Transform Justice

Protecting the protectors? Do criminal sanctions reduce violence against police and NHS staff?

By Fionnuala Ratcliffe, Alexandra Kimmons and Penelope Gibbs

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Foreword

Society's growing concern about assaults on police, NHS workers and prison officers intensified as the covid-19 pandemic shone a light on the plight of key workers. There has been a groundswell of support from emergency workers, their representatives, and the public, for action to tackle the problem of violence meted out against them. The response from the government and the criminal justice system lays a clear emphasis on a punitive approach; a new offence and harsher penalties. For many this is perfectly logical; assault an emergency worker and you will almost certainly be charged and sanctioned. However, in its own impact assessment the government acknowledges that harsher sanctions will not prevent violence and abuse: **"the evidence of the existence and scale of any deterrent effects or incarceration effects is weak and mixed."**

This report takes a closer, evidence-based look at increased penalties for assaults against emergency workers and demonstrates the ineffectiveness of this approach on any level. In fact, it is simply likely to channel even more vulnerable people into a criminal justice system where they fare very badly. People with mental health vulnerabilities who are suspected of an offence are significantly more likely to be charged and spend longer in custody than other suspects in the same offence categories. Many if not most of these individuals have long-term, life affecting vulnerabilities that are poorly supported by current services and will not be addressed through prosecution and prison.

If the intention is to deal with the harm caused by an assault and prevent future occurrences, we need a different approach. The solutions have been on the table for many years. Lord Bradley's 2009 review led to the funding of a range of diversionary options for people with mental health vulnerabilities across all police forces – the most prominent being liaison and diversion services. But as we see in this report, these services are still underused, and their expertise overlooked in charging decisions, meaning mental health vulnerability continues to be criminalised.

Peer reviewed research has shown clearly that people who are diverted rather than charged go on to commit significantly fewer offences post diversion, including assaults. So why do we persist in pursuing the "does not work" option, especially since assaults appear to have increased rather decreased since harsher sanctions were introduced?

One reason is the political will to be seen to be tough on those who assault emergency workers regardless of their circumstances or the effectiveness of the sanctions. Not for the first time, this has overridden the evidence.

Poor training for most emergency workers in identifying and relating to those with mental health vulnerabilities is also key. This lack of training and awareness has been directly linked to situations escalating rather than being effectively managed by emergency workers, as one ambulance worker put it: **"risk assessment training could reduce incidents. Better understanding of mental health and how to look out for signs."**

Shortages in alternative services, such as mental health treatment, and difficulties accessing them are also factors. Without doubt, addressing these and other obvious gaps would be expensive, but that well-rehearsed and rather hackneyed argument should not be allowed to carry the day.

One other new initiative may offer an opportunity to reduce violence and abuse towards emergency workers without dragging more and more mentally vulnerable people into a dysfunctional criminal justice system. The move to a new out of court disposal framework in 2023 could offer the chance to put in place a standardised vulnerability assessment process and effective, specific diversion options, the use and impact of which is rigorously monitored. Only time will tell if this and other opportunities are taken but this report sets a clear agenda for this critical issue.

Treating vulnerable people effectively and humanely is hardly a new concept. Neither is offering safety at work to emergency service personnel. Counter to the political rhetoric, these aims aren't mutually exclusive. Rather than greater punishment for these offences, more fertile ground lies in effective diversion options, proper support and recognition for staff, and training to prevent these incidents happening in the first place.

Professor Eddie Kane,
Director of the Centre for Health and Justice
Institute of Mental Health, University of Nottingham

Executive summary

Of course no one should be assaulted while carrying out their work. But I do question whether prosecution really helps. It's expensive and time consuming and I don't know what it accomplishes. These aren't premeditated acts, after all. Instead, we should be looking at ways of de-escalating situations, and providing support to victims when needed. (magistrate)

Many emergency workers suffer violence from members of the public in the course of their work. Stories from police officers and A&E staff are particularly common, but such violence also affects staff on hospital wards and in specialist hospitals, as well as prison officers.

Those who employ or represent emergency workers, under pressure to deal with increasing assaults against staff, look to the criminal justice system as a solution. The government, jumping at the (seemingly cost-free) opportunity to signal support for public sector workers, introduced a new offence and harsher punishments for violence and abuse towards emergency workers in 2018, before making penalties harsher still in the Police, Crime, Sentencing and Courts Act this year. Since the offence was introduced, almost 130,000 assaults on emergency workers have been recorded (the vast majority of which were towards the police), and approximately 75,000 were brought to court.

It's easy to believe that a more punitive response will deter people from being violent and abusive towards emergency workers. But there is no evidence that harsher sanctions deter this sort of crime, and the government has denied any deterrent effect. Instead, the hike in prosecution and sentencing is having serious unintended consequences; sweeping more people into the criminal justice system, particularly those with mental health conditions, cognitive impairments or who are neurodivergent.

Lawyers told us that most assault on emergency worker court cases involve a defendant who is neurodivergent or has a mental health condition or cognitive impairment, and that this was often a relevant factor in the incident. In theory, the police, prosecution and court can take this into account, but lawyers told us this rarely happens. Defendants fall foul of the system's "hard line" stance on assaults on emergency worker offences, and the paucity of information available to police and prosecutors about the person's mental health. Existing tools for identifying mental health conditions at the police station are inadequate, meaning many mental health conditions are overlooked.

A universal mental health screening tool would help, as would better use of bespoke diversion courses and restorative justice.

There's plenty more employers can do to support victims of assault without resorting to the criminal justice system. They could start with responding more empathetically. NHS workers shared examples of when they felt their supervisor was blaming them; police officers were advised to **"suck it up"**. Staff who are assaulted want **"recognition, and some sort of remedy"**; employers can provide this through consistent debriefings, welfare plans, counselling and taking action to prevent incidents happening again.

Assaults on police are correlated with police use of force and perceived mental health status of the person committing the assault. There are serious shortcomings in police training for how to engage and communicate with people with mental health conditions. New conflict management guidance and training should hopefully improve this. But some police are reluctant to spend time improving how they respond to mental health incidents – they'd rather focus on solving crimes. Promising initiatives like street triage, which integrates the expertise of mental health professionals with the policing frontline, may present a good compromise, but no one has looked at whether these reduce violence and abuse towards officers.

Opportunities to prevent assaults happening in the first place exist in NHS settings as well. Mental health training for most NHS workers is basic, and one NHS worker said they knew nothing about how to de-escalate a situation that risked turning violent. There is room to improve training about physical contact with patients and members of the public. Elsewhere, Bedfordshire NHS Trust has introduced a uniformed police liaison officer on their ward – a controversial approach, but the move has reduced violence on the ward, and the officer has helped to design out crime by identifying incident hotspots and adapting staff shift patterns accordingly.

Harsher punishments will not deter people from violence and abuse. The number of assaults on emergency workers have actually increased as sentences have got harsher. If we want to reduce the harm caused by violence and abuse, employers can improve their support to victims, and give better training to staff to prevent incidents happening in the first place. Where a criminal justice response is necessary, we can make much better use of effective options for resolving the harm without going to court, such as diversion and restorative justice.

Methodology

Sources

The findings in this report are based on a literature review of recent research, reports and policy guidance relating to assaults on emergency workers, mental health and neurodivergence. We also surveyed police officers and NHS staff to understand more about their experience of violence and abuse in the workplace and their attitudes to how it was dealt with. This survey was open 21 June – 1 August 2021 and received 339 responses. Two further surveys gathered views of defence lawyers (122 responses) and people with mental health conditions, cognitive impairments and/or who are neurodivergent who had been accused of assaulting an emergency worker (12 responses). Seven follow-up interviews were conducted with police, NHS and lawyer respondents. This work was further informed by engagement with a wide range of stakeholders – a list of organisations is included in the appendix. We held a roundtable meeting of 13 stakeholders in December 2021 to gather feedback on early findings from the research. All quotations in this report are from our survey, interviews or roundtable unless otherwise stated.

