would meet to consider multiple cases in a day, and invited others to comment on particular aspects of the individual's needs. The specialist mental health prosecutor could refer to a panel once the evidential threshold has been passed and consideration is being given as to whether it is in the public interest to prosecute.[156]

3.25 There are a number of questions to consider in relation to how the Panel would operate. For example, whether it would only convene on an admission of guilt, so as to avoid a delayed trial were the programme not complied with; or whether admissions should not be required given that a suspect may not fully grasp their behaviour and/or not wish to admit an offence, and it may not be appropriate to exclude them from the opportunity of diversion. Consideration would also need to be given to the length of the programme offered and whether any sanctions might be appropriate were the person not to engage with it.

3.26 The conditions of any diversionary package must be realistic for the person to be capable of engaging with them. Support should be provided where necessary, for example, to enable attendance at appointments. This is a core element of the

[155] The Bradley Report, *supra*, p. 30.

[156] The recommendation for a contract could be added to the list of considerations, see CPS Legal Guidance for Mentally Disordered Offenders, *supra*.

L&D service provision.[157] There are various third sector organisations committed to facilitating and encouraging ongoing engagement with healthcare and other services, as part of L&D or otherwise.[158]

3.27 From our research, diversion panels or processes have a number of key features:

a. Composition: many of the panels are composed of both legal and mental health professionals, and several also have people with a background in social work.

b. Referrals: referrals often are left to the discretion of the prosecutor, but some programmes allow judges to take an inquisitorial role. In several jurisdictions investigations are much less formal and evidentiary requirements are more relaxed when considering a referral.

c. Timing: most panels begin their work after an individual has been charged, but before a trial takes place. Many panels use the promise of withdrawing the charge to incentivise compliance with diversion.

d. Criteria: several criteria are considered when determining whether or not to divert an individual. Some jurisdictions have formally documented these in statute and/or guidelines.

- Many jurisdictions only allow diversion for minor and/or nonviolent offences. However, there is a growing movement to expand diversion schemes to include more serious offences.
- Many jurisdictions consider the severity of an individual's illness and the probability of rehabilitation.
- Several jurisdictions explicitly do not consider an individual's past convictions and arrests. However, many pre-charge diversion schemes consider the individual's likelihood of reoffending as a reason not to divert an individual, while a few post-charge diversion schemes specifically target chronic reoffenders.
- A few jurisdictions require an admission of guilt, however, many jurisdictions seem to be moving away from this, and just require that individuals take responsibility for their actions in another way.

---

[157] Offender Health Collaborative, Liaison and Diversion Manager and Practitioner Resources: Core and Extended Teams, https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-03.pdf

[158] Together for Mental Wellbeing's Community Link Workers in London work as part of the L&D service, whereas its York Care Pathway is operating prior to L&D arriving there.

- Jurisdictions may or may not consider a person's competency (i.e. to stand trial; to waive their right to a jury trial).

e. Powers: most diversion schemes involve a judge to some degree, and their decisions and powers are final.

- Post-charge diversion schemes often stay or adjourn criminal proceedings against an individual. The indication that charges could be withdrawn provides an incentive to participate and complete treatment programmes.
- Panels often require compliance with a treatment plan, agreed upon by the individual and others (such as the prosecutor), which could include inpatient care, outpatient care, group counselling, and/or drug and alcohol treatment. An individual's progress may be monitored on a regular basis by both court and mental health authorities.
- A panel may also require other measures that are either rehabilitative or restorative, such as reparations, donations, community service, apology letters, or meeting with the victim of their actions.
- If an individual is detained during their participation, the panel may decide when to release them. This release may be subject to conditions or they may be released into the care of others.

3.28 We have not reached a conclusion as to the appropriate arrangements of a panel for vulnerable individuals pre-charge. However, we think that there are very real reasons to believe that a mechanism of this kind is necessary to enable prosecutors to confidently consider diversion and to ensure that those who ought not to be prosecuted obtain meaningful support and avoid the criminal justice system in future. Equally, any programme of diversion must have fully funded and committed community mental health services available to meet the needs of the programme.[159]

[159] Mental Health Treatment Requirements are rarely ordered despite their potential to assist offenders, because of the reluctance among CCG's to provide supervised programmes for offenders and the waiting times for treatment programmes to become available, see Centre for Mental Health, *supra*, pp 31-33.

IV. PRE-TRIAL AND TRIAL STAGE

It was scary because I just see this man and two women sitting on a great big bench and I was in a glass box and there were all these others looking. A man then came over and said he was my solicitor but he was different from the one the night before. I thought to myself, "What is going on?" An offender with learning disabilities talking about her experience in court[160]

4.1 A decision to prosecute will result in an appearance in a magistrates' court[161] either for trial or if appropriate, committal or sending to the Crown Court. In this chapter we consider the problems the process presents for vulnerable defendants on the one hand and for magistrates, judges, lawyers and court staff on the other. None of the latter currently receive or are required to undertake training on vulnerability.

4.2 The court environment whether a magistrates' court or the Crown Court can be challenging for someone who does not have communication or comprehension difficulties, l*et al*one for a vulnerable individual. For a witness, these difficulties last as long as it takes to give evidence. For a defendant, such difficulties last for the whole process, pre-trial and trial as they have to understand the procedural issues and evidence that is given against them in order to put forward a defence. Those with vulnerabilities may not only need the obvious care to ensure that they understand what is happening, but require less obvious support with emotional containment or managing specific manifestations of their mental health conditions which will otherwise impact on their ability to participate. This may not be evident to those without a clinical background or specific training on mental health communication.

4.3 The first appearance at a magistrates' court can be crucial to the identification of vulnerability that was not picked up at the police station stage. This hearing is also of critical significance in the vast number of offences which are now prosecuted without the defendant having been arrested. In these cases, it is crucial that vulnerability is appropriately identified. Difficult enough as this is in the police station, there are at least procedures under PACE which require the custody sergeant to be responsible for welfare and vulnerability. The magistrates' court is a much more fluid environment, without a formal opportunity for assessment of needs. Liaison and diversion services are now established in every magistrates' court and provide an opportunity to assess defendants who come to court. However, this is done on referral, rather than each person receiving an

[160] See Prison Reform Trust and Rethink Mental Illness website Mental Health, Autism & Learning Disabilities in the Criminal Courts, http://www.mhldcc.org.uk/

[161] Our references to magistrates' courts encompass youth courts unless otherwise indicated.

assessment. L&D practitioners will look at the court lists to try and determine who may need their assistance. They will rely essentially on the defendant's advocate; and where the defendant is unrepresented, on the prosecution, court staff and ultimately the magistrates or District Judge to identify that need.

4.4 The digital reform programme compounds this problem. It raises real difficulties for the proper identification of vulnerability amongst people summonsed to court. It is expected that most summary, non-imprisonable offences will be dealt with online through a plea and sentence website. In fact, this replicates the single justice procedure which has moved to a paper process, unless court is requested.[162] More broadly, the Reform Programme proposes that plea and mode of trial will be dealt with online, avoiding first appearance at the magistrates' court altogether.[163] These procedures do not accommodate vulnerability and must be carefully thought through to ensure that assistance is available for those who are likely to need it, and that face-to-face court proceedings are clearly offered. We are already aware of the difficulty video link hearings pose at the Plea and Trial Preparation Hearing (PTPH) in the Crown Court for vulnerable defendants. Where a defendant is vulnerable, online and virtual procedures are inappropriate. There is limited opportunity for determining whether the defendant fully understands the nature of the plea he or she is tendering or other procedural aspects for which their instructions are required.

4.5 On the other hand, should our recommendations for the police station and charging stages be adopted, defendants with vulnerabilities should have been identified, and those for whom diversion is appropriate should no longer be progressing to court. Those that the specialist mental health prosecutor consider require to be prosecuted should be flagged as requiring to be brought to court and should have already had any reasonable adjustments recommended by the L&D practitioner at the earlier stage. The specialist prosecutor should be in a position to discuss these with the defence team and court and make sure they are in place for when the defendant arrives.

4.6 Where defence practitioners are concerned about vulnerability that has not previously been identified, and consequently a charge is not in the public interest, they should at this stage be able to speak with the specialist prosecutor and ask that continuation of the prosecution be reviewed.

---

[162] See MoJ and HMCTS, *Transforming our justice system* (2016), available at https://consult.justice.gov.uk/digital-communications/transforming-our-justice-system-assisted-digital/supporting_documents/consultationpaper.pdf

[163] Prison and Courts Bill 2017 prior to the General Election.

Guidance

4.7 However, in both magistrates' courts and the Crown Court, we are concerned that there is insufficient knowledge amongst court and legal professionals as to how to deal with vulnerabilities once potential problems are identified. There is no special court, track or procedure in place to ensure that capacity and reasonable adjustments are properly assessed. Criticism has been raised that the practice of ground rules hearings[164] is uneven, and not always constructive.[165] Judges vary in their approach to accommodations for vulnerable defendants, and do not always know how to deal with whether defendant intermediaries are required.[166] We consider that advocates, court staff and the judiciary should all have guidance and training as to the identification of vulnerable defendants, and the procedures which need to be followed in dealing with their cases.

4.8 A range of guidance is available for practitioners. The Advocate's Gateway (TAG) has produced a number of Toolkits on how to identify and respond to vulnerability.[167] However, the general knowledge of this guidance amongst practitioners is unclear. The Bar Council issued a guide in 2014 to assist barristers who have doubts about a client's capacity to understand advice, give instructions, or take part in proceedings.[168] It reminds counsel to satisfy themselves as to the vulnerability of a client by obtaining any necessary reports and determining whether the client is capable of giving instructions. It suggests that if the solicitor and client do not want the issue raised with the court, the barrister should consider withdrawing from the case. In our view this guidance should be extended to cover an obligation to consider all the procedural and other protective mechanisms available to ensure that the client can participate in the trial, if that is the appropriate disposal of the case. Professional standards

[164] These must be scheduled where directions are necessary for appropriate treatment and questioning of a witness or defendant, and if an intermediary has been appointed, they must be present (Crim PR 2015, Rule 3.9(7); CPD 3E.2, 3E3).

[165] Plotnikoff, *supra* p.262.

[166] *Ibid*, pp.262-263.

[167] There are 17 toolkits around identification, case management and questioning of witnesses and defendants, some of which are checklists, see http://www.theadvocatesgateway.org/toolkits See in particular, TAG, Identifying Vulnerability in Witnesses and Defendants, Toolkit 10, (10 July 2014), available at http://www.theadvocatesgateway.org/images/toolkits/10identifyingvulnerabilityinwitnessesanddefendants100714.pdf

[168] See http://www.barcouncil.org.uk/media/399959/client_incapacity.pdf

and guidance must also draw attention to the steps that must be taken to assist a vulnerable client.[169]

4.9 Criminal Practice Direction III.30 extends to adult courts procedures analogous to the youth court where the defendant is considered to be vulnerable: "All possible steps should be taken to assist a vulnerable defendant to understand and participate in those proceedings. The ordinary trial process should, so far as necessary, be adapted to meet those ends."[170] The Practice Direction envisages that there will be consideration and directions given as to the needs of the defendant. Suggestions are made that in most cases of vulnerability, proceedings should take place on one level in the courtroom; the defendant should be able to sit next to family or support workers in a place where they are comfortable and which permits easy communication with their legal representatives; at the beginning and throughout the trial, steps should be taken to ensure that the defendant understands what is happening and that the timetable is arranged so that they can concentrate; the trial should be conducted in simple, clear language that the defendant can understand. The Practice Direction also indicates that arrangements for a live link should be considered where this is appropriate for the defendant's evidence, that wigs and gowns should not be worn unless for good reason and security officers should not be in uniform.[171]

4.10 Chapter 7 of the Equal Treatment Bench Book also identifies that adjustments to court and tribunal procedures may be required and provides guidance on the needs of people with varying characteristics.[172] There is also Judicial College guidance on dealing with children and vulnerable adults,[173] which states that judges and magistrates should be alert to vulnerability, even where previously not flagged up, and gives helpful examples of signs of vulnerability. It asserts that judges must actively case manage[174] and highlights that vulnerable people

---

[169] The guidance on how to use intermediaries does attempt to provide this, see TAG, Intermediaries Step-by-step, Toolkit 16, (10 April 2017), available at http://www.theadvocatesgateway.org/images/toolkits/16-intermediaries-step-by-step-2017.pdf

[170] Criminal Practice Direction III.30.3 at http://www.justice.gov.uk/courts/procedure-rules/criminal/practice-direction/part3#id6328221

[171] Criminal Practice Direction III.30.9-18.

[172] Equal Treatment Bench Book, chapter 7, 'Mental disabilities, specific learning difficulties and mental capacity,' (2013), available at https://www.judiciary.gov.uk/wp-content/uploads/2013/11/7-mental-disabilities-specific-learning-difficulties-and-mental-capacity.pdf

[173] Published November 2013. Available at https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/judicial-college/ETBB_Children_Vulnerable_adults+_finalised_.pdf

[174] See also CPD Section 3A and The Advocate's Gateway case management toolkit.

are often more adversely affected by delay than others, both emotionally and in terms of their ability to recall events. It provides detailed information on trial management and controlling questioning, and also states that judges and magistrates should request regular feedback from those responsible for welfare about what local arrangements work well and what could be improved.

4.11 The sources provide useful guidance. Yet, in our experience, it is rarely the case that defendants are sat outside the dock, with all participants on one level, de-robed and out of uniform. In the Crown Court this often does not even occur with child defendants. In cases where intermediaries are used, they often are required to sit in the dock with the defendant, where it is hard to hear the proceedings.[175] The provisions on special measures in the Youth Justice and Criminal Evidence Act do not extend to defendants,[176] except in respect of live link proceedings, and rely on the discretion of the presiding judge to make directions pursuant to the Criminal Procedure Rules, Rule 3.9(3) and (4) and the Practice Direction. Legal professionals continue to use technical, legal language throughout the trial, irrespective of the defendant's needs. Many of the courtrooms in our criminal court buildings are an inappropriate forum for vulnerable defendants and more must be done to adapt the venue for trial to their needs.

Support at court

Responses of prisoners with learning disabilities and learning difficulties to the question: 'What would have helped in court?' Prison Reform Trust[177]

Over a third of interviewees said that the use of simpler language would have helped:

"*The judges don't speak English; they say these long words that I have never heard of in my life*."

