



Unhealthy Liaisons

NHS Collaboration with the
Counter Terrorism Clinical
Consultancy Service

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medact

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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.

Acknowledgments

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Cover

Images from *There Is No Alternative*, an exhibition by artist Navine G. Khan-Dossos, at The Showroom, London, 5th June–27th July 2019, photographed by Dan Weill Photography.

There Is No Alternative was a performative, durational installation combining live painting, a research archive, and a series of workshops, talks, and events open to the public. The project featured her ongoing research into the complex context of the UK government's development of pre-crime and surveillance policies, questioning the politics of representation and the positioning of care that the strategies around those policies generate. The work aims to both inhabit and expose the fluctuating forces at play within the Prevent strategy, which oscillate between safeguarding, protection and surveillance by focussing on the logos and emblems used by different Police and local Councils to symbolise Prevent in their locality.

For more information, see <http://www.khandossos.com> and <https://www.theshowroom.org>.



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Executive summary

In April 2024, the Counter Terrorism Clinical Consultancy Service (CT CCS) went live across the UK following the tender of a £17 million contract. CT CCS is an NHS–police mental health team intended to ‘facilitate information sharing’ between the two services about people of interest to Counter Terrorism Policing.

- CT CCS is a police-led project involving NHS workers, which evolved from the Vulnerability Support Hubs, which were exposed in the 2021 Medact report *Racism, mental health and pre-crime policing*.
- This new briefing is based on documents obtained via freedom of information requests and interviews with Michael Nelson, the Head of the Vulnerability Support Service in Counter Terrorism Policing, and with a CT CCS senior clinician.
- It raises serious concerns about the nature of medical cooperation with Counter Terrorism Policing and the extent to which it is ethical and appropriate, as well as the potential effect of national security related disclosures on healthcare relationships.

CT CCS manages people who’ve come to the attention of counterterrorism police and may also have a mental health condition.

- The majority have no criminal history and have come to attention as low-level concerns, including as Prevent referrals being managed by Counter Terrorism Policing.
- Demographic data is not yet available but if consistent with its precursor, racialised Muslims are likely to be disproportionately represented.
- CT CCS involves ‘pods’ of ‘co-located’ mental health workers with ‘STRAP’ security clearance (including a psychiatrist, a psychologist, and mental health nurses) working alongside police officers in Counter Terrorism Policing headquarters located in London, Manchester and Birmingham.

Multidirectional information sharing occurs between counterterrorism police and care providers.

- The individuals concerned are not asked for consent for the sharing of their medical information with CT CCS.

Mental health professionals share medical information with Counter Terrorism Policing officers, after a public interest justification is made by CT CCS, to inform the case officer’s understanding of an individual’s perceived security risk.

- CT CCS 'formulates' medical information for counterterrorism police, effectively producing actionable intelligence for the security services.
- This breaches good practice guidelines and ethical principles for the professional use of formulation, which emphasise a person-centred approach with the full involvement and consent of the service user.
- Since medical techniques should only be used to benefit the health of service users – not to further the goals of policing – these activities also go significantly beyond the health remit.

The 'breaking-out' of counterterrorism police intelligence to GPs or other mental health professionals occurs via a carefully agreed 'form of words'.

- Such sharing, or 'gisting', of sensitive security information may be done to enable the implementation of 'tripwires' – where Counter Terrorism Policing requests that care providers report back to them on any changes in a patient's behaviour, including compliance with treatment plans or medication regimes.
- This creates an indirect surveillance relationship between health workers and patients and may compromise a patient's right to discontinue medical treatment since police-led interventions may follow non-compliance.

In rare cases, police-to-health information sharing is done to highlight that the individual may pose an urgent risk to themselves or others. This raises serious concerns about the way counterterrorism concerns may coercively influence an individual's treatment.

- Security disclosures could alter the relationship between the care provider and the patient, potentially changing perceptions of risk, influencing professional judgments and intensifying treatments.
- Disclosures of national security information in urgent scenarios do have influence on medication regimes and can trigger assessment for involuntary detention under the Mental Health Act.

Currently there is no accountability around the CT CCS program's radical approach to collaboration between Counter Terrorism Policing and the NHS.

- Parliamentarians are unaware of the scheme and its operations have not been debated or scrutinised by MPs.
- Nor is there any independent oversight of the service by professional medical bodies or independent experts.

The conclusion of this briefing paper is that CT CCS is part of the intelligence cycle, processing the ‘raw data’ of medical diagnoses and police records into actionable intelligence for Counter Terrorism Policing officers.

Recommendations

Parliament, the Information Commissioner’s Office, the Investigatory Powers Commissioner’s Office, and the General Medical Council should review whether CT CCS’s disclosure of surveillance information by national security agencies to NHS professionals is appropriate.

- These reviews should also consider how independent oversight of the sharing of medical information with Counter Terrorism Policing should take place – as very few cases pose an immediate threat to the public, yet the public interest justification for sharing medical information without consent is used.

Medical professional associations and the General Medical Council should review CT CCS, evaluating its:

- Use of ‘formulation’, which is in contravention of the British Psychological Society’s guidelines on best practice
- Contravention of guidance from the Royal College of Psychiatrists that psychiatrists should be careful about the effects of working in “pressured, hermetic law-enforcement environments”
- Use of medical techniques to further the goals of policing in a police-owned service rather than to improve health
- Undermining of the NHS’s commitment to person-centred care, as the application of psychological formulation is done without consent and CT CCS never meet the service user.

1. Introduction:

Information sharing between the NHS and the police

Psychiatrists should recognise that a greater emphasis on public protection (e.g. multi-agency public protection arrangements (MAPPA) and safeguarding adults procedures) has tended to create a system in which there is an assumption that confidentiality should be breached rather than maintained. You should be ready to defend a patient's rights in this context. As always, you should make every effort to establish and respect a patient's wishes (Royal College of Psychiatrists 2017: 9).

Healthcare professionals navigate a complex environment when deciding what patient information they can or should share, in different circumstances. In the past two decades, multiple forums have emerged where police work alongside health and social care professionals to liaise, divert and safeguard. These arrangements, like multi-agency public protection arrangements (MAPPA) and safeguarding adults procedures, are entrenching the assumption that information sharing is necessary and that confidentiality is an obstacle to be overcome. The Royal College of Psychiatrists (above) cautions against information sharing that exceeds the General Medical Council's guidelines. These guidelines limit the sharing of medical information, where the patient has not consented, to situations:

- where the law requires information sharing
- where the patient would benefit from the information being shared with partner agencies
- or where the disclosure is justified in the public interest (General Medical Council 2017: 13).

The new Counter Terrorism Clinical Consultancy Service (CT CCS) is “a joint NHS and Police Mental Health Team which facilitates information sharing with local mental health services for individuals who have come to the attention of Counter Terrorism Policing and who are thought to either present a risk of serious harm or have safeguarding, welfare or treatment needs in the context of mental disorder”.¹ Counter Terrorism Policing also describes the service as a “programme which provides Counter Terrorism Policing officers with access to specialist forensic clinical support” (Counter Terrorism Policing 2022a: 3).

