Criminalising Distress

Medact

Citation: Aked, H., Bailey, C., Blell, M., Blewitt, A., Botelle, R., Ela, A., Gnaegi, R., Lake, B., Monk-Cunliffe, J.,Palmer, C., Porter, H., Sangtani, C., and Sukles, M., (2024). *Criminalising Distress*, London: Medact.

Design and layout by Sujata Aurora/Gratuitous Graphics

Cover designed based on art by Hat Porter

ABOUT MEDACT

Medact is a charity that brings together health workers to fight for health justice. We recognise that health injustice is driven by political, social and economic conditions, and we mobilise the health community to take action to change the system. Medact and our member groups carry out research that helps us to understand health inequalities and offers solid evidence for effective campaigning and advocacy.

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Registered charity 1081097 Registered company 2267125

Published by Medact, 2024
ISBN 978-1-8381205-6-6
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Content warning

This report covers distressing themes including mentions of state violence, sexual violence, domestic violence, childhood sexual abuse, discrimination, self-injury, suicidality, trauma and iatrogenic harm.

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Acknowledgments

This report would not exist without the collective work of survivors, activists and campaigners, including the StopSIM Coalition. People with lived experience of harm and injustice in the mental health system successfully challenged a programme which was waved through by the entire medical establishment, in a powerful example of grassroots activism.

Medact would like to pay tribute to this and express enormous gratitude for the work of former members of the StopSIM Coalition to enable this research to happen, guided by their expertise as a steering committee. As an organisation with a predominantly health worker membership, we thank all those involved in the campaign for confronting a scheme which encapsulates the harms that can be perpetrated within mental health 'care', in the process forcing us to reflect on what it reveals about the system as a whole.

We would also like to thank the academics on our Ethics Advisory Committee, the National Survivor User Network (NSUN), StopSIM Allies, lived-experience researcher Wren Aves, and John Pring of Disability News Service. Finally, we would like to thank everyone who agreed to share their experiences with us by being interviewed for this report.

Funded by the Joseph Rowntree Reform Trust

The Joseph Rowntree Reform Trust has supported this work in recognition of the importance of the issue.The facts presented and the views expressed in this report are, however, those of the authors and not necessarily those of the Trust.
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Executive summary

This report examines the 'criminalisation of distress' with a focus on practices associated with the Serenity Integrated Mentoring (SIM) scheme, which became a national scandal in May 2021 as a result of a campaign by the StopSIM Coalition.

- It is based on primary research including freedom of information (FOI) requests, interviews, and a literature review, conducted over 18 months.
- We examine SIM's origins and impacts, accountability for it, and alternatives to SIM-like practices which target people at high risk of suicide and self harm who frequently contact emergency services.
- Critically, the report outlines ongoing police and NHS schemes which continue to criminalise distress today, using threats, exclusion, denial of care, behaviour contracts, civil orders and prosecution.

Origins, evolution and systemic causes

- SIM was not an aberration. The mental health system has long managed mental distress in punitive and carceral ways.
- Neoliberal economic policies and philosophies create systemic conditions ripe for exclusion and neglect, ideologically justified by behavioural theories placing blame on individuals.
- This, and the highly gendered, stigmatising, and harmful 'personality disorder' construct that traumatised and autistic people are often labelled with, explain why SIM was embraced as "innovative".

Impacts

- Crucial medical principles of consent and data confidentiality were extremely poorly upheld under SIM.
- Threats of and actual prosecutions were used, which was inherently coercive.
- Contact with police invoked fear and shame, compounding the distress at the root of patients' presentation. Impeding access to care destroyed trust and put patients at risk.
- Given the sexual abuse widespread in mental health settings and the police, the testimonial injustice central to SIM, which encouraged a predisposition to doubt patients' claims of sexual violence, was disturbing and dangerous.

- SIM should be considered a form of iatrogenic harm. It ran counter to principles of trauma-informed care and replicated dynamics of abuse, risking re-traumatising patients – but none of these harmful impacts were *unique* to SIM.
- Service providers believed SIM saved money by reducing demand. Some staff felt it helped them "contain risks" to their careers. It caused moral injury to other health workers, some of whom paid a price for speaking out.
- While it was not unheard of for patients to be positive about SIM, this arose in contrast to the chronic failure of mainstream mental health services to offer adequate support.

Justice denied

- None of the bodies most responsible for promoting, funding and spreading SIM – NHS England, the NHS Innovation Accelerator, the Academic Health Science Network (now known as the Health Innovation Network) and National Police Chiefs' Council – properly evaluated evidence for SIM or the lack of patient outcome measures.
- These agencies have not fully acknowledged, taken responsibility for, or apologised for the harm caused or the multiple failures that led to SIM. The same bodies have also shown considerable resistance to full transparency by rebuffing FOI and interview requests.
- A culture of unaccountability and blame-shifting has resulted in a marked absence of meaningful institutional change. The NHS Innovation Accelerator has continued to promote dubious and potentially unevidenced 'innovations' such as invasive patient monitoring system Oxevision.
- While it called for SIM-like practices to be "eradicated", NHS England failed to publish a joint policy produced with members of StopSIM, showing dangerous disregard for lived experience and leaving patients without adequate protection from harm.
- Established whistleblowing mechanisms failed: health workers who repeatedly raised the alarm were themselves punished.

Ongoing harm

- There is no regulatory mechanism to ensure criminalising practices are eradicated. The Care Quality Commission does not appear to inspect trusts for SIM-like practices.
- There have nonetheless been some positive new developments such as the recent closures of SIM-style programmes ARC and SHIPP, and the adoption of explicitly decriminalising approaches by other trusts.

- Overall, however, our FOI research confirms that the disappearance of models explicitly named 'SIM' has not ended criminalising practices.
- There are multiple examples of schemes which continue to criminalise distress, often but not always spearheaded by the police; these include PAVE, FERN, HaRT and Op Ipsum.

Imagining otherwise

- Removing police from mental health services is the bare minimum that must happen immediately. Removing police from crisis responses altogether requires funding for community-based and other mental health first aid schemes.
- Transforming the mental health system itself means moving beyond calls for more funding towards a rights-based system, embracing non-coercive community-based alternatives and addressing social determinants of mental health upstream to preempt crises.

Conclusions and recommendations

- Punitive, exclusionary and discriminatory practices, and NHS collaboration with police to criminalise people in distress, must end.
- NHS England must immediately publish the full joint policy, apologise to the StopSIM Coalition, and launch an independent inquiry into ongoing SIM-like practices, including schemes like FERN, HaRT, Op Ipsum and PAVE.

1. Introduction

This report examines the 'criminalisation of distress' in contemporary England. By this, we mean the ways in which punitive and criminal justice measures – ranging from police warnings, to behavioural orders, to prison sentences – are deployed by state agencies in response to behaviours which individuals themselves understand to be rooted in mental distress.[1]

Our research shows that – despite the demise of SIM itself – the criminalisation of distress continues

The trigger for this research was the prominent campaign by the StopSIM Coalition to expose and challenge Serenity Integrated Mentoring (SIM). A so-called 'model of care', SIM was a particularly egregious example of the criminalisation of distress, in which police officers were embedded into community mental health teams after undergoing a one-week training course. The police officer's ostensible role was to 'mentor' patients deemed 'high intensity users' of mental health and emergency services, as part of their routine, non-emergency 'care'. These patients were at high risk of suicide and self harm. At its peak, approximately half of all NHS mental health trusts in England had a SIM team, or a variant based on the SIM model (see Appendix 1).

The origins, evolution and spread of SIM – as well as its harmful impacts – constitute a central focus of our study. We explain how SIM was allowed to happen by placing it within a broader historical context that maps out the sociopolitical conditions which enabled its emergence. The report offers in-depth analysis of the impacts of SIM, and SIM-like practices, emphasising the testimonies of patients / service users[2] and highlighting where their experiences echo or diverge from the views and experiences of health workers and other stakeholders. We also scrutinise the fallout from and (lack of) accountability for what became a national scandal.

StopSIM campaign artwork by Hat Porter

Critically, although NHS England would eventually call for SIM-like practices to be "eradicated", our research shows that – despite the demise of SIM itself – the criminalisation of distress continues.[3] It is clear that SIM was not an aberration but a *symptom* of wider problems which persist today. The report outlines several ongoing schemes using SIM-like practices, albeit under different names, which continue to criminalise distress.

Such practices underline the urgent need for a traumatising system to be transformed and structures put in place, instead, which provide genuine care for people in mental distress, rather than criminalising them.

Methodology

This report is based on primary research conducted over the course of 18 months by Medact Research Network members and staff. Our aims were to research the origins and impacts of SIM, as well as accountability for it, alternatives to it, and ongoing examples of criminalising distress. The work had three strands: a literature review, systematic freedom of information (FOI) requests, and a series of interviews.

Our systematic review of academic and grey literature included books, journal articles, policy papers, news articles, blogs and various materials produced by and about the SIM scheme itself, building on prior critiques produced by the StopSIM campaign.

Two rounds of FOIs were filed to extract both qualitative and quantitative information from public bodies involved in SIM. In the first round, we requested data from NHS trusts only, to access the reviews they carried out into SIM. In the second round, we asked further questions about ongoing practices via FOIs sent to 10 ambulance trusts, 26 NHS trusts and 39 police forces (plus the British Transport Police). In addition, we requested information from NHS England, the National Police Chiefs' Council, the Care Quality Commission, the British Transport Police and the Academic Health Science Network (which has since rebranded as the Health Innovation Network).

Prior research focusing on the perspectives of individuals who have experienced police involvement in mental health has been surprisingly limited.[4] During the development of SIM specifically, qualitative data on patient experiences was completely devalued. To counteract this tendency, we conducted fifteen semi-structured interviews, principally with service users and health workers but also with some professionals employed in mental health policy and the police. Interviews

were either conducted in person or on video calls. Participants were recruited via an open call shared on social media as well as a combination of purposive and snowball sampling. Of the fifteen interviewees, six had direct experience of SIM or schemes directly based on the SIM model, while the rest had other experiences of punitive and criminalising responses to mental distress or indirect knowledge of SIM. All names of patients cited in this report are pseudonyms.

Ethics

Our study went through a rigorous ethics review and was approved by the University of Greenwich departmental Research Ethics Committee. It was also reviewed by an inter-disciplinary Ethics Advisory Committee composed of experienced academics: Dr China Mills, Professor Charlotte Heath-Kelly, Dr Feryal Awan and Dr Tarek Younis.

In addition, we convened a Steering Committee composed of former members of the StopSIM Coalition – a group led by people with lived experience of the mental health system – and consulted regularly with them from the inception of the project to its conclusion. We view this involvement as a central part of ethical research and sought to engage in as transparent and collaborative a way as possible, in accordance with Survivors Voices' research charter.[5] The Steering Committee's meaningful involvement contrasts sharply with NHS England's failure to follow through on the lip-service it paid to 'co-production' with the group (see part 4). Steering Committee members also contributed a wealth of knowledge and resources about SIM, acquired through the course of their campaign.

The Steering Committee's meaningful involvement contrasts sharply with NHS England's failure to follow through on the lip-service it paid to 'co-production' with the group

On the advice of our Steering Committee, we took additional measures to maximise the accessibility of interviews and minimise the risk of causing distress or re-traumatising participants. These measures included producing plain English and easy-read versions of our Participant Information Sheet, ensuring debriefs were offered after interviews, checking that patients' family members had their relative's consent to speak to us, and asking each participant to fill out a personalised Wellbeing Plan before scheduling interviews.

The latter document helped us tailor bespoke interview schedules and take a transparent and person-centred approach to caring for participants' welfare, avoiding

a top-down safeguarding approach where possible. For example, it asked participants if there were particular topics or language they would like us to avoid, and gave them the opportunity to share with us in advance any signs or behaviours indicative of distress or dissociation, particular to them, that they would like us to be aware of. A copy of the Wellbeing Plan template is included in Appendix 2.

Given this study's distressing themes, we took steps to ensure the involvement of Medact Research Network members conducting the research was as safe and positive as possible too, including considerations around emotional and practical safety.[6] In addition, we engaged reflexively as a team in considering our motivations and positionality. In particular, as a group mostly composed of health workers – including trainee and practising psychiatrists – it was important to acknowledge a potential medicalising bias, as well as the tensions inherent in researching an issue predominantly impacting service users, some of whom have been harmed by the psychiatric system and view dismantling it as a prerequisite to disability justice and a truly abolitionist public health.[7]

2. Origins, evolution and systemic causes

The emergence of SIM, and the broader phenomenon of the criminalisation of distress, can only be understood in the context of systemic issues within mental health care and social policy. The reviews which NHS trusts would eventually conduct into SIM – given their narrow scope – did not consider such issues. Our research, however, made clear that the scheme's emergence was not an inexplicable blip in an otherwise compassionate system. On the contrary, it constituted the logical conclusion of a constellation of tendencies with deep historical roots: longstanding trends towards punishment and criminalisation over care, intensified by neoliberal economic policies and ideology, behaviourist approaches to public health, and the harmful 'personality disorder' construct.

A short history of SIM

Serenity Integrated Mentoring (SIM) emerged and developed on the Isle of Wight, a small English island off the coast of Hampshire. SIM's immediate predecessor was Operation Serenity, one of the UK's first street triage response teams, set up in October 2012 and led by then Hampshire police sergeant Paul Jennings. Jennings noticed that just eight people – all of them women, all with a history of trauma including abuse, neglect, and domestic violence, and all diagnosed with Borderline Personality Disorder – made up 32% of all Section 136 detentions and used local healthcare and emergency services regularly. He dreamt up a new scheme to target this small group, initially calling it the 'Integrated Recovery Programme'.[8]

Jennings noticed that just eight people – all of them women, all with a history of trauma and all diagnosed with Borderline Personality Disorder – made up 32% of all Section 136 detentions

Jennings' idea involved embedding police officers within community mental health teams to have "mentoring style discussions" with patients over weeks or months, during times that they were *not* in crisis. Ostensibly, the purpose of this contact was to "encourage personal accountability, a more consistent and focused mind set and greater social awareness and competence" on the part of service users.[9] The police officers were non-uniformed, had honorary NHS contracts and NHS identity badges, as well as full

access to patients' clinical records. Far from being co-produced, the views of service users themselves were of little to no importance in the development of SIM.[10]

In the summer of 2013, Hampshire police launched a pilot study with the Isle of Wight NHS Trust. In its own words, the pilot posed the question, "Could the police proactively support the NHS with these increasingly unmanageable and institutionalised patients who were failing to make any real clinical progress?"[11] Of the eight women identified, Jennings "persuaded" six to speak to him and participate in the programme.[12] When he came to write up results of the intervention, however, that number had reduced to just four. While this was acknowledged to be a very limited sample, it would later transpire – thanks to a freedom of information request made by a supporter of the StopSIM campaign – that Hampshire Police had itself subsequently raised repeated serious concerns about the removal of the other two patients, which it said rendered the reported results a "grossly distorted set of statistical outcomes", "erroneous", "not remotely accurate" and "not ethical".[13]

As lived experience researcher Wren Aves explains, one of the six service users had left the scheme and subsequently died. Another was sectioned and became an in-patient. These inconvenient cases were simply removed from the data set. Of the remaining four women whose data *was* included in the pilot evaluation, one left the scheme after the first year. From year two, her service use was reported as zero but, in reality, she continued to have regular contact with both police and health services and was hospitalised for a time.[14] Another of the four women whose experiences supposedly demonstrated the positive impacts of SIM had an eating disorder which got worse during the pilot. She was also convicted of grievous bodily harm after stabbing her boyfriend, receiving a Community Behaviour Order and a Probation Order. Another, who was threatened with a Community Behaviour Order, continued to self-harm at home although her public suicide attempts stopped.[15]

Paul Jennings (second left) and SIM colleagues collecting a Nursing Times Award. Credit: Nursing Times.

Despite the complete absence of robust evaluation data generated by this study,[16] from that point onwards the scheme grew and spread across England over the course of the next eight years. It was endorsed and actively promoted by NHS England and affiliated bodies. With his wife, Jennings set up a private company called the High Intensity Network, which owned and ran SIM. He aggressively marketed the scheme, which won awards and funding thanks to his grandiose but false claims of efficacy. Box 1 provides a timeline of the rise and fall of SIM over the course of a decade.