A note on terminology

This report focuses on violence or abuse towards emergency workers by people with mental health conditions, cognitive impairments and/or who are neurodivergent. The definition of emergency worker in the 2018 Assault on Emergency Workers Act[1] covers those engaged in policing, prisons, fire search and rescue, and the NHS (including private healthcare workers providing NHS services). This engagement can be paid or unpaid, and includes people providing support or services to emergency workers who are not emergency workers themselves.[2] Police officers, NHS workers, prison officers and firefighters all work in vastly different contexts with different drivers of violence and abuse towards staff, requiring different solutions. We have therefore limited the scope of this research to violence and abuse towards police officers, including special constables, and NHS workers.[3]

We recognise that the experience of people with mental health conditions, neurodivergence, or cognitive impairments are different. We address them together in this paper because our initial research indicated that the response from organisations, police forces, and courts towards those who are neurodivergent or have a cognitive impairment or mental health difficulties is similar when accused of assaulting an emergency worker. For example, sentencing guidelines consider them together (while advocating for an individualistic approach). Our survey data also showed many cases in which someone accused of assaulting an emergency worker was identified as being both neurodivergent and having either mental health conditions or a cognitive impairment. Where a finding is specific to those who are neurodivergent or have a mental health condition or cognitive impairment, we specify as such.

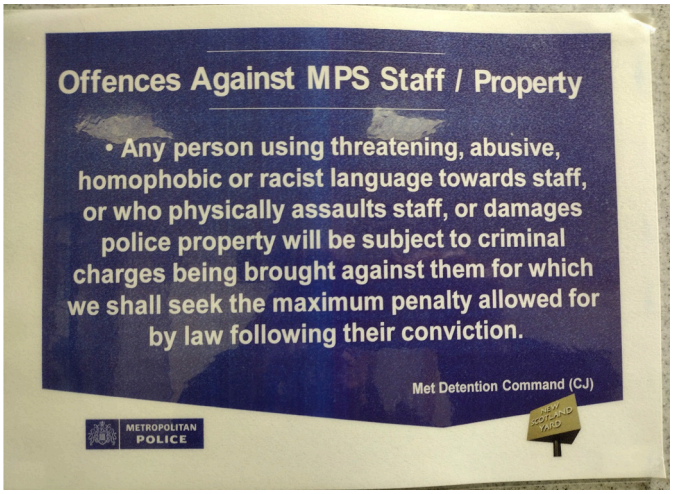
Introduction

Arrest of a male from home after a domestic incident. He swore at me, called me names such as "bitch" and racial insult. (police officer)

Patient with personality disorder threatened to throw acid on staff in an emergency department. (NHS worker)

Stalked for a period of 7 months by convicted sex offender. He stood outside my office window every day watching me, waited outside my car every evening, followed me on the grounds, told me that he loves me, told others that he was going to have a relationship with me. When I reported it, he began making implicit threats of sexual violence and violence towards me. (NHS worker)

I was in general hospital being treated for self-harm. Staff attempted to restrain me as they wanted to move me to a different room. They grabbed me by the knees and wrists. I was accused of hitting one of the staff although I don't remember doing it, I was just trying to get away.
(person accused of assaulting an emergency worker)



Poster in a London Metropolitan Police station

The problem of violence and abuse towards emergency workers

No one goes to work to be a punch-bag, particularly those trying to protect or care for their attackers. But in recent years, NHS, prison and police unions and employers have become increasingly concerned by the violence meted out to public sector workers by members of the public and by patients.

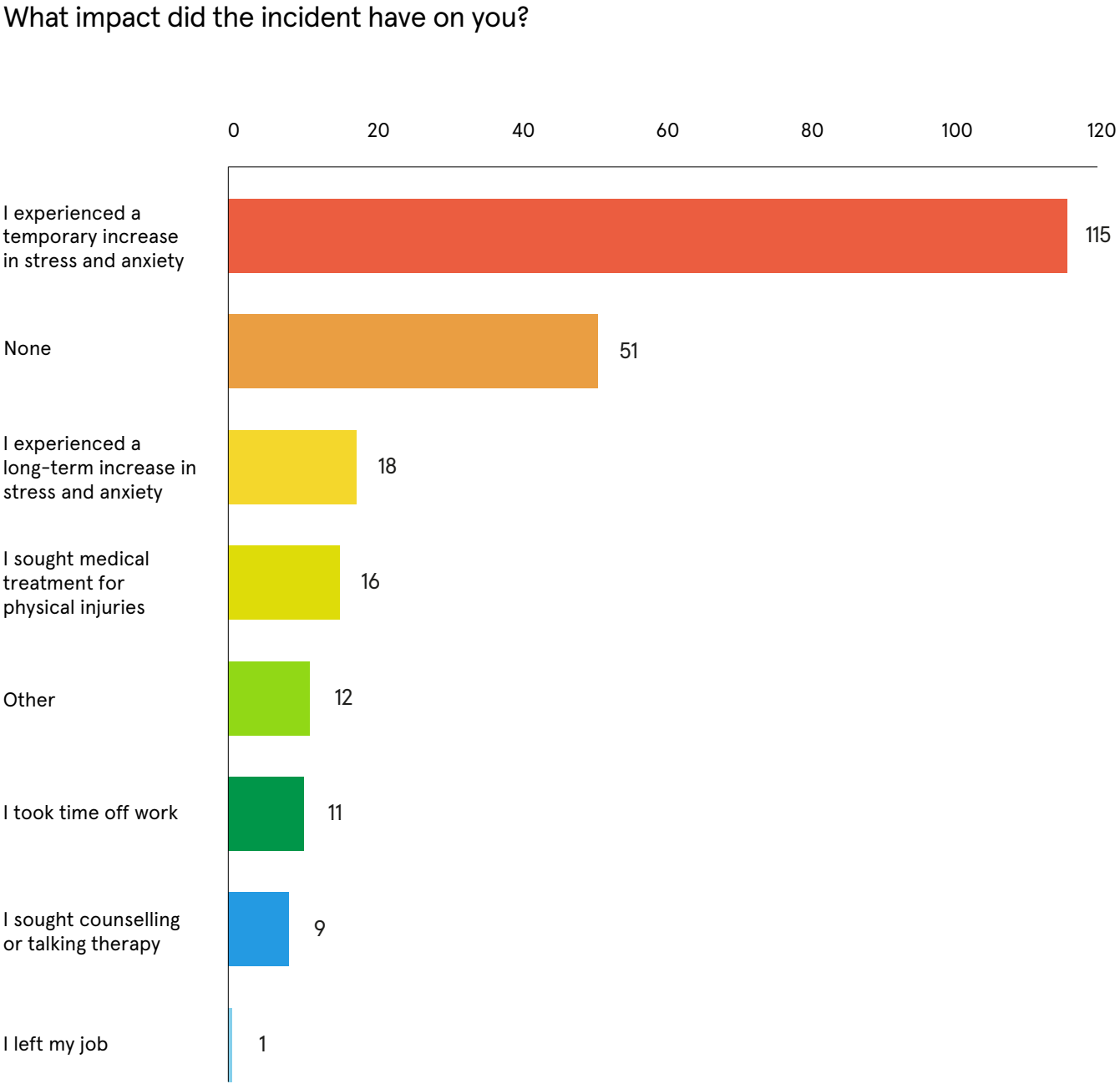
The violence and abuse suffered by health care staff and police ranges from being shouted at to serious physical assault and even murder. The death of PC Andrew Harper, who was dragged behind the car of some teenage suspects in 2019, has highlighted the dangers faced by police officers acting in the line of duty. The successful campaign of his widow Lissie Harper resulted in a government amendment to the Police, Crime, Sentencing and Courts Act – the introduction of mandatory life sentences for anyone convicted of killing an emergency worker whilst committing a crime.

The most common attacks on police and health workers are covered by a single offence – assault on emergency worker. This includes verbal threats, shoves, spitting and punching, where there are either no or minor visible physical injuries. Many police and NHS workers are the victims of more serious violence. They are kicked, headbutted, bitten, scratched and some are threatened with and/or wounded by knives. Others are subject to campaigns of harassment.

Any assault causes harm, but it can be particularly harmful if it is suffered in the line of duty, where there is no clear line of escape. An ambulance worker or police officer who is attacked can seldom simply walk away. We asked police officers and NHS workers about the personal impact of the most recent violence and abuse towards them (see figure 1). The most common response was "a temporary increase in stress and anxiety", but many said the incident had no impact. However 18 out of 339 said they that they had suffered a long-term increase in stress and anxiety and 16 said that they had to seek medical treatment.