One fifth said more support in court would have helped, including moral and practical support:

[175] JUSTICE considers that the dock should be abolished in all cases, but its impact on vulnerable defendants is particularly apparent and hard to justify, J. Blackstock, *In the dock: reassessing the use of the dock in criminal trials* (JUSTICE, 2015), available at https://justice.org.uk/in-the-dock/

[176] s.33BA and 33BB Extend the role of an intermediary for giving evidence but are not in force.

[177] J. Jacobson & J. Talbot, *Vulnerable Defendants in the Criminal Courts: a review of provision for adults and children*, Prison Reform Trust, (2009), p. 18, available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/vulnerable%20defendants%20in%20the%20criminal%20courts.pdf

"*I had a family member with me. They helped by just being there*."

"*I had my foster mum there; she was like an appropriate adult really*."

"*The solicitor told me what was going on, as I couldn't understand half of it*."

Around one in ten said they had difficulties expressing themselves and felt rushed:

"*I am not good at speaking and they don't listen. I needed more time to explain myself*."

Two interviewees told how their support needs had not adequately been met:

"*...I have a bad stutter. I didn't give evidence because of that; as if I'm nervous it begins to get worse. I should have given evidence, as my solicitor didn't tell the judge everything that I wanted him to say*."

"*Because I have special needs I can't just send a note to my QC, and so I was stuffed if I didn't agree with what they were saying*."

Support assistants

4.12 It is something of an anomaly that so much reliance is placed on AAs during the investigative stage, yet there is no assistance provided to defendants at court. The Witness Service provide free and independent support for both prosecution and defence witnesses in every criminal court in England and Wales. Citizens Advice trained volunteers provide practical information about the process, as well as emotional support to help witnesses feel more confident when giving evidence.[178] We consider that this same support service should be extended to vulnerable defendants.

Liaison and diversion

4.13 The introduction of L&D services in the Crown Court is a welcome addition, though still in its infancy in most areas.[179] However, the Central Criminal Court has had the assistance of a psychiatric nurse for 10 years and provides a good example of how this service can be utilised.[180] Psychiatric nurses have also been

[178] See https://www.citizensadvice.org.uk/about-us/citizens-advice-witness-service/

[179] And being trialled this year specifically in Birmingham, Bristol, Liverpool and Nottingham, see https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/#q1 Luton Crown Court will have a permanent L&D service from November 2017.

[180] Because mental ill-health was identified to be a regular feature in the serious cases being tried there, the role was initially paid for out of the Court budget.

present in some magistrates' courts for a long time, though the specific L&D scheme is relatively new.

4.14 For L&D services at court, it may not always be the case that they are aware of defendants with vulnerability. Cases are referred in a variety of ways in the Central Criminal Court, from an assessment at the magistrates' court, police custody, or prison.[181] Barristers may refer their clients. L&D practitioners also look at case summaries, if available, to see if they reveal any vulnerability issues. As set out in **Chapter III**, the Common Platform will be a valuable tool to ensure that vulnerability is flagged on the case file, not only for the CPS but once the case arrives at court. Currently L&D practitioners do not have access to the Digital Case System, which means there is unlikely to be access to case summaries. Running lists are the only other place to monitor, which show the defendant's name, age and summary of the charge(s). If L&D practitioners at Court could have access to the Common Platform once it arrives, they would be able to see clearly which cases involve vulnerability and where they need to assist.

4.15 Justice's clerks have told us that L&D has made a significant improvement to the information known about defendants in magistrates' courts. While it takes time to embed, in places where the service has been operating for some time, L&D practitioners are well known and court staff and defence practitioners will turn to them for advice. Experienced L&D practitioners will confidently update the court and legal professionals with their assessments and suggestions.[182] Of significance is the information flow that L&D practitioners generate, by providing training and information about mental health to court personnel. In magistrates' courts, the impact of L&D practitioners is particularly felt with regard to the need for psychiatric assessment in relation to disposal and liaison with health services for relevant treatment programmes. It should also be the case that L&D assists with assessment of what reasonable adjustments are necessary for trial.

4.16 At the Crown Court rarely will L&D practitioners carry out an assessment, although this does happen on occasion if needs have been missed at an earlier stage or emerge at court. L&D at this stage is more a case of facilitating access to appropriate services, for example to psychiatric assessment and hospital placements, or intermediaries. L&D practitioners see their role as ensuring defence lawyers and the court know that there is a vulnerability and the steps that

[181] L&D practitioners will often ask the prison health service for an assessment of the defendant's court needs.

[182] Ensuring L&D practitioners are familiar with the court process is key to the service embedding and being utilised, see Offender Health Collaborative, Liaison and Diversion Manager and Practitioner Resources 8: *Police and Courts* (August 2015), available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-08.pdf

need to be taken to address it. They use their initiative to make sure appropriate measures are in place for trial[183] or that the right information is provided for a psychiatric assessment. In an established service like that at the Central Criminal Court, this can save considerable court time, in trial or delay to proceedings and legal costs.[184] Charles de Lacy, the L&D practitioner at the Central Criminal Court, considers that the scheme is successful because of the support from the court community for his work and a recognition of its value. Key to its effectiveness is ensuring communication between the court and defence team, not acting unilaterally and both sides asking for advice when they are not sure what either the legal or medical procedure is.

4.17 However, there are difficulties in ensuring that the scheme operates well. Access to medical records, particularly in London where there are a number of NHS areas, can be limited. GPs or hospitals may not be familiar with the L&D role or practitioner, and therefore reluctant to provide access.[185] Without access to medical records, the immediate assistance L&D is able to offer can be frustrated. As L&D is rolled out, a key aspect of its work will be to identify where there are gaps in medical service provision and aim to improve this so that referral and diversion are effective.[186]

4.18 As at the police station, it seems to us that L&D services are crucial to ensuring that vulnerabilities are identified and appropriately responded to at court. L&D practitioners should play a key role in ensuring that the vulnerability case management protocol is progressed (see below). We consider that the embedding

---

[183] Charles de Lacy gave us an example of a defendant needing a specialist bed because they were paraplegic. He found a charity on the internet that provided these, got a court order to guarantee payment and arranged for the bed to be put in the court room. There are all sorts of different arrangements that the L&D practitioner can help with, because they understand both the medical and legal environments and what practitioners in each require.

[184] For example, by ensuring that a psychiatric assessment takes place quickly, proceedings can be discontinued and the patient transferred to hospital rather than prison.

[185] L&D practitioners should have access to the medical records database of the NHS area they are employed by, but will need permission to access other areas' records.

[186] The L&D website explains that it is "a commissioning-led model of development. NHS England's Health and Justice Regional Teams will work with the youth and criminal justice systems, health and local authority partners to ensure that L&D services are integrated into a framework of mental health, drug and alcohol rehabilitation, learning disability, youth offending, school nurse partnerships and physical health services to make the most of the services available at a local level. L&D services will provide crucial intelligence of key areas of unmet need and how services can be reconfigured to best support vulnerable individuals passing through the justice system," see https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-faqs/#q1

of L&D practitioners in all court centres should be a priority in the next stage of the roll out.[187]

Intermediaries

4.19 If a case against a vulnerable defendant progresses to trial, an intermediary is an important resource to draw on to enable them to participate effectively. At this stage, intermediaries ensure effective two-way communication between a vulnerable defendant and the Court by setting appropriate parameters around procedure and questioning at ground rules hearings (GRHs), identifying questioning that will not be understood during examination and explaining to the defendant what evidence is being presented against them during the trial.[188] The intermediary is also necessary for effective communication during conferences with the defence team.

> A defendant on remand who had schizophrenia was assisted at all conferences. Due to his paranoia he found it very difficult to decode and understand what was said. Only a written statement had been taken although he was clearly unwell and vulnerable. The overload of 'too many words' caused him to fly into rage. With careful planning with the solicitor and barrister we managed to help him focus and concentrate in order to make important decisions which affected the outcome of the trial. By using grounding techniques and simplifying language he remained in the trial. Example from an intermediary

4.20 Appointment of intermediaries is still very low compared to the number of criminal cases passing through the courts.[189] Research suggests that where a court appoints an intermediary it will usually be for the whole trial.[190] This is logical since it is usually the case that if a person has communication difficulties,

---

[187] In magistrates' courts, "core hours" are agreed locally to meet local case listing patterns but with an expectation to provide a Monday-Saturday service including bank holidays. In the Crown Court, the aim is to provide referrals within core working hours. L&D will not be routinely situated in the Crown Court apart from in the highest-volume courts at this stage. For probation services, the aim is to be accessible during court hours to provide input into bail, and pre-sentence report services, L&D Service Specification, p.34.

[188] Plotnikoff and Woolfson, *supra*.

[189] Figures provided by Communicourt and Triangle show that in 2016, just 352 intermediaries assisted defendants at all stages of the trial process. If we take the 2016 figure for magistrates' courts receipts of 1,528,880, this amounts to intermediaries assisting roughly 0.0023% of defendants in 2016. It is interesting to note that out of 409 assessments carried out by Communicourt appointed intermediaries, 76% of defendants were recommended to need an intermediary.

[190] Communicourt, 'Report Number 1: Number crunching' (August 2014); Plotnikoff and Woolfson, *supra*, pp 249-251; P. Cooper, *Highs and Lows: the 4th Intermediary Survey* (13th October 2014); Law

it is much broader than speech impairment.[191] However, an amendment to the Criminal Practice Direction concerning use of intermediaries has introduced the following guidance: "Directions to appoint an intermediary for a defendant's evidence will… be rare, but for the entire trial extremely rare."[192] The recent judgment of *R v Yahya Rashid* [2017] EWCA Crim 2 emphasises this by noting that there is a distinction between the need for general support and calm explanation (which can be provided by any adult with suitable life experience) and the need for skilled support and occasional intervention (which requires a registered intermediary). The Court optimistically suggested that "the court can rely on the fact that the advocate has been properly trained to deal with vulnerable defendants. It is an ordinary part of the competent advocate's duties to be able to do what is needed to ensure the Defendant can participate in every aspect of the trial."[193] It went on to state that, "[w]here the advocate is not competent, the remedy is not to provide an Intermediary for the whole of the trial. That would be placing financial pressure on the criminal justice system, when the responsibility lies with the legal aid authorities."

4.21 This development causes us concern, since advocates, and judges, are not currently suitably trained to adapt their conduct of trial for vulnerable defendants.[194] This

---

Commission, *Unfitness to Plead*, Law Comm No. 364 (2016), available at http://www.lawcom.gov.uk/wp-content/uploads/2016/01/lc364_unfitness_vol-1.pdf para 2.16.

[191] For example, people with severe dyslexia may have problems with processing information and word finding. Other vulnerabilities result in restricted vocabulary and limited ability to understand and follow the nuances of the court case. Mental health conditions have an adverse impact on the person's understanding, especially in the alien environment of the dock. People who have a learning disability will be expert at masking this and say "yes" when asked "do you understand?" as they do not want to appear stupid. They may then sit back and disengage for the rest of their trial because it is too difficult to follow. An appropriately skilled intermediary can address all these issues, and difficulties are rarely insurmountable. See Intermediaries for Justice, 'Evidence only?' available at http://www.intermediaries-for-justice.org/wp-content/uploads/2017/07/Evidence-only.pdf

[192] Criminal Practice Direction 3D on Vulnerable People in the Courts, paras 3F.12 and 3F.13, citing cases *R v Cox* [2012] EWCA Crim 549; *R v R* [2015] EWCA Crim 1870 and *OP v Secretary of State for Justice* [2014] EWHC 1944 (Admin).

[193] The Court of Appeal in *R v Grant Murray et al*, [2017] EWCA Crim 1228 (11 August 2017) at [226] went further in stating: "*We would like to emphasise that it is, of course, generally misconduct to take on a case where an advocate is not competent. It would be difficult to conceive of an advocate being competent to act in a case involving young witnesses or defendants unless the advocate had undertaken specific training. That consequence should help focus the minds of advocates on undertaking such training, whilst the Regulators engage on the process of making such training compulsory*."

[194] This is underlined by the pilot of pre-recorded cross-examination of child witnesses, which found that, although GRHs were held to consider questions, when witnesses and their parents/carers were interviewed (a small sample of 16 participants, with 5 children) they thought that advocates should be more considerate

demands a significant shift in the approach to trial craft and language. Words which seem part of usual language have different meanings in court. For example: *admissions*, *case*, *furnish*, *putting the case*, while other words are specific legal terms: *prosecution*, *evidence*, *mitigation*, *collaboration*. These are hard for legal professionals to avoid since they are trained to use technical and specific terms, and are not skilled in recognising when this this is poorly understood or how to adapt their language.[195] Remembering to adapt language for the benefit of the defendant while trying to examine prosecution witnesses, some of whom may be giving technical evidence, is wholly unrealistic. This is a particular, clinical skill, which should not be left to legal professionals to attempt to protect.

4.22 The key incentives to restrict use of intermediaries amongst legal professionals appear to be firstly, their cost, secondly, delay to the trial in sourcing an intermediary for assessment and thirdly, their interference in the process (by highlighting difficult questions or requesting breaks at inappropriate times).[196] Costs prior to trial are borne by the defence solicitor, who must seek approval from the Legal Aid Agency, and at trial by the court.

4.23 As a consequence, we consider that the intermediary model needs to be revised. The current model is too fragmented and there is confusion about the role and who should provide the services. There are intermediaries who are only part of the witness intermediary scheme, intermediaries who only work with defendants and those who do both. We think that those who work with both have a better knowledge of the criminal justice system and therefore can be more effective.

4.24 As explained in **Chapter II**, defendant intermediaries are not provided by the Ministry of Justice Registered Intermediary Scheme, but by private companies or on an individual basis. The costs charged factor in training, administration, and

---

of, and responsive to, witnesses' age and other vulnerabilities. Only negative experiences were felt about live cross examination: "*the worst thing is the way that they say it*": J. Baverstock, *Process evaluation of pre-recorded cross-examination pilot* (Section 28) (MoJ Analytical Series, 2016), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/553335/process-evaluation-doc.pdf

[195] The Equal Treatment Bench Book acknowledges this: "In practice, many advocates find it more difficult to adapt key questions than they anticipate. It can also be difficult to keep in mind all aspects of questioning that may be problematic for the individual witness. An intermediary who has already assessed the witness's communication is able to alert the court to any problems or loss of concentration," Chapter 5, para. 47.