Despite the complete absence of robust evaluation data generated by this study, the scheme grew and spread across England

Box 1: Timeline of SIM

2012	A street triage programme, Operation Serenity, begins on the Isle of Wight
2013	A pilot study of SIM (known initially as the Integrated Recovery Programme) begins
2015–2017	SIM is commissioned on the Isle of Wight
2016–2017	SIM is shortlisted for the *Health Service Journal*'s Value in Healthcare Awards and wins a *Nursing Times* Award
2016	NHS England endorses the model; the Wessex branch of the Academic Health Science Network, an NHS England initiative, begins supporting the rollout of SIM
2016	Sergeant Paul Jennings is awarded a fellowship from the NHS Innovation Accelerator, another NHS England initiative, to scale and spread the SIM model nationwide
2016	Surrey police visit the Isle of Wight to look at SIM; supported by the NHS Innovation Accelerator, they set up a trial in collaboration with the local NHS, later expanded and funded
2017	Hampshire police, which piloted SIM, quietly discontinues the scheme after flaws in the evidence base come to light
2018–2020	SIM is chosen by the Academic Health Science Network for national adoption and spread
2018	SIM is launched in six London boroughs; variations exist across trusts, some of which adapt the model under a different name
2018–2020	SIM is implemented in a further 13 London boroughs and elsewhere in the country; in total, approximately 26 mental health trusts in England adopt some variant of SIM. Paul Jennings aspires to expand to GP services and overseas; a trial takes place in the Netherlands[17]
2021	The StopSIM Coalition writes to NHS England and launches a petition and a website, publishing detailed critiques of SIM; the campaign gains attention on social media and in the national press; under pressure, a range of professional bodies, royal colleges, national mental health charities and user-led organisations speak out

2021	High Intensity Network, the private company behind SIM, shuts down; NHS England eventually tells trusts to review the model – these reviews vary widely in rigour and scope
2021–2022	NHS England asks to meet with StopSIM Coalition members, who then spend 15 months working with NHS England on a policy based on trusts' reviews, a potentially unprecedented example patient involvement
2023	After legal threats from Wessex Academic Health Science Network and public relations concerns, NHS England chooses not to publish the policy; instead, it issues a position statement which says SIM-like practices should be "eradicated";[18] the StopSIM Coalition publishes the policy and then disbands[19]

Notably, the timeline in Box 1 touches briefly on the role of key bodies like NHS England and two of its side projects, the NHS Innovation Accelerator and the Academic Health Science Network, in promoting and propagating SIM. These institutions, and their lack of accountability, are discussed in more depth later in the report (see part 4).

The timeline also outlines the emergence of a grassroots campaign led by the StopSIM Coalition which – in the absence of any strong critiques from the health establishment – launched a challenge to the SIM scheme, questioning its "evidence base, safety, legality, ethics, governance and acceptability to service users".[20] It charts how this campaign mobilised a range of actors in the mental health space to speak out against SIM and eventually, the High Intensity Network shut down and the SIM scheme unravelled.

After the demise of SIM, two misguided narratives emerged. One implied that the criminalisation of distress ended with it, which (in part 5) we show to be sadly untrue. The other, related, narrative placed the blame for the spread of the model purely on Paul Jennings himself. However, this is only part of the picture. Equally important is the question of why his scheme was adopted so readily by the NHS. The answer incorporates a number of systemic issues which deserve in-depth examination and explanation.

Carcerality and mental health

It is widely evidenced that mental illness is disproportionately represented in the population caught up in the criminal justice system.[21] Explanations for this are hotly debated. Some theorists argue that the process of deinstitutionalisation – the closure of asylums since the middle of the twentieth century – has led to 'transinstitutionalisation', in which people with mental health needs are funnelled, instead, into the prison system.[22] According to this analysis, the criminalisation of distress is a re-labelling phenomenon through which "certain forms of deviant behaviour came to be defined within a legal, rather than a psychiatric framework".[23] Others have questioned this hypothesis.[24]

The mental health system – in particular in-patient psychiatric wards – can be violent and harmful *even without the involvement of the police*

Critically, despite variations in the specific apparatus of social control, it is clear that mental distress has long been managed in coercive, punitive and carceral ways. As the normalisation of restrictive practices and numerous cases of abusive treatment demonstrate, the mental health system – in particular in-patient psychiatric wards – can be violent and harmful *even without the involvement of the police*.[25] However, as part of a wider securitisation phenomenon, use of criminal behaviour orders and police powers are currently increasing across British society, including within mental health and other areas of vulnerability.[26]

Some form of police involvement in responding to mental health crises has been codified in law since at least the Lunatic Asylums Act of 1853. Section 136 powers, allowing police to detain people in crisis in order to 'protect the public', were introduced in the Mental Health Act 1959[27] and in the last fifteen years Section 136 detentions have been rising.[28] Moreover, despite the decriminalisation of suicide in 1961, criminal sanctions including court orders, prosecution and imprisonment persist today as responses to suicidality, even in the absence of a risk to the public.[29]

Dame Angiolini. Credit: UK Government

As police involvement in mental health crisis response has been increasingly normalised, a concomitant increase in injuries and fatalities to service users has occurred.[30] As noted in the 2017 Angiolini Review of deaths in custody, police "use of force and restraint...poses a life-threatening risk" to people experiencing mental distress.[31] Indeed, approximately half of all those who died in custody in recent years had a mental health condition.[32] Consistent with wider patterns of police violence and mental health system violence, such harms are disproportionately skewed towards racialised populations.

Co-responder 'street triage' schemes pair police officers with mental health workers to respond to crisis situations involving apparent mental distress

Amid a wider drive towards multi-agency partnership working and data sharing, the relationship between health and policing has grown closer. Initiatives like the Global Law Enforcement and Public Health Association (at whose conference Paul Jennings spoke in 2016) and the National Police Chiefs' Council's 'police and health consensus' attest to the growing interest in this interface. In this landscape, terms like "trauma-informed policing" have been popularised and various models of 'blue–green' (police–health) cooperation have emerged within mental health services.[33]

Liaison and diversion schemes, for example, combine police and mental health workers, and aim to identify people with mental health diagnoses as early as possible after arrest, ideally diverting them away from the criminal justice system.[34] Meanwhile, co-responder 'street triage' schemes pair police officers with mental health workers to respond to crisis situations involving apparent mental distress. Such schemes, often known as Crisis Intervention Teams in the US, have been backed by substantial investment in North America and much of Europe, despite being criticised for the "striking lack of evidence" that they actually work.[35]

Crucially, they are often seen as complementary – rather than alternatives – to criminalisation. This was made clear by Superintendent Justin Srivastava, a co-author of the 2019 discussion paper *Public Health Approaches in Policing*,[36] who told us:

> "taking a public health approach doesn't mean that you can't be punitive or can't take an enforcement approach. It doesn't preclude you from charging somebody, taking them to court and potentially even going into prison...you need to have a system that actually addresses the underlying causes, but at the same time, gives that person what they need, and that could be charge, arrest, and imprisonment.

In contrast, the World Health Organisation distinguishes between criminal justice measures based on the threat of punishment and public health approaches based on primary prevention.[37] Yet the blurred boundaries expressed here between these two fundamentally different approaches was a marked feature of SIM. For example, when Paul Jennings spoke publicly about SIM he would often include lengthy, detailed excerpts from the diagnostic criteria of the latest edition of the Diagnostics and Statistics Manual. He was often accompanied by a mental health nurse, Vicki Haworth, who spoke about why prosecution could be useful. (Patient and health worker interviewees agreed that mental health staff could at times be very enthusiastic about punitive responses to service users.[38])

A professional, who witnessed the pair presenting on SIM, recalled:

> I was sitting there thinking this is…you know…you're completely the wrong way round!…it just is an obvious kind of visual contradiction to see the police talking about clinical matters and the nurse talking about prosecution and the value that brings.[39]

This role reversal remained a trait of SIM throughout its implementation. SIM teams generally consisted of at least one registered mental health nurse and one police officer, though the latter led the scheme. As one NHS trust's review into SIM acknowledged, "at times there was a blurring of roles" between police and healthcare workers.[40] Indeed, SIM literature boasted about this, describing how "police officers started to sound a bit like nurses and nurses a bit like police officers".[41] SIM, then, built on a long history of criminalising distress and was embedded into a mental health system already accustomed to coercion in which cooperation with police was normalised.

Neoliberalism and behaviourism

Dominant since the late 1970s, neoliberal economic paradigms, advocating the strengthening of the 'free market' and weakening of the welfare state, have intensified the criminalisation of distress and constitute another important factor enabling the rise of SIM.

In Britain, austerity measures imposed on the public sector during periods of economic recession have long fostered the interrelated problems of poverty, deprivation, and rising mental illness and distress.[42] In turn, these sociopolitical conditions have given rise to growing exclusion and neglect of vulnerable

populations,[43] expressed in multiple arenas and described by some commentators as "organised state abandonment".[44]

At the micro level, burnout and 'empathy fatigue' have become increasingly common amongst mental health staff in a landscape of understaffing and overwork (though these phenomena do not excuse discriminatory attitudes towards, or treatment of, patients).[45] Simultaneously at the macro level, chronically underfunded NHS providers – particularly mental health services, due to a chronic lack of parity – have long been compelled to look for efficiency saving, cost-cutting opportunities and ways to ration care.[46]

Chronically underfunded NHS providers have long been compelled to look for efficiency saving, cost-cutting opportunities and ways to ration care

Mental health policy experts we spoke to argued that these cuts to services failed to care for those in *most* need. Dr Jay Watts, a consultant clinical psychologist, explained:

> basically, we throw the money at the mild and moderate people who are more likely to become taxpayers again, and then we can produce good digits...that's led to less and less for people with more complicated problems who are then left in this horrific situation.[47]

Similarly, Lucy Schonegevel of Rethink Mental Illness told us that people's experiences of community mental health care often involved:

> [being] told that they're either too unwell for talking therapies, or IAPT [Improving Access to Talking Therapies] as it was, or not unwell enough for inpatient care, so there's nothing for them apart from maybe joining a community mental health team and maybe seeing a psychiatrist every now and again...That, obviously then [led] to a huge demand for crisis support, and people becoming more and more unwell because there isn't that earlier upstream support.[48]

In this sense, service cuts are false economies since they remove preventative, protective measures and lead to more crises, thus actually helping to create the patterns of service use labelled 'high intensity' which schemes like SIM sought to target.

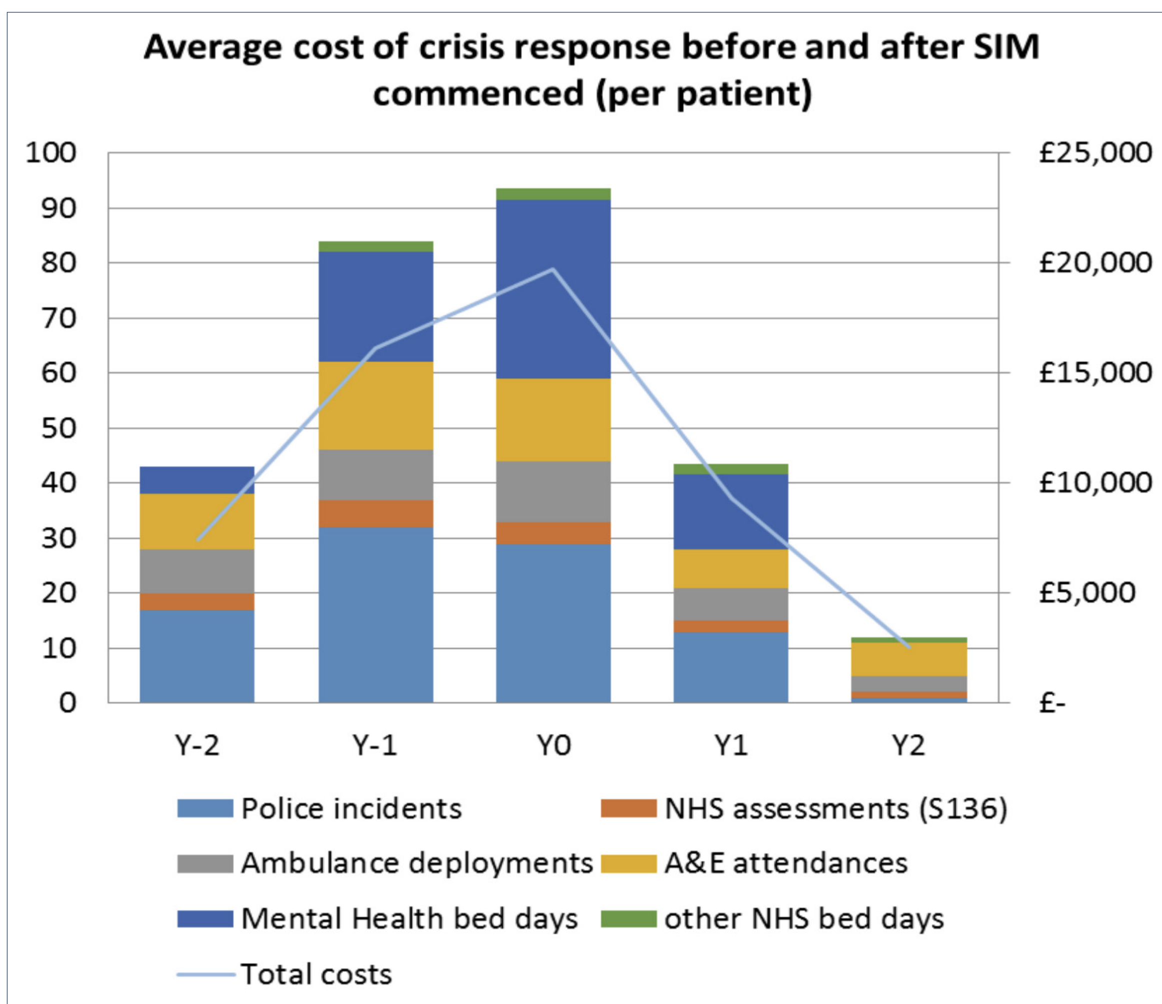
Moreover, since deinstitutionalisation did not occur with a corresponding increase in the provision of costly community mental health care,[49] it therefore merely "reshaped the management of mental distress in public spaces". Police were left to fill the vacuum and respond (ineptly) to a vast ocean of unmet need. Estimates suggest that police spend 20–40% of their time responding to incidents involving mental health concerns.[50] Rather than address the underlying need, demand-reduction schemes like SIM have been championed. As Mary Sadid, formerly of the National Survivor User Network, summed it up:

Police spend 20–40% of their time responding to incidents involving mental health concerns

> they'll look at the top 50 people who attend A&E most frequently in a region and target those people, instead of the root causes. It's this attitude where it's individual behaviour that's the problem, and not the crumbling, dysfunctional system.[51]

The appeal of SIM to both health providers and the police can only be understood in the context of these dynamics. SIM mandated the collection of five "minimum data sets" for each patient and the creation of an individual "escalation and de-escalation graph" – which inspired the scheme's logo – to show the cumulative "demand placed each month by the service user" on public services. The metrics recorded each month were:

- police incidents
- ambulance deployments
- emergency department attendances
- mental health bed days
- Section 136 detentions and Mental Health Act assessments[52]



Early SIM crisis response demand chart based on aforementioned erroneous statistics. Source: SIM

The SIM logo was based on the chart above showing alleged cost reductions. Source: SIM

The dramatic reductions in operational costs of up to 92% that SIM claimed to deliver (crudely extrapolated to produce a figure of £82 million in potential national annual savings) rested on its alleged ability to reduce these metrics.[53] But fundamental flaws in the evidence base, as noted, leave major questions over the reliability of these claims. Regardless of the extent to which SIM savings were real, however, it is clear that they proved a powerful incentive for NHS trusts to adopt the scheme.

SIM positioned patients' help-seeking as the problem and sought to modify their *behaviour* to reduce their requests for support

Critically though, any savings were not achieved by reducing service users' mental distress, meeting their emotional needs, or improving their wellbeing. Patient-centred outcomes were of little to no interest. Instead, SIM positioned patients' help-seeking as the problem and sought to modify their *behaviour* to reduce their requests for support. This reflected the influence of behaviourism, a theory which chimed neatly with the emphasis placed on individual responsibility in neoliberal thought.

B. F. Skinner's theory of behaviourism, developed in the 1950s, has been influential across social policy. For instance, the introduction of conditionalities and sanctions to the social security system was rooted in the behaviourist idea that 'dependent' benefits claimants needed to be 'nudged' back to work.[54]

B. F. Skinner, founder of behaviourism. Source: Wikimedia user SillyRabbit, CC BY 3.0

Similarly, in public health, the behavioural model stresses people's individual choices and de-emphasises the role of social determinants of health. It has been observed that behaviour modification theory can be used to justify punitive approaches to mental distress, framing patients as consciously and acquisitively exploiting a vulnerable state.[55] Similarly, consultant liaison psychiatrist Chloe Beale observes:

> we've come to see ourselves as victims of these people, and when we see it like that it's much easier to justify punitive approaches. They should learn aversively. So if nothing else works, then we need to teach them that if you keep trying to kill yourself in a public place or whatever, then you get punished for it.

In addition to the strategic application of punishment, this theory could also be used to justify neglect and denial of care:

> [It] frames self-harm and suicidality as a behaviour which can be reinforced in the style of operant conditioning by the response of emergency services, and conversely can be extinguished by withholding compassionate responses.[56]

These ideas clearly constituted the ideological foundation for SIM, which conceptualised patients as having "behavioural disorders" who had "become highly dependent on behaviours that attract the attention of public service teams"[57] and presented regularly at A&E in order "to get the 'hit' of compassion they so craved".[58] The "mentoring" provided by police officers was said to "re-distribute the responsibility for behaviour and outcomes more appropriately to the service user".[59] SIM literature argued that "it is not unusual for changes in behaviour to take several months" but also enthused that "the mere presence of a police officer seemed to reinforce boundary setting",[60] since the officer:

> brought with him boundaries and consequences not offered by the NHS. The rules started to change and the service users soon realised that behaviours that had once worked were no longer acceptable, excusable or usable without consequence.