Figure 1: Impact of most recent incident of violence and abuse on emergency workers (n=233)

Source: Transform Justice survey



Unions and employers are concerned that violence and abuse are not just problems for individuals but for the system as a whole. There is very little research on the cumulative effect of violence and abuse on morale and retention. But we heard of people moving roles, resigning or retiring early due to the violence and abuse they suffered.

Although minor, it was the last straw, I moved to a non-front line department. (police officer)

It took months of me reporting it to managers and senior staff for the behaviour to be recognised and is still not being taken seriously in many respects. The individual who was stalking me is being discharged to a location very close to my workplace, which is why I am changing jobs. (NHS worker)

Both unions and employers' organisations have looked to the criminal justice system to provide a solution – to punish individuals who commit violence and abuse, to deter such behaviour and to provide resolution and retribution for those harmed:

Being assaulted as a frontline worker, whether that's police, fire, health or prison, must not be tolerated and those who do so must feel the full weight of the criminal justice system come down on them. (John Apter, former national chair of the Police Federation for England and Wales)[4]

New and harsher sanctions

The criminal sanctions available to courts for assaults on emergency workers have changed in nature and scope due to successful campaigning by unions and employer groups. Until 2018, those who worked in the NHS and in prisons were protected by the criminal law as it applied to all citizens. If they were assaulted, their attacker could be charged with common assault, actual bodily harm, or grievous bodily harm depending on seriousness. Sentences could be increased if the victim was a public sector worker.[5]

Police officers could press for a different charge – assault police constable[6] – which was generally sentenced more harshly than common assault, though the same crime in every respect other than the victim. In the 2000s, health and prison service unions advocated for their members to be treated the same as police officers - for the creation of a new offence of assault emergency worker, in effect common assault against a police officer, healthcare worker, firefighter or prison officer.

There has also been a long-standing campaign led by the Police Federation to increase the punitiveness of the criminal sanctions for the offence of assaulting an emergency worker. NHS and other public sector unions supported this campaign on the basis that more punitive sanctions would deter abuse of emergency workers, and would signal society's support for emergency workers.

The campaign to increase criminal sanctions has had two successful phases. The first was led by Labour backbench MP Chris Bryant. He introduced a private members bill to create the offence of assault emergency worker, and increase the maximum penalty from six to twelve months imprisonment. This was soon adopted as government policy and the new penalties came into force in November 2018. With the wind blowing in their favour, the unions, again led by the Police Federation, campaigned for the penalties to be increased once more – to a maximum of two years imprisonment. A year after the previous sentence increase was implemented, before the impact was known, the Conservatives proposed the new increase in their 2019 manifesto. The new government then consulted a small number of organisations representing victims (no one else was allowed to respond) about the new proposals and said the majority of consultees were in favour. The results of the consultation were never published[7] but the measure was introduced as part of the Police, Crime, Sentencing and Courts bill. The measure sailed through both Houses of Parliament unopposed.[8]

We must recognise that our police officers and other emergency service personnel are on the front line day in, day out, often facing many things daily that ordinary members of the public would hope never to see once in their lives. That for decades police officers have "manned up" and internalised problems, because that was the culture, perhaps makes mental health pressures even more inevitable. (Baroness Brinton)

By means of increasing the maximum penalty for the assault of an emergency worker, we want to protect those who protect others. (Lord Wolfson)

The new legislation will mean that the maximum sentence for assaulting an emergency worker will be the same as for selling knives as weapons or slipping someone a date-rape drug[9], and that the maximum sentence for assault emergency worker will be four times that of common assault. There is no other offence where the maximum sentence in primary legislation differs according to the victim's job.

What difference will increased penalties make?

The government suggests the new penalty will increase the confidence of victims, their families and the general public in the justice system because **"the [new] sentence better reflects the harm caused."**[10]

Also that **"by increasing the maximum penalty for this offence, the justice system may be portrayed as reaffirming the social value of emergency workers by aiming to protect them."** However, citing US research, the government says the new measure is unlikely to put anyone off committing this or any other crime: **"the evidence of the existence and scale of any deterrent effects or incarceration effects is weak and mixed."**[11]

The government has estimated that the new, more punitive, sentence will disproportionately affect women - 29% of those currently convicted of assault on emergency worker are women (compared to 15% of those accused of common assault) – and Black people, who will be even more disproportionately affected (currently 8.8% of those convicted vs 3.3% in the population).[12] The average custodial sentence for this offence is longer for Black and Asian people than for White people. The government has no data on whether those convicted of this offence are disabled. Yet over two thirds of emergency workers are healthcare workers and a very high proportion of those they care for are disabled. So it seems inevitable that the new sentence powers will discriminate against disabled people.

Almost all common assault offences are heard in the magistrates' court. However the higher maximum sentence for assault emergency worker makes it a "triable either way" offence, meaning defendants can choose to be heard in the Crown Court. The chief inspector of the CPS recently raised concerns that this was leading to hundreds of defendants, often with mental health problems, appearing without a lawyer in a Crown Court trial:

Many people elect for trial in the Crown Court. So you have hundreds of these cases in the Crown Court, sometimes for serious matters, but often for spitting at a police officer, or maybe smacking a police officer. It is something that needs to be dealt with by the justice system, but it does not need a trial in the Crown Court, and often these people are self-representing. Often, they've got mental health issues, and it chokes up the system when you might have something much more serious—such as a rape—to deal with. (Andrew Cayley, chief inspector of the Crown Prosecution Inspectorate[13])

The chair of the Bar Council, Mark Fenhalls QC is also concerned that the increased maximum sentence will impede efforts to reduce the court backlog since Crown Court cases take longer and are subject to long delay:

If you were to ask, I suspect, every resident judge at a Crown court centre in England and Wales, "what effect has the decision to make assault on an emergency worker an electable either-way offence had on your lists?", it will have been to vastly increase the number of trials they have to deal with...The blunt reality is that, if it had stayed as a common assault with aggravating features..., thousands of cases which would have stayed in the magistrates' court and resulted in prison terms would not have put pressure on the Crown court backlog.[14]

Lawyers also worry that perverse financial incentives in the legal aid system will leave those accused of assault emergency worker without lawyers. These cases take a lot of time, and are often loss-making. If the case is sent to the Crown Court and the defendant pleads guilty or the trial cracks, lawyers will end up working at a loss. Solicitors say they regularly turn away clients accused of assault emergency worker because the legal aid payment will not cover the work involved. A lawyer tweeted about this:

Defendant clearly mentally unwell caught on camera assaulting a police officer. Remanded in custody and case committed to Crown Court. Put straight into healthcare wing of prison.

Two months later still in prison healthcare as there has been no available bed for his admission [to hospital]. Defendant has now served equivalent of highest likely sentence for this offence. CPS refuse to review without medical evidence. We can't get the medical evidence. This is an "elected" case so we will get the grand total of £330 fixed fee to sort out this mess. Have spent more time than this total fixed fee just making calls today.[15]

The gap between the time needed for an assault emergency worker case and the fee available has driven solicitors in London to recently announce they will stop taking these cases (and burglary), in protest against low legal aid rates.[16]

How many assaults on emergency workers are recorded and what are the outcomes?

The offence of assault emergency worker was introduced in 2018, and since then the number of prosecutions has been growing steadily – up to 17,043 prosecutions for assault emergency worker in 2021 (see figure 2). Combined with the older assault police offence, prosecutions rise to 22,460. By contrast, prosecutions for common assault (against members of the public) has decreased by almost 40% since 2018.

The vast majority (94%) of recorded assaults against emergency workers in the year ending March 2021 were towards police officers, rather than other emergency workers, indicating either police officers were more likely to report assaults, and/or they were assaulted more often.[17]

The difference in charging rates between common assault and assault on emergency worker is stark (see figure 3). On average there is no further action in 85% of common assaults, compared to 40% of assaults on non police emergency workers and 23% of assaults on police.[18] Assaults on police officers (with or without injury) have some of the highest charge rates of any crime (see figure 4).

