# Detainees in Police Custody in Yorkshire, United Kingdom: A Survey of the Common Mental Health Problems

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**Abstract:** *Purpose*: The purpose of this paper is to identify and study the common mental health problems presented by detainees in police custody as well their demographic characteristics. This would help to create awareness and sensitise health care practitioners working in custody, as well as custody staff towards early recognition and detection of cases, which should facilitate the health promotion and psycho social education of detainees and reduce the overall clinical risk in custody.

*Design*/*Methodology*: The 'anonymised custody records' of a random sample of two hundred and fifty eight detainees in police custody as well as the Forensic Medical practitioners contemporaneous notes including 'direct clinical interviews 'were examined. Data was collected from the Risk assessment record completed by the custody officers and record of medical assessment by forensic Medical Examiners using a 'Standard Questionnaire format '. Data then was analysed.

*Findings*: Detainees admitted into custody experienced a wide range of mental health problems.The most common mental health problems seen in detainees during the period of study were, substance misuse, depression, self-harm, anxiety disorder, epilepsy and schizophrenia in that order. Other conditions were identified such as Learning disabilities. The sex distribution was Male (83%) and Female (17%). In terms of age distribution most of the detainees were in the age range 20-41 (67.5%) for both sexes. The female detainees tend to be older compared to males.Heroin use was the most prevalent drug of abuse in custody. Some of the most common medications prescribed for detainees are Methadone, Mirtazapine, Citalopram, Diazepam, Sorbutex, sodium valproate and Thiamine.

*Originality/Value*: The findings from this study would help to further identify and bring awareness to the common mental health problems encountered in detainees in police custody. It would help to reduce clinical risks and facilitate a safer detention in custody. It would also help to address the issue of the limited availability of data regarding the mental health of detainees.

**Keywords:** Detainees, police, custody, mental health, risk, forensic medical examiner, drugs and alcohol.

## INTRODUCTION

Some studies have reported high levels of psychiatric and physical morbidity amongst detainees in police custody (Robertson, Pearson and Gibb 1996; Shaw *et al*., 1999; McKinnon and Rubin, 2010; Payne - James *et al*., 2010; Carter and Mayhew, 2010).

Many studies have highlighted the common physical health problems seen in custody such as high blood pressure, diabetes, asthma, heart problems, however there is limited available data in terms of studies focussing mainly on the elaboration of the mental health problems and the needs of these detainees in custody.

Detainees in police custody can often present with multiple physical health problems as well as a range of co morbid mental health problems as defined in the International Classification of diseases by the World Health Organisation and the American Psychiatric Association (WHO ICD10, 1992; APA DSM 5, 2013) such as depression, anxiety, self harm, bipolar affective disorder, Mania, obsessive compulsive disorder, autism spectrum disorder, attention deficit hyperactivity disorder, schizophrenia and other psychosis, intellectual disabilities and substance misuse problems.

There is a need for constant surveillance, early recognition and detection of these mental health problems once detainees are admitted into custody. This is one of the key recommendations of the Bradley report for awareness training (Bradley 2009). This would help to reduce the overall clinical risk in custody during the period of detention. It would also help to maximise a positive outcome such as for example, the early recognition and treatment of potentially harmful drugs and alcohol withdrawal symptoms and to ensure that the prescribed medications of detainees are continued for as long as is possible and or is practicable even whilst in custody.This is because at the point of arrest some detainees may not have enough drug supply to take with them and it may take some time in terms of the logistics to make alternative

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arrangements via the general practitioner as most custody suites only have a limited stock of medications

The Mental Health Act (Mental Health, Act 1983) under section 1 (2) recognises four categories of mental disorder which includes mental illness, mental impairment, severe mental impairment and psychopathic disorder. However this legislation was amended by the Mental health Act 2007 (Mental Health Act, 2007) and the four categories are now replaced by the single term 'mental disorder' which refers to any disorder or disability of the mind. Some of the detainees may be detained under the mental health act in custody and some may require transfer to hospital for assessment and treatment once detained under the appropriate section of the Mental health Act. It is worth highlighting that the police custody is no longer deemed as an acceptable place of safety since December 2017 for people under 18 years of age this was following amendments to legislation in relation to Section 136 of the Mental Health Act 1983, as amended by the 2007 Act.

