Irish Journal of Psychological Medicine, (2023), **40**, 494–499.

doi:10.1017/ipm.2021.25

PERSPECTIVE PIECE

What is the role of doctors in respect of suspects with mental health and intellectual disabilities in police custody?

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People with severe mental illness and intellectual disabilities are overrepresented in the criminal justice system worldwide and this is also the case in Ireland. Following Ireland's ratification of the United Nations' Convention on the Rights of People with Disabilities in 2018, there has been an increasing emphasis on ensuring access to justice for people with disabilities as in Article 13. For people with mental health and intellectual disabilities, this requires a multi-agency approach and a useful point of intervention may be at the police custody stage. Medicine has a key role to play both in advocacy and in practice. We suggest a functional approach to assessment, in practice, and list key considerations for doctors attending police custody suites. Improved training opportunities and greater resources are needed for general practitioners and psychiatrists who attend police custody suites to help fulfill this role.

Received 28 November 2020; Revised 27 February 2021; Accepted 09 March 2021; First published online 19 April 2021

Key words: Forensic, intellectual disabilities, mental illness, police, Garda.

Introduction

People with severe mental illness and intellectual disabilities are overrepresented in the criminal justice system worldwide (Bradley, 2009; Fazel & Seewald, 2012). This is also the case in Ireland, where the prevalence of severe mental illness in prisons is at least four times that of the general population with studies suggesting that the proportion of those with intellectual disabilities is substantially higher (Gulati *et al.* 2018, 2019). Following Ireland's ratification of the United Nations' Convention on the Rights of People with Disabilities (UNCRPD) in 2018, there has been an increasing emphasis on ensuring access to justice through a rights-based approach during the pre-custodial element of the criminal justice pathway (Gulati *et al.* 2020*a*, 2021). There is also a more general momentum to accommodate such parties in the Irish criminal process (Edwards *et al.* 2015; Kilcommins & Donnelly, 2014). It is accepted internationally that people with severe mental illness and intellectual disabilities require additional safeguards as they attempt to navigate a criminal justice pathway (Clare, 2003; Gulati *et al.* 2020*b*).

People with intellectual disabilities often face systemic barriers in access to justice. For example, in England & Wales, access to safeguards such as Appropriate Adults in police interviews for people with mental illness or intellectual disabilities has been reported as inconsistent (Gulati *et al.* 2020*b*). In the United States of America, a quarter of exonerations related to false confessions involved people with intellectual disabilities (Schatz, 2018). In Ireland, although the situation is improving (Mulkerrins *et al.* 2020), it remains the case that, at the time of writing, few formal and consistently used pre-trial safeguards exist (McNamara, 2020).

The Policing and Crime Act 2017 in England and associated guidance for ss. 135 and 136 of the Mental Health Act 1983, which came into effect in 2017, placed an onus on police constables to consult with an allied health professional prior to compulsorily removing a person to a 'place of safety'pursuant to the sections of the Mental Health Act 1983. Such enquiries may usefully comprise existing crisis plans that may in some cases avoid the need for criminal justice system involvement. The new rules also reduced detention periods and placed stringent limitations on circumstances whereby police stations could be used as places of safety. This is one useful example of legislative reform and interagency cooperation in enhancing the rights of people with mental illness and intellectual disabilities. As Ireland enters a decade when reforms to mental health and criminal law (insanity) legislation are likely,

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measures that enhance equal access to justice require careful consideration.

The Irish criminal justice pathway and its interface with medicine

In an Irish context, a person facing arrest will interact initially with Gardaí (members of the Irish police), and thereafter more Gardaí if detained for interview. They will be cautioned, given a notice of rights and they will be informed about their right to access a solicitor (An Garda Síochána, 2015; Conway & Daly, 2019). In the majority of cases, a 'typical' suspect will encounter law enforcement officers and, less frequently, a solicitor (Lally, 2017). On fewer occasions, if there is an acute concern about physical or mental health, they would be seen by a General Practitioner contacted on a call-out basis. Less frequently, the General Practitioner can make a recommendation for admission under the Mental Health Act 2001 if they believe there is a mental disorder within the meaning of the Act necessitating involuntary psychiatric admission (although the ultimate decision falls to the admitting psychiatrist at the approved centre).