One case study from the pilot concluded triumphantly:

> After several months of mentoring, it was a final threat of arrest and legal intervention that persuaded Jane to stop all disruptive behaviour towards emergency services.[61]

A central tool for changing patients' behaviour was the creation of an individual SIM crisis "Response Plan". An example contents page of such a plan is shown in Appendix 3. These multiple-agency documents served, in effect, a disciplinary function as a behaviour contract (not unique to SIM and also applied, for example, through Community Treatment Orders). In essence, the SIM scheme rested on the supposed deterrent effect of the criminal justice system, for which there is very limited evidence. But, as part 3 explains, SIM plans could be used to legitimise the prosecution of a patient who breached a plan – or to deny care altogether.

SIM conceptualised patients as having "behavioural disorders" and presented regularly at A&E in order "to get the 'hit' of compassion they so craved"

Behind the latter practice was the belief that such patients had become 'dependent' on the mental health system, a concept which provided an ideological justification for exclusion.[62] Again, such practices are not unique to SIM. The approach is reminiscent, for example, of the harmful narrative around suicidality which justifies non-intervention on the basis that an individual has mental capacity.[63] It also bears comparison to what lived-experience researcher Wren Aves called "'coercive' positive

risk-taking", in which decisions to discharge patients despite the risks are taken by health workers, rather than led by service users themselves.[64]

Aves traces the growing popularity of positive risk taking in the NHS to the influence of consultant Steve Morgan, who has at times advocated for "taking the risk of withdrawing services that…have created a dependency".[65] In an analysis which applies equally well to SIM, they conclude:

> For a service desperate to discharge, offroll, and reduce patient numbers, what could be better than an intervention which allows staff to rid themselves of their legal responsibilities and duty of care under the guise of patient empowerment and recovery.

Positive risk taking is heavily targeted – like SIM – at patients diagnosed with personality disorders.

Personality disorder or trauma?

Another part of the explanation for why SIM emerged and was embraced so enthusiastically lies in the fact that it targeted people diagnosed with personality disorders, a much-maligned group already viewed as a 'problem' population. The validity of the various 'personality disorder' psychiatric diagnoses is fiercely disputed. While we should respect the fact that some people given such a diagnosis say they find the concept helpful, we must also acknowledge that many others reject the label as illegitimate and harmful. For this reason, when we use the phrase "people diagnosed with personality disorders" in this report it should not be interpreted to mean we necessarily view the construct as valid.

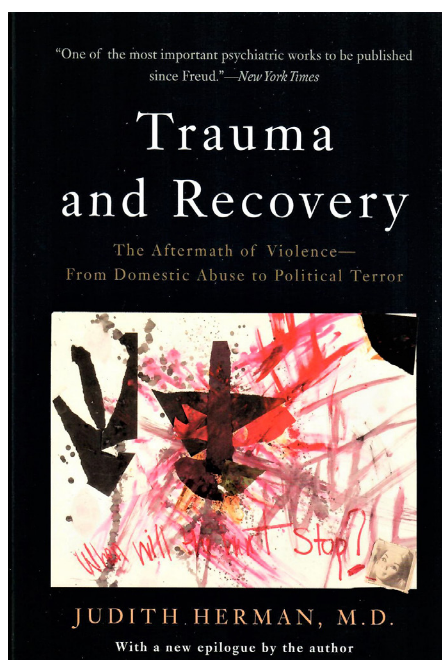
SIM overwhelmingly focused on women diagnosed with Borderline Personality Disorder

In each mental health trust which adopted the scheme, a handful or a few dozen people at most tended to be placed under SIM. Combined with limited transparency, this means we were unable to gather systematic demographic information on who was impacted by SIM across the NHS from our Freedom of Information (FOI) requests. However, we know that from its inception SIM sought to target 'high intensity users', sometimes more pejoratively referred to as 'frequent flyers', 'revolving door', 'problem' or 'heart sink' patients, and effectively viewed as a troublesome burden on cash-strapped services.[66] Consistent with the original group of people Paul Jennings' initial pilot programme was designed to

respond to, the data we have strongly suggests that it therefore continued to be overwhelmingly focused on women diagnosed with Borderline Personality Disorder (sometimes also called Emotionally Unstable Personality Disorder and hereafter referred to as BPD/EUPD).[67]

Many traits stereotyped as "feminine" are pathologised as symptoms of BPD/EUPD

Both qualitative and quantitative data demonstrate this. In some trusts, the SIM Team was embedded within the Personality Disorder Service. In Essex, the SIM officer was given "training" in Personality Disorders and Complex Needs. Of the 37 patients on the scheme in Essex between 2018 and 2021, 26 (70%) were women, and 28 (75%) were diagnosed with personality disorders (all but two, with BPD/EUPD).[68] In Rotherham, Doncaster and South Humber, 23 out of 26 (79%) of the service users placed on SIM were women.[69] This demographic picture is supported by accounts from health workers we interviewed.[70] Yet despite this reality, the few Equality Impact Assessments that were carried out in line with the public sector's equality duty made no mention of this gendered impact and raised no concerns about potential discrimination.[71]



Judith Herman's 1992 Trauma and Recovery

The BPD/EUPD diagnosis is broadly, although variably, described as a longstanding instability in psychological functioning associated with problems with emotional regulation, impulsivity, relationships, self-image, and suicidality. It is notable that many traits stereotyped as "feminine" such as dependency and emotional lability/intensity are pathologised as symptoms of BPD/EUPD. It has long been observed that the majority of those given the diagnosis are women, leading some to view it as a misogynistic diagnosis founded on a deep-seated patriarchal culture within psychiatry.[72] Transgender people, and LGBTQ+ people more broadly, are also disproportionately likely to be diagnosed with personality disorders.[73] There is increasing recognition, too, that autistic people are often misdiagnosed with BPD/EUPD,[74] especially in women and people assigned female at birth.[75] In her book *Trauma and Recovery*, psychiatrist and trauma specialist Judith Herman described BPD as often little more

than “a sophisticated insult”.[76] Survivor accounts describe being labelled with the diagnosis as belittling, shaming, blaming, silencing,[77] and a “curse”.[78]

Moreover, even within mainstream psychiatry where personality disorders are generally still seen as valid, there is virtual consensus on the fact that they are a highly stigmatised/stigmatising diagnosis. Unsurprisingly, a discriminatory mindset inevitably paves the way for violent and exclusionary practices, and people with personality diagnoses frequently experience interpersonal and systemic denigration.[79] While many mental health conditions are viewed as “illnesses of the mind”, personality disorder diagnoses are often interpreted as “illnesses of character”, legitimising deeply judgemental attitudes towards service users.[80]

We interviewed two women with direct experience of SIM who had been diagnosed with BPD/EUPD but later discovered they were autistic. Both rejected the diagnosis and spoke about the stigma associated with it, which they believed negatively influenced the way they were treated.[81] Two health workers we interviewed acknowledged the strong negative emotions (anger, rage, and hatred) which professionals often hold towards BPD/EUPD patients. Consultant psychiatrist Graham, for example, told us:

> “ what I’m struck by is talking to a large number of other health professionals, particularly nurses, who feel very ill-equipped to help people...often feel quite angry towards them, often feel quite negative towards them, often feel as though they’ve been manipulated and messed about, feel angry that they’re being put in a situation where they have to make difficult decisions and worried about what the consequences of those decisions might be. And often physically...you see people sort of shaking with the upset and rage.

Similarly, mental health social worker Danielle said:

> “ I work with a lot of acute colleagues quite closely because of the sort of severity of self-harm and they were in very, very difficult positions. They were having very extreme projections and sometimes hatred towards the patients that I worked with...they were literally often seen as problems in the service.

Such attitudes are worryingly commonplace. For example, a guide previously used by the Ministry of Justice states that a lack of professionalism *by healthcare staff* could be the result of a *service user’s* personality disorder,[82] implicitly blaming the patient by

misappropriating the concept of countertransference.[83] In 2022, the Royal College of Psychiatrists published conference promotional materials which described people diagnosed with BPD/EUPD as "a thorn in the flesh of many clinicians".[84] Following outcry from survivors, it was subsequently withdrawn.[85] With harmful attitudes like these so deeply entrenched, it is little wonder so many people diagnosed with personality disorders are treated harmfully by the very services charged with their care, despite the fact that rejecting punitive approaches to the care of people diagnosed with personality disorders is an explicit commitment of the NHS Long Term Plan.

SIM tapped into this deep well of disdain. People diagnosed with BPD/EUPD are frequently subjected to testimonial injustice, whereby their own accounts are invalidated, discredited and disbelieved.[86] They are often deemed 'not really suicidal' (partly due to poor understanding among health workers about the function that repeat self-injury can play as a coping strategy),[87] and may instead be labelled 'difficult', 'manipulative', 'attention-seeking' or 'undeserving'.[88] That SIM's approach and mentality was based on these underlying assumptions is evident from some of the language used to describe patients:

- "threats, to obtain a particular response"
- "her behaviour causes an avoidable demand on services"
- "unwilling to follow acceptable behaviour"
- "behaves badly"
- "deny the wider community access to emergency services"
- "not illness driven"
- "forces services to undertake an action".[89]

Similarly, there is palpable hostility in the language used to describe one woman in a SIM case study:

> Jane* was in her mid-40s. She was diagnosed with BPD...she made malicious reports of being assaulted by her husband...demonstrated manipulation and dishonesty when challenged...behaved in attention-seeking ways in public places...regularly called mental health services up to 40 times a day...claimed to have been raped by a male relative, but had not been believed.

This troubling account vilifies and demonises 'Jane'. Further, by dismissing her account offhand, it serves as a disturbing example of testimonial injustice.

Discounting claims of sexual violence in this context is especially concerning. Critically, evidence shows that the BPD/EUPD diagnosis is strongly associated with trauma.[90] Notably, women/people diagnosed with BPD/EUPD are more likely than their counterparts to have experienced childhood sexual abuse,[91] sexual violence and/or domestic violence.[92] Research shows that most people with recurrent suicidal crises who are repeatedly detained by police under mental health powers are most often women with "complex histories of unresolved trauma".[93] And this was precisely who SIM targeted. Our FOI requests showed, for instance, that in Rotherham, Doncaster and South Humber NHS Foundation Trust 23 out of 26 (79%) of the service users placed on SIM were women, 75% had adverse childhood experiences (ACEs) and 100% had previous or current psychological trauma.[94] Similarly, in Devon Partnership Trust, all seven people whose cases were reviewed had documented histories of significant trauma and abuse.[95]

Evidence shows that the BPD/EUPD diagnosis is strongly associated with trauma

SIM patients' trauma histories are extremely significant. Yet despite paying lip-service to the notion, the SIM model was far from trauma-informed. As a result, one NHS trust which reviewed its use of SIM noted, with "particular concern", the "lack of evidence that [SIM] plans take account of trauma histories".[96] In short, despite survivors making clear that therapeutic approaches "shift the focus from 'what is wrong with us' to 'what happened to us'",[97] SIM instead blamed victims for their coping strategies.

3. Impacts

Our research found that crucial medical principles of consent and confidentiality were extremely poorly upheld in SIM. It showed clearly that the threat or implementation of prosecution through SIM was coercive and served to either criminalise or impede access to care – both directly and indirectly, by eroding trust. The research also supports previous evidence indicating that involving police in mental health tends to invoke shame and compound distress in service users, who report feeling stigmatised and intimidated.[98] As such, SIM and other punitive practices reinforce a culture of abuse and neglect and risk re-traumatising people.

While it was *not* unheard of for some patients to be positive about their experiences of the scheme, this mostly arose in contrast to the almost uniformly negative experience people reported of *mainstream* mental health care. Meanwhile purported benefits of SIM and similar schemes chiefly accrued to service providers and to staff, some of whom spoke positively about its ability to "contain risks" to their professional careers. However, we also heard from health workers who vehemently opposed the scheme and paid a price for speaking out against it.

Consent, confidentiality and coercion

While there were differences in the SIM model across local contexts and some trusts claim they *did* require service users to consent to be placed on the scheme,[99] others placed little importance on consent. For example, the South London and Maudsley trust's manual, adapted from the SIM template, claims that involvement is "voluntary at all times", yet later states that if a service user refuses to participate:

> " attempts to persuade them to engage should be actively pursued, even if they do not understand that participation would be in their best interests. The use of incentives and rewards for engaging with mentors is considered acceptable if those rewards are in the best interests of the patient.

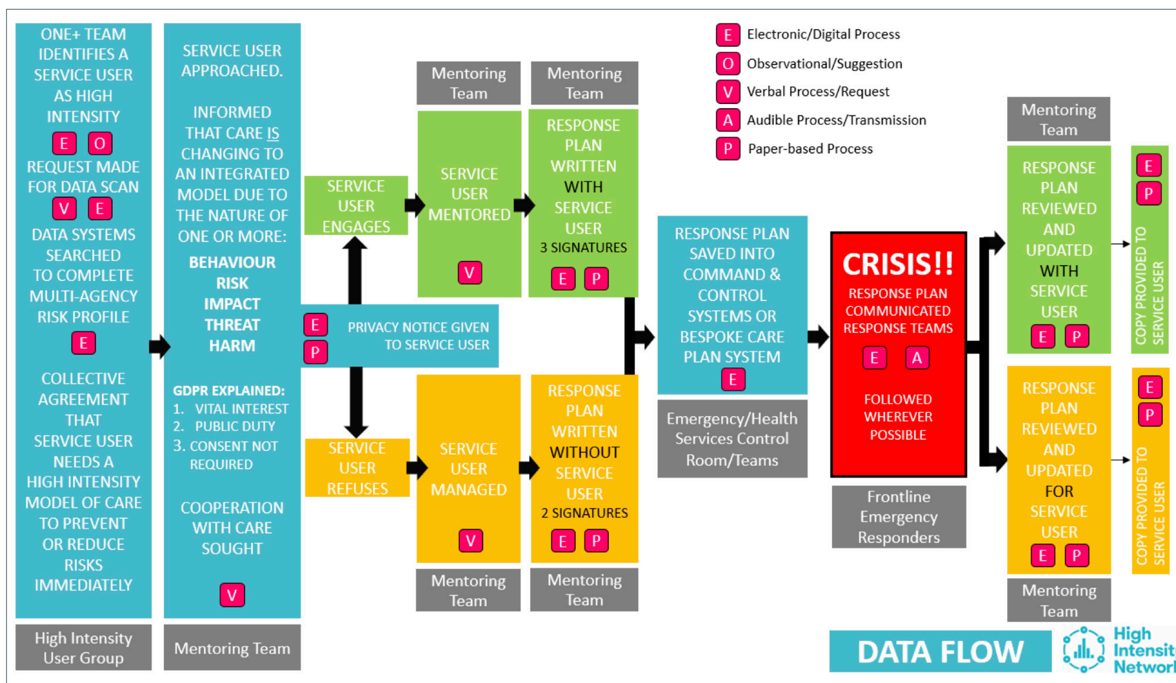
In East London, SIM was explicitly described as a "non-consent model".[100] In Essex, the trust received at least one complaint from a service user unhappy about being referred to the SIM team. And in practice, multiple service users report not being given a choice about being placed on the SIM programme. One service user interviewee, Annabel, described to us how she was placed on SIM in direct contradiction of her own wishes and her care coordinator's recommendation:

> My care coordinator told me, "They have referred you to SIM, the officer has asked to meet with you." I said I didn't want to see him... She said, "yeah, I told them it wouldn't be a good idea and would be counterproductive, but they said you have to, and you have no choice".[101]

The creation of crisis response plans also generally seems to have been done without the individual's consent. Tellingly, the Devon Partnership Trust's review lamented that "co-construction of [SIM] plans is difficult in practice when individuals do not wish to engage".[102] Meanwhile, mental health social worker Danielle described to us a bizarre incident in which:

> one local force...tried to recruit my patient to be involved in a TV program to show how great the police are doing with mental health. I had to put a stop to that as well, and again had to push quite hard because they were really, really pursuing her and she didn't want to do it.[103]

This suggests that SIM schemes were shot through with coercive practices, which extended beyond initial referral decisions and the creation of crisis response plans. Indeed, SIM literature explicitly described the police officer's role as "coercive".[104]



SIM data flow diagram used by one NHS trust. Source: Devon Partnership Trust[105]

Lack of consent for data sharing and lack of respect for data confidentiality also emerged as prominent issues. This data flow diagram from Devon Partnership Trust's SIM scheme, for example, states explicitly that "consent [is] not required" to share

data and shows virtually identical processes regardless of whether or not a service user consents and engages.[106] The trust's own review of the scheme therefore concluded that there was "insufficient documented evidence that individuals on the programme understood what data was being shared and gave informed consent".[107]

The police continue to push for increased sharing of health data

Despite launching "a digital case management portal which...allows teams across the country...to access...service user's information at any time" and view "highly accurate cost graphs for each patient", the High Intensity Network (the company behind SIM) was not registered with the Information Commissioner's Office, the body responsible for enforcing information processing legislation in the UK.[108] Nonetheless, a Service User Information Sheet produced by the High Intensity Network, informed patients that it was permissible for the NHS to share their data with the police in certain circumstances.[109]

Multiple service users report that the police accessed their medical records without their knowledge. Annabel described two concerning instances of police mishandling sensitive data, confidentiality breaches in which the SIM officer assigned to her sent her personal information to an incorrect email address, and soon after copied it to an acquaintance.[110] Seb – whose experiences of criminalisation resulting from distress were *not*, to his knowledge, associated with SIM (a reminder that such practices are more widespread) – even described how police were advised of an autism diagnosis that he himself had no knowledge of.[111]

The StopSIM Coalition critiqued SIM's practices and arguments including its reliance on "vital interests" as a legal basis for processing data as overly broad and potentially unlawful.[112] In the main, these concerns have been vindicated[113] – yet the police continue to push for increased sharing of health data. For instance, Superintendent Justin Srivastava, who has worked at the intersection of policing and health but had no direct involvement in SIM itself, reasoned when interviewed:

> if we shared information effectively, then that person doesn't have to keep re-telling their story, and if they don't have to keep re-telling their story, then they're less likely to be more traumatised.