In 2021, Medact exposed the pilot project to CT CCS, called ‘Vulnerability Support Hubs’, in the report *Racism, Mental health and pre-crime policing: The ethics of vulnerability support hubs* (Aked *et al.* 2021). In 2022, the internal evaluation of the Hubs by Counter Terrorism Policing was completed and a government tendering process began, to nationalise the service. This tender for ‘Forensic Mental Health Services’ went live in 2023.²

The tendering authority was the Metropolitan Police Service. The tender lasts initially for 36 months with an option to extend for a further two years, and the appointed contractor is listed as Barnet, Enfield and Haringey Mental Health NHS Trust. The value of the contract is, excluding VAT, £17 million (Figure 1).

II.1.7) Total value of the procurement (excluding VAT)

Value excluding VAT: £17,090,615

Figure 1: Extract from <https://www.find-tender.service.gov.uk/Notice/028360-2023>.

While Barnet, Enfield and Haringey Mental Health NHS Trust is the primary contractor for CT CCS, there are other CT CCS ‘hubs’ maintained in Birmingham and Manchester. CT CCS in the Midlands operates through a co-located unit, where clinicians from the Birmingham and Solihull Mental Health Trust are positioned inside the West Midlands Counter Terrorism Policing HQ. In the North, the NHS Trust providing CT CCS services with Counter Terrorism Policing North West is *either* Lancashire and South Cumbria NHS Foundation Trust or Greater Manchester Mental Health NHS Foundation Trust. Both provided clinicians for the initial Vulnerability Support Hubs pilot project which ran from 2016 until 2024 (Aked *et al.* 2021: 11), but one of the Northern NHS Trusts has since ceased collaborating (Interview with Michael Nelson 2023). It is unclear which one has remained in collaboration as interviewees declined to say.

Like the Vulnerability Support Hubs, CT CCS is designed to use 'co-located' units of NHS and Police staff in Counter Terrorism Policing units in Manchester, Birmingham and London. A hub usually consists of a consultant forensic psychiatrist and clinical lead, a consultant clinical psychologist, registered mental health nurses, administrative support staff and a detective constable or sergeant working in the regional Counter Terrorism Policing unit (Northern Vulnerability Support Hub 2021: 3–4).

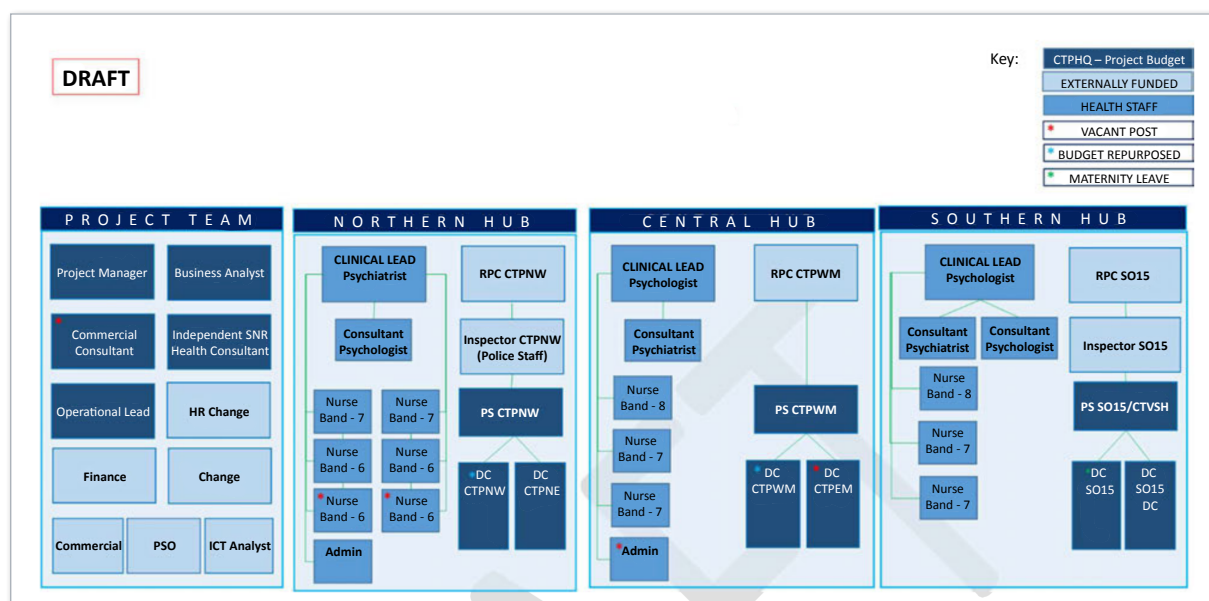


Figure 2: Extract from Counter Terrorism Policing HQ (2022b: 16).

CT CCS does deal with those incarcerated for terrorism offences who are subject to MAPPA arrangements in the community upon release – but these make up a small minority of their cases. Most cases are low-level inquiries from Counter Terrorism Policing officers managing Prevent referrals or other low-level cases. Prevent is the UK's counter-radicalisation program which provides multi-agency interventions where there are concerns about extremist ideological beliefs, prior to any crime being committed. The primary referrer to Prevent is the education sector, highlighting the youth of many referred to Prevent.

The processes for CT CCS formulation are the same for all referrals to the team, whether that referral comes from the pre-crime Prevent space or Pursue (which deals with investigations): the referring officer in Counter Terrorism Policing shares information from police databases which the clinicians then 'formulate', before potentially moving to contact the individual's GP and/or mental health team to obtain deeper information about their engagement with treatment and medication.

Formulation in clinical settings

'Formulation' is a technique used in both psychology and psychiatry. There is no standardised definition of formulation, but the British Psychological Society (BPS) explain in their *Good Practice Guidelines on the use of psychological formulation* (2011: 6) that formulations "summarise the service user's core problems; suggest how the service user's difficulties may relate to one another, by drawing on psychological theories and principles" and develop "a plan of intervention which is based in the psychological processes and principles already identified".

Importantly, the construction of a formulation is described as a "shared narrative" by the BPS *Good Practice Guidance*; it is a co-produced narrative "concerned with the personal meaning to the service user of the events and experiences of their lives [...] A formulation is not an expert pronouncement, like a medical diagnosis" (British Psychological Society 2011: 7).

Psychiatric formulation differs slightly from psychological formulation and often begins from 'lists of factors' frameworks and problem-specific (rather than person-specific) protocols. Even then, however, the BPS *Good Practice Guidance* emphasises that:

with the exception of conditions of clearly organic origin such as dementia, it is recommended that best practice psychological formulations in mental health settings are not premised on psychiatric diagnosis. Rather, the experiences that may have led to a psychiatric diagnosis (low mood, unusual beliefs, etc.) are themselves formulated. If this is carried out successfully, the addition of a psychiatric diagnosis becomes redundant (British Psychological Society 2011: 17).

This strong emphasis on co-production and avoiding 'expert pronouncements' which are not based on patients' own understandings of their problems reflect the centrality of person-centred care within NHS values and staff training. But CT CCS does not engage individuals in the formulation process, nor do its clinicians even meet them. CT CCS formulations are produced from diagnostic information provided by the NHS and information contained in police databases. Sometimes the 'formulations' are based *only* on information contained in police databases. This is a striking divergence, given the centrality of a person's own views and understandings in the *Good Practice Guidance*, and within all understandings of person-centred care.