Identification of persons in custody requiring additional safeguards, such as those with intellectual disabilities is widely accepted as challenging (Young *et al*. 2013; Cusack, 2018). Police forces internationally may use informal approaches and screening tools, although the evidence for such assessments lacks large-scale validation studies (Douglas & Cuskelly, 2012; Ali & Galloway, 2016). Gardaí cannot therefore be expected to identify persons with mental illness or intellectual disabilities consistently, and especially without training in the area (Cusack, 2018). Such training has historically been tenuously resourced (McNamara, 2020). It is reasonable then that without identification of a disability, necessary safeguards would not be offered (Cusack, 2018; Cusack, 2020*a*). Similar challenges exist for the legal profession, and a paucity of supports in both spheres of professional practice requires correction if protection of those at risk is to be assured (Edwards *et al.* 2012; Cusack, 2020*a*, 2020*b*).

Social discourse

Social studies discourse over the last two decades has been critical regarding the over-medicalisation of disability, asserting that viewing of disability exclusively as a medical condition can prevent inclusion by minimising regard to the societal aspects of exclusion (Edwards, 2014; McNamara, 2020). In advocating a departure, then, from the traditional, pathological 'medical model of disability', social studies theorists have advanced a 'social model of disability' which constructs disability, not as a direct consequence of a person's biomedical impairment, but rather as a product of society's failure to accommodate his or her individuated needs. As Finkelstein (1980) explains, this social model of disability is premised, on a belief that '[o]nce social barriers to the reintegration of people with impairments are removed, the disability itself is eliminated'.

While the evolution of this line of scholarship has been important in the sense of highlighting the range of environmentally constructed barriers facing persons with disabilities in society, the dichotomy between medical and social models of disability can be unhelpful where it seeks to exclude medical practitioners as a whole from debate and from pathways that can fulfil the objectives of inclusion as envisioned in the UNCRPD. Collaboration may be a more helpful approach.

In due course and with the passage of time, in an ideal criminal justice system, all professionals will be adequately trained to identify disabilities, particularly hidden disabilities, and consistently apply safeguards that ensure equal access to justice. These may include the provision of information in an accessible format, and practical and emotional supports for people with disabilities in custody. This will not rely solely on medical professionals. This is a vision for the future. However. we must also address the 'here and now'.

How can medicine contribute towards equal access to justice?

As systems are currently structured, doctors can play an important role in ensuring the accurate identification of disabilities amongst those detained in the custody of An Garda Síochána – a first and often crucial step to the criminal justice system putting the necessary safeguards in place. This in itself is not without problems. Although most medical school curricula include fundamental psychiatry and exposure to psychiatry practice, and many General Practitioners have additional training in psychiatry, it is unclear what training GPs are provided to enable effective assessment for intellectual disability when attending police stations or prisons.

There is a requirement for a member in charge to summon a doctor under the Criminal Justice Act 1984 (Treatment of Persons in Custody of in Garda Síochána Stations) Regulations 1987 ('Custody Regulations') in certain specified situations (including where a person fails to respond normally to questions or appears to suffer from mental illness), and this is usually a general practitioner. Few cases involving detained suspects get referred to psychiatry. Helpfully, in the limited cases where such referrals do take place – namely, where a question of involuntary psychiatric admission exists (see further below) – an opinion on fitness to be interviewed can be requested.

https://doi.org/10.1017/ipm.2021.25 Published online by Cambridge University Press

The Republic of Ireland, compared with England and Wales, has a deficit with regard to pathways available to Gardaí in accessing early clinical advice (See Table 1). Specifically, in Ireland, access to psychiatry in acute policing situations can be limited to those requiring formal assessment for involuntary psychiatric admission under mental health legislation, under the provisions of the Mental Health Act 2001. In contrast, the UK has established a national model – the 'liaison and diversion operating model' – to inform the development of liaison and diversion services regionally that can offer advice and support to the police more consistently (NHS England, 2013). Access to diversion earlier in the criminal justice pathway in Ireland is therefore limited when compared to the neighbouring jurisdiction (Gulati & Kelly, 2018).