In the case of SIM, however, a far more significant risk of re-traumatisation lay in the criminalising practices which constituted its unique selling point.

SIM marketed itself as an early intervention programme which, nonsensically, would decrease service users' "risks of encountering the police".[114] In reality, it brought police officers into the lives of people in profound distress to proffer unsolicited "support" – which chiefly involved warnings and threats. An excerpt from a section of an operational manual entitled "Use of Criminal and Behavioral Sanctions" makes this clear:

> discussions within mentoring sessions that focus on behaviour and the likely legal consequences are an important element of the team's support...response plans will clearly explain the behaviours that can and cannot be achieved by the patient when in crisis and the consequences that have been explained to the patient if these behaviours are repeated. This...assists the patient to stop before they instinctively repeat the same negative, offensive behaviours.[115]

Wielding threats of criminalisation, despite being presented here as a positive or even *therapeutic* approach, is inherently coercive. It is therefore counter to the principle that good mental health care is as consensual and empowering as possible, and to National Institute for Health and Care Excellence (NICE) self-harm guidelines which explicitly warn against punitive approaches.

Notably, SIM deterrence often failed. But even when "SIM interventions unfortunately did not result in a reduction in risk", and a patient's continuing "high risk behaviour" was said to be "having a significant detrimental impact on members of the public", supposedly justifying "a proportionate response...via the criminal justice system",[116] this was *still* not deemed a failure on the part of SIM; only the *service user* could fail. According to the SIM philosophy:

> In the event of a criminal act being committed by the service user, any arrest/process for an offence is not considered a negative outcome by the mentors but rather an event where clearly set boundaries have been reinforced.[117]

Wielding threats of criminalisation, despite being presented here as a positive or even *therapeutic* approach, is inherently coercive

Following through on threats of prosecution was not uncommon (and was legitimised if patients had breached the behavioural stipulations of their SIM crisis response plans to which they had often not consented in the first place). For example, though no specific figures were given, it was confirmed through

our Freedom of Information (FOI) requests that "several people" on SIM at South London and Maudsley trust were cautioned, prosecuted or charged in relation to offences.[118] At Rotherham, Doncaster and South Humber NHS Foundation Trust, we found that 4 out of 29 service users on the scheme – a rate of 14% – were "prosecuted as a direct result of SIM interventions".[119]

Box 2: 'Decision taken to prosecute' Service User B – a case study

Service user B has a history of problematic behaviour and contacting the emergency services reporting suicidal ideation on an almost daily basis. They have a previous conviction of an Anti-Social Behaviour Order (now termed a Criminal Behaviour Order, CBO) and continues to believe this was unjust and remains pre-occupied by this.

Service user B's typical presentation is to contact the emergency services wanting to discuss historical events and unrelated subjects, often reporting suicidal ideation, while being verbally abusive and hostile (there has been no evidence of planned suicide ideation, intent or active plans).

Service user B would generally not engage in meaningful conversation with call handlers or emergency services, and would regularly abruptly terminate the call after making suicidal statements if their perceived needs were not being met. They would also decline being transported to the Accident and Emergency Department on each occasion during the deployment of an ambulance or police service to their home address...

...decision taken to prosecute Service user B for a breach of their Criminal Behaviour Order.

Source: Rotherham, Doncaster and South Humber NHS Foundation Trust[120]

The case study in Box 2 outlines, in that trust's own words, the "decision taken to prosecute" one of these patients, known as Service User B. As the case study illustrates clearly, the Criminal Behaviour Order previously imposed on Service User B had notably worsened her mental distress. Yet the SIM team decided to prosecute her for breaching it, based on the costs of her multiple contacts with emergency care services over 18 months, shown in Table 1.

Table 1: SIM data used to demonstrate total costs of 'Service User B' emergency service contacts.

Emergency service	No of contacts/ calls & deployments	Total associated cost of contacts
111 service	179	£2148
South Yorkshire Police calls	420	£3654
South Yorkshire Police deployments	15	£4185
Yorkshire Ambulance Service crisis calls	599	£4193
Yorkshire Ambulance Service deployments	50	£11,600
A/E attendance	8	£1280
SPA contact (RDaSH)	179	£1790
Contacts following Service user B being informed of being prosecuted and having to attend court for a breach of her Criminal Behaviour Order (CBO)	Contact with services completely ceased for a period of 6 weeks and then escalated prior to court date	-
Total	1450	£28,850

Source: Rotherham, Doncaster and South Humber NHS Trust[121]

Table 2 shows how the same trust recorded the "behavioural impact" of the aforementioned prosecutions, exclusively understood in terms of the impact on emergency services. Although the *threat* of prosecution had not deterred the patient in crisis from engaging in a problematised or criminalised behaviour, the implication that prosecution itself would often do the trick is clear. Clearly this was not the case for Service User B. More importantly, no interest is shown in the potentially devastating mental health impact of criminal prosecution proceedings on the patient. We will turn to look at these critical emotional and psychological impacts shortly, after first examining another key impact of SIM: denial of access to care.

Table 2: The purported 'behavioural impact' on four service users of prosecutions said to be 'a direct result of SIM'

Service user	Offence/charge	Outcome from court attendance	Behavioural impact
A	Arson	2 year suspended sentence	No further incidents/ high risk behaviour
B	Breach of CBO	Awaiting court attendance	Brief (6 weeks) cessation of contact, then an escalation in calls
C	Repeated closure of railway network / public highway Assault on PC when intoxicated with alcohol	Custodial sentence Charged with drunk and disorderly	No further incidents involving railway networks/ police
D	Repeated closure of railway network / public highway. Drunk and disorderly	Case dismissed Fine given	No further trespassing on railway property or motorway bridges

Source: Rotherham, Doncaster and South Humber NHS Trust[122]

Impeding access to care

The International Association for Suicide Prevention argues against the criminalisation of suicidal behaviour, noting that legal sanctions undermine access to appropriate care by exacerbating social stigma, which in turn impedes help-seeking.[123] In the case of SIM, however, reducing service use – "demand management" – was an explicit *aim* of the programme. As outlined in part 2, the key performance metrics that were tracked to measure the scheme's 'success' included numbers of ambulance deployments, A&E presentations, mental health bed days and Section 136 detentions by police.

It is important to acknowledge that exclusion and denial of care are not unique to SIM. For instance, one service user we interviewed who was *not*, to her knowledge, on SIM – but had experienced SIM-like practices – reported being denied occupational therapy as a result of making complaints about her NHS trust.[124] Box 3 provides another example, an account recollected by a psychiatrist who witnessed a suicidal patient being denied care. Notably, this example was *not* known to be SIM-related either.

Box 3: A psychiatrist encounters a patient with a 'Corporate Risk Assessment'

I was an on-call psychiatrist. A patient arrived in the 136 suite for an assessment. The patient had engaged in an act of self harm. After undergoing A&E assessment and treatment, the patient was brought into the mental health unit.

She belonged to a neighbouring area so efforts were made to obtain clinical notes indicating past psychiatry history. It transpired that the patient had made many such similar self harm attempts in the past. The patient's presentation was consistent with her diagnosis in which patients undertake multiple acts of self harm.

There appeared to be an element of therapeutic frustration in the team treating the patient and we were told that she had something called a 'Corporate Risk Assessment'. It basically said that the patient should not be admitted to an acute psychiatric ward unless there was a drastic change in her presentation, and that the only option for her was to engage with their community mental health team.

This was the directive given by the on-call consultant and on-call team manager. So, the patient was discharged and made to find her own way home.

Source: anonymous psychiatrist based in London[125]

SIM, however, codified, propagated and further legitimised such denials of care.[126] SIM officers could advise 999 call handlers "to not deploy" emergency services[127] and, as the excerpt in Box 4 shows, call handlers were told to "politely end the call" and "hang up if necessary" when patients on the SIM programme called.[128] Some SIM response plans explicitly stated that service users could be refused care if they presented at A&E.[129] This could, the StopSIM Coalition pointed out, potentially impede access to care in the case of physical health emergencies too.[130] Indeed the SIM Business Case boasted that SIM response plans gave frontline responders "the confidence NOT to treat or respond in ways in which they would have felt compelled to before" and mentioned, for example, health workers feeling empowered to withhold X-rays and blood tests if requested.[131]

SIM response plans gave frontline responders "the confidence NOT to treat or respond in ways in which they would have felt compelled to before"

Box 4: An example of a SIM response plan's advice for 999 call handlers

Problematic behaviour:
Xxxxxxx makes frequent contact with services regarding historical events that they wish to discuss. They can become verbally abusive and hostile to call handlers if they feel their perceived needs are not being met. They also have a history of making statements that they will end their life by suicide due to feeling frustrated and overwhelmed by the phone call.

Response plan:
On receiving a call from Xxxxxxx or from someone on their behalf reporting the same information as discussed above, we advise you to use the following statements:

1. "[SIM practitioners] are able to support you with this Xxxxxxx. We are unable to help you any further with this call and I advise you to contact them regarding your concerns." Then politely end the call.
2. **If Xxxxxxx refuses to end the call –** "If you continue to refuse to end the call, I will have no choice but to end the call myself" – hang up if necessary.

Source: Rotherham Doncaster and South Humber NHS Trust[132]

Sure enough, multiple service users interviewed reported being denied access to care: notably, this again applied to *both* service users on SIM *and* some who were not. They included service users who presented at A&E while suicidal and reported being turned away, and even removed from the premises by force.[133] When service users *were* able to access care, they reported being accused of lying and prematurely discharged.[134] In one circumstance, a service user resorted to presenting at a different A&E four hours away from their usual site of care, to attempt to access care anonymously. According to this service user:

They were nice to me at the first assessment, and then they somehow coerced me into giving them my name. They called [NHS trust] and then turned around and were like, 'sorry we can't help [you]'.[135]

Some accounts from the frontline health workers involved in denying care under SIM are highly critical, presenting it as breaching professional codes of conduct, by impinging upon their duty to provide care and dewfend the interests of their patients and uphold principles of anti-discrimination, equality and confidentiality.[136] For

example, in its submission to a review of SIM conducted by the local NHS trust, the Yorkshire Ambulance Service (YAS) delivered a sharp critique of the approach:

> the SIM team had an expectation that our service would accept the high risk of refusing to assess or triage the patient, thus reducing the number of attendances...This was disappointing and lacked understanding of the fundamental duty of care that YAS has for its patients.[137]

Consultant liaison psychiatrist Chloe Beale describes the "psychological toll" on health workers "that comes with having to ration resources" and how this either leads to the erosion of compassion or to moral injury among those who retain their compassion.[138] Most notably in this regard, one mental health social worker we interviewed had been so appalled by the criminalisation and neglect of service users she worked with that she repeatedly tried to blow the whistle on these harmful practices.[139] As part 4 explains, she was suspended from her job as a result.

Some senior managers at NHS trusts, however, praised SIM. Camden and Islington's review of the scheme, for instance, declared approvingly that "the partnership between a Mental Health Nurse and Police Officer proved effective" in "reducing unhelpful contact" and "showed a significant reduction in the use of emergency and crisis services".[140] As interviewee Jay Watts observed:

> behavioural contracts are, to be honest, effective at [achieving] the state's goals. But they are incredibly ineffective at [achieving] survivors' goals...It's brutal and it's horrific and it's dangerous. But it can give the performance of...good figures.[141]

The direct and indirect denials of care through which these "good figures" were achieved came at a cost, albeit one which health managers were prepared to pay: the SIM scheme destroyed what little remaining trust service *users* had in service *providers*. This is clear from the words of service users quoted in various NHS trusts' reviews:

- "At first I [made fewer suicide attempts] but then when I saw people weren't doing it [providing care], I did...more. Now I just don't bother telling anyone".[142]
- "It really destroys your trust in mental health services and police."[143]
- "For me...it would make me not want to get help".[144]

Watts explains:

> The most advanced evidence base for anything in mental health, whether it's how much medication works, to whether you're going to do psychotherapy, to outcomes, to suicide rates, to self-injury: all of it is predicated on a good therapeutic relationship.[145]

In the numerous cases where SIM (or SIM-like practices)[146] removed the possibility of health workers building trusting, therapeutic relationships with patients, it thus risked gravely *exacerbating* the mental distress which was precisely the reason for service users' repeated presentations.

Compounding distress, risking abuse

In many respects, the impacts of SIM on service users' psychological and emotional state were treated as largely irrelevant, despite the patients in question often already having low self-worth and high levels of distress as a result of trauma. These impacts, however, could be deeply detrimental.

SIM plans which stipulated that service users should not seek care created profound isolation. Jay Watts argued that the scheme forced people to suffer in silence, alone:

> For me, the saddest thing has been seeing a couple of people that I know just not safe enough, in acute suicidal pain, with societal messages and campaigns the whole time going 'if you need help just phone'. And they know locally that if they do, they might end up in court.[147]

SIM risked gravely *exacerbating* the mental distress which was precisely the reason for service users' repeated presentations

Again, SIM was not original in this regard but built on similar practices. For example, this characterisation echoes the words of one service user and survivor whose mental health declined after they were raped, leading to persistent suicidality. They recalled how they felt when the response from police was to issue a Community Protection Notice Warning, forbidding them from expressing thoughts of self harm or suicide, writing: "I have never felt more isolated…knowing that if I do need help I can't so much as tell a friend or even a family member."[148]

When it comes to direct interactions with police which the SIM programme engineered, patients talked about feeling scared, shamed and distressed. This should come as no surprise, since academic research has previously shown that police involvement in mental health "can harmfully reframe acute psychological distress as a moral or ethical failing".[149] Survivor accounts also describe these negative emotions vividly.[150] Indeed, the SIM pilot report acknowledged, albeit in passing, that police interventions could potentially be "incredibly stressful at first" for patients.[151]

The language used by interviewees in our study to describe their encounters with the police was often much stronger than this euphemistic description admits. It was that of fear and shame ("terrified", "horrific", "mortified"), and police behaviour was experienced as "aggressive" and "threatening". Annabel, for instance, described to us how a member of her care team had to intervene after a SIM police officer's uninvited visit caused her extreme distress, due to previous experiences of state violence:

> I've hardly ever been that distressed. I remember sitting in the corner hyperventilating and panicking, and just so triggered. My care coordinator eventually told him to leave; it was the worst...[152]

Another interviewee, Clare, explained how being diagnosed with BPD/EUPD, combined with police contact via SIM, further damaged her sense of self:

> having this EUPD label – people thinking I'm this horrible, manipulative person, to then being told "there'll be consequences for time wasting," by the police, it made me think I was, like, a criminal. And I took it really to heart.[153]

Madness is not a Crime. Artwork by Hat Porter

The fact that SIM viewed them as 'time-wasters' and 'attention-seekers' was not lost on service users. One patient quoted in an NHS trust review, for example, noted feeling "patronised, that they were basically saying I didn't deserve any help and I wasn't ill".[154]

This counter-therapeutic emotional invalidation and testimonial injustice was baked into the SIM philosophy. The SIM operational manual argued that NHS trusts should expect "malicious and litigious behaviours" by service users. In a section entitled "Allegations", the guide asserted that SIM patients were likely to make complaints about staff as a means "to avoid consequences or responsibility".[155] An accompanying video reportedly explained "the nature of high intensity cases and the behavioural disorders commonly found" including "the motivations for making false allegations" – by implication, all part of the patient's 'manipulative' behaviour.[156]

Counter-therapeutic emotional invalidation and testimonial injustice were baked into the SIM philosophy

Alarmingly, SIM specifically primed health providers to doubt and dismiss allegations of sexual violence. A section of the pilot report entitled "What challenges can intensive behaviours present to the wider community?" asserts that SIM patients were likely to be found "[m]aking accusations of rape or serious sexual assault, (later discovered to be false)". As the StopSIM Coalition pointed out, the addendum below this statement seemingly qualifying this presumption – by stating "[t]his does not mean that all allegations are false...[e]very allegation when made to Hampshire Constabulary is true until evidence shows otherwise" – is highly contradictory given that the main thrust of the text's meaning is to warn the reader to err on the side of doubt.[157]

On page 27 of this report, we previously quoted a SIM case study about 'Jane'. The case study called her "malicious" and "attention-seeking" and said she had "demonstrated manipulation and dishonesty". This clearly insinuated that when she "claimed to have been raped by a male relative, but had not been believed", this incredulity was correct. And this was not an isolated example. Another SIM document describes a patient called 'Katherine' in the following way:

> " medical evidence from her childhood...strongly suggests that she deliberately had accidents in order to seek attention and this pattern

appeared to have continued...she would often call emergency services claiming to be either injured or a victim of crime. There have also been

allegations of rape over the years...Katherine also repeatedly demonstrated behaviours that harmed the safety or reputation of other people...made false allegations of criminal conduct about both NHS and police staff...[158]

SIM's adoption of a predisposition to doubt service users' claims of sexual violence is disturbing

As the StopSIM Coalition pointed out, by apparently indicating to staff that complaints would be unlikely to be credited, the default scepticism SIM encouraged put service users "in a position of heightened vulnerability to abuse".[159] Given the prevalence of traumatic abuse in so-called high intensity users' histories, combined with recent news coverage of widespread sexual abuse of patients by staff within mental health settings, the mentality evidenced here is extremely troubling.[160] Add to this the exposure of systemic and deep-seated misogyny and sexual abuse within the police force and SIM's adoption of a predisposition to doubt service users' claims of sexual violence is even more disturbing, with the potential to not only leave them open to further serious abuse but also to close the door on justice and accountability.