[196] If the cross-examination questions have been prepared and the GRH has been effective, the intermediary should not have to intervene to highlight difficult questions. One of the discussions that takes place during the GRH is how the intermediary should notify the court that the defendant is too distressed to listen or is tiring. Intermediaries usually say that the court can then decide if it is an appropriate time for a break or not. Recently, a judge said to our intermediary member that she must flag up distress or fatigue, and not hesitate to do so. However, even where used appropriately, this will necessarily have an impact upon the pace and flow of the trial, which can be frustrating for advocates unfamiliar with the process.

travel costs. If the MoJ Scheme were extended to defendants, these additional costs would be borne by that fund. Furthermore, the MoJ would be responsible for training and recruitment, which would increase the few practitioners available. If intermediaries were embedded in their local courts, through a duty scheme, there would be no travel costs or delay. Since a certain level of capacity is required for defendants to progress to trial, the range of intermediary specialism to provide suitable assistance is much narrower than that which might be required for witnesses, and should be easier to provide.[197] However, any specialist need should have been identified at the police station and passed on by the L&D practitioner such that a specialist could be booked.

4.25 We also consider that a regulatory body, with training requirements, should be established so that courts can be confident that intermediaries are of a competent standard and understand the nature of their role in the legal proceedings. Training should be comprehensive and encompass not only the communication skills required and the effect of mental ill health, anxiety and trauma on communication but also procedure in police stations, at court and other criminal justice settings.

4.26 These changes will assist in dispelling much of the confusion and mistrust of this important service, which can be crucial to enabling a fair trial for the defendant.

Venue

4.27 We considered the introduction of specialist mental health courts, however we concluded that the volume and range of people with vulnerabilities once properly identified would make this unfeasible. Instead, we make suggestions for targeted and specialist case management below. We also considered whether moving the venue for the hearing to the hospital or prison where a defendant is detained may be an appropriate consideration for defendants with particular difficulties.[198] Mental health tribunal and parole board hearings take place at the secure venue rather than transporting the patient or prisoner to court. We recognise that this will be more problematic for jury trials. However, we think that consideration should be given to this for magistrates' court trials and procedural hearings, in

[197] Such as the two year old child who was recently able to give a statement to the police with the support of an intermediary, see https://www.theguardian.com/law/2017/oct/10/two-year-old-girl-gives-evidence-in-uk-abuse-case

[198] A defendant was tried in the Crown Court this summer who had to be transported to court each day for a number of weeks, accompanied by five psychiatric nurses, was kept in the secure dock, and frequently requested to return to the cells because he could not cope with the proceedings. His advocates thought it would have been a far more humane and fair process, and one which he would have had a better prospect of participating in, if the trial had taken place in the secure hospital.

the interests of the defendant receiving a less distressing, and therefore fairer, process.

Information

4.28 As we set out in **Chapter II**, provision of easy read information is not compulsory in the police station. However a notice of rights and entitlements must be provided and an easy read version should be given if available. For court, there is no such equivalent and we think this should be developed to enable vulnerable defendants to understand the process better.[199] An easy read summons for non-imprisonable offences should be developed as a priority that makes clear that people can go to court rather than simply plead guilty by post or online.

Case management

4.29 In order to ensure that proper consideration is given to the needs of vulnerable defendants, in our view a number of significant changes are required to the current process.

4.30 Firstly, a dedicated judge should be appointed, with responsibility for ensuring that cases involving vulnerable defendants are appropriately dealt with. In magistrates' courts this should be a district judge. The judge should be the reference point for other judges who have cases that may involve vulnerability, and should conduct the first appearance in the magistrates' court and Plea and Trial Preparation Hearing or additional preparatory hearings in the Crown Court as often as possible to ensure that the necessary reasonable adjustments are taken to meet the defendant's needs. Most crucially, they would need to be familiar with the procedures that should be followed where vulnerability has been identified – for example, consideration of the L&D report from custody and/or the magistrates' court, assessment of capacity and need for psychiatric or other reports, and necessity for reasonable adjustments to be taken to improve the defendant's participation in the trial.

4.31 Secondly, the dedicated judge should have the power to direct that the CPS review its decision to prosecute following a procedural hearing. There will be circumstances where it appears to the court that it would not be in the interests

[199] We have come across an easy read document from 2012 for the magistrates' court, but this does not appear to be widely available or used, see https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjyzNmT6JDXAhU mD8AKHdw6DZkQFggmMAA&url=http%3A%2F%2Fwww.bild.org.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D6708&usg=AOvVaw1hcC-Cxw2cfNguYXxp3FOw

of justice to prosecute a particular defendant. Given our recommendations and the increasing options for diversion, we think it appropriate that the decision to prosecute in these circumstances be justified. Currently, although some judges do this, prosecutors are known to provide a limited response, simply confirming the original decision. A power to order the specialist mental health prosecutor to provide a further review and full written reasons for the decision to continue to prosecute will go some way to ensuring that all decisions are accountable and appropriate. Prosecutors are now used to providing written reasons for their decisions to discontinue as part of the Victims Right of Review.[200] The case management power should be set out in the Criminal Procedure Rules. If there were a refusal to review the decision, the matter could be referred to the dedicated judge, if not already before them, or if necessary the Presiding Judge or their nominee.

4.32 Thirdly, a protocol should be put in place to ensure that the Criminal Practice Direction and guidance is correctly followed and reasonable adjustments are made as necessary.[201] This should be a mandatory process for all court professionals when vulnerability is identified. It should require that:

a. All defence practitioners know who the dedicated judge is at each court venue and be able to raise concerns about their client with them;

b. Where vulnerability is identified, the case automatically be allocated to the dedicated mental health judge;

c. A procedural hearing be listed, ideally with the first appearance in the magistrates' court/PTPH in the Crown Court;

d. Prior to the hearing, the L&D practitioner should assess the defendant;

e. Such hearing will consider the L&D assessment at custody and/or the magistrates' court and any further Crown Court L&D advice as to the needs of the defendant;

---

[200] See MoJ, Code of Practice for Victims of Crime, (2015), para 2.2, available at https://www.cps.gov.uk/legal/assets/uploads/files/OD_000049.pdf

[201] An example of a really helpful protocol is that produced in the Northern Territory of Australia. For many lawyers, especially those who do not identify themselves as Aboriginal or Torres Strait Islander, those who do not have Indigenous heritage and those who are new to the Territory, communicating with Indigenous clients poses some special challenges. It is a set of six protocols, some related discussion and tips for a legal practice that is culturally attuned to the special requirements of communicating with and representing Indigenous people, Law Society Northern Territory, Indigenous Protocols for Lawyers, Second Edition, (2015), available at http://lawsocietynt.asn.au/images/stories/publications/indigenous_protocols_for_lawyers.pdf

f. Following our recommendations in **Chapter II**, an intermediary should have been present at custody if the defendant needed them, and this support should therefore continue to the procedural hearing to advise as to the needs of the defendant at trial;

g. If required, a GRH be listed;

h. If there is a capacity issue, a psychiatric assessment should take place. Ideally, the first appearance/PTPH should be booked on a day when the community mental health team, either through L&D or otherwise, are able to conduct this assessment.[202] If a more specialist assessment is required, the dedicated judge should be able to order this, or support an application by the defence solicitor to the Legal Aid Agency for funding and assessment as soon as possible, which L&D will facilitate;

i. If the assessment reveals that the person should be in a hospital rather than custodial setting, the psychiatric team at court as part of L&D should be able to recommend and arrange this;

j. A fitness to plead hearing should be fixed as soon as possible before the dedicated judge, should the psychiatric assessment reveal capacity concerns, and disposal dealt with on the same day;[203]

k. If the trial goes ahead, reasonable adjustments to the trial room should be considered, at a minimum involving one level, the removal of robes and uniforms, and the placement of the defendant with family or support assistance as standard conditions, unless particular reasons justify otherwise;

l. The need for assistance from an intermediary should be carefully considered along with other particular requirements of the defendant, such as how language and questioning will be adapted throughout the trial so that the defendant understands the proceedings, whether breaks and shorter days are needed, whether public presence should be restricted, and if adaptations to lighting or sound are required. Familiarisation visits should also be considered.[204]

---

[202] We are aware that the provision of practitioners to conduct psychiatric assessments varies; some court centres have the facility on each sitting day, others one or two days a week.

[203] See **Chapter V** for our thoughts on this process.

[204] TAG Toolkit 8 cites as good practice an explanatory visit to court out of hours for a vulnerable defendant to help alleviate anxiety, pursuant to CPD 2013, para 3G.2.

m. The PTPH form in the Crown Court should have a vulnerability section, setting out a checklist of the protocol and record the directions from this hearing.[205]

n. At the end of the trial or fact finding procedure, should the defendant be found guilty or the act or omission be made out, disposal should be referred back to the dedicated judge, if they have not tried the case, and be informed by the L&D practitioner's consideration of what treatment is available in the community.[206]

Training

4.33 In order for such a protocol to be fully effective, familiarisation with vulnerability should be part of training. This is not about identifying vulnerability, but what to do about it once it is identified. In our view, every District, Circuit and High Court judge, magistrate, and court legal adviser should have had some training on enabling him or her to recognise what steps need to be taken to deal with the particular vulnerabilities of a defendant; the procedure that must be followed to make reasonable adjustments; and the law. This training should be about knowing how to respond to mental health needs. Given the prevalence of mental health problems in the criminal justice system, it must be embedded in core and refresher criminal training and utilise mental health practitioners to illustrate the kinds of needs that defendants have.[207]

---

[205] In *R v Grant Murray*, *supra*, at [227] the Court records that it has asked the Criminal Procedure Rules Committee to review the form used for the PTPH hearing: "this form has proved an effective and vital means of identifying the issues that are likely to arise at the trial. The Committee had been asked to include within the form a check list of all the relevant matters that need to be considered when young persons are to be tried in the Crown Court. As the form will require the judge to give reasons for departing from the Practice Direction, focus on the needs of young defendants will be intense. The Committee has agreed to make revisions to the form." This revision will also include vulnerable defendants.

[206] See **Chapter VI**.

[207] The training could take inspiration from the Mental Health Tribunal training. All judges must undertake mandatory induction training. To sit on restriction order cases judges must undertake two days of training per year, over a three year cycle, which must include two days attendance at a particular training event. For the other four days in that cycle, they can choose from a prospectus of courses. These are run across the country by experienced doctors and lawyers and cover areas such as communicating with someone with vulnerability, legal updates, appropriate treatment in hospital and the community, and unconscious bias. A day is planned next year for training that includes people with ASD and their experiences. Although legal members sit with a consultant psychiatrist on the tribunal, the training aims to equip judges with the ability to recognise the issues that people have and identify their needs so that they understand better the difficulties people with mental ill health face.

4.34 The same must be available for solicitors and barristers, as part of their professional training. There is currently no training for new practitioners on how to respond to mental health needs for either solicitors or barristers. The Inns of Court College of Advocacy has developed training on vulnerable witness handling in criminal cases, which it intends to be mandatory for all practitioners.[208] This is a significant step forward. However, it does not extend to providing guidance on the procedural steps that must be taken to respond appropriately to vulnerability in a client.

The Judicial College has developed an e-diversity site, accessible to all judges, which includes five modules on communicating with people with disabilities, including speech and language difficulties. The chapters are designed to be short and snappy, for judges who need quick answers. Some also have interviews with people giving tips about communication skills. The modules include questions and provide a certificate upon completion.

Informal training is being adopted on an ad hoc basis in some areas, often as a result of the L&D team being introduced. A practitioner we spoke to tried running training for magistrates on Saturdays but found there was low attendance. An example given at The Advocates' Gateway conference in June 2017, see https://www.theadvocatesgateway.org/conferences/2017-conference by Mignon French was of monthly lunchtime awareness sessions for magistrates in Northamptonshire, where 80-100 magistrates and other court staff attend to address Lord Bradley's recommendations, in order to increase mental health and learning disability awareness, and make appropriate remand and sentencing decisions. Post-session awareness was reported to have been very positive – 100% said they would ask for a professional opinion; 93% said they were more likely to use community options when sentencing.

[208] See https://www.icca.ac.uk/advocacy-the-vulnerable The ICCA intends to train 16,000 advocates over a two-year roll out programme.

V. LEGAL CAPACITY TESTS

I thought everything I said, did and thought was not real, that I was not real, almost as though I did not exist, so I could never affect anyone because I was not real, no-one could possibly take me seriously because I was not real. Prisoner describing the effects of psychopathy[209]

5.1 As the introduction to our report has made clear, we considered that the overriding concept upon which we should concentrate was vulnerability, in the sense that we have described it. Where procedural questions are concerned, the context does not necessarily either require or permit consideration of the niceties of definition. But the question of legal responsibility does require the identification and application of such tests.

5.2 These tests relate to the fitness to plead process, the insanity defence and the diminished responsibility defence. All three processes are problematic, due to their age and confrontation with the clinical understanding of capacity, which has developed. Over the past decade the Law Commission has considered these tests and reported its recommendations for change. We could not attempt anything close to that breadth of review and scrutiny, and for the most part endorse its conclusions.

5.3 In this chapter, we therefore set out in very brief summary the Law Commission's recommendations for each test, and where we might seek to go further. The main difficulty that the Law Commission has had with its approach to this area is that the tests have been considered in isolation. Once placed together, it seems to us that some inconsistencies and practical problems arise. It is with these that we are primarily concerned in this chapter.

Fitness to plead and stand trial

5.4 With the benefit of our recommendations from the earlier chapters, it should be the case that the dedicated judge, specialist prosecutor, defence team and L&D services have identified early in the case that a fitness to plead or stand trial procedure is required.[210]

---

[209] H. Prins, *Offenders, Deviants or Patients?* (Routledge, 2005), p. 153.

[210] In the Crown Court, this is pursuant to ss4 and 4A Criminal Procedure (Insanity) Act 1964 (CP(I)A). In magistrates' courts, there is no statutory power to assess fitness but in practice this is done in order to make sense of the fact finding procedure set out in s37(3) MHA and the medical examination required prior to disposal set out in s11(1)(a) of the Powers of Criminal Courts (Sentencing) Act 2000. This process is wholly unsatisfactory because the powers on disposal where someone is "unfit" are very limited, see **Chapter VI**.