The British Medical Association and the Faculty of Forensic and Legal Medicine have produced guidance on the health care of detainees in Custody (BMA and Faculty of Forensic and Legal Medicine, 2009) highlighting that the detainees in custody are entitled to the same standards of healthcare equal to those obtainable within the National Health service in the United Kingdom and that the framework for this should be provided (Bradley 2009)

There are other legal regulatory frameworks and statutes set out in law that cover the detention, treatment and questioning of persons by police officers such as the Police and Criminal Evidence Act (PACE 1984) which came into force in 1986 and its associated Code of Practice, Code C (Code of Practice, PACE, 1984) which details how certain elements of the police procedures should be carried out. This includes the standards of medical care and treatment to be provided to detainees.

Issues relating to the 'Fundamental freedoms' and the right to liberty and security of persons under Article 5 of the European Convention of Human Rights as enshrined in the Human Rights Act, (Human Rights Act,1998) which came into full force in October 2010, can also arise in the course of provision of health care to detainees in custody and this needs to be borne in mind by the healthcare practitioners delivering care in custody. These relate to issues around Human dignity, degrading and inhumane treatment, communication, consultation and"best interests" which are important.

The 'Custody officer' who is usually a police sergeant is responsible for the welfare of detainees in custody. As part of ensuring that welfare, a 'comprehensive risk assessment' is usually carried out on every detainee taken into custody, for early identification of any clinical risks which is also incorporated into the custody record (Payne James, 2010)

According to the police and Criminal Evidence Act, where a person in detention appears to the custody officer to be suffering from a physical illness, or injured or suffering from a mental disorder or in need of medical attention The custody officer has a duty to immediately call the appropriate health care professional or where appropriate send the detainees to the local hospital. This request to call a health care professional applies even if the detainee makes no formal request for medical attention and whether or not the person has already received clinical attention elsewhere.

Such detainees with a 'mental disorder' and or a learning disability are particularly vulnerable in custody and this would most likely necessitate an additional level of 'safeguard ' such as the need for an 'appropriate adult' to attend before any interviews. The rationale for the need for an appropriate adult as enshrined in the PACE Act, is for the protection of vulnerable adults while in custody to support them and ensure that they don't feel intimidated during the 'interview process'. This is seen as necessary to do and is often referred to as a 'gate way safeguard' (Olubokun 2008) because it leads to other 'safeguards' this is for their own protection whilst in custody to counter balance the increased police powers. (Bottomley *et al*. 1999)

The main objective of this research was to identify and study the range of the common mental health problems seen in detainees in police custody as well as their demographic characteristics in the East and West Yorkshire region of the United Kingdom during the period of study. This included persons with a major mental health problem as well as those with substance misuse problems and persons with varying degrees of intellectual disabilities. The risk issues identified as well as the results obtained are discussed with a view to facilitate safer detention in custody.

## METHODOLOGY

In this study, a sample of two hundred and fifty eight cases of detainees seen in police custody in the East and West Yorkshire over a 2 year period between June 2012 and April 2014 were reviewed.

Detainees were selected from different custody suites which included Leeds Bridewell, Leeds Stainbeck, Halifax, Bradford, Huddersfield, Keighley, Pontefract, Wakefield and Pudsey.

The cases were randomly selected over this period. The 'anonymised 'custody records of the detainees to include a 'comprehensive risk assessment instrument' completed by the custody officers on arrival at the various custody suites as well as the contemporaneous notes of the forensic medical examiners, which includes 'direct clinical interviews' were examined.

Data and information was gathered using a 'structured questionnaire format' to include the age of detainees, sex, mental health diagnosis, risk assessment, drugs and Alcohol use and the current prescribed medications. The rationale for the anonymised data was to protect detainee's confidentiality.

## RESULTS

A total of two hundred and fifty eight detainees were included in the study of which two hundred and fourteen (214) 83% were males and forty four (44) 17% were females. Sex distribution Figure **1**.