Figure 2: Prosecutions of assaults on police/emergency workers over time

Source: Ministry of Justice criminal justice system statistics, outcomes by offence tool

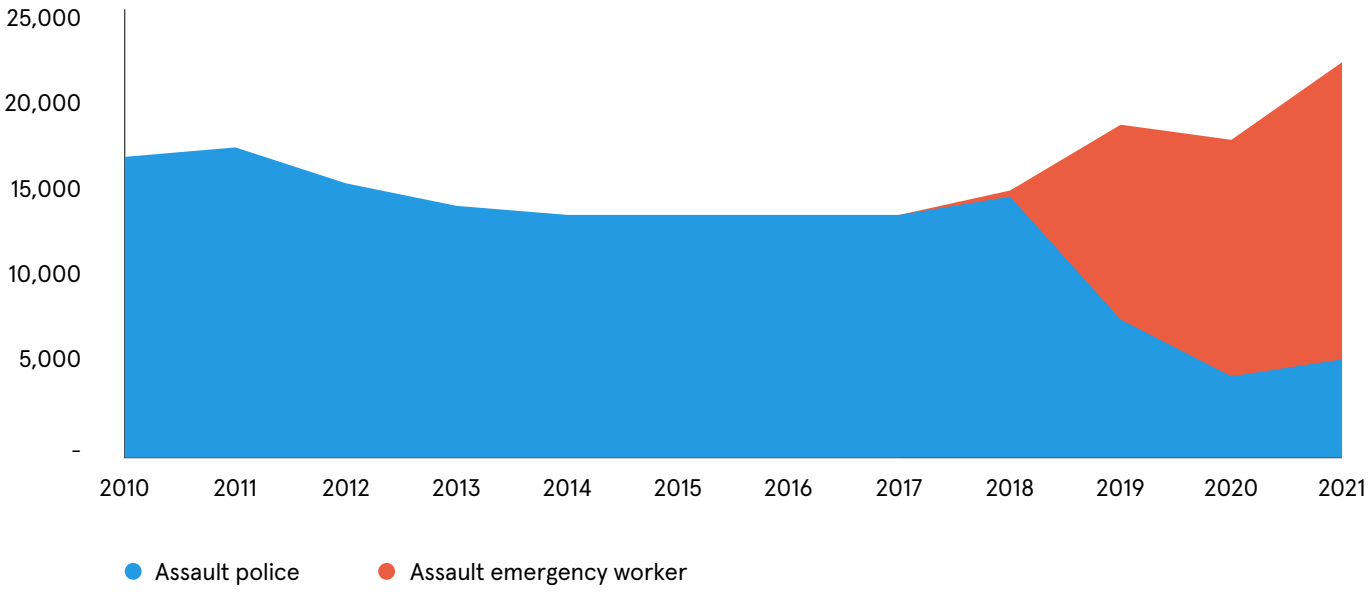


Figure 3: Police outcomes for assaults year ending March 2021

Source: Police recorded crime and outcomes open data tables

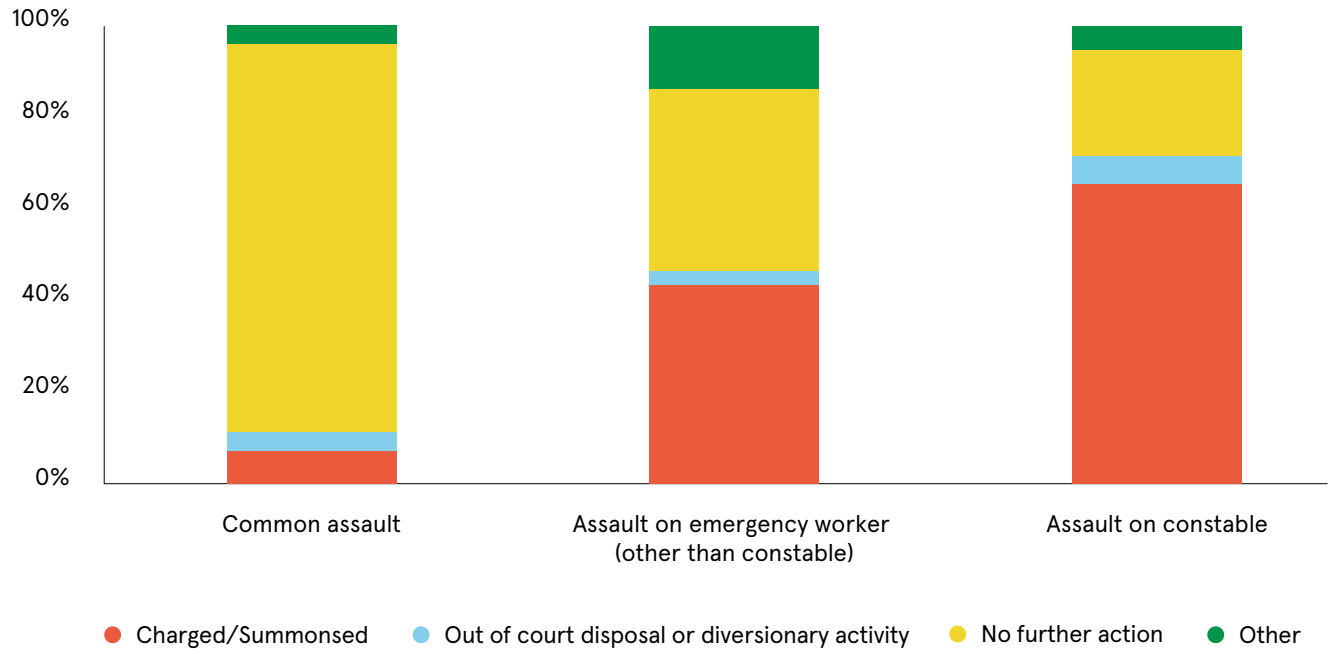
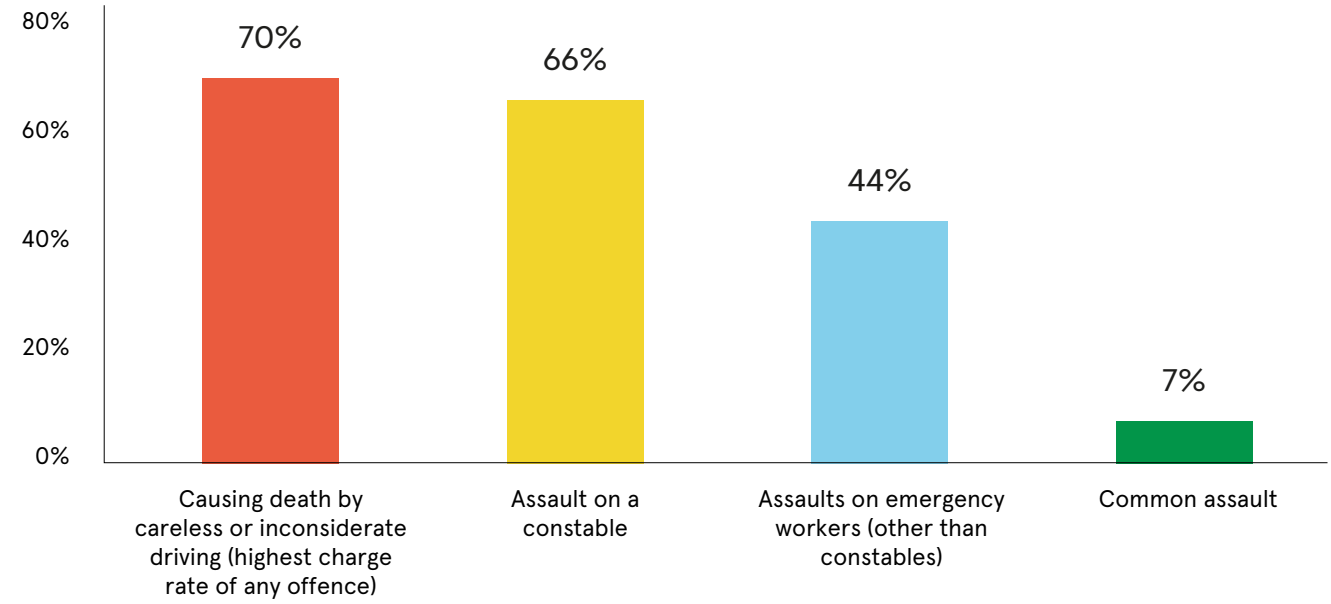


Figure 4: Charge rates for year ending March 2021

Source: Police recorded crime and outcomes open data tables



Lawyers we spoke to questioned the value of prosecution in many of these cases:

I have so many examples of the most minor assaults against PCs involving vulnerable defendants that clog up the mags and Crown Court. Slight jostle on arrest, poking a utility belt, a head jerk that gets called an "attempted head butt". Assault EW on PCs is probably the most overcharged offence in my experience so far. Complicated by the fact that the defendants are normally both drunk/high AND suffering from MH issues. (criminal barrister)

I had a case of a man with long-term schizophrenia who was basically institutionalised. He'd never been out of mental health hospital since he was 14, and he's now in his thirties. He was being escorted somewhere and got aggressive; spat at one nurse, headbutted another. The doctor felt he was aware of what he was doing and the hospital decided to prosecute. It was essentially a futile exercise. The guy was found not fit to plead initially, and wasn't well enough to attend his hearing. The judge put pressure on the prosecutor to withdraw, but because it was an assault emergency worker case the CPS chose not to. It wasn't in the public interest to prosecute. He was mentally ill, he was on severe restrictions anyway, he hadn't left the hospital, and I expect it compounded his condition. He ended up being given a hospital order, meaning the court sent him to hospital for treatment rather than give a punishment. (defence lawyer)

Trends in sentencing are hard to track due to the significant changes in primary legislation. Currently 86% of those convicted of assaulting a police officer are dealt with by a fine or a conditional/absolute discharge (see figure 5). The most commonly used sanctions for assaults against emergency workers (which includes police officers too) is the community sentence. Presumably a greater proportion of the latter involve injuries and are thus considered more serious. Of those convicted, 3% of police assaults and 32% emergency worker assaults are sentenced to suspended or immediate custody. The average custodial sentence in 2021 was 3.1 months, though the MOJ's own impact assessment expects this to rise to four months as a result of the increased maximum sentence.

A teenager dies behind bars: why was she there in the first place?

18-year-old Annelise Sanderson was sent to prison for 52 weeks after drunkenly stealing a pair of trainers, then lashing out at emergency workers during her arrest.

Anneliese appeared at Wigan and Leigh magistrates' court on 26 June, where she admitted stealing a pair of trainers from Asda, damaging a foil blanket provided by the emergency services and assaulting two police officers and a paramedic.

Annelise had travelled to the town "with a peer and got extremely intoxicated" before lashing out at emergency workers who tried to intervene. The local authority said she had "poured petrol on herself and tried to drink it". She had no formal mental health diagnosis but had briefly engaged with NHS mental health services as a child.

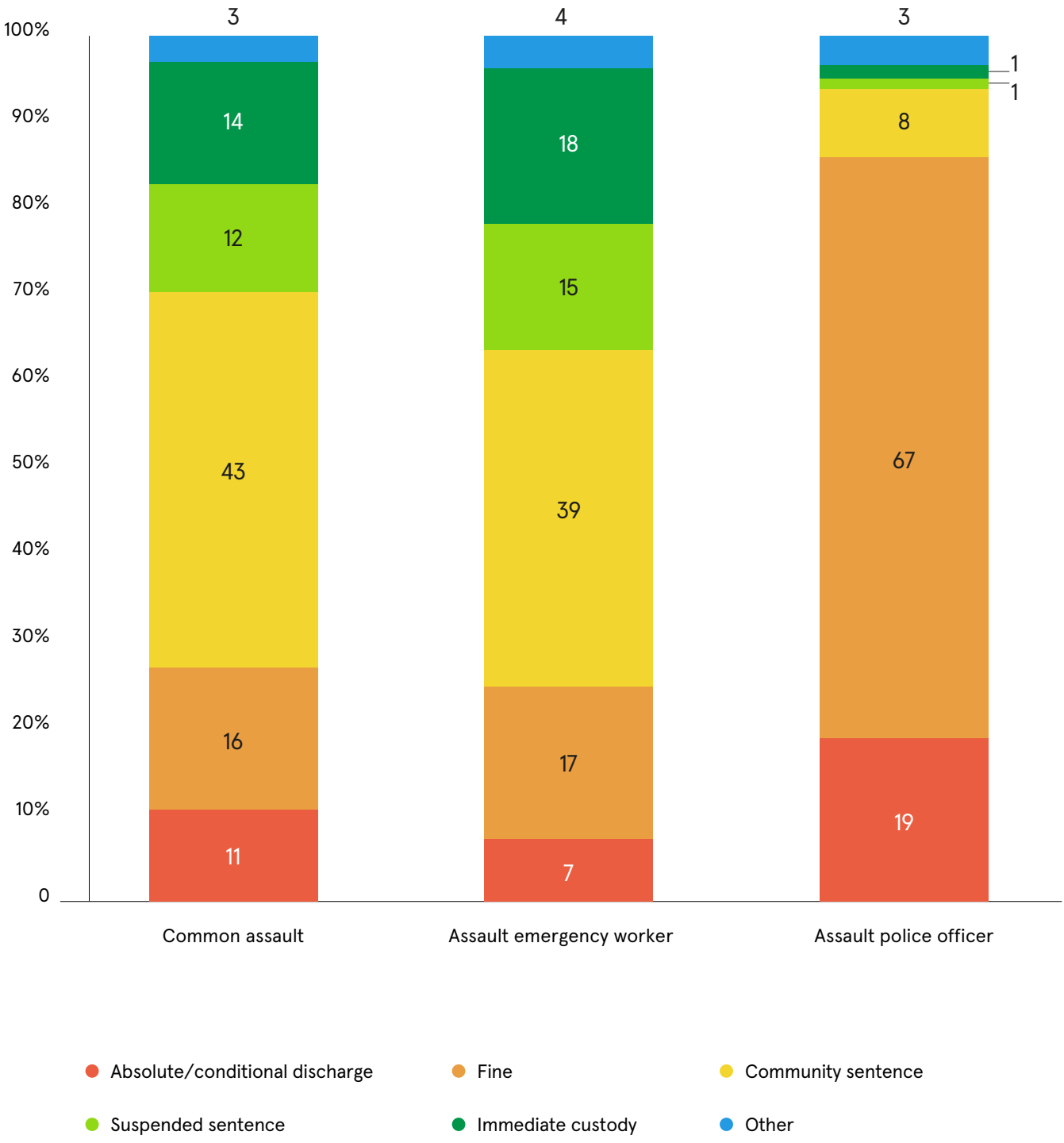
Magistrates, noting Annelise's previous convictions, including a suspended sentence for assault, using abusive words, and damaging a door in the care home where she was living, activated the suspended sentence and handed her a 12-month jail term.

When she arrived at the prison, staff noted she was acting "strangely". Records show she had reported being depressed and had previously attempted suicide. She was given suicide and self-harm prevention measures for a short time, but was not referred to a psychologist or psychiatrist. In December Annelise had another four weeks added to her sentence for an assault offence that occurred before she was first jailed.

The news she would be staying behind bars over the festive period came as a devastating blow. On 22 December, she was found dead in her cell in a suspected suicide. She is believed to have hanged herself as her cellmate slept.[19]

Figure 5: Court outcomes for assaults year ending December 2021

Source: Ministry of Justice criminal justice system statistics, outcomes by offence tool



What's mental health got to do with it?

I don't think the prosecution gave it the thought that they should. They still opened the case, and still put forward submissions to the court that made no allowances for his autism...I think they have a positive prosecution policy when it involves public sector workers. I think they're bound by that even when there is a mental health issue.
(defence lawyer)

The police seem to take no account of the mental health of suspects when making a charging decision. Further if the matter is referred to the Crown Prosecution Service to decide on a charge, they seem to omit to advise the CPS of the mental health issues. (defence lawyer)

Mental health in assault emergency worker cases – overlooked or overplayed?

We don't know what proportion of assaults on emergency workers are committed by people with mental health conditions, cognitive impairments and/or who are neurodivergent (although we can estimate – see box). We also know little about how such conditions are factored into decision-making about how to deal with the assault.

Lawyers told us that the person's mental health was a relevant factor in many assault on emergency worker cases. Sentencers are guided to consider the person's mental health at the time and (perhaps) reduce the severity of the sentence accordingly.[20] But the overwhelming majority of lawyers we surveyed felt that prosecution was not in the public interest, and that the mental health of the defendant was glossed over by the police and prosecution who were keen to charge and prosecute.