5.5 Currently, the courts decide whether the defendant is "unfit to plead" applying the Pritchard test (*R v Pritchard* (1836) 7 C&P 303). The most useful formulation of this is currently set out in *R v M(John)* [2003] EWCA Crim 3452, which is a six-point test asking if the defendant is capable of:

i. Understanding the charges;

ii. Deciding whether to plead guilty or not;

iii. Instructing solicitors and counsel;

iv. Exercising his right to challenge a juror;

v. Following the course of proceedings;

vi. Giving evidence in his own defence.

5.6 If "unfit," magistrates or a jury must then decide at a fact finding hearing whether the defendant "did the act or made the omission charged against him." If a defendant later becomes fit, there may be the opportunity of resuming the prosecution in limited circumstances.[211]

5.7 The Law Commission's main recommendation[212] for revising these procedures is that a statutory test is needed to clarify the repeated restatement of the common law, which has led to uncertainty about its formulation, scope and proper application. We largely agree with the Law Commission. In order to ensure that the fair trial guarantees in article 6 ECHR are considered, the test should require an assessment of the defendant's ability to participate effectively in the proceedings on the offences charged, taking into account reasonable adjustments that can be made to support capacity. The test should explicitly incorporate decision-making capacity and include an assessment of the defendant's ability to, amongst other capacities:

a. understand the trial process and the consequences of being convicted;

b. give instructions to a legal representative;

c. make a decision about whether to plead guilty or give evidence;

---

[211] Where a hospital and restriction order has been imposed, pursuant to s. 5A(4) Criminal Procedure (Insanity) Act 1964 the Secretary of State can exercise the power to remit for trial. CPS guidance requires prosecutors to consider various factors, including the defendant's condition, the current available evidence, the views of victims and witnesses, the delay, the length of the defendant's detention in hospital and whether the public interest can be satisfied by an out of court disposal, see http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/

[212] See Law Commission, 'Unfitness to Plead, Volume 1: Report' (House of Commons, 12 January 2016), available at http://www.lawcom.gov.uk/wp-content/uploads/2016/01/lc364_unfitness_vol-1.pdf

d. give evidence.

This recommendation would remove the current focus on intellectual abilities and more appropriately identify those who are unable to engage with the trial process, in line with the civil test set out in section 2 Mental Capacity Act 2005.[213]

5.8 The Law Commission was also concerned that the ability to plead, even if unfit for trial, is not separately considered, which may unnecessarily deny the defendant his or her legal agency,[214] and undermine victim confidence in the system. While we have some reservations with how this might operate in practice, we agree that the capacity to recognise wrongdoing is different to the capacity to effectively participate in legal proceedings. We think that there should be one assessment, which makes recommendations as to the two capacities. If the assessment concludes that the defendant displays sufficient capacity to enter a plea, subject to legal advice and any communication assistance from an intermediary, this opportunity should be offered.[215]

5.9 The Law Commission recommended changes to the current evidential requirements:

a. That the definition of experts be broadened to include psychologists as well as MHA registered medical practitioners. This would avoid the fact that often a report is also required from a psychologist, thereby demanding a third report.

b. A party should disclose, as soon as reasonably practicable, an expert report that indicates that the defendant lacks capacity, rather than waiting for both reports. The court should then order joint instruction of the second expert, unless the interests of justice require otherwise, to avoid the prosecution seeking their own, separate assessment of the defendant.

c. All experts should address the prospects of recovery and likely timeframe for achieving capacity for trial and the court should consider whether it is appropriate to postpone proceedings for up to 12 months for the defendant to achieve capacity.[216]

---

[213] In its draft legislation, the Law Commission specifically adopts the test in s 3 MCA to define the ability to make a decision.

[214] Which would undermine their rights set out in the UNCRPD.

[215] In practice this would only arise where the defendant, after taking advice, was considered able to plead guilty to the offence. If they could plead not guilty, but were unfit to stand trial, the usual fact finding process would be necessary.

[216] Further, a finding of a lack of capacity should remain effective in the proceedings unless and until the contrary is established on the basis of two experts' evidence to the court, and the current limitation on

5.10 The Law Commission's recommendations aim to reduce the number of costly expert reports, delays and attendant distress for the defendant; to ensure that all efforts are made to allow the defendant to recover and be tried in full; and to prevent the court having to rely on section 48 MHA transfers from custody, which can make it hard to achieve continuity of treatment. We agree with the intention and sentiment behind each of these recommendations. However, we are concerned that if a defendant is unlikely to achieve capacity until 12 months later, a trial at this point may risk being unfair for the complainant, witnesses and the defendant. We suggest that a shorter timeframe could be considered, subject to extension, if deemed necessary by the dedicated judge.

5.11 The Law Commission also made detailed recommendations to improve the procedural requirements, to which we largely agree:

a. The fitness process should apply from the outset of proceedings in magistrates' courts, including plea before venue and mode of trial.[217]

b. Judges and magistrates should have the discretion to delay the fact finding hearing, which should be called the "alternative finding procedure" to be resumed if and when the defendant recovers, where none of the available disposals are appropriate, or where more suitable provision could be made in the community by diverting the defendant. We think this problem can be dealt with by broadening disposal powers, see **Chapter VI**.

c. The prosecution should prove all elements of the offence at the fact-finding hearing. The current process interferes with the presumption of innocence, pursuant to article 6(2) ECHR. This will remove the artificial split of external and fault elements and the need to identify objective evidence in order to mount a defence.

d. A single-stage fact-finding process should take place where the insanity defence also applies. Available verdicts should be: the allegation is proved (not a conviction), acquittal, or a qualified acquittal (the "special verdict" for the insanity defence).

e. A court appointed defence advocate should put the defence case. Such arrangements should take the views of the defendant into account as far as possible, but also ensure that someone is appointed even where the defendant

---

remand to hospital for treatment under s.35 MHA should be extended to 12 months for defendants in the Crown Court, reviewable every 12 weeks.

[217] Where the defendant is found unfit to choose the venue for trial, the proceedings should remain in the magistrates' court.

would prefer not to be represented. A representative who is already instructed should usually be the person formally appointed.[218]

Insanity defence

5.12 The insanity defence is distinct from the fitness to plead or stand trial assessment because it relates to the capacity of the defendant at the time of committing the offence. Capacity is often not a constant, and may fluctuate over time, dependent upon the nature of the illness or disability, treatment, or environmental factors.[219] Therefore, although the person may have lacked capacity at the time of the offence, they could have regained it by the time a prosecution is brought. The defence is rarely used in practice, in some respects due to the difficulty posed in meeting its complicated criteria, the stigma attached to the defence and the limited disposals available.[220] It should also not be necessary because where defendants clearly lack capacity, a decision may have been taken not to prosecute, they may have been diverted earlier, or they may have been found unfit to plead.

5.13 The M'Naughten Rules were pronounced in the House of Lords in 1843:

> *to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong*.

5.14 Although the test is outdated, it has been modernised through case law. A "disease of the mind" must cause impairment of the faculties of reason, memory and understanding – a "defect of reason". The disease can be a mental or physical condition, but must be internal to the individual. It is a legal determination rather than a medical one.[221] The defence of insanity can be pleaded in magistrates' courts, and the process is set out in *R (Singh) v Stratford Magistrates' Court* [2007] EWHC 1582 (Admin); [2007] 1 WLR 3119.

---

[218] Additional recommendations are made relating to the right of appeal and for resuming prosecution where a person is subject to a hospital order with a restriction order.

[219] See MCA Code of Practice 2007, *supra*. Para 4.26.

[220] For disposals see **Chapter VI**.

[221] Per Lord Diplock, *R v Sullivan* [1984] AC 156, see D. Omerod & D. Perry QC, Blackstone's Criminal Practice 2018 (OUP, Oxford, 2017), pp. 48-49; and Archbold, *Criminal Pleading, Evidence and Practice 2018*, (Sweet and Maxwell, 2017), p. 2111.

5.15 The defendant bears the burden of proof to show that they were "insane" on the balance of probabilities. If the defence is accepted, in magistrates' courts the defendant is acquitted. In the Crown Court, a special verdict is pronounced that they are not guilty by reason of insanity.

5.16 In 2013 the Law Commission presented provisional proposals for reform of the defences of insanity and automatism,[222] based on lack of capacity.[223] It is not currently in a position to conduct a consultation on the proposals. We do think this should be made a priority, however, since it is essential to ensure the legal tests work appropriately together.

5.17 The Law Commission proposed a statutory lack of capacity defence:

a. A defence of 'not criminally responsible by reason of a recognised medical condition'. The new defence would lead to a special verdict, with special disposal powers.

b. Defendants should be exempted from criminal responsibility for an offence if they lack all criminal capacity. Three capacities would be applicable:

   i. To make a judgment rationally – how a person makes a decision.[224]

   ii. To understand that they are doing something legally and morally wrong

   iii. Control of body – loss of physical control arising out of a recognised medical condition.

c. The defence requires a complete loss of capacity as a result of a *recognised medical condition*.[225] Whether the condition is a recognised medical condition is a question of law for the judge to determine, guided by medical reference

---

[222] Law Commission, 'Criminal Liability: Insanity and Automatism discussion paper' (2013), available at https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/06/insanity_discussion.pdf p.4.

[223] It explains how these defences would operate in the context of intoxication and why it believes that the related issue of children's developmental immaturity warrants separate investigation.

[224] The Law Commission gave the example of a defendant who killed someone because he believed them to be the reincarnation of Napoleon, who must die. They may realise it is morally or legally wrong to take the law into their own hands, but be unable to think rationally about what they are doing.

[225] A person may lack these capacities because they are yet to develop them and there is a discussion to be had about a defence for those who lack capacity due to their "developmental immaturity". Some individuals will have a level of developmental maturity that is much lower than their age, but does not constitute a recognised medical condition. This is outside the scope of our work, but diagnosing whether a child satisfies the insanity test is a very complex exercise as a consequence.

texts and expert opinion.[226] This will enable the confusion caused by whether the condition is an "external" or "internal" factor to be resolved.[227] We observe, however, that combining these conditions would result in a special verdict rather than acquittal for sane automatism, which may not be appropriate in the circumstances.

d. The defendant must not be at fault for their lack of capacity. The condition must also be a qualifying condition. For example anti-social personality disorders would not qualify, on policy grounds.[228]

e. The proposed defence would operate in relation to any offence, and so would be available in magistrates' courts as well as in the Crown Court.

f. The defendant would only have an evidential burden, to produce two supporting expert witnesses. It would then be for the prosecution to prove, beyond reasonable doubt that the defendant is not excused of criminal responsibility by reason of a recognised medical condition. This would attempt to address the problems caused by separating out the mental and fault elements, which is not always easy where offences involve a blend of the two, and the right to the presumption of innocence under article 6(2) ECHR.

5.18 The proposals raise some very interesting ideas and would bring much needed clarity to this area, as well as enabling defence lawyers to fully explore the defence with their clients without using the term "insane." However, we consider that there are some conceptual difficulties with the proposed test, which we explain below.

5.19 We also consider it important that there be a judicial power to find a lack of capacity where it is clear that a case should not proceed to trial. For example, when the prosecution and defence are agreed that the facts are completely made out and that the expert evidence demonstrates the defendant lacked capacity at the time of the offence. In this circumstance, the defendant should be able to offer and the prosecution to accept a plea of not guilty by reason of lack of

[226] Evidence need not come from a doctor, but where the relevant expert is a psychiatrist they must be approved under the MHA.

[227] Currently, if the involuntary conduct is caused by an internal factor, the special verdict of insanity applies; if by an external factor, it is classed as (sane) automatism, leading to an acquittal. This has led to illogical and strange results, particularly in cases concerning sleepwalking, epilepsy and diabetes.

[228] The Law Commission does not think that people should be allowed to rely on an anti-social personality disorder that manifests itself solely or principally by abnormally aggressive or seriously irresponsible behaviour to excuse what would ordinarily be regarded as serious criminal behaviour.

capacity. This would avoid a difficult and complicated trial for the defendant and jury, and save unnecessary expenditure.[229]

Diminished responsibility

5.20 Diminished responsibility is a partial defence available to murder, which reduces the charge to one of manslaughter. Section 2 Homicide Act 1957 was amended pursuant to section 52 Coroners and Justice Act 2009 following the Law Commission's 2006 report on homicide.[230] Not all of its recommendations were implemented, in particular around division of homicide into a clearer structure.

5.21 However, the amended diminished responsibility test is essentially the modernised version that the Law Commission recommended.[231] The test requires that the defendant be suffering from an abnormality of mental functioning which:

a. arose from a recognised medical condition;

b. substantially impaired the defendant's ability to exercise one or more capacities (to understand the nature of their conduct; to form a rational judgment; or to exercise self control); and

c. provides an explanation for the defendant's acts and omissions in doing or being a party to the killing (if it causes or is a significant contributory factor to the conduct).

5.22 The defendant must prove the partial defence on the balance of probabilities.

5.23 The Law Commission's aims with these proposals were to ensure that the law would not be constrained by a fixed and out of date definition.[232] It also sought

---

[229] It would appear that this is possible in magistrates' courts, see Singh, *supra*.

[230] Law Commission, Murder, Manslaughter and Infanticide, 2006, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228782/0030.pdf

[231] Excluding developmental immaturity, which the Law Commission had concluded should be included because experts may find it impossible to distinguish between mental functioning as a result of development immaturity and mental abnormality. It found it wholly unrealistic and unfair to require experts to ignore developmental aspects, though it considered that it should be possible to consider these as part of an assessment if mental abnormality is present. We recognise that developmental concepts such as capacity are part of a continuum of developmental immaturity that Child & Adolescent Psychiatrists and other mental health experts must address during assessments of young people.

[232] The prior s. 2 Homicide Act 1957 test was: *Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or*

to make the roles of the expert and jury clearer: It is for the experts to offer an opinion on: (1) whether the defendant was suffering from an abnormality of mental functioning stemming from a recognised medical condition, and (2) whether and in what way the abnormality had an impact on the defendant's capacities, as these are explained in the new provisions. It is then for the jury to decide whether, in the light of that opinion (and all the other relevant evidence) they regard the defendant's relevant capacities to have been 'substantially impaired'.[233]

Coherency of the defences

5.24 In our view a coherent philosophy in approach to the treatment of mental illness and criminal responsibility is required for these procedures. Although it is possible to discern a legal capacity oriented focus to each of the proposed or adopted Law Commission tests, we consider it necessary that a further review take place of what defences should be available in cases where mental capacity will be in issue, taking into account the range in degree of diminished capacity that might exist for defendants with vulnerabilities. There are two particular aspects of the proposals which illustrate the problem:

5.25 Firstly, if the Law Commission's proposed test of "not criminally responsible by reason of a recognised medical condition" is compared with the diminished responsibility test now set out in law, taking into account rephrasing by the legislators, the only difference between the two tests becomes the degree of effect that the abnormality must have on capacity: under the full defence, a *complete* lack of capacity; under the partial defence a *substantial* lack of capacity.