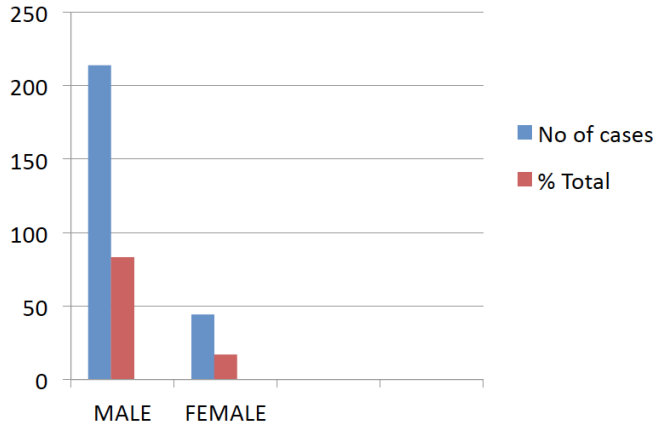


**Figure 1:** Sex distribution of detainees.

In terms of the age distribution of the detainees Figure **2**. Most of the detainees were aged between 21-40 (67.6%) for both sexes. In Figure **3** Sex distribution by Age. On the average for males the 21-40 age group

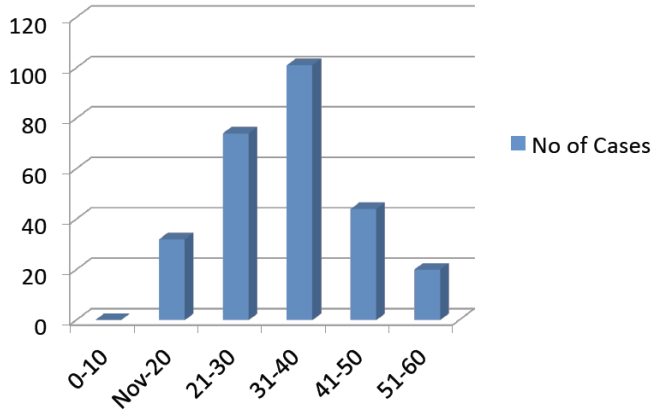


**Figure 2:** Age Distribution of detainees.

constituted 70% which accounted for 151cases and for females 55% which represented 24 cases. There was a higher representation of the age group 41-50 in females.

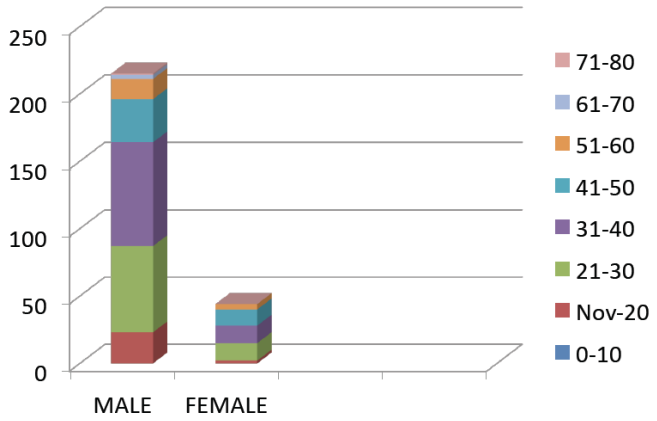


**Figure 3:** Age Distribution by Sex.

Figure **4** shows the range of the common mental health problems seen in detainees in police custody during the period of study. This includes substance misuse (drugs and alcohol) problems 144 cases (56%), depression 114 cases (44%), self-harm 103 cases (40%), Anxiety disorder 29 cases (11%), Epilepsy 25 (9.6%), Schizophrenia 16 (6%), Personality disorder 12 (4,6%) Obsessive Compulsive disorder, other psychosis, Learning disabilities, Attention deficit Hyperactivity disorder, Bipolar Affective Disorder/Manic depression and Korsakov's Syndrome.