As I will describe in this report, by applying psychiatric formulation at a distance, without consent, and with no input from the service user, CT CCS contravenes the commitments made by the NHS to person-centred care. NHS England has embedded person-centred care within their workforce training and education plan, defining it as:

Being person-centred is about focusing care on the needs of individual. Ensuring that people's preferences, needs and values guide clinical decisions, and providing care that is respectful of and responsive to them. Health and wellbeing outcomes need to be co-produced by individuals and members of the workforce working in partnership, with evidence suggesting that this provides better patient outcomes and costs less to health and care systems (Healthcare Education England: undated).

CT CCS does not consult a service user and does not attempt to understand their life in their own terms. Rather, it is a service owned by Counter Terrorism Policing which supports officers by giving them renderings of mental health conditions, how they might impact an individual, and advice on how the mental health system operates. So, there are serious questions to be asked about the participation of the NHS in CT CCS, contrary to the stated goals of NHS England to embed person-centred care in everything they do.

The sharing of medical information builds a picture of the individual's engagement with services, which contributes to their 'management' by Counter Terrorism Policing in the community. However, CT CCS will also obtain information and formulate cases where there is no criminal history – including many children. The vast majority of their cases are low-level, coming from the early stages of Prevent referral when a Counter Terrorism Policing officer is undertaking deconfliction and Prevent Gateway Assessment checks. As I was told by the police lead for the service, CT CCS can engage with any case referred by a Counter Terrorism Policing officer where there is a concern about mental health (Correspondence with Michael Nelson 2024).

Accordingly, CT CCS can and does take referrals from Counter Terrorism Policing officers working across Investigations, Intelligence, Nominal Management (managing those released from incarceration for terrorism offences), Multi Agency Centre (MAC – for closing MI5 investigations), and across certain parts of Prevent where the risk is still 'owned' by a Counter Terrorism Policing officer. This is demonstrated in Figure 3 – an extract from internal documents, referring to CT CCS by its previous name (the CT

Integrated Clinical Formulation Service) and the precursor from which it evolved, the Vulnerability Support Hubs.

1.1. Background

The Vulnerability Support Service (VSS), formally known as Prevent-in-Place (PIP), is a pilot programme which provides CTP officers with access to specialist forensic clinical support, delivered through three Vulnerability Support Hubs (VSH). These Hubs, created in 2016 with support from the Department of Health and Social Care, offer advice and consultation to CTP officers on cases where there may be mental health (MH) considerations relating to the subject of interest.

Project Cicero has been tasked with taking the learnings from the pilot programme and scaling the service offering into a nationally accessible, consistent service. In addition, the project has been asked to expand the scope of the service in order for it to be available across four CTP core capabilities (Intelligence, Investigation, Prevent and Nominal Management). The future service will be known as the CT Integrated Clinical Formulation Service (ICFS) and is planned to go-live in 2023.

Figure 3: Extract from Counter Terrorism Policing HQ (2022a: 3).

The extract mentions Prevent – but there is a specific context to how CT CCS engages with Prevent. Prevent referrals adopted by local authorities *will not* engage CT CCS, because local authorities work openly and obtain consent for the Channel process. However, adoption by a local authority comes at a late stage in the life of a Prevent referral. At *all other stages* of a Prevent referral CT CCS can take referrals, because the case is still being processed and deconflicted by Counter Terrorism Policing officers. The flowchart in Figure 4 indicates the possible routes available to a Prevent referral (blue arrows) and where CT CCS can be engaged (green).

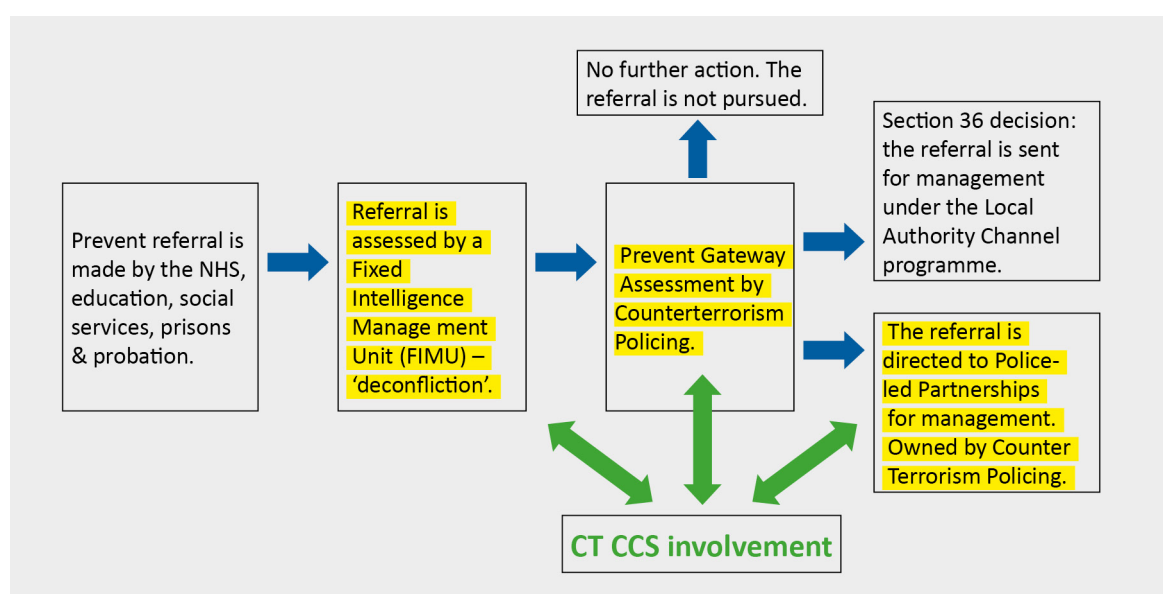


Figure 4: Diagram of the stages of a Prevent referral and where engagement with CT CCS is possible.

As CT CCS will retreat from involvement with a Prevent referral when it is adopted by a local authority, this underlines the non-consensual basis of its operations. Local authorities should be obtaining consent from an individual for their discussion at a Channel panel. CT CCS, however, is a police-owned service – providing ‘formulation’ for cases owned by Counter Terrorism Policing.

The release of the Counter Terrorism Policing HQ’s ‘Prevent Policy’ documentation made clear that while multiagency Prevent is run, openly, by local authorities, there is a companion program to Prevent run by Counter Terrorism Policing. It is called Police-led Partnerships (PLP) and delivers multi-agency liaison and diversion services to those deemed ‘unsuitable’ for Channel, but without the consent or knowledge of its subjects (Figure 5).