5.26 We have found it very difficult to determine what conduct would fall under one test or the other. The Law Commission provided examples of the relevant diminished responsibility capacities in its 2006 report. However, we concluded that each of these examples could fulfill a complete lack of capacity test, not just a substantial one. This may mean that it will be very difficult for a jury to decide what amounts to a substantial, but not total, lack of capacity. Yet in order

---

injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.

[233] The Royal College of Psychiatrists observed that it is common for the courts to accept, or even encourage, a psychiatric expert to comment upon whether the defendant should be seen as 'substantially impaired' (the 'ultimate issue'), but that this should be resisted, Law Commission (2006), *supra*, paras 5.117 – 5.118, and in our view this is a legal question, requiring a determination of the facts.

to conclude that someone has diminished responsibility under the current law, logically this is what they are required to do.[234]

Law Commission examples of diminished responsibility

1. **Substantially impaired capacity to 'understand the nature of his or her conduct':**

   a boy aged 10 who has been left to play very violent video games for hours on end for much of his life, loses his temper and kills another child when the child attempts to take a game from him. When interviewed, he shows no real understanding that, when a person is killed they cannot simply be later revived, as happens in the games he has been continually playing.

2. **Substantially impaired capacity to 'form a rational judgment':**

- a woman suffering from post-traumatic stress disorder, consequent upon violent abuse suffered at her husband's hands, comes to believe that only burning her husband to death will rid the world of his sins;
- a mentally sub-normal boy believes that he must follow his older brother's instructions, even when they involve take part in a killing. He says, 'I wouldn't dream of disobeying my brother and he would never tell me to do something if it was really wrong';
- a depressed man who has been caring for many years for a terminally ill spouse, kills her, at her request. He says that he had found it progressively more difficult to stop her repeated requests dominating his thoughts to the exclusion of all else, so that 'I felt I would never think straight again until I had given her what she wanted.'

3. **Substantially impaired capacity to 'control him or herself':**

   a man says that sometimes the devil takes control of him and implants in him a desire to kill, a desire that must be acted on before the devil will go away.[235]

5.27 Secondly, the partial defence of substantial incapacity is only proposed for murder and not all specific intent crimes. Although the Law Commission considered this

[234] The UK Supreme Court considered the meaning of "substantial impairment" last year in *R v Golds* [2016] UKSC 61 and concluded that it meant not "total" but more than "trivial" or "minimal" and that this is a matter for jurors to use their common sense to decide. In two subsequent cases the Court of Appeal Criminal Division criticised the trial courts for failing to consider diminished responsibility or properly direct the jury on it, but did not consider the question of whether a total lack of capacity might also have been present on the facts: *Brennan* [2015] 1 Cr. App. R. 14; *Blackman* [2017] E.M.L.R. 17.

[235] Law Commission, *Murder, Manslaughter and Infanticide*, *supra*, para 5.121.

question it did not reach a conclusion because it was focussed on reform of the law of murder.[236] The rationale behind the distinction is that an automatic life sentence applies to a conviction for murder, whereas a range of sentencing options are available for manslaughter and other lesser crimes. However, the stigma attached to a conviction for a specific intent crime is significant, irrespective of the sentence imposed. If a person has a substantial lack of capacity to commit murder they must surely have the same substantial lack of capacity to commit, for example, grievous bodily harm with intent, rape or robbery.

5.28 In practice, these defences should be needed less frequently if vulnerability is carefully considered by the specialist prosecutor and the dedicated judge who, under our proposed protocol set out in **Chapter IV**, should review the charges and decide, or invite a decision respectively, in light of any experts' opinions on the defendant's capacity. We consider that the specialist prosecutor should ensure that the appropriate charges, if any, are brought, irrespective of the available defences.[237]

5.29 Each amended test should be set out in primary legislation. There may also need to be amendment to the Criminal Procedure Rules relating to vulnerable defendants so that they apply to defendants who lack capacity.

Medical assessment

5.30 The starting point for each of these tests ought to be to recognise that while this is a legal question arising in the context of a criminal trial, it is essentially a medical assessment of what the defendant is able to do. The difficulty for medical professionals is that there is no agreed framework with which to assess the capacity of the defendant. Clinicians need to consult the Mental Health Act 1983 (as amended), its code of practice and internationally accepted reference books[238] to identify or exclude relevant mental disorders, learning difficulty or other impairment, as well as the Mental Capacity Act 2005 and its accompanying

---

[236] See Law Commission, *Partial Defences to Murder*, (6th August 2004), available at http://www.lawcom.gov.uk/app/uploads/2015/03/lc290_Partial_Defences_to_Murder.pdf para. 5.14.

[237] CPS guidance states that, before accepting a plea to manslaughter on the grounds of diminished responsibility, there should be agreement between the police, CPS and prosecution counsel; Consultation with the family of the victim and a satisfactory psychiatric report. We think the guidance should be amended to enable prosecutors to proactively charge manslaughter on the grounds of diminished responsibility if these conditions are satisfied, see http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/#procedure

[238] DSM-5 (American Psychiatric Association, 2013) and ICD-10 Version 2016 (World Health Organisation, 2016).

code of practice. Critical to the assessment is an understanding of the context to the alleged crime, the mental elements of the offences, and the criminal trial process that the defendant will be subjected to. Without this understanding, it is impossible to give an accurate assessment of whether the defendant has the specific capacity under consideration.

5.31 The Royal College of Psychiatrists, along with the British Psychological Society, should prepare a guide for lawyers and clinicians to follow on the assessment of capacity in criminal proceedings to ensure that both sets of professionals fully understand their role – lawyers in instructing on the specific legal capacities that need addressing, and clinicians on how to word their responses to the letter of instruction so that they can be applied in the criminal justice system. A structured template should also be developed to ensure that all assessments of competence are conducted using the same approach by clinicians and produce clear, evidence based reports.[239] The L&D practitioner should be utilised by defence teams to assist in suggesting instructions to clinicians.[240]

[239] Examples of good practice with competence frameworks used in other jurisdictions include T. Grisso, *Evaluating Juveniles' Adjudicative Competence: A guide for Clinical Practice* (Professional Resource Press, 2005) for the US justice system, where there a range of other structured instruments available, S. Dawes et. al. 'Adjudicative Competence,' Curr Opin Psychiatry, 2008 Sep, 21(5), 490-494, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2570182/

[240] Where assessments are conducted by the psychiatric team regularly attending court, they will be much more familiar with the capacities that are required. These practitioners should be consulted wherever possible, both for their knowledge and to reduce the delay in waiting for an assessment to be conducted. The Criminal Procedure Rule Committee currently has a working group considering the commissioning of psychiatric reports to ensure that they are produced in a timely manner.

VI. DISPOSAL AND SENTENCING

When I went to court the solicitor explained about my condition. One of the first things they said was that they needed a psychiatric report. Then the judge said I should be in hospital but there weren't any secure beds so I went straight to Scrubs. Offender with schizoaffective disorder.[241]

As one Youth Offending Team worker put it, "The message seems to be: 'You aren't sick enough yet – come back when you are really ill and then we will treat you'." The Taylor Review, commenting on Child and Adolescent Mental Health Services (CAHMS)[242]

6.1 In this Chapter, we deal with the final stage of the process. Under "Disposals" we consider the Court's options where a person is found to be unfit or found to meet the lack of capacity test, and the facts are proved. Under "Sentencing" we deal with cases where the defendant is fit to plead and has the capacity to stand trial and either pleads guilty or is found guilty.

Disposals for fitness to plead and lack of capacity

6.2 In its work on fitness to plead and homicide,[243] the Law Commission considered the current available disposals. Although this work was set out in separate reports, the findings and recommendations are similar.[244] We do not intend here to replicate the detailed work undertaken by the Commission. We agree that the current available options are incoherent; and broadly agree with its recommendations, which we summarise below.

6.3 In the Crown Court the available disposals for an unfit individual or individual lacking capacity found to have done the act or made the omission, are:[245]

---

[241] M. O'Hara, 'Mental health and offending: One man's prison experience,' *The Guardian*, (30 April 2009), available at https://www.theguardian.com/society/2009/apr/30/prisons-and-probation-mental-health1

[242] The Taylor Review (2016), *supra*. p. 9.

[243] Law Commission, *Unfitness to Plead*, *supra*; Law Commission, *Murder, Manslaughter and Infanticide*, *supra*.

[244] In its proposals on reform of the insanity offence it raised and discussed many of these options, concluding further consideration was necessary. In its Unfitness to plead report these were then given detailed consideration and fully formulated recommendations.

[245] Pursuant to section 5 of the Criminal Procedure (Insanity) Act 1964 (as amended).

a. A hospital order[246] (with or without a restriction order)[247] by which an individual is detained in a secure hospital. The court must be satisfied on the basis of evidence[248] that:

   i. The individual suffers from a mental disorder of a nature or degree which makes medical treatment appropriate;

   ii. Treatment is available; and

   iii. In the circumstances, such treatment is the "most suitable method" of disposing of the case.

b. A supervision order (a community order with or without a treatment requirement) for a period not exceeding two years. A person subject to a supervision order is required to keep in touch with their supervising officer, and must notify that supervisor of any change of address. The order may require the individual to submit, during the whole of the prescribed period or part of it, to treatment under the direction of a registered medical practitioner – known as a "treatment requirement". The order may also include a "residence requirement".

c. An absolute discharge.

6.4 A number of ancillary orders,[249] and notification requirements are also available, as are Multi-Agency Public Protection Arrangements.[250] Courts can also make interim orders where they consider further assessment is necessary.[251]

---

[246] Pursuant to section 37 MHA.

[247] Pursuant to s. 41 MHA, which is made without limit of time such that discharge must be subsequently directed by the Secretary of State or ordered by the Mental Health Tribunal. Without a restriction order, detention is limited to 6 months, though may be renewed, s. 20 MHA.

[248] From two registered medical practitioners, one of whom must be approved under section 12 MHA.

[249] Such as Sexual Harm Prevention Orders.

[250] Introduced by the Criminal Justice Act 2003, s.325. These are designed to protect the public from serious harm by sexual and violent offenders. They require local criminal justice and other agencies to work together to assess and manage the risk posed by such individuals. An individual will be subject to MAPPA where s/he is made subject to notification requirements under Part 2 Sexual Offences Act 2003 or where s/he has been found to have done the act of murder, or a specified violent or sexual offence and has received a hospital order, failure to comply with which constitutes a criminal offence.

[251] For example, ordering detention for assessment pursuant to ss. 35 and 36 MHA and interim hospital orders under s. 38 MHA. Hospital orders can also accompany sentences of imprisonment (usually with very long or life sentences) so that once treatment is completed, offenders can be transferred to prison, pursuant to s. 45A MHA. The Court of Appeal has cautioned that judges must be very careful in their

6.5 In magistrates' courts, where the court is satisfied that the defendant did the act or made the omission, a hospital or guardianship order[252] is the only available disposal, pursuant to section 37(3) MHA, without the defendant being convicted. However, these are applicable only to imprisonable offences, those suffering from a mental disorder within the terms of section 1 MHA, (which excludes learning disability unless associated with abnormally aggressive or seriously irresponsible conduct) and, with respect to guardianship, only to those aged 16 years or over. If these conditions are not satisfied, the only options are for the Crown to discontinue the proceedings, the defence to make an abuse of process application or for the court of its own volition to adjourn *sine die*. These options are clearly far too limited to provide an appropriate response to the offending behaviour and the individual's needs.

6.6 The Law Commission has made a number of recommendations for the improved operation of disposals, largely in relation to supervision orders, which should be available in both magistrates' courts[253] and the Crown Court.

Supervision orders

6.7 The Commission's main recommendations in relation to these orders are that:

a. The maximum length should be extended from two to three years to provide a longer period within which the individual can receive constructive support in the community;

b. The person's local authority alone should have responsibility for their supervision, as it is inappropriate for probation providers to supervise individuals who have not been convicted of an offence. Social workers are better placed to co-ordinate the supportive and health elements of the order. The local authority should also nominate a social worker to supervise the programme to prevent the current problem of officers being unwilling to supervise people with vulnerabilities;

c. The supervised person should be required to attend supervision meetings and a constructive support requirement (which would include education, training,

---

choice of imprisonment (where transfer to hospital may then be necessary), interim orders, and hospital and limitation directions, *R v Vowles et al* [2015] EWCA Civ 56.

[252] S. 8 MHA states that a guardianship order confers the power to require the patient to reside at a specified place; to attend at a specified place for medical treatment, occupation, education or training; and to require access to be given to the patient by a medical practitioner or other person specified.

[253] Excluding restriction orders.

employment and accommodation) should be available to provide effective support in the community;

d. Restrictive requirements should be available (e.g. to prohibit the possession, use or carriage of a firearm, or prohibiting the individual from attending at a specified place). Moreover, a restraining order should be available to the court where a defendant has had an allegation proved against them at the alternative finding procedure;

e. The court imposing the supervision order should have the power to:

   i. include a requirement to periodically review the order;

   ii. require the individual to attend a review hearing (and allow for subsequent reviews to be conducted without an oral hearing);

   iii. require reports by the supervising officer (and any registered medical practitioner who may be delivering treatment under the order);

   iv. make a finding that the supervised person is in breach of the order; and,

   v. following this finding, impose more restrictive elements as part of the order, such as a curfew, with or without electronic tag; and where a previous notice has been given, the power in exceptional cases to impose custody for breach of the order.

6.8 Similar to our concerns with regard to possible sanctions in relation to a diversion panel in **Chapter III**, the Law Commission recognised that there are problems with imposing orders with a review power at this stage in terms of (1) ensuring that an individual is able to understand the requirements of the order and facilitated to comply; (2) establishing that an individual who lacks capacity has indeed breached an order, and is able to participate effectively in breach proceedings; and (3) reconciling a punitive approach to an individual who lacks capacity and has not been convicted of an offence. However, it concluded that having no sanction for breach is more problematic, because individuals who pose a significant risk of harm, but who are not suitable for hospitalisation, may wilfully breach their supervision orders and an order without a mechanism by which to ensure compliance is likely to undermine public confidence in the court system.