The most common mental health problems in detainees in the order of importance and prevalence are listed in Figure **5**. The top six are substance misuse (drugs and alcohol) 144 cases, Depression 114 cases, Self harm 103 cases Anxiety disorder 29, Epilepsy 25 and schizophrenia 16.

| Drugs and Alcohol | 144 |
|---|---|
| Depression | 114 |
| Self Harm | 103 |
| Anxiety Disorder | 29 |
| Epilepsy | 25 |
| Schizophrenia | 16 |
| Personality Disorder | 12 |
| Obsessive Compulsive Disorder | 2 |
| Other psychosis | 7 |
| | |
| Learning Disabilities | 7 |

**Figure 4:** Common mental health problems/diagnosis of detainees in custody and number of cases. ICD 10.

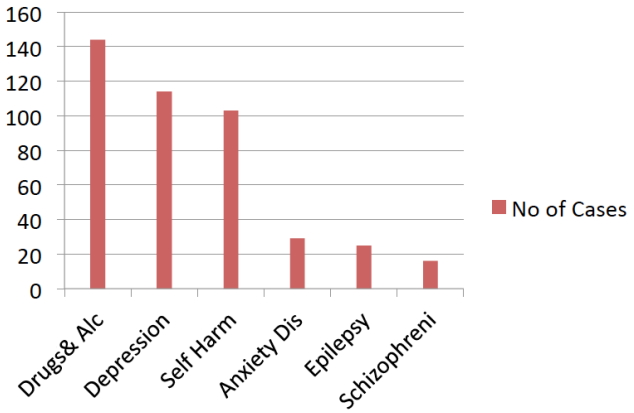


**Figure 5:** Most common mental health problems/diagnosis seen in detainees in police custody. ICD10.

Figure **6**, Shows a breakdown of the drugs and alcohol use by detainees in custody. Heroin use in 93 cases 64.5% was by far the commonest, followed by alcohol use 78 cases 54% and Cocaine 49 cases 34%.

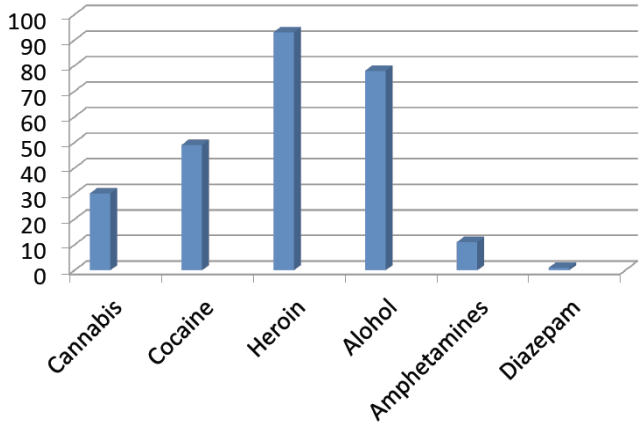


**Figure 6:** Drugs and Alcohol and the number of cases.

Figures **7a** and **7b**, show the range of medications prescribed for detainees in custody. Many of the detainees were already taking some of these medications prior to admission into custody. Figure **8** shows a list of the common medications prescribed for detainees mental health in custody. The commonest in the study was Methadone in fifty two (52) cases, followed by antidepressants Mirtazapine, Citalopram, and then Sorbutex, Diazepam, Sodium Valproate and Thiamine.

| Methadone | 52 | Risperidone | 4 |
|---|---|---|---|
| Sorbutex | 13 | Temazepam | 2 |
| Mirtazapine | 18 | Vit B Complex | 1 |
| Citalopram | 16 | Clonazepam | 1 |
| Diazepam | 10 | Lithium (Priadel ) | 1 |
| Sodium Valproate | 8 | Fluoxetine | 1 |
| Thaimine | 6 | Clopixol | 1 |
| Olanzapine | 5 | Propranolol | 1 |
| | | Lorazepam | 1 |

**a**

| Sertraline | 11 | Zopiclone | 1 |
|---|---|---|---|
| Pregabalin | 5 | Nitrazepam | 1 |
| Amitripityline | 4 | Folic Acid | 1 |
| Trazodone | 3 | Vitamin B Co | 1 |
| Quetiapine | 3 | Aripiprazole | 1 |
| Fluoxetine | 2 | Seroquel | 1 |
| Venlafaxine | 2 | Acamprosate | 1 |
| Gabapentine | 1 | Carbamazepine | 1 |
| Paroxetine | 1 | Torpiramate | 1 |
| Amilsulpiride | 1 | | |

**b**

**Figure 7: a**. List of medications prescribed for detainees in custody. **b**. List of medications prescribed for detainees in custody (contd).