The police can downgrade the seriousness of an assault if they believe the person is, or was at the time, suffering from **"significant mental ill-health"** or has **"a mental disorder or learning disability, where linked to commission of the offence".**[21] Officers must judge each case individually, bearing in mind that **"generally the more serious the alleged offence, the less relevant someone's mental health problems to the police or CPS decision to prosecute."**[22]

Prosecutors, meanwhile, are advised that **"mental or physical ill health accordingly does not determine that no charge may follow"** and that **"there are a very wide range of mental health conditions and developmental disorders, and each will impact on individuals in different ways. The fact that someone has a mental health disorder or condition may be relevant to the offence, but it may not."** They are instructed to assess the public interest of prosecution based on **"(i) whether the suspect is or was affected by a significant health issue and (ii) balancing that with seriousness, re-offending and safeguarding as relevant factors."** Our evidence suggests that (ii) often overrides (i).[23]

Lawyers in our survey were critical of the CPS' lack of flexibility in charging and pursuing prosecution. They felt that the CPS took a particularly hard line with these offences (much more so than with common assault), even when it was clear that the mental health conditions or neurodivergence of the accused had contributed to their behaviour. They complained that the CPS would not drop charges, even where new information on mental health issues was revealed.

Assault emergency worker is an offence the CPS is swift to charge and slow to review, regardless of the circumstances or state of the evidence. (defence lawyer)

I have found that there appears to be a blanket policy within the CPS that assaults on emergency workers must be prosecuted; even for low level matters which would ordinarily attract a fine if convicted. (defence lawyer)

Judges could be hard line too: **"There's one district judge that even with mental health difficulties if they've spat at a police officer, and it's charged as assault emergency worker, they'll get a prison sentence...So there's a real issue here as to how much weight the courts are giving mental health in terms of these charges."** (defence lawyer)

But some emergency workers say the opposite. The union for ambulance workers cites **"widespread frustration that police forces and the Crown Prosecution Service can be reluctant to initiate proceedings against assailants with a mental health condition...One representative comment was that 'people with mental health problems can seemingly attack us all they want'."**

An NHS manager responding to our survey said: **"Many, many times over the years the police decline to become involved if the person behaving in a violent or abusive manner has any history of mental health issues."** So the NHS blames police for not charging and police officers blame their own colleagues or the CPS for the same thing. And unions and police officers blame judges for giving sentences which are too lenient.

What proportion of people assaulting police and NHS workers have mental health problems or are neurodivergent?

We know that people with cognitive impairments, mental health conditions or who are neurodivergent are overrepresented in the criminal justice system. Between a quarter and two fifths of adults in police custody have a mental disorder, psychosis, major depression or learning disability.[24, 25] NICE estimates that around 40% of people detained in police custody have a mental health condition.[26]

Given the circumstances in which assaults on emergency workers happen, the figure will undoubtedly be higher amongst those accused of this offence. Some lawyers told us that the majority of their clients prosecuted for assaults on emergency workers had some sort of mental health issue or neurodivergence. One solicitor who regularly worked on these cases estimated 80-90% involved a defendant with mental ill-health or who was neurodivergent. We have no definitive answer, but we estimate that two thirds to three quarters of those accused of assaulting emergency workers have mental health problems – above the average proportion in police custody, and significantly higher than that in the general population.

Are mental health conditions properly identified and accounted for?

One of the problems we've had is getting that information. When you're making a public interest decision, you need as much information as you can get. But if he's not coming forward, you have to make a decision based upon the information you have. (prosecutor)

Are police officers and prosecutors equipped to judge whether someone has a mental health problem, cognitive impairment or is neurodivergent? A recent inspection report on mental health and criminal justice says not. It described a criminal justice system that overlooks mental health conditions at every stage: **"Police officers whose primary role it is to investigate offences had received little specific input on the mental health of suspects and how this may affect decision-making."**[27] A report by the National Appropriate Adult Network found that police were under-identifying mental vulnerabilities amongst suspects in police custody. In 2018/19, 6% of suspects were recorded as mentally vulnerable (and thus needing an appropriate adult), much less than the estimated prevalence (in the region of 22% to 39%).[28]

The police are not mental health professionals, so it's not surprising that they aren't recognising many mental health conditions. Police could be better trained in how to identify mental health issues and disabilities, although this is not an easy fix at the scale required.

Liaison and diversion services (L&D) are now present in all police forces and should be helping to reduce the criminalisation of people with mental health vulnerabilities. L&D service providers conduct a health needs assessment of suspects in police custody which is supposed to inform, amongst other things, the police officer's decision on diversion and charging. However, they don't assess everyone – only those the police think require it – and they're not in custody 24/7.

The joint inspection also found that police rarely sought out their expertise anyway: **"All forces had L&D practitioners based in custody and we were surprised how few officers considered these to be an available source of advice in relation to their cases."**[29]

Professor Eddie Kane found that police officers were reluctant to heed the advice of health professionals who advocated for a lower level response (such as a diversion rather than charge). Officers worried that the buck stops with them if the person is diverted and something goes wrong, even when mental health professionals had advised against further police action, or where alternatives to detention and charge had been identified.[30]

A more transparent, trusted system for identifying mental health conditions and factoring them into criminal justice decision-making could help build trust in police decisions and ensure police and CPS thoroughly consider mental health factors in deciding whether to charge. One way to do this would be to have better mental health screening tools in police custody (see box). This would support police officers who are trying to decide whether someone's mental health state at the time is "relevant to the offence". A simple screening tool provides an audit trail showing how mental health was considered as part of the charging decision-making process. If the police decide to divert, the tool provides evidence of why this decision was appropriate.

Screening tools for mental health conditions, cognitive impairments and neurodivergence

Screening is a process that can be carried out by non-health specialists such as police officers to quickly determine whether someone should be referred for further assessment. A recent review of neurodiversity in the criminal justice system found a mixed bag of screening tools and too much reliance on individuals to identify mental health needs.[31]

The review recommended the introduction of a "common screening tool for universal use within the criminal justice system". This would provide a simple, reliable way for police officers to identify who should be referred to a health professional for a full assessment and diagnosis.

Thames Valley police force is looking at how it can equip police officers with better information about a person's mental health. The area's L&D service (who have their own screening tool) are not in custody 24/7. And existing screening tools don't include all mental health conditions, cognitive conditions or neurodivergence. A new screening tool, suitable for police officers to use, would provide a routine and reliable way to identify mental health conditions and neurodivergence, and give the police more confidence that they're making the right decisions.

How should employers respond to violence towards staff?

Image from University Hospital Southampton's No Excuse for Abuse campaign

At the moment, employers of emergency workers look to the criminal justice system to respond to assaults on their staff. Campaigns like Protect the Protectors[32] by the Police Federation and No Excuse For Abuse[33] by the NHS argue for a stronger criminal justice response to assaults. But our research suggests there is scope for employers to improve their own response to violence towards staff without resorting to the criminal justice system.

"Nobody did anything for 18 months"; how employer support falls short

A member of staff approached me on the ward to say that he had been involved in an accident and wasn't injured, but his shoes were ruined, and his clothes were ruined. And he put in a claim form. And nobody had done anything about it for over 18 months…I was very angry about it for him because he's been sitting harbouring this. He was just so pleased to get the money within a week, and a letter of apology which he should have got 18 months earlier. (NHS executive director)

Although police and NHS workers experienced similar kinds of violence and abuse, our survey found big differences in how happy staff were with their organisation's response (see figure 6).

Broadmoor forensic hospital staff were happiest – more than two thirds felt the incident had been appropriately handled/resolved by their employer, the police and/or the courts. This compared to just over a quarter of general NHS workers (although many were unsure), and about half of police officer respondents.