In short then, SIM and SIM-like practices could be understood as a form of iatrogenic harm, contradicting – in the words of the StopSIM Coalition – "fundamental principles of safeguarding; posing a risk to vulnerable adults" and potentially constituting a form of "institutional abuse".[161] Furthermore, the criminalisation of distress violates key principles of trauma-informed care in multiple ways. While precise definitions vary somewhat, the fundamental prerequisites of trauma-informed care are generally agreed to include the following:

1. **Safety:** creating physical and emotional security, preventing re-traumatisation
2. **Empowerment:** recognising and validating individuals' experiences, views and agency
3. **Choice:** enabling control and allowing individuals to make decisions about their own care
4. **Trust:** building transparent, consistent, respectful and reliable relationships
5. **Collaboration:** meaningfully levelling power differences to create mutual partnerships.

Counter to these principles, by being coercive, disempowering, invalidating, and reproducing "a pattern of being punished",[162] SIM replicated the dynamics of abuse.[163] As such, it risked *re-traumatising* a group of patients with already high levels of trauma.

Criminalisation, in some instances, can compound distress to the extent that it increases suicide risk and contributes to fatalities. For example, the mother of Sasha Forster, a young woman who was autistic, had Obsessive Compulsive Disorder, and – as a result of these mental health difficulties – "felt that she was inherently evil", has explained how being prosecuted in relation to persistent suicidal crisis behaviour (though *not* under SIM), made her daughter's situation much worse:

> It exacerbated her sense of worthlessness and the fact that she was evil, because evil people get arrested...It made her so anxious and she found it really, really difficult to deal with, and it sent her a little further down the path that we ended up with.[164]

Sasha died by suicide in March 2017 at the age of 20. Her death speaks tragically to the shame and stigma invoked by being policed and the deeply dangerous impacts of criminalising distress.

Positive accounts

Despite the serious harms outlined, some health workers gave positive accounts of SIM. Often, they reported that service users' had benefited from the scheme. Some of the glowing reviews from healthcare staff quoted in NHS trusts' reviews included the following:

- "I am hopeful that we can get SIM back in some format as myself and my client have found it a complete game changer."[165]
- "I feel the [SIM] model needs to become an integral part of mental health care. The feedback received from the individual I support on the pilot is positive."[166]

Likewise, we interviewed health workers who sought to defend SIM, even after it had been discontinued. Mental health nurse Brian, for example, insisted to us that SIM "cut through the excuses" and helped to manage patients' "bad behaviour".[167] He described one service user whom he claimed had benefited from SIM and later "got herself into a lot of trouble"

Mental health nurse Brian insisted to us that SIM "cut through the excuses" and helped to manage patients' "bad behaviour

when the scheme, and her contact with a police officer, was withdrawn.[168] This language illustrates some health workers' readiness to blame patients and ascribe moral value to their behaviour. Placing responsibility and blame solely on a patient for behaviours rooted in distress, and as a consequence praising SIM for doling out criminal sanctions, is an individualised, punitive and ultimately also ineffective response.

Another interviewee, consultant psychiatrist Graham, told us he believed it was "a shame" that SIM had to be discontinued at his trust. He characterised the scheme as potentially lifesaving:

> "there was definite evidence of a reduction in very risky ways of presentation. And then in some people who were on the waiting list for it, unfortunately, there were some deaths. So, there was a sort of feeling that maybe if we'd had more capacity and been able to engage people more readily then possibly some of those deaths could have been avoided.

He also acknowledged, however, that the appeal of the SIM model was the way it enabled health workers to manage risks to their careers. When psychiatrists detain people under the mental health act, he argued, "often…the risk that's been contained, really, is the risk to the professional", because:

> "they're worried that if they don't admit the patient to hospital, then they'll be criticised in the event of a subsequent death by suicide. So often they default to admitting somebody to hospital because they're worried about the professional consequences of not [doing so].

This point is made by service users as well, such as lived-experience researcher Wren Aves who notes that the impact on, or risk to, patients is often treated as less important.[169] This is demonstrated most alarmingly by a section of the SIM guidelines entitled "Death of a service user whilst being managed by a mentoring team". It argued that "high intensity patients can often place themselves in risky situations and there is often a higher risk of accidental death" and advised a SIM team to contact Paul Jennings for "support" in the eventuality of a death.[170]

Moreover, as the StopSIM Coalition pointed out, elsewhere the case of a SIM patient in Surrey who took an overdose was proudly presented as proof of how SIM contained professional risks: the Independent Office of Police Complaints had reportedly investigated and found the officers had no case to answer because they

had followed the SIM plan.[171] Thus when psychiatrist Graham praised SIM because it "offered an alternative to what's often referred to as containing the risk", he was elucidating its empowering and protective impact on health workers, rather than patients.[172]

It would be reductionist and inaccurate, however, to portray *only* health workers as offering praise for SIM. Some service users offered positive – even glowing – accounts, such as the following selection from NHS trusts' reviews:

- "It helps knowing they are there when I need them. They are friendly, lovely and have been an absolute godsend."[173]
- "He [police officer] was nice and came to see me...every week".[174]
- "My SIM officer has been really kind to me like a mum or a big sister, she helps me when I am not sure if I should call the Police or not. I was a bit nervous to meet her at first but my nurse made sure we all agreed on things."[175]

Similarly, service user interviewee Becky told us that she had been "lucky" to be on SIM, even insisting "it saved me, it really did save me". Asked how this happened, she described how "it helped me to realise I am stronger and more resilient than I thought I was" and also repeatedly mentioned specific individuals:

> the people involved...the police guy was really good, I think we just clicked...he was very grounded, very non-judgmental, very common-sensical, he was a breath of fresh air. He said it how it was.

Aside from the neoliberal rhetoric of individual "resilience" used only by Becky,[176] what all these positive service user accounts share is a focus on relationships. As Becky herself observed, "it provided me with some kind of contact and structure to my life that I didn't previously have", which she and some other patients appreciated.[177] As previous research has concluded, a "consistent relational context" is indeed key to managing recurrent suicidality and lack of care continuity is a recognised issue in mental health care.[178]

Mental health services were failing so profoundly that individual police officers were, at times, experienced as more interpersonally supportive

Critically, what emerged strongly from all the service user interviewees – even those who were critical of SIM – was that mental health services were failing so profoundly to provide this consistent, intensive, relational support, that individual police officers

were, at times, experienced as more interpersonally supportive than NHS workers.[179] Clare, for example, was overall very critical of SIM but drew this contrast when sharing a memory:

> So I'm in suicidal crisis. If I go to my crisis, my community team, I'm getting nothing, being spoken to like shit, so I'm just stuck in this suicidal situation where I don't want to die, I want some help, so you go to the police...in that moment, I was just desperately suicidal, and I was [thinking] 'I can't ask for help from them [NHS team] cos they're just being horrible to me'. So you just go to the police.[180]

Scratching beneath the surface, then, of these supposedly positive accounts of SIM, reveals something important. The fact that the chronic "absence of adequate systemic support",[181] made *any* regular, consistent relationship – even from the police – useful to some patients is not necessarily a vindication of the SIM scheme or of broader practices criminalising distress, given the evidence of harm cited previously. Instead, it could be understood as a sad indictment of the chronically dire quality of provision within mainstream mental health services.

4. Justice denied

Institutional transparency and accountability in the face of failings is critical to the improvement of health systems and seeking justice for patients.[182] In order to meaningfully change practices, accountability must begin with full acknowledgement of institutional failures. As part 2 explained, the development, adoption and spread of SIM speaks to a number of systemic issues. As part 3 documented, service users were subjected to harm as a result of the SIM programme. Despite this – and despite clear *opportunities* for accountability – there has been a distinct *lack* of accountability from the stakeholders most responsible for promoting and implementing SIM, within both the NHS and the police, and as a result, a marked absence of meaningful change.

Smoke and mirrors

Despite the work of the StopSIM Coalition, NHS bodies have failed to fully acknowledge the multiple ways they failed in relation to SIM, from its inception to its eventual demise. Firstly, the scheme's adoption and spread raises important questions about the extent to which the evidence base for new 'innovations' within mental health – which, as this report previously outlined, was absent in the case of SIM – is robustly evaluated, prior to being rapidly rolled out. It is deeply troubling that, as researcher Wren Aves observes, the local NHS provider on the Isle of Wight, the first adopter of SIM:

> "allowed a police officer with no clinical training to openly recruit extremely vulnerable mental health patients into a totally novel, untested, and high risk clinical intervention, which had no ethical approval, risk assessment, or external supervision.[183]

Yet the Isle of Wight SIM programme might have remained an isolated example had *national* bodies not seized on the scheme and worked to spread it around the country. In fact, as part 2 explained, it is clear that public agencies on the Isle of Wight were already raising serious doubts about the smoke-and-mirrors nature of the evidence base for SIM by the time national actors had latched onto the model.[184]

SIM was given national awards. For example, the *Nursing Times* called the scheme "truly original", praising the way it "challenged established perspectives and brought [policing and health] two very different, very traditional cultures together". Most fundamental to the widespread adoption of SIM, however, was support from NHS

England (NHSE) and two of its initiatives – namely, the NHS Innovation Accelerator (NIA) and the Academic Health Science Network (AHSN; since renamed the Health Innovation Network), especially its Wessex branch. None of these bodies carried out rigorous evaluation of the evidence.

Mental health social worker Danielle bemoans the "gung-ho approach…taken to allow this model into our patients' lives without any reflection…clinical governance, [or] risk assessment".[185] She believes the discriminatory attitudes of staff towards 'high intensity users' and people diagnosed with BPD/EUPD were key reasons why evidence was not questioned, and the fact that SIM had not been co-designed by service users was not challenged:

> What I often found was that there was this sort of repetitive nature of giving short-term funding to pilots and schemes that would try and deal with this cohort of patients without really kind of asking the people who were trained or service users themselves. So, there was this kind of militarised process, which I think happens across all trusts, especially in quite toxic cultures, that was saying 'we need to do something about this group of patients'.[186]

Similarly, Wren Aves' analysis of the "immediate and enthusiastic support SIM received" is that the programme "echoe[d] back to staff their thoughts, feelings and frustrations with certain patient groups, legitimising negligence and abuse". That SIM was "so quickly funded and rolled out across the country with no evidence to support it", they argue, "reflects just how deeply those prejudices are embedded within the NHS".[187]

In an interview, Lucy Schonegevel, associate director of policy and practice at Rethink Mental Illness, suggested that the problem is broader still:

> there's always one rule for mental health and one rule for other acute illnesses. So, if it had been introducing a new model of supporting people with cancer, you'd have to show randomised control trials, you'd have to show huge amounts of research behind it…But…[there is a] severe lack of funding into mental health research…it's almost like people just accept you don't need an evidence base to roll out a mental health model because we're testing and learning as we go…it's a lack of parity.[188]

Another part of the story is the way neoliberal policies and philosophy have seen 'entrepreneurialism' and 'innovation' championed in every sphere. Within healthcare,

this has led to technological solutions and sometimes untested new models of care often being rolled out rapidly, on the false premise that they can solve the symptoms of structural crises provoked by decades of austerity.[189] NIA and AHSN are prime examples of this tendency.

As Boxes 5–7 explain, neither NHSE nor these offshoot institutions, which helped to market SIM as an "innovative" and cost-saving new model, have taken responsibility for the harm caused, or faced substantive consequences. In particular, NHSE ultimately refused to publish the policy worked on by members of StopSIM detailing what was known about SIM and what was wrong with it, despite internal endorsement from its mental health policy team. Another damning indictment of the lack of change is the fact that during the same period that SIM became a national scandal, another harmful "innovation" – Oxevision – was being promoted by AHSN and NIA. Once more, this forced people with experience of the harms of mental health services to launch a campaign – Stop Oxevision. And yet again, it was this campaign which finally prompted NHSE to warn NHS trusts not to use the technology illegally.

NHS England and two of its initiatives heavily promoted SIM

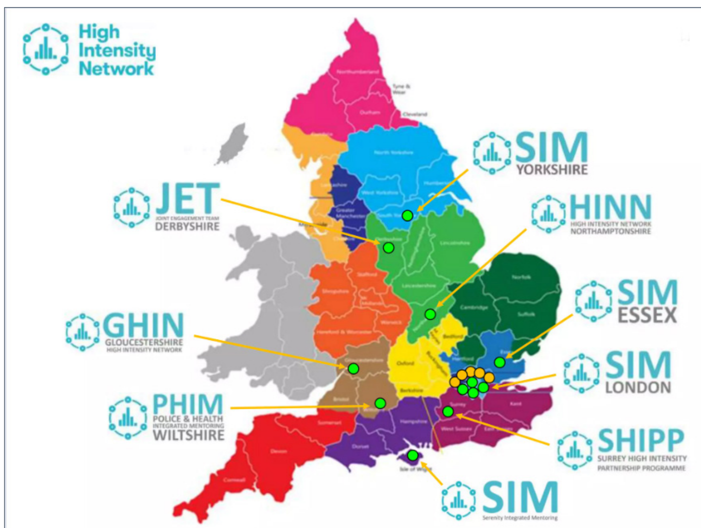
Box 5: NHS England

NHS England (NHSE) is an executive non-departmental public body of the Department for Health and Social Care. By overseeing commissioning of NHS services it sets the priorities and direction of the NHS. According to SIM's promotional materials, "in 2016, a team led by NHSE clinical director Sir Bruce Keogh reviewed SIM and decided that it was ready and fit for national scaling across the NHS". Despite repeated FOI requests, NHSE has not provided any information pertaining to how it evaluated SIM, if at all, in 2016. Nor did NHSE disclose information in relation to the arrangement through which it provided funding for Paul Jennings to be officially seconded from the police to the NHS to develop the scheme.[190] We formally requested to interview Keogh but received no response.

When concerns about SIM started to be raised, accounts suggest that NSHE was initially unreceptive.[191] Only when the grassroots StopSIM Coalition's campaign gained social media traction and national headlines did the organisation appear to become more responsive. NHSE mental health director Claire Murdoch issued a statement in May 2021 saying that NHSE was "not formally endorsing or promoting" SIM, despite reportedly being personally very supportive of the scheme initially. We formally requested to interview Murdoch, this was declined by her PA.

Also in May 2021, NHSE national clinical director for mental health Tim Kendall asked all mental health trusts to review their SIM scheme or SIM-like practices. Members of the StopSIM Coalition were asked by NHSE to help analyse these reviews and they spent 15 months working on a potentially unprecedented joint policy. However, the publication of this policy was subject to long delays – arguably an example of the "weaponisation" of time.[192] After NHSE's public relations department raised reputational concerns and the Wessex branch of the AHSN made threats of legal action, the statement was shelved.[193]

Instead, in March 2023, Kendall issued an NHSE position statement which said SIM-like practices should be "eradicated".[194] While this *did* acknowledge that SIM and SIM-like practices were harmful, it did not apologise for NHSE's role in promoting SIM originally, nor did it set out clear mechanisms to ensure SIM-like practices are indeed eradicated. Thus, there has been very limited institutional accountability and people at risk of being subjected to SIM-like practices have been left without adequate protection. The StopSIM Coalition declared that NHSE had "a greater interest in protecting their reputation than protecting service users' lives".[195] We requested interviews with Tim Kendall and with NHSE. The former failed to respond; the latter declined to provide a representative.