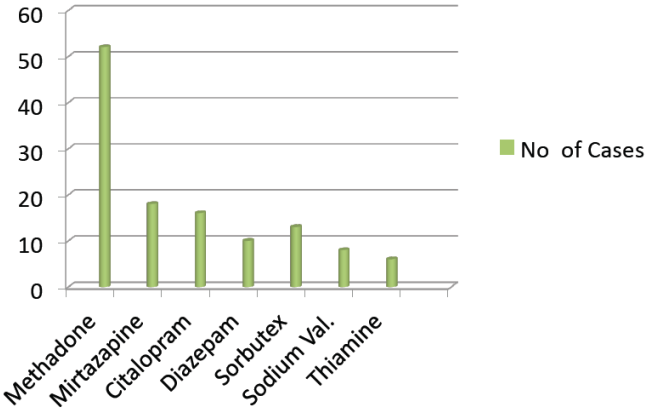


**Figure 8:** Common medications prescribed for detainees in custody.

## DISCUSSION

The study shows that out of the 258 detainees included in the study the majority were males which

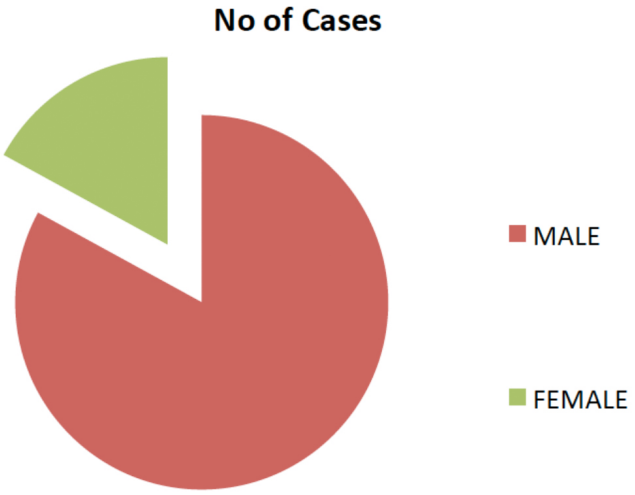


**Figure 9:** Sex distribution of detainees in custody.

constituted 83% of the study sample compared to females 17%. This means that the detainees in police custody were more likely to be males than females which gives a female to male ratio of 1:5. This finding is similar to the findings from other studies in terms of the male to female distribution. In the study by McKinnon & Grubin (McKinnon and Grubin 2013) looking at psychiatric and physical morbidity in detainees they observed a sex distribution of 83% males. Scott and colleagues (Scott, McGilloway and Donnelly 2009) found a female to male ratio of 1:5. The study by Payne James, Wall and Bailey (Payne - James, Wall and Bailey 2005) also found a sex distribution of 82% males and 18% females.

In terms of the age distribution by sex most of the detainees 68 % were aged between 21-40 years old for both sexes. This age group accounted for 62% of the male detainees in custody and for 55% of the female detainees. It was observed that there was a higher representation of the age group 41-50 years old, among the female sex accounting for 27% compared to 14.9% for males which means that the female detainees tend to be older compared to the male detainees. The reason for this was not clear. This may be a reflection of the complexity and the interplay of the range of factors that contribute to offending in the female population such as a previous history of trauma, sexual abuse, substance misuse, mental health problems, abusive relationship with coercion and control, chaotic lifestyles, homelessness, disruption to families and children which may lead to a cycle of inter generational offending (Female Offender Strategy, Ministry of Justice 2018; Bradley 2009) but it may also be partly due to the fact that overall there were fewer numbers of female detainees in custody which has a tendency to increase the percentage of this age subgroup in females compared to males.