Forensic Medical Examiners, or Police Surgeons, in the UK are usually General Practitioners with additional training and experience in legal medicine. They attend police stations to, for example, conduct examinations of people who are victims or suspects of sexual offences or where custody officers require health-related advice on an individual in custody. In respect of people with mental health or intellectual disabilities, they may advise police on a number of matters including whether a person is fit to be charged and/or interviewed, and/or fit to be detained in police custody and/or make a recommendation for an appropriate adult to be present at interview. This, in the UK context, includes an opinion on whether '(a) conducting the interview could significantly harm the detainee's physical or mental state; or (b) anything the detainee says in the interview about their involvement in the offence about which they are being interviewed might be considered unreliable in subsequent court proceedings because of their physical or mental state' (Herring & Stark, 2006).

Recommendations

In the Irish context, a series of measures – including a holistic review of current risk assessment and vulnerability assessment practices (Cusack, 2020*c*; Mulkerrins *et al.* 2020) – have been undertaken by the Human Rights Unit of An Garda Síochána recently with a view to assisting 'Superintendents with the assessment of the most vulnerable in the criminal justice system' (Government of Ireland, 2018). In parallel with the implementation of any operational reforms arising from these initiatives, we recommend that any medical practitioners who are employed to assist Gardaí at the pre-trial stage of criminal proceedings, are provided with specialist training so that they can play a more active role in identifying people who may require additional safeguards in police custody.

A useful set of questions that Gardaí may ask of medical practitioners, in this regard, include:

1. *In the opinion of the practitioner, is the person fit for police interview? Is the person able to understand the reasons for their arrest and the police caution? Is the interview likely to harm their physical or mental state?*
2. *In the opinion of the practitioner, does the person require the notice of rights to be provided in a more accessible format?*
3. *In the opinion of the practitioner, does the person require an intermediary present for support in communication or with emotional support through the interview process?*

For doctors, a functional approach to assessment (such as in capacity assessments) could be supplemented usefully by aspects of the individual's history and a mental state examination. This would start with a presumption of capacity. For example, not everyone with mental illness would be unfit for interview. However, if someone is presenting with such acute symptoms of mental illness that they cannot understand the police caution, they would likely be unfit for interview. Separately, if someone has a known diagnosis of significant intellectual disability, this should not make them unfit automatically for interview. They may require information presented in an accessible format and the presence of a responsible adult at interview. For general practitioners needing specialist advice, the availability of psychiatric expertise should not be predicated on making a recommendation under the Mental Health Act 2001.

The assessment necessary to advise the Gardaí in respect of these matters would arguably involve additional time and resources for doctors. Accessing such an opinion early, however, would provide an opportunity to ensure provision of appropriate care and support that reduces risk of health-related issues in custody and all that entails and improve the forensic accuracy of processes. There are systemic considerations that need further development. The 1987 Garda Custody regulations already account for the presence of a 'responsible adult' (s. 22(2)) where an individual in custody is a child or suspected to have an intellectual disability. These need to be audited for consistency of application. The 'Notice of Rights' or Form C72(s) requires urgent formalisation in an easy-to read format for people with intellectual disabilities. Such work has been done in other jurisdictions (Parsons & Sherwood, 2016).