6.9 The Law Commission argued that there will be some individuals who, although they lacked capacity for trial, are capable of understanding and participating effectively in more straightforward breach proceedings. For example where the individual has repeatedly failed to attend appointments, without good reason, or has failed to keep the supervisor informed of where he or she is living.

6.10 It therefore suggests:

a. Limiting a punitive approach to those who have wilfully breached an order which they were capable of understanding;

b. Providing a discretion to the court whether to impose a sanction even where breach of the order is established;

c. Limiting custodial sanction to adults (for youths, a youth rehabilitation order with intensive supervision and surveillance is suggested, limited to imprisonable offences) and that this only be available where the defendant has been warned at an earlier breach hearing that such an order may be imposed in future breach proceedings. The power should not be available in magistrates' courts.

6.11 The Law Commission identified in its discussion on the insanity defence, that a requirement to undergo medical treatment may raise the issue of the legitimacy of coercing a person by the threat of criminal sanction into undergoing medical treatment. Article 25(2) UNCRPD requires that health care be provided to people with disabilities "on the basis of free and informed consent". Some types of orders which require medical treatment, e.g. a mental health treatment requirement, can only be imposed where the offender has expressed a willingness to comply with such a requirement. It is therefore important to ensure that treatment requirements are consented to by the individual and a lack of engagement in treatment cannot be a reason to breach an order.

6.12 We agree with the Commission that review is necessary, but that the consideration of breach under these circumstances is complex and difficult. We are also concerned about the imposition of restriction and restraining requirements where capacity is in issue and breach may be inevitable. In the first instance, ensuring that the appropriate disposal is chosen is a decision that we believe should be reserved to the dedicated judge. Judges need greater assistance in doing this, to which we set out recommendations under "Sentencing" below.

Mandatory restriction orders

6.13 Restriction orders are mandatory where the defendant has been found to have done the act of murder, where they suffer from a treatable mental disorder suitable for a hospital order. This means that they can be detained without limit of time, regardless of whether they represent a serious risk to the public. However, another defendant in the same position but who does not have a treatable mental disorder will receive at most a supervision order. This will lead to discriminatory treatment in breach of the Equality Act 2010 and article 14 UNCRPD. The Commission therefore recommends lifting the mandatory restriction, so that

the court has a discretion to impose restriction where this is necessary. The Commission does not think restriction orders should be available in magistrates' courts, but a power to commit to the Crown Court should be available where the justices think one needs to be made. We agree.

Sentencing

6.14 Where a person with a vulnerability is convicted (but is fit to stand trial and cannot rely on a complete lack of capacity as a defence to the crime), the court must consider the appropriate sentence for their conduct.

6.15 The appropriate sentence will depend upon the crime, but certain sentences can reflect the need to address the vulnerability that the individual may have. Hospital or guardianship orders are available upon conviction; Community orders of up to three years and suspended sentences can be accompanied with specific requirements, such as a mental health treatment requirement, a drug rehabilitation requirement or an alcohol treatment requirement.[254]

6.16 A community order may be appropriate where the defendant's culpability is substantially mitigated by his mental state at the time of the commission of the offence, and where the public interest is served by ensuring he continues to receive treatment for his mental disorder). It is not usually suitable for a defendant who is unlikely to comply with the treatment or who has a chaotic lifestyle.[255]

6.17 The court must obtain a written or oral report from a section 12 MHA approved doctor for any of these orders. The report should indicate whether the person is to be admitted to hospital, or attend as a non-resident patient, and the registered medical practitioner or chartered psychologist by whom or under whose direction treatment is to be provided.[256]

6.18 There is little guidance for judges on ensuring that the correct sentence is passed in cases of vulnerability.[257] We consider that, ideally a dedicated judge, but at

[254] These can be ordered pursuant to s. 177 Criminal Justice Act 2003 (CJA) for community sentences and s. 189 CJA for suspended sentences. Their ingredients are set out in ss. 207; 209 and 212 CJA respectively. A treatment requirement accompanying a suspended sentence cannot last longer than two years or exceed the time for which the sentence is suspended.

[255] K. Rix, *Expert Psychiatric Evidence*, (Royal College of Psychiatrists, 2013), p.108.

[256] S. 39 MHA also states that the Primary Care Trust in England/the Local Health Board in Wales should also provide the court with information about the availability of facilities for hospital treatment in the area in which the defendant last lived. This role can be conducted by the L&D team.

[257] The Judicial College, 'The Crown Court Compendium, Part II: Sentencing,' (February 2017), available at https://www.judiciary.gov.uk/wp-content/uploads/2016/06/crown-court-compendium-pt2-sentencing-

a minimum, a judge who has undertaken appropriate mental health training, should conduct the sentencing exercise.

6.19 L&D practitioners also have a key role in preparing recommendations for the court on appropriate sentences and what treatment provision is realistic and available in the person's local area.[258] This is crucial given the difficulties in getting Clinical Commissioning Groups to accept responsibility for offenders with vulnerabilities.[259] As we have indicated in **Chapters II** and **III**, if medical services are not available to give individuals access to the treatment they need, no amount of improvement in the criminal justice system will prevent their risk of re-offending.[260] The L&D specification aims to improve the effectiveness of these orders by including support for people to attend their appointments.

> *...one of the clients I am supporting gets very anxious and in the past this has led to them being silent and or at other times they have just kicked off...when I am with them it is almost like I am a translator, I can help them represent themselves and also hear what is being said to them...* L&D practitioner[261]

feb-2017.pdf is a helpful list of all the sentencing options and procedures but does not focus on mental health. There is brief CPS guidance on sentencing in its Mentally Disordered Offenders guidance, (which is under review) available at http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/#a12 which sets out the approach recommended in *R v Birch* [1990] 11 Cr App R (S) 202.

[258] Offender Health Collaborative, Liaison and Diversion Manager and Practitioner Resources: *Core and Extended Teams*, August 2015, available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-03.pdf L&D teams should keep a directory of the available pathways and prepare written agreements to formalise these relationships, Offender Health Collaborative, Liaison and Diversion Manager and Practitioner Resources: *Pathways Development*, August 2015, https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/ohc-paper-07.pdf

[259] Concerns expressed to us by L&D practitioners and managers. See also Centre for Mental Health (2016), *supra*. A mental health diversion panel could assist at this stage to identify the local treatment and support options and provide a contract for the appropriate provision.

[260] This is a particular concern for children and young people. Youth Offending Teams have repeatedly criticised the difficulties in getting support and treatment for children in need. The thresholds for involvement from CAHMS appear to be impossibly high in some areas. Children who do reach the threshold for support are often unable to access it because clinics are too far from home and a rigid approach to missing appointments is taken, Taylor Review (2016), *supra*, pp 9-10. The Review recommends a move away from a clinic-based model and improvements in outreach provision. With Government investment in improving mental health treatment, CCGs have developed transformative plans to give effect to the new approach, which must now be implemented.

[261] Offender Health Collaborative, Liaison and Diversion Manager and Practitioner Resources: P*athways Development*, *supra*, p. 6.

6.20 These measures should go someway to improving the familiarity of judges with the appropriate disposal and sentencing options. We also consider that a Sentencing Guideline on mental health and vulnerability would be immensely useful to courts, prosecution and defence advocates, and other practitioners (such as probation and L&D), in determining the appropriate outcome for a convicted person with vulnerabilities. Section 120(2) Coroners and Justice Act 2009 provides that a sentencing guideline may be general in nature or limited to a particular offence, or category of offender.

6.21 Indeed, the Youth Sentencing Guideline has been adopted in recognition of the complexity of sentencing for children.[262] Some of the principles in that Guideline in our view ought to be considered in relation to the approach to sentencing those with vulnerabilities. In assessing culpability, the Guideline advises that there is an expectation that in general children will be dealt with less severely because they are "unlikely to have the same experience and capacity as an adult to understand the effect of their actions on other people."[263] The Guideline indicates that the key elements to consider are:

a. The principle aim of the youth justice system (to prevent re-offending by children and young people through rehabilitation. Judges are directed to take an individualistic approach focussed on the child or young person, as opposed to the offence);

b. The welfare of the child or young person and which disposal will best support them and/or exacerbate any underlying issues;[264]

c. The age of the child or young person (chronological, developmental and emotional) and their ability to fully appreciate their actions;

d. The seriousness of the offence;

e. The likelihood of further offences being committed; and

f. The extent of harm likely to result from those further offences.

---

[262] Sentencing Council, Sentencing Children and Young People: Definitive guideline, (1 June 2017), available at https://www.sentencingcouncil.org.uk/wp-content/uploads/Sentencing-Children-and-young-people-Definitive-Guide_FINAL_WEB.pdf

[263] At para 4.5.

[264] The court must have regard to several factors including any mental health problems or learning difficulties/disabilities, and any speech and language difficulties and the effect this may have on the ability of the child or young person to communicate with the court, to understand the sanction imposed or to fulfil the obligations resulting from that sanction, para 1.12.

6.22 A mental health guideline could readily be developed based on the same principles. Further, it should set out the necessary evidence to gather and how this should be considered, as well as the specific sentencing options available to the court in particular scenarios.

6.23 As with the Law Commission's recommendations above in the context of a supervision order, we consider that the court should continue to have oversight of how an order is progressing to ensure that the person is both receiving appropriate assistance and treatment and engaging in the programme. This will enable courts to understand how treatment requirements and other elements of community orders can work effectively to prevent further offending and direct vulnerable people into treatment. The conditions of any order must be achievable, fully comprehended by the individual and supported.

6.24 Where a hospital order is made, the Mental Health Tribunal will be responsible for determining if the person should be discharged. We understand that often the Tribunal does not have the original court papers relating to the offence when making this decision. This is unsatisfactory as the Tribunal does not then have the full information upon which to base its decision. Closer information sharing is necessary between courts and hospitals. The relevant case papers should be sent to the hospital and form part of the case papers at the Tribunal hearing. If these are not available for the Tribunal, it should be possible to obtain them. Now that the Digital Case System is in operation this should be easy to rectify.

6.25 Our ideas are in line with the movement towards problem-solving courts used in some other jurisdictions,[265] which utilise treatment and rehabilitation programmes, as well as regularly reviewing the progress of the individual involved. They specialise in distinct issues – such as drug abuse, domestic violence or mental health – placing judges at the centre of rehabilitation programmes. The key features of problem-solving courts are: specialisation of the court model around a target group; collaborative intervention and supervision; accountability through judicial monitoring; a procedurally fair environment; and a focus on outcomes.[266] Evidence points to mental health court participants being more likely to engage in treatment than comparison groups and to be imprisoned and reoffend less. Mental health court pilots in 2009 in Brighton and London showed that out of 55

[265] Problem solving courts are used in some US jurisdictions, New Zealand, Canada, Norway, Scotland for a range of specific issues, Centre for Justice Innovation, P*roblem-solving courts: an evidence review* (2016), available at http://justiceinnovation.org/wp-content/uploads/2016/08/Problem-solving-courts-An-evidence-review.pdf p.3, and a dedicated mental health court operates in Queensland, Australia. Some of the features are considered in Annex 2.

[266] Centre for Justice Innovation, *Problem-solving courts: a delivery plan*, (2016), available at http://justiceinnovation.org/wp-content/uploads/2016/10/Problem-solving-courts-A-delivery-plan.pdf p. 3

offenders who were given community orders, only nine breached.[267] The L&D model takes up a similar approach to this pilot.[268] This evidence suggests that appropriate intervention can reduce reoffending.[269]

6.26 There is a desire to "explore the use of innovative 'problem-solving' criminal courts" set out in the *Transforming our Justice System vision*,[270] and we welcome this commitment. However, we believe that the recommendations we make above are the most effective and practical way of achieving an appropriate response to vulnerability.

[267] Pakes, F., Winstone, J. *Process evaluation of the Mental Health Court pilot*, (Ministry of Justice, 2010), available at https://www.justice.gov.uk/downloads/publications/research-and-analysis/moj-research/mhc-process-evaluation.pdf at 1.

[268] The Rand Evaluation of L&D, *supra*, did not have sufficient data to determine sentence outcomes given the short period L&D had been in operation when it reported.

[269] CJI suggests that the reason problem-solving courts succeed is because they embrace procedural fairness, effective judicial monitoring with certainty and clear communication, evidence-based deterrence, and interventions based on risk and need, Centre for Justice Innovation, *Problem-solving courts: an evidence review supra.*

[270] Ministry of Justice, Lord Chief Justice, Senior President of Tribunals, *Transforming Our Justice System*, (2016), *supra*.

VII. CONCLUSION AND RECOMMENDATIONS

7.1 Society has increasingly recognised the problems presented by those who are mentally ill. But this report has deliberately refrained from restricting its consideration to those who fall within any particular definition of illness or capacity. We recognised early on that vulnerability arises from many causes; but the effects are the same, namely the need for measures to ensure that the criminal justice system does not produce injustice by failing to recognise those who need help to understand and navigate it and failing to provide appropriate mechanisms to achieve this.

7.2 The Working Party has reviewed how vulnerability is identified at each stage of the process – from street to disposal - and, if identified, how that vulnerability is responded to. There are still fundamental problems with the criminal justice system's response to vulnerability and too few people receive reasonable adjustments to enable them to effectively participate in their defence. But that is not to say that practitioners in the criminal justice system are not aware of the problem. We are impressed by the efforts being made to create an integrated criminal justice and mental health sector, through the programme of Liaison and Diversion. As Lord Bradley envisioned with his 2009 report, done properly, this has the potential to radically improve the treatment and experience of vulnerable people coming into contact with the criminal justice process.

7.3 There are also examples across the country of policing, court and health services working together to respond appropriately to vulnerability, and training proposals for advocates to better question people with vulnerability during trial. Amendments to the PACE Codes and CPS guidance are also underway. Significant change to the legal tests of fitness to plead or stand trial and defence of insanity were proposed by the Law Commission some years ago but have never been properly considered. We think that the majority of the comprehensive and persuasive recommendations that the Commission makes must be put onto the statute book as soon as possible.