The range of the common mental health problems seen in police custody during the period of study, using the International Classification of Diseases manual by the World Health Organisation, ICD 10 chapter 5 which deals with the mental and behavioural disorders has already been listed (World Health Organisation, ICD 10 1992). These are mental and behavioural disorders due to substance misuse 56%, depression 44%, self harm 39.8%, Anxiety disorders 11%, epilepsy 9.65%, schizophrenia 6%,personality disorder 4.6%, obsessive compulsive disorder 0.8%, psychosis 2.7%,attention deficit hyperactivity disorder, bipolar affective disorder, manic depression, Intellectual disabilities 7 cases and Korsakov's syndrome which was reported in only one case.

The six most common mental health problems seen in detainees in custody during the period of study were substance misuse (drugs and alcohol) which was top of the list followed by depressive disorder, self-harm, anxiety disorders, epilepsy and schizophrenia in that order.

The overall psychiatric morbidity reported in this study is much higher than the 20% reported by Recrut - Lapa and Lapa (Rekrut - Lapa and Lapa 2014) in a review of literature looking at the health needs of detainees in custody in England, but lower than the 91% reported by Scott and colleagues. However in terms of the prevalence of drugs and alcohol use by detainees in custody, the finding from this study is high and similar, as over half of all the detainees included in the study sample have a drugs and alcohol problem.

Although this study shows that there were 114 cases of drugs and alcohol use it is worth highlighting that the actual number of detainees using drugs and alcohol may be different from this in real terms, because of multiple substance misuse. This may also be partly due to the tendency for many detainees to withhold information and to sometime deliberately conceal information about their drugs and alcohol use when interviewed in custody for fear of prosecution.

A further breakdown of the pattern of dugs and alcohol use in custody shows that heroin was the most prevalent and accounted for 93 cases (64.5%) then alcohol 54%, cocaine 34%, cannabis 20%, amphetamines and diazepam. This finding is also similar to the findings from other studies (Payne -

James, Wall and Bailey 2005; Scott, McGilloway and Donnelly 2009) which identified heroin as the most frequently used substance in custody of up to about 93%. This finding is interesting as one would have expected the use of alcohol to be top of the list as alcohol is more widely available in the community (National Institute for clinical excellence (NICE), Clinical Guideline no 115, 2011; Fuller 2008).

Some of the detainees with drugs and alcohol problem also required emergency and routine care while in custody. These were the detainees with opiate and alcohol withdrawal symptoms, they were given prompt treatment for their withdrawal symptoms and then referred on to the local community drugs and alcohol team for further follow up as is necessary by the available health care professional. They were also given additional support by the local drugs and alcohol and liaison teams which included the Drug Referral and Arrest Teams.

Depressive disorder was the second most common mental health disorder identified during the period of study. Some of the detainees were already on antidepressant medication and these were continued in custody as much as possible and practicable. Poor concordance with medication before arrest was a major problem observed with detainees as well as co morbid substance misuse problem. Both factors are more likely to reduce the effectiveness and efficacy of any antidepressant medication.

Self harm was the third on the list and also a common mental health problem observed during the period of study with a prevalence of 38.9%. Other studies have reported a higher incidence of about 54% (Scott, McGilloway and Donnelly 2009). The self harm is usually within the context of a depressive disorder and or an anxiety disorder or a combination of both or another psychiatric disorder. There are other important contributory factors to self harm which include genetic vulnerability, psychological, familial, social and cultural factors. Self harm may also serve as a means of communication and an expression of the sheer frustration and poor distress tolerance to everything going on for the particular detainee at the time of arrest. This is partly explained due to the 'Cognitive vulnerabilities' as highlighted by Evans and colleagues in terms of the impaired and or poor social problem solving and coping skills combined with exposure to negative life events including early and recent life adversity (Evans, Hawton and Rodham 2004). The 'Diathesis - stress' explanation model, in terms of the aetiology of self harm is another theoretical formulation (Hawton, Saunders, O'Connor, 2012) which sees self harm to be the result of an innate predisposing biological imbalance such as serotonin imbalance which can then be triggered by a 'critical incident'.

