



special articles

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Service innovation: policing mental health – the St Andrew's scheme

Assaults against healthcare staff have gained increasing attention, prompting the Zero Tolerance Zone campaign in the National Health Service (NHS) (Department of Health, 1999). This advised that treatment could be withheld as a sanction, although not from 'anyone who is mentally ill or under the influence of drugs'. More recently the NHS Security Management Service (Department of Health, 2005) found that the greatest number of assaults (over 43 000) were found in mental health and learning disability environments.

An initiative on tackling violence against NHS staff (Department of Health, 2005) recognises the limitations of the Zero Tolerance approach. There are particular considerations in mental health services (Behr *et al*, 2005), where it is useful to consider patient-on-staff and patient-on-patient violence together. Coyne (2002) explored how decisions to contact the police are made in mental health services. Few incidents are reported to the police, who in turn take few matters beyond an initial discussion. Staff are unclear of the benefits of prosecution and this perpetuates the failure to address the problem. Some mental healthcare professionals accept violence as an occupational hazard, with little organisational response, and cope with violence without support.

Bayney & Ikkos (2003) review the police perspective, highlighting that current training focuses on diversion from the criminal justice system. Police officers see psychiatric hospitals as a place of safety where a patient should remain. The police often perceive psychiatric in-patients as poor witnesses, unlikely to assist in prosecution (Brown, 2006). They are unclear where the public interest lies, especially for detainees under the Mental Health Act 1983. The Crown Prosecution Service has in the past been similarly reluctant to progress proceedings (Joseph, 1990), although the Home Office (1995) has highlighted prosecution for serious offences and risk of repetition. A recent memorandum of understanding between the Department of Health, the Association of Chief Police Officers and the Health and Safety Executive sets out a collaborative approach to the investigation and management of behaviours that compromise safety in NHS environments (Health and Safety Executive, 2006).

Dinwiddie & Briska (2004) outline the dilemmas around confidentiality, and in balancing the rights of

patients and staff. They recommend a systematic approach to the reporting and prosecution of those perpetrating violence, and collaboration with the criminal justice system as the only way to safeguard other patients and staff. This sets out clear criteria for prosecution (see Box 1).

Box 1. Criteria for prosecution of violent patients

- Clinical staff have informed a patient with a history of violent behaviour that assaults will be prosecuted when other interventions have failed and prosecution is considered clinically appropriate
- Unprovoked physical aggression which resulted in significant physical trauma to the victim (e.g. fracture, loss of consciousness, severe bruising, cuts requiring suturing, etc.)
- Sexual assault or attempted sexual assault with physical contact
- Intentional destruction of property causing damages beyond an agreed amount.

The St Andrew's scheme

St Andrew's is a charity providing for over 500 in-patients, mainly in Northampton. Secure and specialist services treat men, women, adolescents and older people in separate facilities for mental health, learning disability and acquired brain injury. Many patients present a significant risk of violence; there is a high level of staffing and a strong multidisciplinary skill base in managing challenging behaviour.

In 2004, with an improved reporting system for assaults, it was recognised that police response was variable and decision-making unclear, with limited expectations from hospital staff as to the criminal justice response. After a visit from the new chief constable, the local chief superintendent of police was invited to support a new police liaison forum. Led by the lead social worker in the men's service, a membership including local police officers, the Crown Prosecution Service and key hospital staff developed a joint policy on information-sharing and reporting, with clear expectations of each



party. However, it was soon recognised that communication on the ground inevitably varied between nursing staff, police and others in differing teams in their respective round-the-clock services. Inefficient use was being made of the resources of the local beat officer, the force communication centre and hospital staff.

The key to innovation was to recognise that significant resources were being used inefficiently, in the absence of a dedicated resource to address such an important area. The solution was for the hospital to offer funding for a community officer dedicated to the St Andrew's Hospital site. A service-level agreement was developed, and both St Andrew's staff and police officers were involved in the selection process. This included a tour of the site and visits to ward areas. The officer is managed as a police officer, liable for other emergency police duties but with primary duties within the hospital, has an office on site, and direct access to the police and hospital information technology systems.

There were initial concerns about whether having a uniformed police officer on site would make patients uncomfortable. However, in the first 12 months of the scheme, the officer has become well integrated into the hospital community, and is welcomed as a visible, positive and friendly presence and an important resource. The local criminal mental health justice team later assigned a senior member of staff as a link worker, to screen all referrals. Allegations from patients and staff are processed in an organised manner, and informal inquiries welcomed. Referrals and incidents have been audited.

We found initial over-reporting of minor incidents, which was addressed by a seminar for nurse and ward managers. Improved understanding between police and mental health professionals has allowed a much clearer and realistic reporting process to evolve. There has been a focus on serious assaults, but also criminal damage, racial abuse and drug misuse. There is improved access to and use of a range of special resources, such as the hate crimes unit, the mentally disordered offenders team, the drug squad, crime prevention unit, etc. This has brought synergy with key hospital initiatives, such as the diversity strategy, and has allowed the carefully managed use of a professional drug detection dog service.

The officer now contributes to patient groups on personal safety and on hate crimes; she plays an important role in staff induction, and supports staff and patients attending court. She coordinates information for defence solicitors and the Crown Prosecution Service, Police and Criminal Evidence Act interviews, intelligence on drug misuse on site, and takes part in inter-agency liaison and policy development. There are plans to train police probationers in the scheme.

There has been a significant positive effect on aggressive incidents, most notably in the secure men's service, where the number of aggressive incidents has dropped by over two-thirds to around 10 per week in the first 12 months of the scheme. The progress and funding of the scheme is kept under regular review, and it has been decided to extend the scheme for a further year.

Conclusion

Violence in psychiatric hospitals is a long-standing problem which national and local policy initiatives have failed to address. The allocation of a specific resource in the form of a dedicated hospital police officer has had a dramatic impact in a large psychiatric hospital. This could be a useful model for other hospital sites.

Declaration of interest

None.

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