7.4 Nevertheless, too many criminal justice actors, all along its pathway, are unfamiliar with the range of mental health conditions and learning disabilities that can create vulnerability, nor what to do about them. As such, we recommend core training on the consequences of vulnerability and the procedures that should be followed where this is suspected to be present. We make what we consider to be a critical distinction between diagnosing vulnerability – which we do not believe police officers or legal professionals are ever capable of doing - and recognising that vulnerability needs to be assessed and correctly responded to. Diagnosis is the role of suitably qualified medical professionals who are co-or closely-located with police stations and courts and can conduct proper assessments.

Such assessments will more accurately determine whether the person has any vulnerabilities that need to be addressed and whether they have the capacity to follow the process at each stage.

7.5 Once identified, we consider that far more support should be available to vulnerable people. Mandatory legal representation should be provided during police custody and intermediaries during police and court stages where this will enable the defendant to understand and communicate. We agree that all advocates must be trained in appropriate questioning and communication with vulnerable defendants, but in some cases this will be insufficient, especially to enable a defendant to fully follow their trial. Greater provision of trained support assistants is required during the police and trial stages to reduce the anxiety and distress criminal proceedings cause for those who are vulnerable.

7.6 We also consider that new roles are needed in the legal profession to ensure that vulnerability is correctly responded to. We propose the creation of a specialist mental health prosecutor for each CPS area who will decide whether charges should be brought in cases that raise vulnerability and will be responsible for the conduct of any case that proceeds to court. We also propose that there be a dedicated district judge in each youth and magistrates' court and judge in the Crown Court to administer a protocol for cases where there is vulnerability. Such a protocol must ensure that assessment and adjustments are made to enable the defendant to participate in a fair process, or be diverted if this is the appropriate outcome.

7.7 Although we have not come to a final conclusion as to the place within the system of a mental health diversion or advisory panel, we nevertheless think that further, detailed consideration should be given to the creation of such a body in view of its potential to assist specialist prosecutors with their charging decisions and sentencers with finding workable disposals. Diversion is a credible and appropriate outcome for some vulnerable individuals. The decision as to whether it is in the public interest to prosecute must take into account the person's mental capacity to both understand their conduct and the proceedings that will follow. It must also consider whether a medically focussed approach could provide a legitimate alternative. In this respect we depart from the General Comment of the UN Committee for the Rights of Disabled Persons. We think that to criminalise in these circumstances would discriminate against people with disabilities and deny them a fair trial.

Recommendations

Introduction

1. Accurate recording should be required of the police and courts on the number of people identified as having a vulnerability in the criminal justice system, what that vulnerability is and at what stage of the process. Outcomes for those individuals should also be recorded. This data should be regularly reported as part of policing and court statistics.

Investigation stage

2. Policing and mental health cooperation schemes should not be an ad hoc creation of dedicated professionals at a local level, but be available comprehensively and permanently across the country.
3. Arresting officers should be assisted by a street triage scheme wherever possible to identify whether a suspect is vulnerable, and help officers decide whether a suspect should be further investigated, arrested or offered a voluntary interview.
4. A decision to take no further action should be logged by officers as a diversion for recording purposes.
5. Voluntary interviews must have all the safeguards that we recommend for police custody, particularly where alleged offending takes place in a hospital setting.
6. The phrase "in the absence of any clear evidence to dispel" the suspicion that a suspect is suffering from mental disorder or is otherwise mentally vulnerable should be removed from PACE Code C as it is reducing support.
7. L&D practitioners should screen every suspect who comes into custody. This will ensure that the accurate identification of vulnerability is not left to the police.
8. Fitness for interview/detention and what reasonable adjustments might be needed to enable them to participate, should be assessed by an L&D practitioner if there is a mental health concern, and an approved healthcare professional for a physical condition. The assessment should apply mandatory minimum standards set by the Faculty of Forensic and Legal Medicine.
9. Easy read versions of the notice of rights and entitlements should be provided to suspects.
10. Appropriate adults should be re-named, for example "approved support and welfare assistants" would be more appropriate. Their role should be limited to these functions. Volunteer schemes should be available throughout the country and volunteers properly trained.

11. Mandatory legal representation should be given to suspects assessed as vulnerable.

12. Legal representatives should be given access to the medical assessments of their clients, which should be recorded in the custody record. L&D practitioners must make their reports available to both the police and defence.

13. The need for intermediaries during police custody or voluntary interview must be better identified by L&D, support assistants and legal representatives.

14. Intermediaries for defendants must be provided by the MoJ Registered Intermediary Scheme. Ideally they should be embedded in the police station on a duty scheme basis.

15. Each force area must have a policing mental health lead who can liaise with the local clinical commissioning group, mental health services and policing staff to identify service needs and approaches for the local area.

16. PACE and its Codes of Practice must be amended to give effect to these proposals.

17. Officers require some training on how to respond to vulnerability. Guidance is available, such as Together's *A common sense approach to working with defendants and offenders with mental health problems*, and should be made routinely available.

18. All professionals engaged in the investigation stage – police, lawyers, support assistants, intermediaries, and L&D practitioners – need to have incorporated into their training an introduction to the role of each other in the process, so that their benefit and availability is made clear.

Decision as to charge and prosecution

19. In cases of vulnerability, "release under investigation" should not extend a charging decision beyond two weeks.

20. Case files sent to the CPS must be flagged where there is a vulnerability. This should be a feature of the Common Platform.

21. A specialist prosecutor who has received mental health awareness training should be created for each CPS area.

22. This prosecutor must make the charging decision in cases of vulnerability. To assist them in this task, CPS Guidance *Mentally Disordered Defendants* is out of date and must be urgently reviewed, in particular to explain the nature of diversion and the local options available as an alternative to prosecution.

23. L&D assessments should travel with every case file to the specialist prosecutor to assist with their charging decision.

24. Defence representatives must be able to make representations about charge to the specialist prosecutor.

25. Careful consideration should be given to the establishment of a mental health diversion panel to assist specialist prosecutors, once the evidential threshold has been past, on whether a programme of support for the suspect would achieve an appropriate outcome for the case.

Pre-trial and trial stage

26. Where a defendant is vulnerable, online and virtual procedures are inappropriate and in court hearings will be necessary.

27. Where defence practitioners are concerned about vulnerability that has not previously been identified they should be able to speak with the specialist mental health prosecutor and ask that continuation of the prosecution be reviewed.

28. Embedding of L&D practitioners in magistrates' courts and the Crown Court should be a priority.

29. Support assistants should be available for vulnerable defendants.

30. Intermediaries can be crucial to enabling a defendant to understand and communicate with their legal representatives and during trial. However, the model needs revising and, as recommended above, should be part of the MoJ scheme. Intermediaries should be embedded in courts through a duty scheme. A regulatory body with training obligations should be established.

31. Holding the trial or procedural hearings at the prison or secure hospital where a defendant is detained should be considered in particular circumstances.

32. Easy read information on the court process should be provided, including with paper requisitions.

33. A dedicated mental health judge should be appointed, with responsibility for ensuring that cases involving vulnerable defendants are appropriately dealt with. In magistrates' courts, this will be a district judge, in the Crown Court, the resident judge. The judge should conduct the first appearance, PTPH and GRH.

34. The dedicated judge should have the power to direct that the CPS review a decision to prosecute and provide written reasons for continuing.

35. A protocol should be put in place to ensure that the Criminal Practice Direction and other guidance is correctly followed and reasonable adjustments are made as necessary.

36. Familiarisation with vulnerability should be part of core training for magistrates, judges, court staff and lawyers. The training should be about knowing how to respond to mental health needs.

Legal capacity tests

37. We agree with the Law Commission that there should be a capacity based test of fitness to plead and fitness to stand trial, placed on a statutory footing and applied in magistrates' courts and the Crown Court.

38. Where the psychiatric assessment indicates that a defendant is fit to plead, this opportunity should be offered, subject to legal advice, in order to avoid an unnecessary trial.

39. Evidential and procedural changes are needed to ensure that this process and the fact finding procedure that may follow are fair.

40. We also agree with the Law Commission that the insanity defence should be amended to a defence of "not criminally responsible by reason of a recognised medical condition" available in magistrates' courts and the Crown Court.

41. We consider that in a clear case, for example when the prosecution and defence are agreed that the facts are completely made out and that the expert evidence demonstrates the defendant lacked capacity at the time of the offence, the case should not proceed to trial, and a judge should be able to pronounce a special verdict.

42. A further review should take place of what defences should be available in cases where mental capacity will be in issue, taking into account the range in degree of diminished capacity that might exist for defendants with vulnerabilities. The amended test of diminished responsibility is very similar to the proposed test for not criminally responsible – the difference being either a *substantial* or *complete* lack of capacity. It is difficult to identify which ingredients would satisfy one test and not the other.

43. Consideration must also be given to whether the defence of diminished responsibility by substantial lack of capacity should be available for all specific intent crimes and not just murder.

44. Primary legislation and amendment to the Criminal Procedure Rules will be necessary to give effect to these amended tests and their procedures.

45. Better instructions must be provided to clinicians assessing capacity under these tests, who would benefit from a standard template to follow on preparing their reports. L&D practitioners can greatly assist with this.

Disposal and sentencing

46. We agree with the Law Commission that the range of disposals available where a defendant lacks capacity must be broadened, and largely available in magistrates' courts and the Crown Court. In particular, supervision orders should be extended, and supervised by local authorities rather than probation services. Courts should be able to keep the order under review, including requiring reports from supervisors and medical practitioners. We are concerned about the powers that should be available upon a breach of an order, which is a complex and difficult question where a person lacks capacity.

47. Decisions on disposal and sentence should ideally be reserved to the dedicated judge, but at a minimum to judges that have undertaken mental health training.

48. A Sentencing Guideline on mental health and vulnerability should be created to assist in this decision.

49. L&D practitioners have a key role in preparing recommendations for the court on appropriate sentences and what treatment provision is realistic and available in the person's local area.

50. The conditions of any community order must be achievable, fully comprehended by the individual and supported. Judges should be able to keep sentences under review to ensure that the person is both receiving appropriate assistance and treatment and engaging in the programme.

51. Clinical Commissioning Groups must accept responsibility for treatment of offenders with vulnerabilities in the community.

52. Information sharing about the offender and the circumstances of the offence must be shared with the Mental Health Tribunal to enable appropriate decisions on discharge to be made.

VIII. ANNEX 1

Examples of integrated criminal justice and mental health schemes

Cambridgeshire

We visited the Police Force Control Room (FCR) at Huntingdon, from which an Integrated Mental Health Team (IMHT) operates a "First Response" service. Since March 2016, three clinical psychiatric nurses have been working from the FCR offering advice and support to police officers and staff when dealing with service calls that involve a vulnerable individual. This was initially as part of a one-year pilot, funded by the Cambridgeshire PCC and Peterborough Safer Partnership, which was extended for a further year in October 2016, with funding from the PCC. First Response is designed for people who previously would have been contacting emergency services. When a person who contacts the police is identified as vulnerable, they are rerouted to First Response to speak directly to a psychiatric nurse. Police officers responding to individuals with known or suspected vulnerabilities can also contact First Response, where the nurses are able to provide them with information from the individual's medical notes, advice and access to partner agency pathways, to support their decision-making in relation to that individual. Importantly, the nurses are able to add notes to police call-out records, so that if and when these are accessed again, details about the person's mental health are available. Information is also fed back to the individual's GP, providing them with important and otherwise inaccessible information about whether treatment is effective. A six-month review of the initial pilot found that there had been a positive change in the way that responding officers and staff dealt with mental health issues as a result of the nurses' assistance, leading to quicker and more informed decision-making, and appropriate diversions away from mental health related policing deployments. Of the incidents reviewed, the nurses provided advice in 2,960 incidents, which led to the prevention of police deployment in 422 cases (35%).

Leicestershire

Leicestershire Police operates a number of schemes, including a Mental Health Triage Car service since 2013, which involves a police officer and a mental health nurse responding to incidents together. This has served as a model for street triage schemes elsewhere. It was initially intended as a three-month trial looking at a way of diverting away from s.136 MHA use by police, but was so successful in terms of reducing demand on police services and ensuring a more appropriate response for vulnerable people that it has continued since. It is funded

in equal share by the Police and the NHS. Another initiative in Leicestershire is its Mental Health Partnership Training group, which was created in order to develop a partnership approach to the commissioning and delivery of mental health response services, and to mental health training.

West Midlands

The work led in the West Midlands has focussed on reducing the number of people who are taken to a police cell as a place of safety pursuant to s.136 MHA. Through a series of initiatives, in 2016/17 there were no uses of a police cell for that purpose in the West Midlands. The first street triage team was conceived of and trialled there. A police officer and medical professionals attend people in mental health crisis in an ambulance. This triage team is able to assess the individual on the street. It then has the power to detain pursuant to s.136 MHA if necessary. The team sees about 9,000 people each year. Other initiatives include multi-agency training involving nursing staff speaking to police officers to build relationships and add skills. Training is focussed on awareness of the signs of vulnerability and how to act accordingly. The focus of this work is early intervention and prevention. The West Midlands Is the only force in the country that has 100 percent coverage of liaison and diversion services in custody, meaning that there are mental health nurses in every custody suite. This has helped reduce the number of cases where someone is prosecuted, for example where a person is found to be carrying a knife for self-harm purposes, they can instead be diverted to mental health services. Supt. Russell is currently in the unique role of Director of Implementation for the West Midlands Mental Health Commission, on a two-year secondment approved by the local PCC. He is overseeing the implementation of a holistic action plan aimed at making a significant difference to people's lives by, for example, helping vulnerable people to stay in employment, finding further ways to stem the flow of vulnerable people into the CJS and improve access to quality care. This plan is being jointly funded by the PCC, health partners and the combined authority.

MIND Sanctuaries

The charity MIND runs two "sanctuaries", one in Cambridgeshire and another in Peterborough. Both premises are staffed by MIND, and are only accessible via First Response, who often suggest their use. They are designed to be calming, safe environments where vulnerable people can go to gain composure, if that is all they really need. There is no therapy on offer. In fact, First Response do not provide the sanctuary staff with information about the user's medical history, or why they are being referred, although the user is risk-assessed beforehand. Users are able to stay at the sanctuaries for as long as they wish. The sanctuaries are

open from 6pm to 2am each day, and hold up to eight people at a time. There are usually three or four people in the Cambridgeshire sanctuary at a time, with people staying on average two to three hours. There had been 800 visitors to the sanctuaries at the point at which we visited Huntingdon, in March 2017, many of whom would otherwise have been arrested or gone on to A&E. One woman's case was given as an example: she had frequently used A&E but began being diverted to the MIND sanctuary in Cambridgeshire. She subsequently was able to cut down on the frequency of her visits to the sanctuary, and now is able to avoid visiting at all, in the knowledge that it is there if she needs it. The service does not prevent mental health crisis, but aims to deal with it in a more appropriate manner.