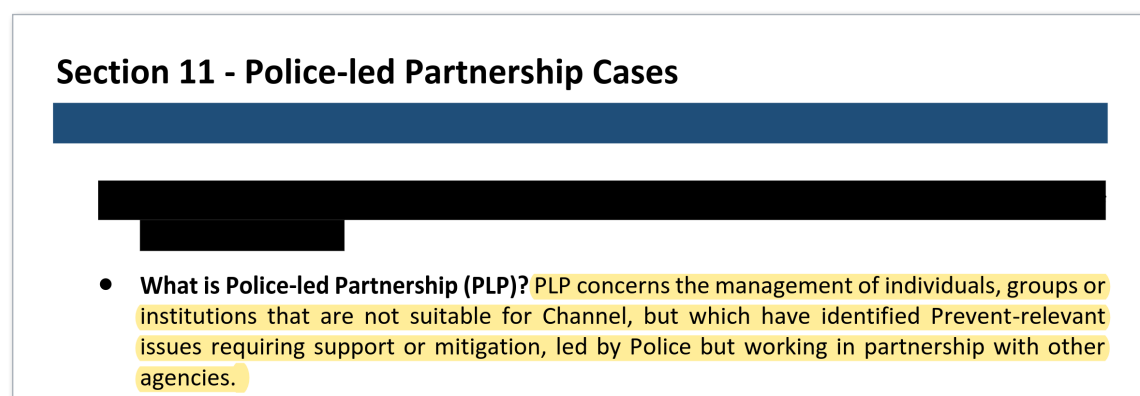


Figure 5: Extract from Counter Terrorism Policing (2020: 29).

The NHS trusts which run CT CCS are directly contributing to the covert management of individuals in the community by Counter Terrorism Policing, through the relationship between CT CCS and Police-led Partnerships. Through CT CCS, individuals’ medical information is shared with Counter Terrorism Policing case officers and clinicians provide a ‘formulation’ of how they might be proactively diverted from engaging with extremism, through the maximisation of protective factors and liaison with mental health services.

If the NHS is committed to person-centred care, why is it contributing medical information, without consent, to covert management undertaken by Counter Terrorism Policing? And why are NHS professionals using medical techniques within a police-owned service, at a distance from service users, to provide actionable intelligence (‘tactics’, in documentation explored later in this report)?

2. Methodology

The information contained within this report has been obtained through interviews with Michael Nelson, the Head of the Vulnerability Support Service in Counter Terrorism Policing, and with a CT CCS senior clinician. The research project I am undertaking studies Prevention of Violent Extremism programs across Europe and the integration of medical professionals in terrorism prevention in seven case study countries. The project is funded by the European Research Council (Starting Grant number 851022), and has been ethically reviewed by the funder and by the University of Warwick, which hosts the study. Pseudonymisation options were presented to both interviewees for use in publications, but Michael Nelson preferred to be named.

Obtaining interviews with senior police and clinical professionals at CT CCS was an organic journey, where contact was made after finding details of the tendering process online. Details of the service had become partially available through FOI requests directed at the National Police Chiefs Council for data sharing agreements, operational policy documents and internal evaluation documents. Medact had previously obtained documentation on the operations of the pilot project up to 2018, which were analysed in *Racism, mental health and pre-crime policing* (Aked *et al.* 2021).

As the new CT CCS program began in April 2024, data is not available on the demographics which make up its caseload. However, if it is consistent with the Hubs, then racialised Muslims will make up a significant proportion of its cases. Using the ideological categorisations of cases in internal Hub reports, the previous Medact report calculated that racialised Muslims were at least 23 times more likely to be referred to the Hubs than a white British subject (Aked *et al.* 2021: 20).

3. Referrals, screening and triage

How could medical information possibly assist the police in preventing terrorism?

There is no evidence to suggest that mental illness or neurodiversity cause, or increase the likelihood, of committing a terrorist act – and no such assumptions should be made about a connection (Royal College of Psychiatrists 2016: 5). Regardless, security agencies have seized upon Emily Corner and Paul Gill's findings (2015) that lone actor terrorists are more likely than group-based terrorists to have psychiatric diagnoses – or are linked to reports of such diagnoses in the media, post-attack. This does not mean that any direct link between mental illness, neurodiversity and terrorism exists; only that lone actors are more predisposed to mental illness or neurodiversity than recruits to organised terrorist groups. So why are Counter Terrorism Policing interested in medical information to the extent that a £17 million joint NHS–Policing project is required?

Counter Terrorism Policing's interest in medical information is not connected to traditional profiling: they do not seek raw data (such as psychiatric diagnoses) in order to escalate surveillance of patients. Rather, the intent – and purpose – is more nuanced. The clinical staff within CT CCS *translate and process medical information* for officers rather than simply handing over raw medical information. Indeed, the police could obtain raw medical information through standardised processes (like forms) and do not need an intervening clinical team to facilitate this. Rather, CT CCS's primary function is *translating and processing* medical information for a policing context. This happens through the production of a 'formulation'.

As I will describe below, this processing and formulation work raises significant questions about CT CCS exceeding the legal duty on medics to share information where the law or public interest demands it, and instead represents a service being drawn into the work of policing. Indeed, counterterrorism police evaluated the Vulnerability Support Hubs project (which piloted the working methods of CT CCS) and found that it offered them 'tactical options' for managing cases (Figure 6).

Persons in the CT system may have differing levels of information known about them, often depending on the source of referral and how well they have previously been known to policing or their partners. Information holdings on individuals will often be held at different levels of classification, owned by different CT partners and are only usable for particular purposes under the law. What classification the information sits at impacts the scope of services that the Hubs can provide:

1. In the closed space the Hubs can offer: access to consultant psychiatric and clinical psychological advice, expertise and guidance on the presentation of the subject, the general effect this may have on broader risk, the tactical options available within health for assessment, the likely timescales and outcomes of clinical intervention, and assistance with identification of relevant material for a successful Form of Words.
2. In the open space the Hubs can offer: engagement with external health partners to highlight concerns, recommendations for intervention and assessment, as well as obtain relevant information from Health to share back to assist in the safeguarding and/or prevention of serious harm of the individual or wider public.

Figure 6: Extract from Counter Terrorism Policing HQ (2022a: 17).

CT CCS clinicians have STRAP³ security clearance and are provided police information about a subject's behaviour as well as information from police databases like CRIMINT. The clinicians can offer contextualisation of behaviours to officers, where an observed behaviour could be explained by the subject's psychiatric condition. This can lessen the concerns of Counter Terrorism Policing officers about the unknown and the unexplained, affecting the potential path of the individual (i.e. the case does not transfer to active surveillance by the Pursue teams).

Referrals

The procedures followed by CT CCS cover a wide variety of scenarios and entry points to the service. The first point of contact with the service is often a telephone or corridor conversation between a Counter Terrorism Policing case officer and CT CCS, to determine whether a case is in the 'ballpark' of a potential referral (Interview with CT CCS Senior Clinician 2024). If it is, then the next stage of work is an initial 'scoping review' where data is recorded on the CT CCS SharePoint. This initial data influences a determination by CT CCS clinicians as to whether it should stay at 'scoping' stage or proceed to becoming a full referral.

Formal referrals from Counter Terrorism Policing officers to the service use its dedicated portal and are stored on a police server, which should not be accessed by anyone beyond the immediate CT CCS team. Formal referrals include 'demographics', information from police databases like CRIMINT or from the initial Prevent referral, and the reason for referral (for example: concerning behaviours, indications of possible mental illness from comments made by family members or those making a Prevent referral, or records on police systems of a declared mental illness). Specifically:

The CT police information they're sharing with us include personal identifiers, dates of birth, PNC warning markers, reasons why they're considered a CT risk, relevant criminal convictions, any information related to health diagnosis that's currently recorded on police systems. And then, special category data in accordance with GDPR, DPA [...] Special category data that is subject to sensitive processing will have a clear bearing on vulnerability to terrorism, such as criminal records, mental and physical health records, convictions, ideological beliefs. This information may come from police intelligence, PNC, police databases, HOLMES, NCIA. We health clinicians will not have direct access to these systems, but they'll [pieces of data] be shared as appropriate (Interview with CT CCS Senior Clinician 2024).