Some of the self harm episodes may also be in the context of particular personality traits for example 'perfectionism' or 'impulsivity' or a personality disorder. This can be associated with any personality disorder but usually more with the 'Emotionally unstable personality disorder' with behaviour and emotional dysregulation (WHO ICD10, 1992). In such cases the Forensic medical practitioner or the health care professional would usually be requested to review the ‘risk assessment and management’ and institute the appropriate level of observation for the detainee in custody to minimise or mitigate any risks.

Epilepsy accounted for 17% of cases. Most of these detainees with epilepsy were already on anti epileptic-medication (s) and these were continued in custody. Depending on the seriousness and severity of their condition, some were transferred to be reviewed at the local hospital and then were linked up with the appropriate local community services. Almost all cases were reviewed by the Forensic Medical Examiner because of the special associated risks with epilepsy in custody.

The prevalence of schizophrenia in the study was 6%. Schizophrenia is regarded as a major and an enduring mental health problem.

In a study looking at drug deaths in police custody (Best *et al*. 2004) reviewed 43 deaths in custody and 18 of the deaths accounting for 42% were associated with a mental health problem. This again highlights the importance of careful screening and identification of those detainees with a mental health problem in custody as soon as possible during the initial period of arrest.

The range of the medications prescribed to detainees in custody during the period of study are also listed in Figure **7a** & **7b**. The most commonly prescribed medications were Methadone in 52 cases, Mirtazapine 18 cases, Citalopram 16 cases and Sorbutex 13, cases for substitution therapy for opiates and other antidepressants as well such as Fluoxetine, Venlafaxine and Paroxetine.

Others include Benzodiazepines such as diazepam, Temazepam, clonazepam and Lorazepam. The

benzodiazepines especially diazepam were used to manage the acute withdrawal symptoms from alcohol. Mood stabilisers such as Lithium carbonate and Sodium Valproate were used for treatment. Sodium valproate was also used as an antiepileptic. Dietary and vitamin supplements such as Thiamine, Folic acid and Vitamin Bco especially for detainees with Alcohol problem were also used as part of the treatment.

## CONCLUSION

There were two hundred and fifty eight cases of detainees in police custody included in the sample during the period of study.

The study shows that there were more male detainees in custody than females. There was a ratio of one female to five male detainees.

The commonest age group in custody for both sexes was the age group 21-40 years old, but female detainees tend to be older.

The commonest mental health problems seen in detainees in custody using the ICD 10 classification were mental and behavioural disorders due to drugs and alcohol use, which was top of the list, followed by depressive disorder, self-harm, anxiety disorder, epilepsy and schizophrenia.

Heroin was the most common drug of abuse seen in detainees in custody, followed by Alcohol and then cocaine. Methadone was the commonest prescription drug used for substitution therapy.

This study is a survey of the characteristics and the common mental health problems seen in detainees in police custody in the various custody suites in Yorkshire in the North of England, United Kingdom. The findings from this study are by no means exhaustive but have been able to shed some more light and provide further insights on this special and vulnerable group of detainees with a mental health problem held in police custody. Knowledge of their mental health needs is essential in order to manage them and optimise treatment strategies. It will also help to maximise the outcome and reduce clinical risks in police custody.

More research is needed regarding the mental health of detainees in police custody in relation to safer detention.

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## REFERENCES

Best, D., Havis, S., Strathdee, G., Keaney, F., Manning, V. and Strang, J. 2004." Drug deaths in police custody: is dual diagnosis a significant factor ?", J Forensic Leg Med, 11(4): 173-182. https://doi.org/10.1016/j.jcfm.2003.12.006

British Medical Association, Ethics Department and The Faculty of Forensic and Legal Medicine. 2009," Guidance on the Health care of detainees in police stations''.