IX. ANNEX 2

Examples of diversion

England and Wales

Youth Offender Panels seek to enable young offenders to improve their behaviour and make reparations to their victims and the wider community. First time young offenders pleading guilty at court may receive a referral order as a sentence.[271] The purpose is to prevent young people reoffending and provide a restorative justice approach within a community context. Youth Offender Panels comprise at least two volunteers from the local community, and one member of the Youth Offending Team. YOPs enable people with specific knowledge of the individual, as well as the community, to have an input. Young offenders are invited to agree a contract that includes two core elements: (1) reparation/restoration to the victim or wider community; and (2) a programme of interventions/activities to address reoffending risk. Panels must convene within 20 working days of the referral. Once the contract has been signed, the Panel will monitor compliance and, if the contract is successfully completed, the conviction will be spent. The contract must be between 3 and 12 months and must begin within five days of being signed. Failure to comply with a referral order may result in the young offender being referred back to court for an alternative sentence.[272]

The Lammy Review recommends deferred prosecution for certain circumstances, reflecting the reality that many people are reluctant to formally admit guilt[273] and highlights Operation Turning Point as a good practice example. This involved both youth and adult defendants, and was piloted in the West Midlands from November 2011 to July 2014.[274] OTP was designed with racial disparities in plea decisions in mind, and did not require an admission of guilt. The experiment involved individuals that the police had decided it was in the public interest to prosecute, but who had no more than one conviction. Those judged by a statistical model to present low risk to the public were divided into two groups: for prosecution as normal, and for deferred prosecution. This group voluntarily entered into a contract and then went through programmes of structured

[271] Pursuant to sections 16-32 and Schedule 1 of the Powers of the Criminal Courts (Sentencing) Act 2000.

[272] Ministry of Justice, *Referral Order Guidance*, 2015, p. 41

[273] The Lammy Review, *An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System* (8 September 2017) p. 28 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

[274] http://whatworks.college.police.uk/Research/Research-Map/Documents/TP_Storyboard.pdf

interventions,[275] after meeting with an offender manager or Youth Offending Service officer. Programmes included a range of rehabilitative, restorative and restrictive features, such as compensation, apology letter, mental health treatment, anger management, drug or alcohol treatment and exclusion zones, with core requirements to complete the programme and not reoffend. Participants had a meeting within 48 hours of police custody to agree their contract, which ran for four months. Additional meetings were agreed, including a final meeting to sign off the Turning Point Contract, in the event that the person successfully completed the process. The threat of prosecution applied – if the programme was successful the prosecution was dropped, if not it resumed.

The Lammy review also looked at the Durham Constabulary Checkpoint Desistance Programme[276] which applies to all offenders for whom there is sufficient evidence to charge. Again an admission of guilt is not a requirement. Instead of a charge, a Checkpoint 'offender' will undergo a needs assessment and agree a 'contract to engage' with a 'navigator' who has skills similar to a probation officer. Checkpoint requires indivudals to meet the following conditions: no reoffending within a four month period (mandatory); participation in a restorative approach (mandatory if the victim agrees); attendance at appointments regarding individual personal issues or completion of one-to-one intervention work; to carry out community/voluntary work for 18-36 hours and/ or wear a GPS tag; and undertake voluntary drug testing. Checkpoint meetings must take place within 24-72 hours of arrest and contracts are also for four months. Of note, offences over three months old cannot be included in the programme because if the person breaches, too long will have passed since the offence took place and may risk an abuse of process if progressed to trial.[277] As with OTP, prosecution may resume if the programme is not complied with.

Other jurisdictions

There are no pre-charge diversionary panels in the jurisdictions that we considered. However, several jurisdictions have diversion schemes, both formal and informal, that can help an individual avoid being charged with a

[275] Early evaluation of this scheme found that victims whose cases went through OTP were 43% more satisfied than victims whose cases went to court, believing it was more likely to stop reoffending. Although reoffending results overall were similar between OTP and traditional prosecution, violent offenders were 35% less likely to reoffend under OTP. OTP also resulted in 68% fewer court cases than traditional cases, resulting in a saving of around £1,000 per case.

[276] G. Routledge, *A Protocol and Experimental Trial: The Checkpoint Desistance Programme in Durham*, p. 56-57 (2015) – http://www.crim.cam.ac.uk/alumni/theses/Gillian%20Porter.pdf

[277] *Ibid* p. 57

crime. Additionally, several have post-charge diversion schemes, where an individual's participation in a diversion program is monitored, possibly by a panel. Compliance is often encouraged by the indication that charges will be withdrawn or the person's record expunged upon successful completion.

Pre-charge diversion

In Australia, Canada, Northern Ireland, and the US, individuals can be diverted from the criminal justice system before charges have been filed. This is usually done at the discretion of police or prosecutors through statutory and informal schemes.

- **Australia**: in New South Wales, there is no formal scheme, but police have the ability to issue a warning or ignore minor offences and prosecutors can elect not to charge an individual. The NSW Law Reform Commission has recommended that a formal statutory scheme is developed.
- **Canada**: police may execute "pre-charge diversion" rather than arresting an individual. They may also decide to connect the individual to local community mental health services or escort them home. However, police are often reluctant to exercise these options.
- **Northern Ireland**: the public prosecution service (PPS) may elect to divert an individual; disposals include informed warnings, cautions, and youth conferencing. They are bound by the PPS Guidelines for Diversion. These options are available when the evidential test for prosecution is deemed to have been met, but the public interest is not.
- **United States**: several jurisdictions in the US have worked to create teams of specially trained police officers and civilian mental health professionals to respond to calls in which mental illness is a suspected factor. A study of 101 subjects engaged by such a team in Los Angeles saw that only 2% were arrested. These teams can provide transportation to a mental health facility or other services (such as counselling or drug treatment), and are often knowledgeable about the procedures and criteria for involuntary commitment.

Post-charge diversion

In Australia, New Zealand, Canada, and the US, individuals can be diverted post charge. While referral processes vary, prosecutors often act as a gatekeeper. A common criterion considered for diversion is the seriousness of the crime. A guilty plea to the charge(s) may or may not be required.

- **Australia**: a section 32 Metal Health (Forensic Provisions) Act 1990 (NSW) order can be made by the court to divert people with particular conditions who have been charged with a summary criminal offence. Summary offences must be defined as such by statute, and have a maximum penalty of two years imprisonment. Magistrates act inquisitorially when determining whether to make a section 32 order. They may also decide to make orders to grant bail, require treatment, or discharge the defendant, with or without additional conditions.
- **New Zealand**: The police prosecution service may exercise prosecutorial discretion after a defendant's first appearance in court by allowing eligible offenders to complete diversion activities (such as reparations, apology letters, counselling, etc.) to avoid full prosecution and the possibility of receiving a conviction. Eligibility is dependent on criteria from both the offender (e.g. has mental health problems, is unlikely to repeat the offence) and the offence (e.g. considered low-level).

  Additionally, defendants can be diverted to therapeutic courts (for homeless defendants accused of low-level offences) or alcohol and other drug treatment courts. The defendant must plead guilty, and then they can ask to be enrolled in the court, which will work with them and the relevant state agencies on rehabilitation. The court continuously monitors the defendant to ensure that he or she is working on the issues that brought them before the court. The court teams often consist of a specific judge, a case manager, a court coordinator, defence counsel, and a police prosecutor.
- **Canada**: Court support workers, lawyers, and the prosecution may work together to divert accused persons with mental illness and to have charges stayed. Discretion lies with the prosecution, and individuals are not required to admit guilt. Ontario has formalised these procedures in the Crown Policy Manual. Elsewhere, prosecutors may require a report of successful treatment to withdraw charges.

  Many courts have established mental health courts (MHCs) for minor criminal offences (although they may not be labelled as such). Referral can be requested by a number of people, including the accused individual. MHCs are typically administered by a dedicated judge, court, defence, and court support worker. Clinical specialists may also participate in the proceedings. Individuals must voluntarily commit to a "Diversion Treatment Plan," approved by the prosecution. MHCs may be able to levy sanctions for noncompliance with treatment plans. Although diversion does not require a guilty plea, the individual will have to take responsibility for their actions.

- **United States**: MHCs are a recent development in the US to divert "mentally ill" chronic re-offenders away from traditional criminal justice systems into long-term treatments. Most support nonviolent offenders only, and may require a guilty plea (especially for more serious crimes) in order to enter a mental health court. Discretion to divert an individual often lies with the prosecutor. MHCs may require a defendant to receive treatment, meet regularly with court or probation officers, confer with the judge, over treatment progress, and participate in group counselling. Compliance is often incentivised with a promise of a cleared criminal record.
    - The San Francisco Behavioural Health Court (BHC) does not require a guilty plea because of the effects that a felony criminal conviction could have on an individual after graduation from their program.
    - The Utah Mental Health Court Program assigns participants a case manager, a therapist, and a medical doctor as needed. Participants are monitored weekly by both mental health and court authorities to ensure compliance.
        - After six years of operation, 90% of participants had successfully graduated
        - It is estimated that the program saved $62,000 per year in prison days
        - The likelihood of graduates recidivating was 22% lower than mentally ill persons who received treatment alone; their likelihood to commit a violent offence was 50% lower.
- A study in Allegheny County (Pennsylvania) showed that, the more serious the charge and illness, the higher the estimated cost savings from participating in a MHC program over a traditional court adjudication.
- Critics recognised a circularity of reasoning: defendants are deemed competent enough to waive their right to trial by jury in order to enter an MHC, but they may not be competent enough to stand trial in a criminal court.

X. ACKNOWLEDGMENTS

The Working Party would like to give particular thinks to Linklaters LLP for its generous support, including Kathryn Ludlow, Felicity Lehane, Elsha Butler, Jazmine Bradfield and Isabelle Xavier.

We are especially grateful to JUSTICE fellow Nadia O'Mara, interns Melanie Blair, Bill Khan, Kitan Ososami and Alastair Young and criminal lawyer Tariq Desai for their assistance in preparing this report.

We would also like to acknowledge and thank the following individuals and organisations who generously gave their time to meet with us, respond to our call for evidence or otherwise support our work:

Salma Ali, Specialist Liaison & Diversion Practitioner, Intellectual Disabilities, Forensic Psychologist in Training, Criminal Justice Liaison and Diversion Team Hammersmith Magistrate's Court, Central and North West London NHS Foundation Trust

DS Sean Almeida, Metropolitan Police Service

Mark Ashford, Partner, TV Edwards Solicitors

Paula Backen, Registered Intermediary, Calm People

Chris Bath, Chief Executive, National Appropriate Adult Network

Harry Bentley, Barrister, 2 Hare Court Chambers

Neisha Betts, Learning Disabilities in the Criminal Justice System Project Manager, Key Ring Living Support Networks

Abigail Bright, Barrister, Doughty Street Chambers

Lord Bradley

Linda Bryant, Forensic Psychologist, Director of Criminal Justice Services, Together for Mental Wellbeing; Co-chair Bradley Report Group; National L&D Programme Board

Maurice Campbell, Northern Ireland Registered Intermediaries Scheme

PC Alex Crisp, Leicestershire Police

Charles de Lacy, Team Manager, NHS L&D Service, Central Criminal Court

Samantha Durrant, 'York Pathways' Project Manager, Together for Mental Wellbeing

Judge Carolyn Fyall, First-tier Tribunal (Health, Education and Social Care Chamber) (Mental Health), Tribunals Training Lead

Felicity Gerry QC, Carmelite Chambers

Insp. Terri Griffin, Cambridgeshire Constabulary; Cambridgeshire and Peterborough Integrated Mental Health Team

HHJ Andrew Hatton, Director of Training for Courts, Joint Dean of the Faculty of the Judicial College

Claire Howell, Barrister, Drystone Chambers

Matthew Hodgetts, former Detective Constable, pupil barrister Red Lion Chambers

Dr. Jenny Holmes, Mental Health Lead, Faculty of Forensic and Legal Medicine

Andy Hunt, National Programme Manager, Health and Justice, NHS England

Linda Hunting, Research & Development Coordinator, The Inns of Court College of Advocacy

Sharon Johnson, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire and Peterborough Integrated Mental Health Team

Cdr. Christine Jones, Metropolitan Police Service

Sian Jones, Justices' Clerk for Cambridgeshire and Essex, HMCTS

Nicola Lewis, Registered Intermediary, Focus Mediation

Claire Matthews, Barrister, Drystone Chambers

Gavin McKenzie, PCB Solicitors

Robyn Murdo-Smith, Barrister, 9 King's Bench Walk Chambers

Catherine O'Neill, Registered Intermediary

Facundo Chavez Penillas, UN Human Rights and Disability Adviser

Debbie Pinion, Deputy Justices' Clerk for Cambridgeshire, HMCTS

Judge Deborah Postgate, First-tier Tribunal (Health, Education & Social Care Chamber) (Mental Health)

Liz Prosser, Registered Intermediary

Tom Ring, Deputy Director, Crime Directorate, HMCTS

Sgt. Polly Rowell, Metropolitan Police Service

Supt. Sean Russell, West Midlands Police, Mental Health Lead; Director of Implementation, West Midlands Mental Health Commission

Wendy Scott-Earl, Directorate Head of Nursing, Cambridgeshire and Peterborough NHS Foundation Trust; Cambridgeshire and Peterborough Integrated Mental Health Team

Julie Spence, Chair, Cambridgeshire and Peterborough NHS Foundation Trust

Joe Stone QC, Barrister, Doughty Street Chambers

Glyn Thomas, Head of Implementation, L&D Programme, NHS England

Chief Insp. Daniel Thorpe, Metropolitan Police Service

Grev Wallington, Effective Practice Manager, National Appropriate Adult Network

Angela Thomas, Westminster Appropriate Adult Service

Dr. Michael Wilks, Registrar, Faculty of Forensic and Legal Medicine

Professor Michael Zander QC, Emeritus Professor of Law, LSE

Sir David Latham

JUSTICE

59 Carter Lane, London EC4V 5AQ
www.justice.org.uk