Access to a lawyer while detained in Garda custody is also particularly relevant for persons with a mental health or intellectual disability. The presence of a lawyer is seen as a means of equalising relations between the accused and the state in the detention process. The right of access to a lawyer in Garda custody is

https://doi.org/10.1017/ipm.2021.25 Published online by Cambridge University Press

Table 1. *Advice available to Police services from medical practitioners in the early stages of the criminal justice pathway – Comparison between Republic of Ireland with England and Wales*

Stage of criminal justice pathway	Republic of Ireland	England and Wales
Pre-Arrest	No formal mechanism for advice to Gardaí	Regional availability of Specialist Teams that work jointly with Police based on a national model
At point of Arrest	No formal mechanism for advice to Gardaí	Regional availability of Specialist Teams that work jointly with Police based on a national model
'Place of Safety'*	–	Police have access to a duty Forensic Medical Examiner (General practitioner) called out on a case by case basis Persons detained using provisions of the Mental Health Act 1983 will be seen by an approved mental health practitioner and two doctors, at least one of whom is a psychiatrist
Police Detention	Gardaí have access to a Duty Doctor (General practitioner) who can be called out on a case by case basis to attend to physical or mental health concerns and/or prescribe medication under Regulation 21 of the Custody Regulations. The duty doctor can advise on fitness to interview, deferral of interview if detainee is intoxicated, and complete a medical recommendation under the Mental Health Act 2001 where necessary.	Police have access to a duty Forensic Medical Examiner (General practitioner) called out on a case by case basis. They can assist with identifying people who need assessment under the Mental Health Act 1983. Liaison and Diversion mental Health Teams exist in many areas.
Interview	Gardaí have access to a Duty Doctor (General practitioner) that can be called out on a case by case basis to attend to physical or mental health concerns and/or prescribe medication. They can advise on fitness to interview, deferral of interview if detainee is intoxicated. This facility is recognised in Regulation 21 of the Custody Regulations. No formal mechanism exists for Gardaí to seek a psychiatry opinion in respect of fitness to interview. Uncommonly, if a person is seen by a psychiatrist either for consideration under the Mental Health Act or if they are otherwise under psychiatric care, an opinion on fitness to be interviewed may be available to Gardaí.	Forensic Medical Examiners or assessing psychiatrists can advise Police about fitness to be interviewed and/or the need for an Appropriate Adult
Initial presentation at Court	Irish court diversion schemes are geographically disparate (largely Dublin based) and operate from a prison setting. Therefore, it is unusual to have psychiatric advice available to a Court prior to a remand to custody.	Liaison and Diversion mental Health Teams exist in many areas.

*Police Custody Suites have previously been used as 'places of safety' under the Mental Health Act in England & Wales although there is a clear move away from this.

constitutionally guaranteed since 1990 (*People (DPP) v Healy* [1990] 2 IR 73 at 80; *People (DPP) v Gormley and White* [2014] IESC 17. The right is also safeguarded by Art 6(3)(c) of the European Convention on Human Rights (*Beuze v Belgium* (2019) 69 E.H.R.R. 1; *Doyle v Ireland* (51979/17). It is important that lawyers are aware of the indicators, and of the risks posed to persons with mental health or intellectual disabilities in Garda custody. They should form part of any multi-agency partnership response.

Conclusions

Ensuring access to justice for people with disabilities, as enshrined in Article 13 of the UNCRPD, and particularly for people with mental health and intellectual disabilities, requires a multi-agency approach and a multidisciplinary partnership between medicine, law, law-enforcement and social sciences. Until systems and structures are developed that can offer a consistent and robust guarantee of access to justice for those with mental health and intellectual disabilities, medicine has a key role to play both in advocacy and in practice. Improved training opportunities and greater resources are needed for general practitioners and psychiatrists who attend police custody suites to help fulfil this role. Joint training opportunities between general practitioners and psychiatrists as well as law enforcement agencies that cross traditional educational boundaries could contribute usefully to the development of expertise.

Conflict of interest

GG has no conflicts of interest to declare. BDK has no conflicts of interest to declare. WC has no conflicts of interest to declare. SK has no conflicts of interest to declare. AC has no conflicts of interest to declare. SK has no conflicts of interest to declare. CPD has no conflicts of interest to declare.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this perspective paper was not required by their local REC.

Financial support

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

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