Screening

CT CCS caseworkers – currently community psychiatric nurses – then undertake an initial formulation of the information contained within the referral (Interview with CT CCS Senior Clinician 2024). If the referral has arrived in the service from an officer dealing with an early stage Prevent referral, it is only police database information on the referral and no details of mental illnesses are obtained from the NHS at this stage. As such, the 'formulation' applied to the case is a strange one. It does not co-produce a narrative about psychological symptoms with a service user, connecting them to problems in their lives in a meaningful way. Nor is there commonly any information about medical conditions available to the community psychiatric nurse. Rather, the application of 'formulation' by CT CCS involves: no co-production, no engagement with the subject, and no details of mental illnesses or contact with mental health services (at this point in a referral process).

The application of 'formulation' – a psychological and psychiatric technique – to abstracted data which has come from police databases is not a recognised use of 'formulation', nor of psychiatry or mental healthcare in general. As well as being in contravention of all the guidance contained in the British Psychological Society's (2011) *Good Practice Guidelines for the use of psychological formulation*, this practice seems to be of little medical value. What value can be obtained from a psychological/psychiatric reading of data from police databases? The 'formulation' is speculative, based on no engagement with a service user. Given that very little medical expertise is involved in the application of 'formulation' to early stage Prevent referrals, this might explain

why the service is currently looking to take on social workers for the caseworker roles (Interview with CT CCS Senior Clinician 2024).

In detail, ‘formulation’ (as applied by CT CCS) refers to the application of the ‘5 P’s’ framework (Predisposing, Precipitating, Presenting, Perpetuating and Protective factors) to the materials, and “will be based on the information in the referral including history of mental illness, current descriptions of concerning behaviours and information about other potentially disinhibiting factors” (Counter Terrorism Policing 2018: 13). Concern will be rated as either high, moderate or low – a rating that will be revisited in weekly multidisciplinary team meetings of CT CCS (including police and clinicians). This represents a slight rebranding of the ‘RAG’ (red, amber, green) method for grading cases used previously by the Vulnerability Support Hubs.

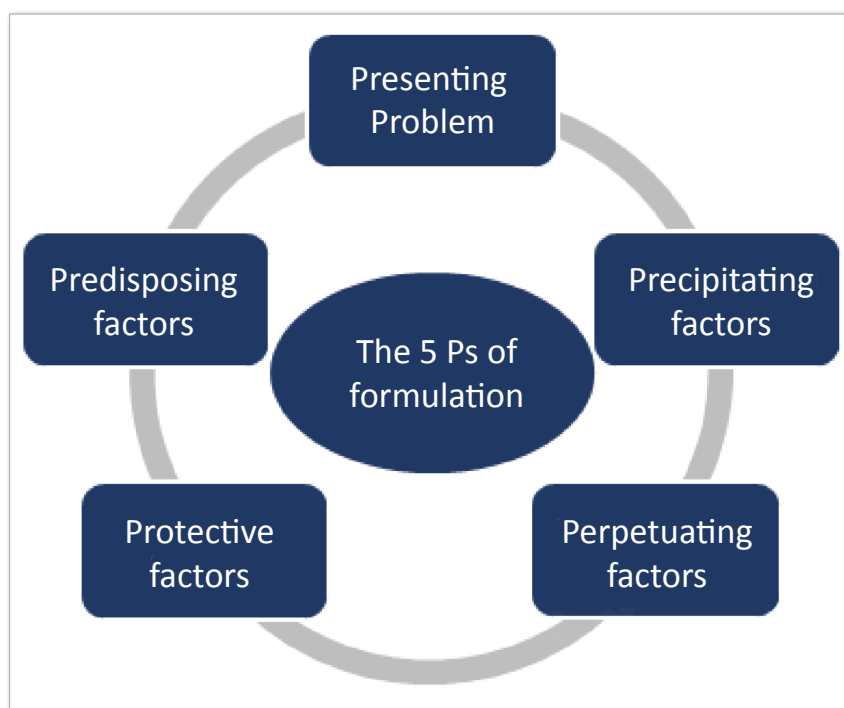


Figure 7: Extract from Counter Terrorism Policing (2022b: 15).

Crucially, it must be noted that – contrary to the guidelines produced by the British Psychological Society (2011) – formulation is being applied from a distance, without any personal relationship or engagement with the service user, in a disempowering and covert fashion. In their ethical principles for the use of formulation, the BPS guidelines state that:

Working collaboratively with service users (and where relevant, families and carers), using everyday language, emphasising strengths as well as needs, and making good use of supervision will help to minimise formulation's potentially unhelpful aspects [...] A formulation that is not understood by, or acceptable to, the service user is not a useful formulation, and implies, at the very least, the need for further collaborative discussion in order to develop a shared perspective [...] formulation is collaboratively constructed and at the service of the person (British Psychological Society 2011: 22).

A non-consensual use of formulation is therefore a contradiction in terms, according to the Good Practice Guidance produced by the British Psychological Society. And CT CCS does not obtain consent from, or engage with, the individual at any time.

After producing an initial formulation, **information gathering** is the next stage in the work of CT CCS. In the weekly multidisciplinary team meetings of CT CCS, the formulation – and concern rating – is discussed. A decision is then made, in conversation between the clinical and police colleagues, about whether the service should reach out to frontline NHS services to request more information. Primarily, CT CCS would seek information on whether the individual is known to community mental health services, 'open' to them, discharged from care, or not engaging with mental health services (Interview with CT CCS Senior Clinician 2024).

However, to request this information from a GP or mental health provider, CT CCS must provide a justification for the information sharing which would meet General Medical Council guidance and the conditions of the Data Protection Act. Effectively, CT CCS must first share 'gisted' police information on why the individual poses a risk to themselves or others, to underscore the request for medical information from the NHS. Occasionally, the Counter Terrorism Policing officer managing the case will not support any contact between CT CCS and the NHS – because it could potentially damage an investigation:

At the weekly pod review (we call ourselves pods – and each pod has, you know, the case worker, police officer, detective and then the psychiatrist, psychologist). So, we would come up with some options, go back to police, and then they may come back to us, if it's a Pursue case, and they might say, "You know what, this is a really tricky operational case. We'd rather you didn't do anything at the moment. We'll come back to you." So, the model is we present options before we get stuck in, because [at] the end of the day, it is a CT policing service (Interview with CT CCS Senior Clinician 2024).

In the vast majority of cases, the Senior Clinician explained, contact with the NHS can go ahead – but police colleagues are aware that any contact from CT CCS would be noted on NHS records, becoming accessible to a service user if they were to make a Subject Access Request.

To support contact being made with the NHS, CT CCS task the Counter Terrorism Policing case officer with producing a 'form of words'. This is a shareable 'gist' of national security relevant intelligence, that CT CCS can then relay to the GP or care provider, in support of a request for medical information:

We have this process where we remind the police of this, and then they frequently go away and come up with a form of words, a formal FOW [form of words], which we will then relay verbatim. It might be in an email, but once we've got a form of words it has to be in writing, because we've got to show that we used the form of words. So, there'll be an email. "Just want you to be aware that, you know, there are concerns that this subject is vulnerable to being, you know, exposed to material that might cause risk of radicalisation" (Interview with CT CCS Senior Clinician 2024).