Despite repeated FOI requests, NHS England has not provided any information pertaining to how it evaluated SIM

Local variants of SIM which spread around the country with the help of the NIA and AHSN[196]

Box 6: The Health Innovation Network

The Health Innovation Network, known as the Academic Health Science Network (AHSN) at the time it was promoting SIM, is another NHSE initiative. Working alongside NHS, academic, third sector, local authority and industry bodies, its stated mission is to "spread innovation at pace and scale – improving health and generating economic growth".[197]

As a review of SIM conducted by the South London Mental Health and Community Partnership observed, AHSN's relationship to mental health trusts is ambiguous, which has "implications for data sharing, accountability and carrying out due diligence".[198] The network's relationship to SIM, on the other hand, is very clear. Initially championed strongly by the Wessex branch of AHSN, the High Intensity Network company behind SIM later received support from other branches of the organisation too. Notably, a health economist's work helped build the "business case" for SIM and AHSN provided practical support by funding the staff training to deliver the scheme across trusts, giving hundreds of thousands of pounds to the High Intensity Network.[199] AHSN's significant investment also lent a degree of credibility to SIM.

After SIM was widely implemented, it is clear that AHSN was aware of concerns. However, it did not commission a serious review until much later. After the fallout from SIM, however, it commissioned an independent review, in particular to assess the decision-making process for selecting and approving the model. This found that only quantitative data, from a small number of cases, was analysed; qualitative data on patients' experiences was not collected or analysed.[200]

The StopSIM Coalition has stated its belief that Wessex AHSN is "unable to support best practice and innovations that benefit patients, and is therefore not fit for purpose."[201] Today the Health Innovation Network asserts that it has "full patient and public engagement in the design and selection of national programmes".[202] Although this falls well short of full accountability for its role in the rollout of SIM, the adjustments made to criteria for similar programmes are an implicit acknowledgement of significant fault. In response to an interview request, Wessex AHSN chief executive Bill Gillespie said he had "no desire to participate".

Box 7: NHS Innovation Accelerator

NHS Innovation Accelerator (NIA) is an NHSE initiative launched in 2015. Working in partnership with the Health Innovation Network, its stated mission is to enable "the spread of innovation for demonstrable patient and population benefit" by "supporting the up-scaling of practical, innovative and real-time solutions to the challenges facing the NHS". It claims to champion "evidence-based" innovations and argues that the slow uptake of new models of care means the "potential benefits of new technologies…can be delayed".[203]

NIA says its fellowship scheme supports "exceptional individuals" to "deliver promising solutions".[204] In 2016, SIM founder Paul Jennings was awarded a NIA fellowship and provided with funding and mentoring from Dr Geraldine Strathdee to develop the project from a pilot into a national scheme. Strathdee said she endorsed SIM "without reservation". In 2018, the NIA proudly cited SIM as an example of its successful incubation of innovative new practices.[205] We requested to interview Geraldine Strathdee but received no response, and NIA director Konrad Dobschuetz, who declined.

As the StopSIM Coalition observed, NIA includes a caveat with its endorsement of innovations, stating that "NIA does not perform independent scrutiny of the evidence base" and that the responsibility to "undertake their own scrutiny of NIA innovations" rests instead with NHS bodies.[206] On this basis, NIA has avoided taking any responsibility for SIM and has continued promoting other questionable and potentially unevidenced 'innovations'. These include: S12 Solutions and Thalamos, both digital apps supporting arrangements for Mental Health Act assessments; MaST, an algorithm to identify patients at higher risk of crisis; and Oxevision, described in Box 8.[207]

Box 8: Oxevision

Oxevision is a remote patient monitoring system which is used primarily in psychiatric hospitals as well as police custody suites and prison clinical monitoring units. First trialled a decade ago and currently used by half of England's NHS mental health trusts as well as in Sweden and the US,[208] Oxevision consists of an infrared sensor and camera placed in patients' bedrooms that monitors patients' pulse and respiration rate, and enables remote observation.

Through analysis of policy documents obtained through Freedom of Information Requests and patients' accounts, grassroots campaign group Stop Oxevision have identified that this technology is regularly used without patients' consent or sometimes even knowledge.[209] It therefore constitutes "blanket, 24-hour

surveillance without ongoing informed consent and individualised risk assessments".[210] While NHSE has now warned NHS trusts to ensure their use of this technology is not illegal, it bears repeating that without the unpaid research and campaigning work conducted by survivors as part of the Stop Oxevision campaign, the technology would have gone unchecked, suggesting little has changed since SIM.

Invited to speak in February 2024 at NHSE's 'Digital Technologies' conference, campaigners from Stop Oxevision lambasted what they called a "circle of everyone evading accountability and responsibility" and demanded apologies from NHSE, AHSN, the Care Quality Commission and others, holding up the conference until these were eventually offered. These apologies have yet to be provided in writing.[211]

Cultures of unaccountability

Just as service users were not involved in designing the SIM model or properly consulted on its implementation by individual NHS trusts,[212] even few *staff* were aware of the model's introduction. Interviewees spoke of SIM's implementation within NHS trusts being "very, very quiet"[213] and done discreetly "by the back door".[214] This likely reflected an awareness that – as one SIM manual put it – "use of a police officer to manage mental health patients…to some is a controversial method of care".[215]

Without the unpaid research and campaigning work conducted by survivors as part of the Stop Oxevision campaign, the technology would have gone unchecked

One service user recounted to us being asked to comment on the introduction of SIM at a London NHS trust – but only on how to market the scheme to service users, not whether it was a good idea.[216] She also recalls that information governance specialists within the trust queried the ease with which police would be able to access health data – but that these qualms were not heeded:

> "there were some concerns raised and I don't know internally how strong they were or what made the final decision to overrule those concerns. The only thing I know [is] that eventually, [the trust medical director] said "NHS England told us we have to".[217]

This version of events conflicts markedly with NHSE's account, which – as mentioned earlier – originally promoted SIM but claimed in the aftermath of the StopSIM campaign that it did not "at this time" mandate, endorse or promote the model.[218] These opposing narratives speak to a culture of buck-passing within the NHS, an issue highlighted by former NSUN policy manager Mary Sadid:

> a classic NHS thing of just shifting the blame…lack of consistency and accountability…it almost feels like the NHS sometimes behaves like…it isn't…responsible.[219]

Precisely the same issue occurred when mental health social worker Danielle tried to blow the whistle on SIM and SIM-like practices. After contacting NHSE, she recalls being told, "we can't help, we know that there's some problems in your trust, but you need to go back to the trust".[220] Yet within her NHS trust, dissent was not welcome either. Danielle recalls that "there was not a culture where you were allowed to speak and question" and describes how she and other health workers who raised concerns were treated:

> There [were] a number of police officers and a number of nurses that were supposedly joint working with them…I found out that summer that a number of them [nurses] had raised concerns themselves and were then being subject to quite bullying processes because they were trying to speak out. And they felt that they were risking their code of conduct as nurses by working alongside them [the police] in this way.[221]

Her own experience was similarly punitive:

> I went to seniors, board members, heads of departments, safeguarding leads. They all said, "oh yes, yes, we'll get back to you." I then went to my 'Freedom [to] Speak Up Guardian' and I said "I'm really, really concerned about this now – something's got to change." She didn't act on it. And then, I think it was about two weeks later…I was suspended for six and a half months.[222]

Danielle believes:

> this was about the fact that I was speaking up for my patients, trying to raise concerns, trying to do the right thing. And the senior management, to this day, has still not apologised or admitted anything.[223]

Thus, as well as harming patients, the NHS's culture of blame-shifting and unaccountability, combined with its hierarchical leadership structures, punished frontline staff who chose to speak out against criminalisation. This points to problematic workplace cultures which have not been addressed since the fallout of SIM, including longstanding problems with whistleblowing procedures, allowing harmful policies and practices to continue to go unchallenged.[224]

The NHS's culture of blame-shifting and unaccountability punished frontline staff who chose to speak out against criminalisation

As for the police, there has been no evidence of accountability.[225] While maintaining a degree of plausible deniability around a new and untested new scheme, the National Police Chiefs' Council (NPCC) certainly gave Paul Jennings' scheme a degree of support. Chief Constable Mark Collins, for example, spoke at the launch of SIM London in April 2018.[226] This gave Jennings the confidence to add the NPCC crest to the High Intensity Network's website – an imprimatur of legitimacy which no doubt helped him market SIM across the country. When SIM finally unravelled, NPCC mental health lead Rachel Bacon simply washed her hands of responsibility. In a letter sent to police forces, she painted the scandal as an NHS issue alone, despite the key role the police had played in developing and promoting the scheme as part of its drive to reduce mental health demand.[227] We requested an interview with the NPCC representative. This was declined.

There has been no accountability from the National Police Chiefs' Council

Service users betrayed

The reviews of SIM and SIM-like practices which NHS mental health trusts were asked by NHS England to review varied widely in terms of scope and rigour. Service users and the StopSIM Coalition expressed concerns about the lack of independence of the reviews, given that NHS trusts were effectively being invited to mark their own homework.[228] Moreover, patient involvement with the reviews was extremely minimal, reflecting the aforementioned erosion of trust. Cambidgeshire and Peterborough, for example, reported that "unfortunately, none of the [service]

users wished to engage" in its review.[229] In total, only eight trusts stated that they consulted with service users during their review.[230] Of these, trusts in Devon, and in Camden and Islington, included the responses of just *one* service user each. Interviewee, Annabel – who found SIM distressing and triggering – reported being excluded from her trust's review, which went on to conclude that most service users had positive experiences. She recounts:

> I knew the Clinical Lead in [the trust], so I asked her why I didn't get a survey, and she said they just sent it to current SIM service users. I was conveniently discharged 2 months too early to provide any feedback... [But] they produced this FAQ briefing document...it says that the surveys were sent out to current and former SIM service users. It [the trust] said "the responses were overall positive!"... I'm like..."no comment!"...it's laughable.[231]

A considerable number of trust reviews, in fact, came to the same paradoxical conclusion: the scheme had mostly been positive, they claimed, yet should be discontinued nonetheless. This points to the fact that many NHS trusts had either not understood, or simply not acknowledged, why or how SIM was harmful and wrong – only that it had become a public relations liability.

Consultant psychiatrist Graham, for example, told us:

> politically the wind was blowing against it and there were powerful influences in the Royal College of Psychiatrists and elsewhere who wouldn't tolerate it. And it was pointless to try and continue it. So rightly or wrongly, to my disappointment...we decided to end the service and the people who were involved were relocated into different services...

It is worth pausing here to qualify this characterisation of the Royal College of Psychiatrists. When SIM became a national scandal, the college did indeed issue a statement expressing concerns, and calling for an urgent and transparent investigation into NIA and AHSN. However, it did not explain why it had been so slow to notice or speak out against SIM or why it only did so after a grassroots service user campaign. Nor did it meaningfully interrogate its own role in spreading harmful practices within mental health care.

As Box 5 explained, StopSIM members agreed to be involved in NHSE's analysis of SIM reviews conducted by individual NHS mental health trusts. However, they were left feeling "betrayed" by NHSE's failure to officially publish the policy and

unilateral publication of a watered down position statement instead,[232] which caused "significant and avoidable distress".[233] The way NHSE ultimately ended what had been a promising process was strongly condemned by service users, by interviewees working in mental health policy, and in an open letter signed by hundreds of practising mental health professionals.[234]

Mary Sadid, former policy manager at NSUN, told us the way NHSE handled the process showed how "institutions are willing to draw on people's time and energy and to extract for ...performative reasons".[235] Consultant liaison psychiatrist Chloe Beale, agreed:

> I think the coalition was treated appallingly. I know there's not been accountability. There's not been anybody in a senior position...nobody sort of saying, "do you know what...this shouldn't have happened, this happened on our watch, this was wrong." No...inquiry into how it happened, which is why we're still asking those questions...Where's the learning? What makes me so mad is that there never seems to be any accountability from the people highest up about how these things happen. It makes it seem like they're untouchable. And how do we as clinicians or patients have any faith in our overlords if they cannot be wrong and they cannot be held to account?

Similarly, Jay Watts called the failure to publish the policy "an absolute travesty and deeply immoral" which showed dangerous disregard for lived experience and "set back co-production" by exemplifying "veneer co-production versus actual co-production". Furthermore, she pointed out, it had "shown in the worst of ways that the contingencies that produced SIM could happen again".[236]

5. Ongoing harm

As the StopSIM Coalition and others have noted, SIM "did not invent the practice of criminally sanctioning suicidality" but merely "assimilated and wrote down practices that are largely unwritten though remain widely accepted in the UK".[237] Data from our FOI research makes clear that neither has the *disappearance* of models explicitly named 'SIM' brought an end to SIM-like practices. Given the absence of any change to the systemic conditions which enabled SIM, combined with the profound lack of institutional accountability – in particular, the failure of NHS England (NHSE) to publish the policy designed to eradicate SIM-like practices – it should come as no surprise that the criminalisation of distress continues.

SIM eradicated?

Following NHSE's refusal to publish the joint policy on which StopSIM members worked, coalition members leaked the latest draft online in May 2023.[238] As well as including an acknowledgement and apology for NHSE's role promoting SIM, this unofficially published document made the important point that "frequent emergency service contact is a marker of ongoing unmet need" and asserted that public services have a responsibility to respond compassionately. On this basis, the policy identified and discussed three specific features of SIM which were particularly harmful and needed to be eradicated from mental health care. These were:

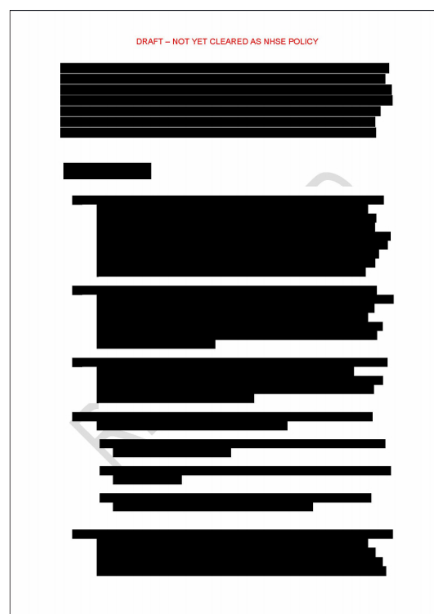
Frequent emergency service contact is a marker of ongoing unmet need

- **Involvement of police in the delivery of planned care** and use of threats of prosecution to control behaviour (which applies even when the police are working in coordination or partnership with healthcare professionals, regardless of whether or not they are in direct contact with patients)
- **Use of punitive and exclusionary practices** including coercion, withholding care, behaviour contracts or criminal sanctions (e.g. behaviour orders) applied in response to people presenting to health services, or deemed to be doing so, regularly
- **Discriminatory attitudes and practices** towards patients who express self-harm behaviours, suicidality and/or are deemed 'high intensity users'.[239]

As part 5 discussed, when NHSE failed to publish this policy, it issued a diluted position statement instead. While the latter still insisted that SIM-like practices

should be "eradicated", it also claimed that problems persisted at only a "small minority of trusts".[240] However, the *unpublished* policy had painted a somewhat different picture, providing figures indicating that at least 19 of the 54 mental health trusts surveyed were still using SIM-like practices in the second half of 2021 when the reviews were completed. It specifically noted that:

- **Only six trusts reported that they had discontinued** use of the SIM model or SIM-like practices
- **Fourteen trusts appeared to be continuing key features** of the SIM model with only minor or cosmetic changes such as the name, branding and/or data handling
- **Five trusts appeared to be continuing SIM or SIM-like models with no significant changes**, or planned to expand it e.g. by reducing the age criteria for inclusion


DRAFT – NOT YET CLEARED AS NHSE POLICY

A redacted page of the suppressed NHS England and StopSIM policy document[241]

StopSIM campaign artwork by Hat Porter

The suppressed policy therefore argued that "local action to drive change" would be needed by individual NHS trusts, and stated that NHSE was "in contact with all Trusts to seek assurances that they will work to eradicate the features of concern". It even added that the Care Quality Commission (CQC) – which has the power to prosecute when deemed necessary – had "confirmed that it will consider how Trusts are responding to this position statement and implementing the changes set out here during its inspections of mental health trusts [and]...will not hesitate to take action where it finds patients are or may be exposed to a risk of harm".[242]

The watered down position statement, by contrast, did not set out clear mechanisms to monitor whether SIM-like practices would actually be eradicated.[243] Critically, although it did mention updated guidelines from the National Institute for Health and Care Excellence (NICE) which explicitly stated that aversive, punitive or criminal justice approaches to self-harm are "malpractice",[244] it no longer mentioned CQC as a venue where patients or health workers could raise concerns. Consistent with this, when we sent an FOI request to CQC asking for any materials showing how it inspects mental health services to ensure SIM or SIM-like practices are indeed "eradicated", the reply stated that the organisation held no information relevant to the request.