Both the NHS and police have a policy for all victims of assault to have a debriefing with their manager to talk through what happened and consider referral to other support services. Our survey respondents said this debrief didn't always happen: **"Did not get a de-brief or formal support for my first time assaulted."** (police officer)

NHS respondents reported waiting several days or even a few weeks for a full debrief. Sometimes delays are designed to allow victims time to process events before reliving them. But if staff don't know the reason behind this delay, it can feel as if their experience is not being taken seriously. Some NHS staff also feel that they are blamed if an incident of violence or abuse occurs, and that the needs of the patient who has been abusive are prioritised over their needs as a victim:

I have witnessed so many staff being blamed and criticised by other staff and managers following assaults and abuse, with the staff member being held responsible for the service user's actions. (NHS worker)

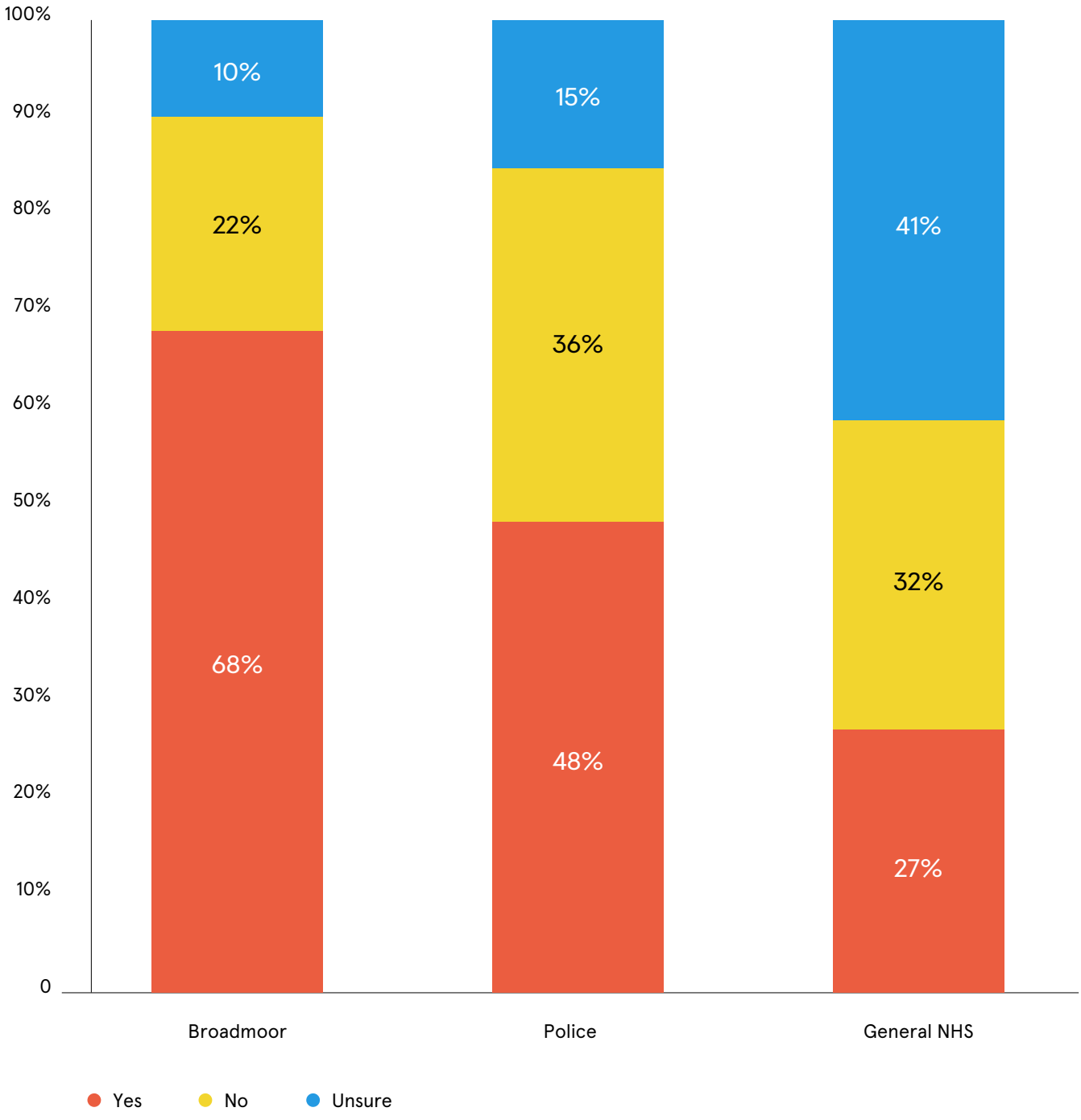
Meanwhile police officers were unhappy with the support provided by their force or supervising officer. Some were made to feel assaults were something to put up with:

Being abused and assaulted is seen as part of the job by command team officers. Multiple promises are made to help and support officers, but our experience is that they are empty words. (police officer)

…it's glossed over and brushed under the carpet and expected to just get on with my job and like a senior manager stated in a recent well-being briefing "suck it up". (police officer)

Figure 6: Views on how respondents' most recent incident of violence or abuse was handled (n=170)

Source: Transform Justice survey



While many police officers felt their force supported them in charging and prosecuting a case, other kinds of support were less reliable. Some highlighted a lack of sensitivity around the emotional impact of assaults. National surveys have found that 65% of police officers felt that the impact of trauma was not well managed in their force[34], and that only 17% of officers said that their supervisor had mentioned or helped develop a plan to support their welfare after an assault.[35]

"I don't want to be put in that situation again" – Stuart's story

Stuart, a police officer, was assaulted at a hospital by someone with poor mental health. During the incident, other officers behaved aggressively and caused the situation to turn violent, resulting in Stuart being assaulted. Afterwards, Stuart experienced post-traumatic stress. He asked not to be teamed up with those officers again and supervisors initially agreed, but a few months later he attended a similar incident with the same officers. The other officers escalated the situation again and Stuart ended up using excessive force because of his post-traumatic stress. This resulted in a four-month disciplinary process. Stuart feels this could have been avoided if supervisors had followed through with their agreement and given him time to recover:

I specifically said to supervisors that I did not want to be crewed with said officers, because they are causing me anxiety, they've caused me to have this breakdown because they've escalated a situation. I don't want to be put in that situation again, until I can have a chance to reflect, go through counselling et cetera for maybe a couple of months. They were like "yeah, fine" and then that just dropped off.

"I'm the victim in this" – Katherine's story

Katherine, an NHS worker specialising in forensic psychiatry, was stalked by a psychiatric patient for several months. This made her feel very unsafe. She reported the behaviour internally, but nothing was done to address the patient's stalking. The situation escalated when the patient falsely accused Katherine of inappropriate behaviour. Police became involved and it was only when they pointed out that Katherine was in fact the victim that the organisation began to take her concerns seriously.

I felt no one was assessing it. And I kept saying, this is the stalking assessment that we should be using. I can't do it because I'm not impartial. I'm the victim in this. But no one was sort of taking that forward.

Katherine had previously been harassed by a patient at another hospital, but that organisation recognised the risk and responded accordingly, which put an end to the problem.

It never impacted me because the organisation was just so supportive, I sort of just felt completely safe, because I felt like this is why these people are in forensics, because they're risky to others. And it's nothing personal to me...he's just very unwell.

Different approaches to criminal justice involvement

There are also big differences in how organisations deal with assaults on staff. The majority of recorded assaults on police resulted in the alleged attacker being arrested, with just under half of those going on to be prosecuted. The police say there is no positive charge policy in place for assaults on officers. They explain the higher charge rate (as compared to non-police assaults) as down to greater use of body worn cameras and professional witness statements from colleagues, which makes it easier to obtain the evidence needed to charge. And to the fact that some suspects accused of assaulting an emergency worker are already being arrested for another crime anyway.

If the evidence is there, and it reaches the evidential and public interest test, we will refer it to the CPS or charge ourselves…because of our role and what we deal with on a daily basis, we can look at the evidence more matter of factly rather than with an empathetic eye sometimes… when a police officer is assaulted, or an emergency worker in a setting with CCTV, we've got body worn video, we've got professional witness statements, the chances are we're going to get a charge on that. Whereas if it's a member of the public and it's one word against the other with no corroborating evidence such as CCTV or an independent witness & the assault is of a lower level, it's highly likely this would not reach the threshold to charge.
(police detective sergeant)

However, some force policies seem to favour prosecution as the preferred outcome, whether or not the alleged victim feels strongly about going to court. One local force policy says that **"If legal, arrest should always be the preferred outcome"** and outlines how officers can make the best case for prosecution. No mention is made of what should or could be done differently in cases where the alleged attacker has poor mental health or is neurodivergent.[36]

And even where forces have a strong diversion culture, this can sometimes go out the window when it comes to assaults on police – the pressure is to charge.