Here, the NHS clinicians working in CT CCS are advising the police on what would be required, by the NHS, to facilitate the transfer of medical information – and then make contact on behalf of the NHS–police team. They do openly state that they are employed in a joint working team between the NHS and police when making this approach to local services. And they receive a range of responses to such requests for information:

We get a range of responses, from, “I’m sorry, you work with police, I’m not at liberty to speak to you. Contact our information governance officer.” Or: “Oh yes, I understand, you know, acting in this person’s best interest, I know that.” [Or] “Yes, this person has had previous contact. They were discharged to GP care, but they’ve twice been in hospital under section, and as far as I knew, they were taking oral medication for a mental illness.” And so, we then have that information, we go back to police [...] We’ll go back. “You can say that this person’s been referred to Prevent, family are concerned about a change in behaviour, and drug use” (Interview with CT CCS Senior Clinician 2024).

This information is then integrated within the formulation of the case and discussed at the next pod meeting.

Triage

Finally, the 2018 documentation described ‘tiers’ of action as ‘tactics’ which result from the receipt of medical information from the NHS and its integration within ‘formulations’ made by CT CCS. These can range from ‘sharing information’ and ‘making recommendations’ in lower-risk cases, to ‘assertive liaison and diversion to mainstream services’ in higher-risk cases – where “forensic opinion and recommendations regarding interventions and tripwires” are made to the GP or responsible clinician (Counter Terrorism Policing 2018: 15). At the top end of the scale, interventions can involve CT CCS clinician contacting an NHS professional to inform them of their view that the threshold for assessment under the Mental Health Act has been met. More often, it involves “monitoring and effective tripwires / trigger plans are in place to monitor increase in concern or reduction of mitigation” (Ibid). In these cases, GPs and responsible clinicians are asked to contact CT CCS should the patient cease engaging with a treatment plan or medication regime.

The process of implementing tactical responses was described by the Senior Clinician in terms of a ‘back and forth’ between police and clinical colleagues in the ‘pod’, then outreach and recommendations being made to frontline NHS staff by CT CCS clinicians:

So, we'd go back to the GP, and say, "Look, we've received information that the family are concerned that there may be a relapse in mental illness." And the GP [might say] "Yes, I agree, I'll put in a referral to the mental health team." Or if it's more acute, we may alert the mental health team as well. I mean, let's say that the police say, "Look, this person's actually got two arrests for offensive weapon in the past, and a street robbery." And so, the risk is, sort of, bumping up. We may then become a bit more involved, and ring community mental health, and say, "We need to let you know this." And again, we get a range of responses, from, "Oh, thank you very much for letting us know. We'll get on to it" to, "We only accept GP referrals, not willing to speak to you." [...] So, we can revise our formulation at that point. So, [the] 'presenting' [factor] is changing behaviour, the predisposing [factor] is previous diagnosis of mental illness under treatment. The precipitating [factor] is drug use, and possible non-compliance of medication. So, we improve that formulation, and we don't go in and amend the formulation every week, formally. You know, the five Ps has been done, we are then gathering information, and we are recording on a rolling record. Every time something comes in, it goes into the record. Every time we have a review meeting, we record who's there, and what our thoughts are (Interview with CT CCS Senior Clinician 2024).

Where sensitive police information is shared with responsible clinicians or a GP, who then request an assessment of a patient under the Mental Health Act, it is important to ask how the 'gisting' of covertly obtained intelligence might influence medical judgments about risk. The Mental Health Act provisions for assessment were written before the era of such disclosures from security agencies to frontline healthcare practitioners. 'Gisting' the interest of Counter Terrorism Policing in an individual is more likely to result in risk averse outcomes for them, such as changes to their medication regime (which can be partially incapacitating) and even lead to involuntary detention in hospital. The 2021 Medact report on Vulnerability Support Hubs (which preceded CT CCS) outlines multiple examples of both outcomes, after the intervention of the Counter Terrorism Policing based clinicians.

In summary then, concerns about current CT CCS practice include:

- The participation of NHS trusts and staff in a Counter Terrorism Policing owned program, beyond the scope of providing healthcare
- The application of 'formulation' to a person's data, outside good practice recommendations for formulation (which emphasise co-production and consent)

- The negation of NHS commitments to person-centred care, where an individual is involved in decisions made about them – rather than pronounced upon by distant experts
- The participation of NHS staff in information-sharing liaison between the police and frontline healthcare services, using their expertise to facilitate the transfer of confidential medical information to a police-owned service
- The effects of national security disclosures (through the conveyed ‘form of words’) upon the doctor-patient relationship.

4. Information sharing and processing legislation

The FOI releases and interviews with senior staff at CT CCS make clear that significant thought has gone into compliance with information sharing and data protection legislation. CT CCS has been designed with information governance in mind. Medical information is requested by the clinical team who then make judgments on proportionality, limiting what is shared with the counterterrorism case officers. Anything deemed inessential for the policing purpose, like a list of recent addresses of the subject, is not shared. Furthermore, the FOI releases clearly document the efforts that go into protecting clinicians from any misguided expectations of counterterrorism officers who approach them, “‘fishing’ for information [...] without reference to a MH or CT concern” (Counter Terrorism Policing 2022a: 23). A dedicated police officer is allocated to CT CCS in order to ‘push back’ against police colleagues who approach the service in this manner.

The Head of the Vulnerability Support Service, Michael Nelson, went on the record to discuss the centrality of information sharing legislation to the work of CT CCS, stating:

The advantage of having co-location and vetted clinicians is that we can work out how best to manage disclosure between each other’s agencies at a local level. So, it’s really information sharing [...] Information governance is really at the top tier of what we are concerned about and daily, [we] try to ensure that we comply with the requirements around where we are asking clinicians to access health records [...] The processes that we follow are standard, are legal disclosure processes so we haven’t created any new legislation to allow different types of disclosure to happen. We used the same legal frameworks and gateways to any police agency would in dealing with health (Interview with Michael Nelson 2023).

As part of its commitment to using the existing legal frameworks for police interaction with the NHS, it is important to highlight that there is no digital ‘backdoor’ that Counter

Terrorism Policing uses to access medical records. Instead, conversations between the agencies are the mechanism for information sharing. The process referred to as ‘active monitoring’ (Counter Terrorism Policing 2018: 33) in the internal evaluation of the Hubs’ practices was described as ‘unfortunate language’ by Nelson, who preferred to call it the ‘implementation of a trigger plan’. This refers to when CT CCS clinicians ‘gist’ police information to a patient’s responsible clinician or GP, to support a request that the GP or psychologist contact them should the patient disengage from treatment. Nelson explained that there is no remote or digital system which ‘pings’ Counter Terrorism Policing when a subject doesn’t turn up for their clinical appointments, but rather:

Subjects we’re dealing with, often a lot of them may find themselves on a depot [slow-release] injection program, you know, on a fortnightly or a weekly basis within the community [...] But it’s not monitoring about whether they are taking that injection. It’s simply about then making that community treatment team aware of the fact that we’ve got an interest in this person. And here’s the explanation why we’re concerned about the person. We would like you to let us know if [...] their behaviour changes. For example, yes, they stop taking their medication and their condition worsens then that’s going to impact our risk assessment. And so, would you share that back with us from a safeguarding perspective in relation to the subject but also to the broader public? So, it’s almost signposting them to their existing legal duties in terms of public protection and safeguarding [...] What there isn’t any capacity to do, and I certainly would not want it to be like this, is any form of link in or remote monitoring of health records or flagging within health systems that indicates or pings to us. It is literally conversations between our clinicians and treating clinicians (Interview with Michael Nelson 2023).

