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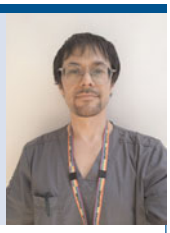
Editorial

Criminal sanctions for suicidality in the 21st Century UK



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Summary

Criminal sanctions including court orders, prosecution and imprisonment persist as responses to suicidality in the UK even where there is no public danger. Their prevalence, the level of clinical involvement and outcomes are unclear. There is an urgent need to examine the national picture of harms, benefits and the responsibilities of mental health professionals.

Keywords

Consent and capacity; self-harm; ethics; psychiatry and law; suicide.

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> *'The police arrested and prosecuted me when I was suicidal and afraid because I couldn't get the right help … In the 2 years since I received the right diagnosis, explanation and drug treatment … I have not tried to kill myself, I have not been brought back to the emergency department at all.'*[1]

The use of criminal sanctions for suicidality has been brought into the spotlight. A campaign group, the StopSIM Coalition, highlighted concerns about serenity integrated mentoring (SIM), a mental health intervention for people who had had previous police involvement in a mental health emergency, developed on the Isle of Wight and expanded to 23 NHS trusts in England with the support of the NHS Innovation Accelerator Programme.[2*]

SIM aims to reduce demand on emergency services by allocating a police officer 'mentor' taking the role of a mental health key worker for regular meetings. In the event of further emergency service call-outs, the SIM operational delivery guide includes a section titled 'Use of criminal and behavioural sanctions' and guidance on framing distress during psychiatric emergencies as a criminal offence, describing such distress as, '… behaviours that whilst not substantive offences in their own right, would be considered disorderly or antisocial for the purposes of any criminal or civil court order.'*

In response to the campaign, NHS England asked all mental health trusts to review use of SIM-type schemes in the summer of 2020. Professional bodies including the Royal College of Nursing and the Royal College of Psychiatrists expressed concern about the manner in which the model was promoted and spread, the lack of evaluation of benefits and harms, and the broader issue of criminal sanctions.[3,4]

The national picture

The full extent of the use of criminal sanctions as a response to suicidality in the UK is not monitored or reported. For understandable reasons, many patients who have been sanctioned, prosecuted or imprisoned are too ashamed to speak about what was done to them, or fearful of further sanctions for doing so. Psychiatrists have not gone on record to describe or explain the reasoning for such practices, and so a national picture tends to be built from local newspaper court reports and accounts from the few people who have been willing to discuss their experiences publicly. What we know from these sources, including prosecutions in both Scotland and England, is that the practice is more widespread than SIM, more longstanding and continues today. Bail conditions, antisocial behaviour orders, community protection notices and criminal behaviour orders are used to set conditions such as forbidding a person from disclosing that they are feeling suicidal, or requiring them to attend medical or mental health appointments.* If a person breaches such an order by asking for help when suicidal or by missing a clinic appointment, they can be arrested and potentially imprisoned.

Prosecution and imprisonment are also used as sanctions in response to self-harm and suicidality. Attempting suicide was decriminalised 60 years ago in England and Wales and 55 years ago in Northern Ireland. It is therefore necessary to construct an offence to secure a prosecution. Illustrative examples include charging a person with breach of the peace for causing alarm to a police officer by disclosing suicidal thoughts, criminal damage for dislodging fencing while jumping from a bridge, or wasting police time for calls made by healthcare staff to police.*

What is the evidence base?

The justification for criminal sanctions appears to be drawn from 20th Century behaviour modification theory. This 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 or through the application of punishment. These practices are not supported by research, are not recommended in 21st Century good practice guidance, and are contrary to international recommendations on decriminalising suicide.* They have potential to harm by increasing suicide rates, reducing access to treatment, and by criminalising and failing to protect victims of abuse. Given the lack of evidence of benefit, if we even accept the premise that criminal sanctions for suicidality have a

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place, they must not be used outwith a clinical trial setting subject to formal research ethics approval.

We have heard the practice justified on the basis that criminal sanctions are only used as a last resort, and only following extensive consultation and safeguards. In practice, this is not the case. The threshold for SIM schemes is as low as two s136 detentions. Outside SIM, people have been prosecuted for alleged offences related to being suicidal while on the waiting list for secondary care mental health treatment or while unable to access treatment for such treatable conditions as obsessive–compulsive disorder or depression.* Even as a last resort, suggesting imprisonment as a means of preventing calls to emergency services calls into question the duties and ethical standards of all professionals involved.

Responsibilities of mental health professionals

Police, psychiatrists and nurses as human beings may have shared values and standards of ethics. As professionals, however, we have different roles and responsibilities and these are reflected in our professional codes of conduct. The General Medical Council requires doctors to 'Make the care of your patient your first concern', to consider and to explain to patients the potential benefits, risks of harm, uncertainties about and likelihood of success of any proposed intervention. The Nursing and Midwifery Council reminds nurses to 'Prioritise people, practise effectively, preserve safety, promote professionalism and trust'. These fundamental principles and duties must be considered in relation to the use of criminal sanctions as an intervention for suicidality.

Conclusions

SIM did not invent the practice of criminally sanctioning suicidality through the use of court orders, prosecution and imprisonment; it assimilated and wrote down practices that are largely unwritten though remain widely accepted in the UK. The StopSIM campaign has highlighted the need for mental health professionals to consider our duties to patients and to openly examine and investigate current practices. The benefits and harms have not been investigated, and there is a need to develop clear standards for ethical oversight, evaluation and monitoring of outcomes. Any such research and development of standards must include those to whom this has been done, and who are living with the consequences. People who have been imprisoned or threatened with imprisonment in relation to suicidality, and their carers, know the impact first hand. However, it is not within their power to change practice or address safety concerns; that responsibility lies with professionals. This is one aspect that must form part of a wider examination of models for emergency mental healthcare and the interface between policing and healthcare services in the 21st Century UK.[5]

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Supplementary material

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this editorial.

Author contributions

A.B.T. drafted the editorial. S.E., E.M. and A.M. helped develop and edit the article. All authors approved the final version.

Declaration of interest

A.B.T. is Vice Chair of the Royal College of Psychiatrists (RCPsych) Liaison Psychiatry Faculty Executive Committee and advised on the RCPsych statement in this capacity, and is a member of the National Institute for Health and Care Excellence Guidelines Committee on Self-harm. S.E. is a Royal College of Nursing (RCN) Expert Representative for Liaison Psychiatry and advised on the RCN statement in this capacity. E.M. is a member of the RCPsych Liaison Psychiatry Faculty Executive Committee and advised on the RCPsych statement in this capacity. A.M. is National Mental Health Lead for the British Medical Association Consultant Committee. The opinions expressed are those of the authors and do not necessarily reflect the views or position of any organization.

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5 Molodynski A, Puntis S, Mcallister E, Wheeler H, Cooper K. Supporting people in mental health crisis in 21st-century Britain. *BJPsych Bull* 2020; **44**: 231–2.

EXTRA CONTENT ONLINE

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