Bottomley, K., Coleman, C., Dixon, D., Gill, M. and Wall, D. 1991." The detection of suspects in police custody: The impact of the Police and Criminal Evidence Act 1984", British Journal of Criminology 31(4): 347-364. https://doi.org/10.1093/oxfordjournals.bjc.a048134

Carter, J. and Mayhew, J. 2010." Audit of hospital transfers January to March 2006 from Sussex police custody", J Forensic Leg Med 17: 38-40. https://doi.org/10.1016/j.jflm.2009.07.014

College of Policing, Authorised professional Practice. 2017. www.app.college.police.uk

Department of Health, 2009. Bradley Report. Department of Health Publications. London.

Evans, E., Hawton K. and Rodham, K. 2004. ''Factors associated with suicidal phenomenon in adolescents: a systematic review of population based studies. Cli Psychol Rev, 24 (8): 957- 979. https://doi.org/10.1016/j.cpr.2004.04.005

European Convention of Human Rights, EHCR. 1950. Article 5. The Stationery Office. London.

Fuller, E. 2008." Alcohol consumption. In health survey for England 2006 vol. 1: Cardiovascular disease and risks factors in adults. eds Craig R & Mindell J. Leeds. The information Centre.

Hawton, K, Saunders K. E.A. and O' Connor, R. 2012." Self harm and suicide in adolescents. Lancet 379: 2373-2382.

Human Rights Act. 1998. The Stationery Office. London.

McKinnon, I. and Grubin, D. 2010." Health Screening in Police custody". J Forensic Leg Med 17: 209-12. https://doi.org/10.1016/j.jflm.2010.02.004

Mental Health Act. 1983. TSO.London.

Mental Health Act. 2007. The Stationery Office. London.

Ministry of Justice. 2018." Female offender Strategy. June. Wwww.revolving doors.org.uk/blog/ministry of justice-female offender strategy.

National Institute for Clinical Excellence NICE. 2011. Clinical Guideline No 115. National Collaborating Centre for mental health. United Kingdom. Leicester. www.nice.org.uk

Olubokun, J. 2008." The vulnerable adult in police custody: lessons learned from the case of R v Paul Aspinall". Med Sci Law 48 (3): 199-202. https://doi.org/10.1258/rsmmsl.48.3.199

Police and Criminal Evidence Act, PACE. 1984. TSO. London.

Police and Criminal Evidence Act. 1986. Code of Practice Code C. TSO. London.

Payne - James, J.J. 2010." Clinical risk and detainees in police custody". Clinical Risk, 16 (2): 56-60. https://doi.org/10.1258/cr.2009.090090

Prison Reform Trust 2018. Bradley Report. Www.prisonreformtrust.org.uk

Payne- James, J.J., Wall, I.J and Bailey, C. 2005." Patterns of Illicit drug use of prisoners in police custody in London, UK". J Forensic Leg Med, 12(4): 196-198. https://doi.org/10.1016/j.jcfm.2005.04.005

Payne -James, J.J., Green, P.G., Green, N., Mclachlan G.M.C. and Moore, T.C.B.2010." Healthcare issues of detainees in police custody in London, UK".J Forensic Leg Med, 17: 11-7. https://doi.org/10.1016/j.jflm.2007.10.011

Recrut- Lappa,T. and Lappa, A. 2014." Health needs of detainees in police custody in England and Wales. Literature review". J Forensic Leg Med 27: 69-75. https://doi.org/10.1016/j.jflm.2014.08.004

Robertson, G., Pearson, R. and Gibb, R. 2007." The entry of mentally disordered people to the criminal justice system", Br J Psychiatry 169:172-80. https://doi.org/10.1192/bjp.169.2.172

Scott, D., Mc Gilloway, S. and Donnelly, M. 2009." The mental health needs of women detained in police custody". Journal of Mental Health 18 (2): 144-151. https://doi.org/10.1080/09638230701879193

Shaw, J., Creed, F., Price, J., Huxley, P and Tomenson, B.1999." Prevalence and detection of serious psychiatric disorder in defendants attending court" Lancet 353:1053-6. https://doi.org/10.1016/S0140-6736(98)08094-5

www.nice.org.uk. 2010." Diagnosis, Assessment & Management of harmful drinking and alcohol dependence. Final Draft CG 115.

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