There is a lot to break down in this quote, regarding the positioning of health professionals as potential collaborators with Counter Terrorism Policing. This is especially concerning in the context of guidance produced by the Royal College of Psychiatrists, which underlines that there is no scientific evidence of a link between mental illness and terrorism (Royal College of Psychiatrists 2016: 5). The professional gravity of contact from Counter Terrorism Policing officers could potentially lead medics to share medical information just because police have asked them to – or could negatively impact the doctor–patient relationship. Furthermore, there is no independent oversight of the ‘gisting’ process, whereby CT CCS provides a public interest justification for the sharing of medical information without consent. If the majority of cases are low-

level inquiries which pose no threat to the public, then the public interest justification does not release obligations to privacy and confidentiality of medical information.

In terms of the information sharing protocols used by CT CCS, consent is considered outside the remit of the service. Because CT CCS does not engage with service users, it has no obligation to seek their consent for information sharing or processing. Conversely, this requirement is something that the NHS itself considers, when deciding whether to share medical information:

We do not rely on consent. So, we just put consent to one side. We're not relying on consent, because under various guidance, it could be detrimental to the management plan for us to seek consent. It's not practical for us to seek consent. We don't have direct, you know, contact with the individual. Now, it may be that, in some cases, a GP might decide, "Look, I'm not willing to tell you anything, unless the patient consents." And they might go away, and say to the patient, "Look, I've had this inquiry through Prevent. They're a bit worried about X, you know, I wanna, can I tell them about your treatment?" And the patient may or may not say yes. But we do not rely on consent, at all. Healthcare providers might (Interview with CT CCS Senior Clinician 2024).

In terms of how the NHS approach a decision to share information with the police, without consent, the NHS Caldicott Guardians apply the professional recommendations of the General Medical Council (2017) to such requests.

But once the data arrives in CT CCS, the service uses provisions within the GDPR (General Data Protection Regulation) to legitimate its processing of this confidential information. These include GDPR article 6(1)(c) and 6(1)(e): processing necessary for compliance with a legal obligation on the data controller and processing necessary for performance of a task carried out in the public interest, respectively. The service also contextualises its processing of confidential medical information through GDPR article 9(2)(g) and 9(2)(h), which legitimate the processing of special category data (on philosophical or religious beliefs, for example) based on a substantial public interest in doing so, and that such processing is needed for the purposes of 'preventive medicine'.

Effectively, the justification for obtaining and processing confidential information in CT CCS rests on the need for the police to prevent serious harms occurring to the public, or on the necessity for health teams to provide medical assistance which prevents

harms to the person and/or others. Information legislation justifies such processing on the grounds that a person is risky or at-risk (Heath-Kelly 2013). The final jigsaw piece in the application of information governance standards to the service, CT CCS makes reference to the CONTEST strategy which uses ‘radicalisation’ as an explanation for how vulnerable people might be put at risk by hardened extremists and radicalisers. Here, the GDPR articles on public interest, preventive medicine and the legal obligation to prevent serious crime are refracted through the concept of radicalisation – a discourse about how a vulnerable person can become dangerous, and how a dangerous person might also be vulnerable. The concepts of radicalisation and vulnerability (Heath-Kelly & Gruber 2023) open significant room for manoeuvre within CT CCS’s application of different legislative provisions.

This framing allows a lot of medical – and medically relevant – sensitive information to travel from the NHS, through CT CCS to counterterrorism officers:

So, health information, which we will share, that may be currently contained within an individual’s personal medical records. If we share it at all, it’s to support a full understanding of the impact mental health issues may have on the risk posed by the subject to themselves, or others. And any information that’s deemed appropriate by the CT CCS clinicians will be shared. So, this might include identification of mental disorder or psychological vulnerabilities. How mental disorder and other factors may be a vulnerability factor in terrorism risk. Treatment and support options that may mitigate or manage risk. Advice on how identified risk may change over time, in response to triggers or change in circumstances. Advice on appropriateness of health services and use of Mental Health Act. Diagnosis. Mental Health Act detention status. Section 17 leave status. Current or past mental state, where relevant to CT CCS case management. For example, type of delusions reported during episodes of psychosis, current mental health service treatment plan, current mental health service risk management plan. Information held by mental health services that may be relevant. Background information for joint assessment of risk of serious harm (Interview with CT CCS Senior Clinician 2024).

Conditions of proportionality still apply to the work of CT CCS, under the Data Protection Act. The service understands proportionality to mean that it cannot share information with the police that falls outside the categories above, such as previous addresses of the individual. It also understands proportionality to require the Case

Management System to not be accessible to police teams beyond CT CCS. But if there is no immediate threat to the public, how is it proportional to share medical information with Counter Terrorism Policing without consent?

Beyond information sharing

Intriguingly, CT CCS is not actually required for police to obtain information from the NHS – although it certainly assists that process. The WA170 form, for example, is a standardised form which facilitates the request of information from health by police. Furthermore, no laws have needed to change to facilitate the multidirectional information sharing undertaken by CT CCS. So, it is important to reflect on the purpose of CT CCS, if it is not formally needed for the transfer of data between agencies.

Rather than making the flow of information between agencies possible, CT CCS largely plays the role of *translating* the mental health system to police officers. Both agencies are highly specialised and may not understand the jargon, culture and compliance standards of the other. By itself, the transfer of medical information to the police is not always helpful (for example: ‘the subject has a diagnosis of autism’). CT CCS does not simply transfer that information from the NHS to police, it also translates its relevance to policing. CT CCS clinicians can consult with counterterrorism case officers to explain how a psychological condition affects behaviour, can watch bodycam footage and offer an interpretation in line with diagnostic information, and – most importantly – *formulate* how and when an individual’s mental health condition could impact on their engagement with terrorist/extremist content or increase the chance of violent behaviour.

This extends significantly beyond the health remit, as well as specifically breaching the British Psychological Society’s *Good Practice Guidelines for the Use of Psychological Formulation*, and the commitment to person-centred care in the NHS. We must remember that CT CCS is a police-owned service, even if three NHS trusts won the contract to deliver the clinical consultancy. Effectively the NHS is contributing to a police-owned service which does not embed person-centred care or follow professional associations’ guidance on how to apply formulation – to which the NHS is committed.

In the other direction of information flow, CT CCS clinicians can also contextualise the confidentiality requirements placed upon doctors, advising police on how requests for health information should be framed and what information to include in a ‘form of words’ disclosure. This is also an act of translation between agencies. The Head of the Vulnerability Support Service, which oversees CT CCS, agreed that translation between professional worlds is an adequate description of the service, stating:

When I go and speak to colleagues from other agencies, I describe our service as a bubble of trust. So, what we have is CT police officers and clinic consultants who are vetted to the same level, we can sit in the office and we built up enough trust with each other and we can have sensitive conversations with each other about both of our agencies' information and collectively work out which bits are going to be valuable and how we might be able to share those through the appropriate channels. And then we can then go away to our own agencies and smooth out that whole disclosure process. So, it goes to the heart of a lot of the challenges that are highlighted [...] inquests about the fact that health don't always know what police want, because we don't always articulate it very well, which is why your translation analogy is excellent (Interview with Michael Nelson 2023).