Box 9: The persistence of SIM-like practices

May 2021	NHSE's Tim Kendall asks trusts to review their use of SIM
Dec 2021	By the end of the year, 98% of trusts send reviews to NHS England
Aug 2022	After obtaining copies of the reviews, the Guardian reports that SIM-like practices continue
Dec 2022	The joint NHSE-StopSIM draft policy is finalised and internally approved
March 2023	Instead of the joint policy, NHSE publishes a diluted position statement on SIM; South West Yorkshire Partnership NHS Foundation Trust announces the closure of ARC
May 2023	StopSIM leaks the draft policy by publishing it unofficially online
July 2023	Medact files FOI requests to NHS trusts, police forces, ambulance trusts and the CQC to assess whether (and where) SIM-like practices continue
March 2024	Surrey and Borders Partnership NHS Foundation Trust announces that SHIPP ceased operating in January 2024

In August 2022, having obtained copies of NHS trusts's review, the *Guardian* reported that SIM-like practices persisted. One year later, we filed FOI requests to NHS trusts, police forces and ambulance trusts to assess whether progress had been made towards the eradication of these practices. The results revealed a spectrum of approaches employed in different areas. Despite the lack of enforcement mechanisms, the legacy of the StopSIM Coalition's campaign, combined with continued scrutiny, has led to a small number of encouraging developments within the NHS since early 2023.

Surrey and Borders Partnership NHS Foundation Trust until very recently jointly operated the SHIPP (Surrey High Intensity Partnership Programme) scheme, headquartered at Surrey Police station. Based on the SIM model, it claimed to "support people who have severe and enduring mental ill-health and who frequently present to the emergency services such as the police, ambulance, and A&E departments". Police officers called SHIPP coordinators were said to "work closely with the person referred" and provide "[a]dvice and support to mental health teams who recommend criminal justice route to deal with specific behaviour", as well as making "[r]egular calls and visits as appropriate including home and ward visits" to the patient.[245]

Documents stated that while "[i]t is preferred that the person consents to be supported by SHIPP...the risk and behaviours presented outweigh the necessity for consent". At the time we filed our FOI in mid-2023, there were 23 people under SHIPP, and there were even plans to expand the scheme to Child and Adolescent Mental Health Services.[246] However, despite being commissioned until at least 31 March 2026, in late March 2024 (as this report was being finalised), Surrey and Borders Partnership NHS Foundation Trust announced that as of January 2024 the programme was no longer operational.[247]

South West Yorkshire Partnership NHS Foundation Trust initially replaced SIM with ARC (Alternative Response to Crisis). Little more than a rebranding exercise, under ARC police would still "accompany nurses to meet patients". Following continued scrutiny, however, the trust also closed down ARC, but nonetheless insisted that multi-agency working would continue.[248]

Table 3: Programmes of concern newly discontinued by NHS trusts

Trust	Scheme	Status
Surrey and Borders Partnership NHS Foundation Trust	SHIPP (Surrey High Intensity Partnership Programme)	Discontinuation announced in April 2024
South West Yorkshire Partnership NHS Foundation Trust	Alternative Response to Crisis (ARC)	Discontinued in March 2023

Other trusts with 'high intensity user' programmes, including **East London NHS Foundation Trust** and **Central and North West London NHS Foundation Trust** have adopted decriminalising models, which appear to be positive responses to

the StopSIM campaign. We note that even these schemes, however, legitimise the deployment of the 'high intensity user' concept which also remains central to a nationwide NHS England scheme.[249]

Moreover, despite these positive trajectories, our research showed that other schemes flagged as concerning in mid-2022 continue to operate and uncovered the existence of new schemes using different names but extremely similar purposes and practices to SIM, indicating that the criminalisation of distress is ongoing.

By any other name: FERN, HaRT, Op Ipsum and PAVE

When SIM founder Paul Jennings was approached for comment by *Disability News Service* in June 2021, after SIM unravelled, he said:

> "Whether individual organisations continue this line of work is now down to each of them...they will ironically be less transparent, less accountable, less measured and less safe outside of a national programme...so if this campaign thinks it has won, it hasn't.[250]

Sadly, it seems there was some truth to these words since a number of schemes operating under a diverse array of names continue to quietly deploy similar practices in various parts of the country. Tables 4, 5 and 7 summarise particular programmes and practices of concern, predominantly drawing on FOI data. Due to the opacity surrounding such practices, we do not believe these lists are comprehensive. We have organised the information into three tables according to where data was obtained (police forces, NHS trusts, and ambulance trusts) but also emphasise that such divisions are not always meaningful since many of the programmes in question are – whether formally or informally – multi-agency schemes. Further details of some of the schemes listed are provided below, making the ongoing criminalisation of distress clear.

Table 4: Ongoing programmes and practices of concern by police forces

Police force	Programme or practice of concern
Avon and Somerset Police	Mental Health Advice Plans
British Transport Police	HaRT (Harm Reduction Team)
Cheshire Constabulary	High Intensity User Officer & Complex Mental Health Demand Team
Hertfordshire Constabulary	Op Ipsum
Lancashire Police	Mental Health PC
Leicestershire Police	PAVE (Proactive Vulnerability Engagement team)
Nationwide	Right Care, Right Person
Northamptonshire Police	Strategic Demand Oversight Group

Table 5: Ongoing programmes and practices of concern by NHS trusts

NHS trust	Programme or practice of concern
Camden and Islington NHS Foundation Trust	Continued consultation and liaison with former SIM police officer
Devon Partnership NHS Trust	HIP (High Intensity Programme)[251]
Gloucestershire Health and Care NHS Foundation Trust	FERN (Frequent Engagement Response Network)
Lancashire and South Cumbria NHS Foundation Trust	Frequent Attender Mental Health practitioner
Leicestershire Partnership NHS Trust	PAVE (Proactive Vulnerability Engagement team)
Rotherham, Doncaster and South Humber NHS Foundation Trust	Doncaster High Intensity Care team
Solent NHS Trust	High Intensity User Group / Multi Agency Collaborative group

FERN

FERN (Frequent Engagement Response Network) was set up by **Gloucestershire Health and Care NHS Foundation Trust** to replace its High Intensity Network/SIM scheme. It involves embedding a police officer into NHS services, counter to NHSE's position statement. It is hosted within the 'complex emotional needs' team (a term now often used instead of 'personality disorder').[252] In late 2023, a job advert for an NHS role describes the FERN team as consisting of "a serving police officer, an assistant psychologist and a lived experience

practitioner".[253] At the time of our FOI, nine people were managed under FERN and in total 23 had been since the scheme was established.[254]

The Team

Co-located within the complex emotional needs service in GHC, the FERN service will consist of
- An Assistant Psychologist
- A Specialist Police Officer
- A Lived Experience Practitioner

The Team will be supported by
CEN Clinical Development Lead
The Lead Psychologist for CEN
&
The Safeguarding Adult Missing and Mental Health Policing Team

Members of the FERN team. Source: Gloucestershire Health and Care NHS Foundation Trust

HaRT

British Transport Police initially – but only briefly – adopted SIM, soon before it became subject to controversy. At that point, it was swiftly replaced by the Harm Reduction Team (HaRT), funded by Network Rail. HaRT is said to "work one to one with vulnerable individuals" in order to "ensure the person is cared for and prevented from taking their life on the rail network."[255] British Transport Police provided very little information about HaRT in response to our FOI request. Interview data, however, raised concerns that the criminalisation of distress and suicidality continues through HaRT.

Mental health social worker Danielle told us that in her region, although the police "claimed that they weren't using SIM...a number of nurses who worked alongside them...were quite clear that it was SIM and that it has been rebranded".[256] She explained:

> the area [where] I worked hadn't gone with [SIM] officially, but I was still seeing prosecutions...around mid 2021 one of my patients had started to be charged and arrested quite frequently by the British Transport Police due to her being in public places, usually railway lines, sometimes bridges.[257]

Danielle added that "for the British Transport Police, the threshold seemed very low... to me, it felt like they were trying to get as many people as possible to show that they were being successful".[258]

Op Ipsum

Hertfordshire Police established a protocol called Op Ipsum in January 2022, less than nine months after the High Intensity Network closed down. Since its explicit purpose is to monitor and manage 'high intensity users' (though notably anyone deemed a "*Medium*-High" (emphasis added) frequent attender over a 12 week period with suicidal presentation or Section 136 can be added), it appears to have been set

up to replace SIM. At the time we filed our FOI request in mid-2022, the police force said 36 high intensity users' cases had been reviewed and three individuals were being managed under the protocol.[259]

The design of Op Ipsum is strikingly similar to SIM. Hertfordshire Police report holding monthly multi-agency meetings "for all professionals involved in the HIU's [high intensity user] care", at which "each HIU is assessed, and a unique response plan is implemented", and an "OP IPSUM Passport" created. The force also states: "we work closely with the HIU's community MH [mental health] team and have met with the HIU to discuss how Police can support them when in a MH crisis within the community". Simultaneously, police acknowledged that "CBO's [criminal behaviour orders] have been issued in the past by intervention teams...for some HIU's with the main objective to keep them safe".[260]

The design of Op Ipsum is strikingly similar to SIM

Hertfordshire Police evidently, then, continue to have direct contact with 'high intensity users' outside of crisis situations, and to prosecute them – and those patients' local NHS mental health teams continue to be complicit in these police practices. Furthermore, eligibility criteria set out for Op Ipsum are replicated in a number of other areas, a few examples of which are shown in Table 6. This may indicate cross-county communication or potentially a degree of national police coordination to develop new local schemes to replace SIM.

Table 6: Virtually identical eligibility criteria used by various regional schemes

Hertfordshire Police Op Ipsum scheme (ongoing)	Cheshire Constabulary's Complex Mental Health Demand Team (ongoing)	Surrey's SHIPP scheme (discontinued January 2024)
Repeatedly being detained under S136 [Section 136] Mental Health Act	Repeatedly being detained under S136 Mental Health Act	Repeatedly being detained under S136 Mental Health Act
Frequent reports to police as Missing/Vulnerable Adult/ Mental Health	Frequent reports to police as Missing/Vulnerable Adult/ Mental Health	-
Frequent attendance at ED	Frequent attendance at A&E	Frequent attendance at A&E e.g. for compassion and emotional reward
Frequent hospital admissions following crisis	Frequent hospital admissions following crisis	-
Frequent or inappropriate requests for an ambulance	Frequent or inappropriate requests for an ambulance	Frequent or inappropriate requests for an ambulance
Behaviour that is putting members of the public at risk	Behaviour that is putting members of the public at risk	Behaviour that is putting themselves and members of the public at risk
A Medium-High risk of death by accidental suicide	A Medium-High risk of death by accidental suicide	An Elevated risk of death by 'accidental suicide'
Behaving in disorderly ways that puts them in contact with the criminal justice system	Behaving in disorderly ways that puts them in contact with the criminal justice system	Behaving in disorderly ways that puts them in contact with the CJS [criminal justice system]
Offending behaviour	Offending behaviour	-
Must be assigned a care coordinator	Inconsistent engagement with clinical team or care plan	The individual currently must be open to the Community Mental Health Recovery Service (CMHRS) for SHIPP to consider a referral
Inconsistent engagement with clinical team or care plan	-	-
Negative impact on those providing support	Negative impact on those providing support	-

Source: Hertfordshire Constabulary[261] Cheshire Constabulary[262] and Surrey and Borders Partnership NHS Foundation Trust[263]

PAVE

Leicestershire Police operates the PAVE (Proactive Vulnerability Engagement) programme jointly with **Leicestershire Partnership NHS Trust** and the local authority substance misuse service. It is designed specifically with "individuals who have complex needs and present to services on a regular basis" in mind.[264] First introduced in 2016, it was advertised on SIM materials as being a SIM model and part of the High Intensity Network.[265] The PAVE team reportedly consists of two mental health practitioners, two police officers and a drug and alcohol worker, supported by a consultant psychiatrist, senior mental health practitioner and a police inspector. The number of people under the protocol fluctuates but is said to be "normally around 15".[266]

The team "work intensively with identified service users to ensure that the correct criminal justice, health and social care pathways are accessed and utilised appropriately" so that "the demands placed upon services by the individual are reduced". The police officer's contribution to the team is, in the words of the police, their ability to "utilise legislation, including Anti-Social Behaviour legislation when appropriate" and "to liaise with the Crown Prosecution Service and the Courts to obtain positive and appropriate outcomes, if there is a reason to prosecute an individual".[267] Whilst Leicestershire Police could not provide a specific number for the proportion of PAVE service users subject to behaviour contracts, community behaviour orders, police caution, arrest, or criminal prosecution, they did provide an estimate of "less than 5%".[268] The purpose, method, and punitive approach of the ongoing PAVE scheme, then, appear to be extremely similar to SIM.

Right Care, Right Person and other practices of concern

Right Care, Right Person (RCRP) is a police initiative initially developed by Humberside Police, then adopted by the London Metropolitan Police, and subsequently rolled out nationwide through an agreement between various agencies including NHSE, NPCC, the Home Office, and the Department of Health and Social Care.[269] While it does not embed police within the NHS, it pursues the same cost-saving goals as SIM and seeks to respond to the same reality that a substantial number of 999 calls are 'non-crime'-related and are instead seeking mental health support. The scheme was announced with a press release stating that it would save "a million police hours".[270]

RCRP does not necessarily criminalise people in mental distress but does mirror SIM's logic of exclusion and neglect

Essentially an attempt by the police to abdicate responsibility for responding to mental health incidents except where there is a threat to life, RCRP does not necessarily criminalise people in mental distress but does mirror SIM's logic of exclusion and neglect. As NSUN and Inquest pointed out, while less police involvement in mental health crises is welcome, police withdrawal has not solved the underlying systemic problem and only highlights the dire need for alternatives.[271] In March 2023, Norfolk police suspended RCRP locally following several deaths and one mental health charity called for the scheme to be paused until an additional £260m in funding was provided to health and social care services in order to plug the gap.[272]

Avon and Somerset Police have, since December 2021, been creating 'Mental Health Advice Plans' for people with known mental health conditions who frequently come into contact with the police – 29 are currently in place. Health information is stored, in the words of the police "quite possibly without the knowledge and / or consent of the individual concerned".[273] Police state that they ask clinicians' advice on "whether the person concerned has reached a point where use of the criminal justice system may be appropriate and whether this is advised or not", but also make clear that they do not always follow clinical advice because "it must be recognised that the police role is very different from a clinical role...and that police may be required to act in order to uphold the law".[274]

Health information is stored, in the words of the police "quite possibly without the knowledge and / or consent of the individual concerned"

Cheshire Constabulary employs at least one 'High Intensity User Officer' whose job description is to work with health partners to "develop multi agency action plans" in order to "reduce the demand impact of individuals by promoting resilience, reengaging individuals with appropriate pathways of support, and where necessary holding to account inappropriate behaviour".[275] In more concrete terms, these officers "investigate and build Criminal and Civil cases where required for the management of clients".[276] Their work is linked to a 'Complex Mental Health Demand Team' co-badged by two local NHS providers and the local ambulance service. This team takes multi-agency referrals on the basis of eligibility criteria virtually identical to Hertfordshire's Op Ipsum scheme, as shown in Table 6.

Header from the referral form for Cheshire Constabulary's Complex Mental Health Demand Team showing the NHS bodies involved

Lancashire Police employs at least one "Mental Health PC". The job description, updated in February 2022, describes the purpose of the role being to "improve the outcomes of those suffering from mental illness and personality disorders, therefore improving the Policing response to such incidents and reducing the demand on services".[277] The police officer reportedly works to "pro-actively identify, research and track patients with mental health needs who frequently present", working with mental health providers on "identifying and managing those making greatest demands on the service" and holding multi-agency meetings to produce "Care/Response Plans".[278] A job description for a Frequent Attender Mental Health practitioner in the same area, based at **Lancashire and South Cumbria NHS Foundation Trust**, does not explicitly mention collaboration with police but does refer to multi-agency working.[279]

Northamptonshire Police operates what it calls a Strategic Demand Oversight Group, effective as of September 2022. This group reportedly "regularly analyses the very top repeat [999] callers and puts long term problem-solving strategies in place to reduce their dependence on police resources".[280] A THRIVE assessment (Threat, Harm Risk Investigation Vulnerability Engagement) determines the grading of their call and the emergency service response will vary based on this grading: "incidents will be subject to either immediate deployment, prompt deployment scheduled appointment or non-attendance".[281]

18 people are currently under Doncaster's new High Intensity Care team

Rotherham, Doncaster and South Humber NHS Foundation Trust, which in 2021 reported to NHS England that its SIM scheme had produced "positive results" and was being "rebranded",[282] appears to have a new scheme in place. In mid-2023, our FOI revealed that 18 people are currently under Doncaster's new High Intensity Care team. While none were subject to behaviour contracts, community behaviour orders or police cautions, the numbers of arrests and criminal prosecutions was said to be less than five, but more than zero.

Finally, as Table 7 shows, **East Midlands Ambulance Service, North East Ambulance Service, North West Ambulance Service** and the **Yorkshire Ambulance Service** all appear to monitor frequent callers of emergency services and make use of some combination of behaviour contracts, antisocial behaviour orders or referrals to police for possible criminal prosecution.[283] These practices contravene NHSE's position statement warning against punitive and exclusionary practices (including withholding care, and use of behaviour contracts or criminal sanctions) "applied in response to people presenting to health services, or deemed to be doing so, regularly".[284]

Table 6: Ongoing programmes and practices of concern by NHS ambulance services

Ambulance service	Programme or practice of concern
East Midlands Ambulance Service	If there is "no evidence of a need for calls, or calls are at a level where they are disrupting the smooth running [of the ambulance service]...they are discussed with the Crime and Security team which may result in local police being contacted".
North East Ambulance Service	Management of frequent callers includes escalating to external agencies including "collaborative working with the police" and potentially obtaining a "behaviour contract or anti social behaviour order". "If the behaviour of the Frequent Caller does not improve...the Frequent Caller should be referred to the police for possible prosecution".
North West Ambulance Service	Mentions making use of behaviour contracts and antisocial behaviour orders and states that "failure to follow [these] will result in police involvement".
Yorkshire Ambulance Service	"may include a behavioural contact in discussion with the frequent caller. Progression towards a civil/criminal behaviour order should be considered on an individual basis." "If the behaviour of the frequent caller does not improve...then the frequent caller should be referred back to the police for possible prosecution."