While the analogy of translation may work well, it is questionable whether this translation work is an appropriate way for psychiatrists and psychologists to work with police. The law does require medics to share information with police when it would prevent serious crime – but is it professionally appropriate for mental health professionals to be conducting formulations for police and contributing, indirectly, to the management of Counter Terrorism Policing cases? This goes significantly beyond the good practice guidance produced by professional associations about the use of formulation, and beyond the sharing of information. Medical expertise is being deployed for a policing purpose, to analyse the role being played by mental illness in cases held by Counter Terrorism Policing – potentially reaching the threshold of co-option warned about by the Royal College of Psychiatrists in “pressured, hermetic law enforcement environments” (2016: 6) where a medic's professional values and objectives can merge with those imposed by other agencies.

5. Conclusion and recommendations

Intelligence Studies defines ‘intelligence’ as data which has been processed from its raw form to make it valuable to decisionmakers (Johnson 1986). This is called the ‘intelligence cycle’. Even the weather forecast can become ‘intelligence’ if it is packaged and presented in relation to a national security matter, such as the D-Day invasions. The conclusion of this briefing paper is that CT CCS is part of the intelligence cycle, processing the ‘raw data’ of medical diagnoses and police records into actionable intelligence for Counter Terrorism Policing officers. CT CCS refers to this as ‘formulation’ undertaken in a co-located unit – but this could just as easily be referred to as the involvement of medics in the production of actionable intelligence for the security services. Clearly, this raises questions about the appropriate scope of medical cooperation with policing.

Recommendations

- Parliament, the Information Commissioner’s Office, the Investigatory Powers Commissioner’s Office, and the General Medical Council should review whether CT CCS’s disclosure of surveillance information by national security agencies to NHS professionals is appropriate.
 - These reviews should also consider how independent oversight of the sharing of medical information with Counter Terrorism Policing should take place – as very few cases pose an immediate threat to the public, yet the public interest justification for sharing medical information without consent is used.
- Medical professional associations and the General Medical Council should review CT CCS, evaluating its:
 - Use of ‘formulation’, which is in contravention of the British Psychological Society’s guidelines on best practice
 - Contravention of guidance from the Royal College of Psychiatrists that psychiatrists should be careful about the effects of working in “pressured, hermetic law-enforcement environments”
 - Use of medical techniques to further the goals of policing in a police-owned service rather than to improve health

- Undermining of the NHS's commitment to person-centred care, as the application of psychological formulation is done without consent and CT CCS never meet the service user.

CT CCS (and its predecessor, Vulnerability Support Hubs) present themselves as safeguarding those with mental health conditions who have come to the attention of Counter Terrorism Policing. Their work does involve screening the subject to ascertain the level of contact with mental health services and, where necessary, making recommendations to increase this contact. But CT CCS also renders a patient's decision to discontinue treatment (which is their right) into actionable intelligence for Counter Terrorism Policing, through the use of 'tripwires' set up with frontline services. This introduces consequences for the decision to discontinue treatment, which is an imposition upon the individual's rights. Also concerning is the 'breaking out' of sensitive police information (including that obtained by the intelligence agencies) in a 'form of words' to GPs and responsible clinicians. Disclosures of security agencies' information to health professionals will have a significant impact on their professional judgement, may impact the doctor-patient relationship, and could influence a decision to undertake an assessment which leads to involuntary detention in hospital.

MPs, the Information Commissioner's Office, the Investigatory Powers Commissioner's Office, and the General Medical Council should undertake an evaluation of CT CCS in relation to the Mental Health Act, to ascertain whether the disclosure of surveillance information by national security agencies to NHS professionals is appropriate – or whether it prejudices the provisions of the act for fair and impartial assessment of an individual's state of mind. This evaluation should also consider whether the multidirectional information sharing between health professionals and CT CCS prejudices the right of individuals to discontinue medical treatment, given that it introduces potential police-led consequences for disengagement. Furthermore, the review should ascertain whether it is appropriate for police to obtain medical information under the public interest justification, when most of the cases dealt with by CT CCS do not involve threat to the public. At the very least, independent oversight should be established to regulate this process, given the very real considerations regarding privacy.

Finally, CT CCS's contravention of the British Psychological Society's guidelines (2011) on the use of formulation, and its clash with guidance from the Royal College of Psychiatrists (2016: 6) that psychiatrists should be careful about the effects of working in "pressured, hermetic law-enforcement environments" upon their professional ethics, should trigger a review of the service by medical professional associations and the General Medical Council. It is embedded within psychiatric and psychological ethics that

medical techniques should only be used to benefit the health of the service user – not to further the goals of policing, however well-intentioned these may be. Furthermore, there is a substantial tension between CT CCS and the commitment of the NHS to person-centred care which involves the service user in decisions made about their care. Everything CT CCS does is outside the realm of consent.

To conclude this report, it is appropriate to end with reflection on formulation and person-centred care. Professional medical associations and the NHS all emphasise person-centred care as a necessary and respectful relationship between health services and individuals, where nothing is imposed without discussion, co-production and consent. Commitments to person-centred care also influence the way psychological and psychiatric techniques, like formulation, can be applied: professional associations explicitly require the involvement of an individual within any formulation of their feelings, needs and behaviours. But CT CCS is owned by Counter Terrorism Policing, whose working methods and objectives are different. When investigating conspiracies and plots, Counter Terrorism Policing take the view that consensual engagement with a person of interest would be inappropriate and could derail investigations – because it would alert the subject that they are receiving police attention. It is no surprise that a service combining two different ways of working, with different cultures of engagement, different norms, different institutional missions, and different operating models, would experience a clash of norms during collaboration.

In CT CCS, we can clearly see the dominance of the police's operating model and assumptions – and the sidelining of contemporary health norms about person-centred care. The question posed to the participating NHS trusts, then, is whether it is appropriate to suspend norms of formulation and person-centred care when interacting with police. The majority of CT CCS's cases are early stage Prevent referrals or low-level concerns, rather than people convicted of terrorism-related offences and released under MAPPA supervision. Should a person lose their rights to consideration, to inclusion in formulations made about them, and their liberty to discontinue psychiatric medication, just because they appear on the radar of Counter Terrorism Policing for a Prevent referral? And if this is inappropriate for persons referred to Prevent, then is it also inappropriate for individuals being managed under Police-led Partnerships? And at what stage do we draw the line, and remove someone's rights to be involved in medical decisions – or formulations – made about them?

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Notes

- 1 In the absence of a service website which defines CT CCS's remit, I have copied this description from the email signature of a senior clinician working in CT CCS with their permission.
- 2 <https://www.find-tender.service.gov.uk/Notice/028360-2023>
- 3 STRAP is a codeword, used to indicate a level of security clearance. It has no meaning in and of itself. STRAP is combined with numerals, or the words 'SECRET' or TOP SECRET', to indicate levels of security clearance.