6. Imagining otherwise

We explored a range of alternative approaches to mental distress. We also asked the people we interviewed, including patients – whose voices that are too often ignored in the design of mental health care programmes and interventions[285] – how they would like to see the system change. Interviewee responses varied widely. Some alternative schemes, and some interviewees' responses, involved reforms and adjustments such as better patient-centred care. Others involved more radical overhaul which not only removed police from mental health care but also transformed the mental health system itself. On the basis that SIM was a symptom of a wider crisis in mental health care, there was scepticism amongst some interviewees that merely tweaking the system by ending SIM would be sufficient, particularly since – as the previous section outlined – practices which criminalise distress continue under different names.

Removing police, criminalisation and prosecution from health services is a minimum requirement

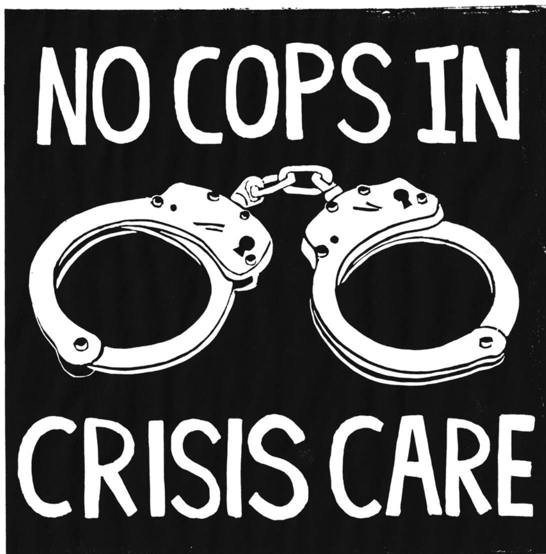
Cops out of crisis care

As service users have noted, a degree of reluctance on the part of some professionals to accept how poorly the current system works is unsurprising.[286] Some health worker interviewees struggled to imagine a world in which police did not play a role in responding to mental distress. Mental health nurse Brian, for example, told us:

> I think that within these roles of working with very complex people and complex situations, multi-agency working is the way forward. I think excluding the police [from] mental health [is unrealistic]...often, the police are the first port of call on [Section] 136s, so we have to have a realistic conversation.

Similarly, NHS England's position statement was at pains to emphasise that its call for an end to "police involvement in the delivery of therapeutic interventions in planned, non-emergency, community mental health care" was "not the same as saying all joint work with the police must stop".[287]

However, at the level of reform, removing police, criminalisation and prosecution from health services is a minimum requirement. Patients who were re-traumatised



StopSIM campaign artwork by Luna Tic

by their encounters with SIM saw removal of police contact as a prerequisite for truly trauma-informed care. Some service user interviewees expressed the desire for more peer support workers instead so that someone who understands their experience could support them in a crisis.[288] Patients and health workers alike expressed the need for recognition of the fact that frequent contact with services is a result of inadequate psychosocial support and that punitive rather than compassionate responses make mental health crises worse.

To go one step further and realise the aspiration of excluding the police from mental health crisis situations, robust and sustainable community alternatives would be needed.[289] In the USA, several first responder schemes have been implemented, for example in the San Francisco area.[290] The organisation Interrupting Criminalization has created a resource guide which aims to:

> highlight considerations for real, meaningful shifts away from law enforcement and towards autonomous, self-determined community-based resources and responses to unmet mental health needs.[291]

Further examples include community-led alternatives to police mental health responses such as Sacramento's Mental Health First programme, which launched in 2020.[292] There, local activists have taken the matter into their own hands by providing services directly so as to render police involvement superfluous:

> They provide support and services across the wider community of Sacramento, available 24 hours, seven days a week, with volunteers from medical backgrounds: doctors, nurses, clinicians, and medical students. Shifts are 12 hours long, and their volunteer involvement on top of their standard work hours is a testament to the need for the program.[293]

In addition, a culture shift towards more patient-centred care also emerged as a key theme. Programmes built on the experiences and needs of service users and flexible

in their approach to take account of the needs of each individual were deemed lacking, for example by service user Becky:

> It's been said so many times but being really patient-centred. So, working out where someone is in their life, where they need to be, where they want to be and how best to get there. So very basic but authentically basic and person-centred.[294]

Another service user, Annabel, whose experience of SIM differed drastically to Becky's nonetheless agreed with her about the need for better person-centred care.[295] We would add that conceptualising people as 'high intensity users', not to mention the personality disorder diagnoses, are another part of the problem. Wren Aves writes:

> Stopping SIM will take more than closing down SIM programmes. To truly stop SIM, the beliefs which underlie the intervention need to be challenged and rooted out of staff and services.[296]

Transformative alternatives

Notably, even health workers who were positive about SIM recognised that its existence was indicative of a systemic problem. Consultant psychiatrist Graham, for instance, observed that:

> the [SIM] service became the tip of the iceberg over a much bigger problem really, and the issue is...what is it about services that aren't fit for purpose that lead to these 136 presentations? Because I think really they should be the exception not the rule, whereas they've become the rule now.[297]

A more transformative alternative, therefore, would recognise that criminalising practices in mental health have arisen in the context of mainstream mental health care structures not providing support to people and communities and so displacing the issue to police. Mary Sadid, former NSUN Policy Manager argued:

> The mental health system needs wholesale reform. And we're not going to get it through these really bitty interventions that pander to people in power, who are pretty much purely concerned with resourcing and doing the bare minimum.[298]

A structural solution would look towards primary prevention at the population level

Rather than individualising the problem and asking the question "How do we stop [high intensity users] coming into our services all the time?",[299] a structural solution would look towards primary prevention at the population level. Such an approach would move away from a biomedical model towards a holistic and human rights approach, as called for in recent joint guidance from the United Nations and World Health Organization, building on the UN's Convention on the Rights of Persons with Disabilities.[300]

Recognising that the mental health system as it currently looks is often coercive and harmful *even without police*, would mean two things. Firstly, we would need to make upstream interventions that preempt crises occurring, by addressing the social determinants of mental health such as poverty, housing and employment. As NSUN point out, we must build "systems in society that create conditions in peoples' lives where they are less likely to reach crisis."[301] Addressing underlying unmet needs in this way would necessarily mean a paradigm shift away from neoliberalism, which has created the socioeconomic conditions conducive to the current malaise.

Secondly, we would need to move beyond the myth that properly funding NHS mental health services would solve all these problems. Instead, we could embrace, expand and fund community-based alternative sources of support. These could include 24/7 drop in spaces providing an open, safe environment for people to find support free of coercion, and short-term residential survivor-led crisis houses.[302] Some promising initiatives of this type in Britain include The Listening Place, Dragon Cafe, Maytree, Drayton Park and the Soteria network.

The Listening Place

The Listening Place was set up in London in 2016 due to the lack of face-to-face support available for many people with chronic suicidal feelings. It offers free, ongoing listening appointments provided by warm, non-judgemental, carefully trained and professionally supervised volunteers in a non-clinical setting.[303]

The Soteria network

The Soteria network, which traces its roots to 1970s California, was founded in the UK in 2004 in Bradford. It brings together service users, survivors, activists, carers and professionals to promote therapeutic environments that are not coercive or medication-based for people experiencing 'psychosis' or extreme states.[304]

The most radical alternative would be the abolition of psychiatric systems altogether. In Japan, the Tōjisha-kenkyū approach has gained visibility in recent years.[305] But the 'Trieste Model' is perhaps the best known example of a drastically different approach, regularly held up as an example of a more humane mental health care system. As Micha Frazer-Carroll explains, as a result of the work of Franco Basaglia, a figurehead of the 1970s Democratic Psychiatry movement who drew parallels between asylums and prisons, the Italian city has no psychiatric hospitals. Instead it:

The 'Trieste Model' is regularly held up as an example of a more humane mental health care system

> relies on a system of publicly-funded, community-based healthcare… [which] reject the logics of restraint and forced treatment.[306]

Service users' needs are at the heart of care. Core principles therefore include participation and respect for service users' agency:

> Trieste's approach is based on four principles: patients are citizens deserving dignity and respect; there is great therapeutic value in including them in the city's daily activities; work with the community creates an inclusive social fabric that welcomes patients; and patients function best when we preserve their freedom and play to their strengths.

Other fundamental innovations include the broader involvement of the community in the care system and the exclusion of coercive tactics:

> Trieste promotes mental health with its strong emphasis on interpersonal relations, family involvement, improved living conditions, and opportunities to work and play. Involuntary treatment, seclusion, and closed doors are eliminated in a system that is markedly caring and inviting.[307]

In the UK, we are a long way from a rights-based mental health system, let alone a radically alternative model like that of Trieste.

7. Conclusion and recommendations

"Because the violence at the source of trauma aims at domination and oppression…the suffering of traumatised people is a matter not only of individual psychology but also, always, of social justice"

– Judith Herman[308]

Conclusion

The NHS had been sleepwalking towards an 'innovation' like SIM for years. Mental health services in particular have developed what Chloe Beale characterises as "an ethos of exclusion at an organisational level which naturally drives and perpetuates poor practice at an individual level".[309] The shocking adoption and rollout of the SIM scheme should serve as a wake up call on several fronts. The conditions which allowed SIM to flourish must be confronted: not only the lack of rigorous evaluation of novel schemes, the lack of parity of mental health care and chronic underfunding, but also deep-seated discriminatory attitudes towards certain patients, crude behaviourist thinking, and entrenched neoliberal policies and mentalities. We must be honest about the punitive and carceral tendencies in which the mental health system is rooted, and ask why the presence of police was so easily normalised and the lines between criminalisation and care so easily blurred.

SIM was an example of a wider problem. Lack of compassion, failure to respect confidentiality, coercive practices, exclusion, denial of care, criminalisation and outright abuse are all far too common. Nor can we hope to truly eradicate SIM-like practices while the NHS's culture of blame-shifting and unaccountability at the top remains intact and whistleblowing frontline staff continue to be punished. This same culture meant that the medical establishment waved through SIM, and it was left to people with lived experience of prior harm and injustice in the mental health system to challenge the programme. The abject failure of NHS England and the Care Quality Commission to meaningfully listen to survivors' voices and take responsibility for creating real change means that patients – in particular, some of the most profoundly traumatised, stigmatised and failed by society – continue to be criminalised, neglected and used as scapegoats for a grossly inadequate system in need of radical overhaul.

Medact echoes the StopSIM Coalition's call "to all those who have capacity to continue resisting SIM and the criminalisation of distress by taking action locally and nationally, in whatever way you can".[310]

Recommendations

To health workers:

- Take action however you can to resist the criminalisation of distress, calling it out where you see it and not perpetuating it yourself

To medical royal colleges and mental health charities:

- Be vigilant for, and speak out against, ongoing criminalising and exclusionary practices
- Fund survivor research and activism against criminalisation

To NHS trusts and ambulance services:

- End all punitive, exclusionary, and discriminatory practices
- End collaboration with police in criminalising people in distress
- Create whistleblowing mechanisms which enable patients and staff to address practices of concern in line with the NHS 'Freedom to Speak Up' policy

To NHS England:

- Immediately publish the full joint policy and apologise to the StopSIM Coalition
- Launch an independent inquiry into ongoing SIM-like practices across the NHS, including schemes like FERN, HaRT, Op Ipsum and PAVE
- Recognise the central importance of experiential knowledge and reflect this in policy and practice
- Ensure that the NHS Innovation Accelerator and Health Innovation Network robustly evaluate evidence, most fundamentally on patient outcomes, before promoting new innovations

To government:

- Fund a crisis response service exclusively staffed by mental health workers, to plug the gap left by the Right Care Right Person scheme and instead of street triage
- End the ongoing criminalisation of distress by police forces and NHS trusts through schemes like FERN, HaRT, Op Ipsum and PAVE
- Fund non-coercive community-based mental health schemes to pre-empt crises, and address social determinants of poor mental health such as poor housing and the punitive benefits system

Appendices

Appendix 1: English health providers which adopted a variant of SIM

- Avon and Wiltshire Mental Health Partnership NHS Foundation Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Camden and Islington NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Devon Partnership NHS Trust
- East London NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust
- Gloucestershire Health and Care NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- Leicester Partnership NHS Trust
- Livewell Southwest
- Norfolk and Suffolk NHS Foundation Trust
- North East London NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- West London NHS Trust

Source: stopsim.co.uk/list-of-sim-teams

Appendix 2: Participant Wellbeing Plan

The questions on this form are designed to help us ensure your safety and welfare during your participation in this research study. As with all the personal information you provide to us, your answers will be restricted to a small number of people who are conducting these research interviews and will only be used for the purpose of this study.

On page 3, there is also an important transparency statement on crisis situations and emergency services and a box for you to fill in the name and number of a trusted contact.

If you need support filling out this form or have any questions, please contact Hil on hilaked@medact.org or 020 7324 4734.

1. Your name

2. **Your pronouns** (e.g. she/her, he/him, they/them)

3. **Where / how would you feel most comfortable being interviewed?** Options could include: an **online** interview via a video call, or an **in-person** interview in the Medact office (near Old Street in London), or an **in-person** interview somewhere else

4. Can you tell us about any access needs you have and how we can meet them?

5. **We recognise that the content of the interview might be distressing. Are there particular topics, questions or language, which we should NOT cover/say?** We will also send you the interview questions in advance of the day of the interview.

6 . **Are there signs or behaviours of distress that you would like us to be aware of so that we can check in with you if we see them and ask if you would like to pause or stop the interview?** And/or would you like to agree in advance on a "safe word" or "safe signal" which means you would like to pause or stop the interview?

7. **Are you aware if you experience dissociation? If so, do you know if there are any signs of dissociation which we might be able to observe?** If we think a participant is dissociating, we'll pause or stop the interview, so we would like to know how to spot this.

8. **In case you do become distressed or dissociated, what might help?** Ideas might include: being in a quiet room, breathing exercises, phoning a trusted contact for support.

9. **In case you do become distressed or dissociated, what should we avoid doing which might make it worse?** For example, particular phrases or actions.

10. **In case you do become distressed or dissociated, who should we call who can offer you support?** For the reasons we describe below, we will not be able to proceed with an interview unless you are able to provide the name and phone number of a trusted contact who will be available when the interview is taking place to support you if needed.

IMPORTANT: TRANSPARENCY STATEMENT ON CRISES & THE EMERGENCY SERVICES

- We recognise that calling emergency services can lead to serious harm. Because of this, we will only call the emergency services as an absolute last resort.
- However, in the interests of transparency, we want to make clear that we cannot completely rule out calling emergency services if we believe a crisis situation could lead to serious harm or loss of life and we feel we have no better option.
  - We hope to avoid feeling that we need to do this. As the Participant Information Sheet and this questionnaire explains, we will do everything we can to minimise the risk of distress, and of distress escalating into crisis.
  - By asking you to provide the phone number of a trusted contact, we hope to always have a better option than calling emergency services.
- **We ask that you please let your trusted contact know when the interview is taking place and ask them to make sure they are available to support you if needed.**
- If they can accompany you to the interview, that would be even better (either in the room or waiting outside, whichever you feel more comfortable with), but at a minimum we'd like to know that they are available to speak on the phone, either to you or to us if needed, to help us understand how to best ensure your safety.
- We are happy to rearrange the date/time of your interview to make sure your support contact is available.

If you need support filling out this form, need to rearrange an interview or have any questions, please contact Hil on hilaked@medact.org or 020 7324 4734.

11. Is there anything else you'd like us to know?

Appendix 3: Contents of a SIM Crisis Response Plan

CONTENTS:

COMMAND AND CONTROL KEY POINTS

Key Notes to guide Control Room decisions. This is the only section that may include information not seen by the service user. e.g. it may include confidential or restricted info about other people. This form is stored separately as "Response Plan A"

MY SAFE PLACES, PEOPLE & ROUTINES

My Safe Places, Safe People and Safe Procedures.

"I" STATEMENTS

Key Statements about my health, abilities and skills.

CRISIS SPECIFIC DASHBOARD

How to respond to me when I'm in each type of crisis.

MEDICAL INFORMATION

Relevant information about my physical and mental health.

MEDICATION

Relevant information about the medication I take.

RISK OF OFFENDING WHILST IN CRISIS

Information about my crisis related offending.

MENTOR CONTACT INFORMATION

Information about how to contact my Mentoring Team.

Source: Derbyshire Healthcare NHS Foundation Trust ‘ Joint Engagement Team Policy and Procedure’, 1

Notes and references

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