The response of NHS employers to violence against its staff focuses more on supporting staff who have been assaulted. Managers offer to involve police, but it's not a given:

I think generally, staff are looking for support, from the line manager, from the team, perhaps…and some police involvement, although some people do not want to pursue things…And I think that has to be very carefully managed. But I think broadly [staff are] looking for recognition and some sort of remedy. (NHS executive director)

The NHS also has various ways of responding to assaults internally without involving the police. NHS representatives we spoke to felt confident that, if a case involving mental health, neurodivergence, or a cognitive impairment did reach the stage of police involvement, it would have been through a lot of internal steps and processes first.

For example, unacceptable behaviour letters are formal warnings for patients whose behaviour is seen as abusive or violent. The premise behind these letters is that they can help enforce boundaries and show patients that unacceptable behaviour will not be tolerated. They also state that the trust will support prosecution if the behaviour continues.

Although there is no evidence these letters make a difference to behaviour of patients who are abusive or violent, they do reassure staff that their experience has been formally recognised and that their employer is willing to support them.

Operation Cavell

According to our survey, less than half of recorded incidents of violence or abuse against NHS staff by people with mental health difficulties were reported to the police and only a very small number of suspects were ultimately arrested or interviewed. But a new police-led programme is trying to increase prosecutions of people who assault NHS workers.

Operation Cavell began in Sussex where it aimed to increase prosecutions of assaults in a forensic mental health hospital (a hospital that specialises in treating people who have mental health conditions and have been convicted of a crime). It has since expanded to cover all NHS settings. The initiative dedicates more police resource to assaults on healthcare staff, for example having a senior police officer review all reports of assaults, and holding regular meetings to review case progression. The approach was trialled in London where it drove up the charge rate for assaults on NHS staff to 26% and increased the number of staff willing to support police investigation of assaults.[37] The scheme is now being expanded across London.[38]

Such schemes may make staff feel that their experiences are being taken seriously, but it's questionable whether increasing convictions is a useful end in itself. There's no evidence it works to deter violence or abuse, and a criminal justice response can do more harm than good, particularly in cases involving people with mental health conditions, cognitive impairments or who are neurodivergent. Our survey respondents highlighted ways employers could support them outside the criminal justice system.

Lessons to learn from forensic mental health settings

NHS staff from Broadmoor mental health hospital who responded to our survey were significantly more satisfied with their organisation's response to incidents than both general NHS staff and police.

This may be because staff and supervisors in a forensic mental health setting are more prepared for the possibility of violence or abuse and therefore have better systems in place to respond. Employers acknowledge the likelihood of violence and abuse and focus on managing that risk through training and equipment, such as personal safety alarms.

There is a foreseeable risk of violence and aggression within NHS settings. These risks are present in all healthcare environments but within Learning Disabilities and Mental Health Services, this risk may be increased, due to the nature of patient's health issues. (Leicestershire NHS violence prevention and reduction policy)[39]

The ongoing care staff provide to patients in a forensic mental health setting also explains why staff there are more satisfied by their employer's response. Unlike other NHS settings such as A&E, forensic mental health hospitals have long-term relationships with patients. Staff get to know patients over time and understand the reasons for their behaviour. They are also able to make changes to the patient's care plans and risk assessments. Several Broadmoor staff felt that recording an incident and making such adjustments was a sufficient response to an assault.

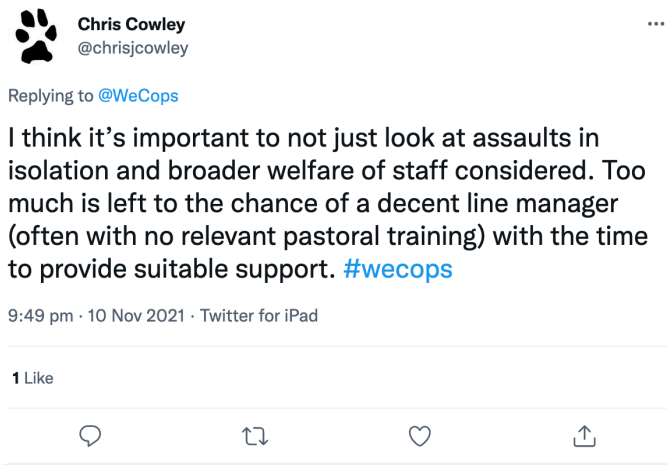
The person was seen by police but no further action taken; in the circumstances I think that was sufficient to log the incident and contribute to the data on his level of risk. (Broadmoor hospital staff member)

However, ongoing relationships with patients can make things complicated if violence or abuse persists or becomes serious enough to warrant police intervention. Police ask doctors if their own patients should be prosecuted. Some psychiatrists feel this should not be their call.

How can employers reduce the harm caused by violence and abuse towards staff?

I spoke to my manager and we had a laugh about it but it was never formally recorded. I was just told "welcome to the ambulance service". (ambulance worker)

Risk assessment training could reduce incidents. Better understanding of MH and how to look out for signs. (ambulance worker)



Many police and NHS workers told us they were dissatisfied with their organisation's response to violence and abuse towards them. What can employers do to improve satisfaction and reduce harm?

- Inform healthcare workers of all the steps taken following an assault, including the recording of abusive and/or violent behaviour on a patient's notes. This demonstrates to staff that their experience has been recognised and is being addressed.
- Make sure check-ins and debriefs actually happen, in a timely manner, and that the victim is notified of the reasons for any delay.
- Train supervisors to respond sensitively to colleagues who have experienced assaults, to offer flexible support and to follow through on any promises given.
- Put less pressure on police who are assaulted to take the criminal justice route. Many officers want support dealing with the impact of an assault, but may not want to formally report it or see the person prosecuted. As with any crime, the victim should be given the agency to decide whether to participate in a criminal justice process. Provide more information to assaulted police officers about options that don't involve charging the alleged attacker. And make sure wellbeing support is available to officers even if they did not formally report the assault.

If employers work on their internal response to incidents, they can improve staff satisfaction and reduce reliance on the criminal justice system, which often acts as a blunt instrument particularly for people with poor mental health or who are neurodivergent.

Does prosecution help? The case for diversion

We need to push more out of court disposals for low level assault EW but are prevented from doing so by senior officers...wanting to know why offender wasn't charged. (police officer)

We looked at assaults PCs in 2015 and for the one's that went to court, the average outcome was a £15 fine. It didn't really change anything for the offender or the victim. (police officer)

[Harsher sanctions] won't reduce [assaults on police and NHS workers]. Most assaults are in the moment. The sanctions need to leave the officers feeling supported after the event. (police officer)[40]

The purpose of prosecution is to punish, deter and/or rehabilitate the person who commits the offence. And to help resolve the harm done to the victim.

There is very little evidence that any criminal sanction deters crime, and no evidence that it deters assaults on emergency workers in particular. Someone who has committed a crime while in a mental health crisis or as a result of a cognitive condition or mental ill-health is particularly unlikely to be deterred. Deterrence only works if people weigh up the pros and cons of committing crime and make a rational decision not to take a particular course of action. Most assaults on emergency workers are not premeditated. They happen in the heat of the moment.

Criminal sanctions clearly punish, but it is questionable whether punishment in itself achieves any worthwhile outcome in these cases. Some victims of assault will feel that the harm caused to them deserves punishment, but others do not seek retribution (particularly those who work in mental health settings) and punishment is unlikely to relieve the pain caused. Many victims welcome financial compensation, but this can be achieved without prosecution.

Do criminal sanctions reduce assaults on emergency workers?

Some criminal sanctions are designed to be rehabilitative, but fines and absolute or conditional discharges are not. All evidence suggests short prison sentences (often used in these cases) are ineffective.[41] The only aspects of prison or community sentences which are rehabilitative are offender behaviour programmes and probation supervision. However, there are no prison or community programmes specifically designed to address the assault emergency worker offence, nor have they been designed for use by neurodivergent people and those with mental health issues. A community sentence can be accompanied by a mental health intervention (called a mental health treatment requirement) but these are rarely used. Many of those charged don't get a criminal sanction at all. Lawyers told us that many such defendants go on to either be acquitted, get a hospital order or have the case discontinued.

All our interviewees agreed that emergency workers should not be subject to violence and abuse by anyone, but the lawyers were sceptical that criminal sanctions were an effective or humane remedy in most assault cases. 37 of the 39 lawyers who had a view either way said they didn't think that it was in the public interest to prosecute in their most recent case:

Often client is in period of extreme distress (e.g. following suicide attempt) & assault committed while attempting to escape/flee intervening officers. Prosecution does little to deter future offending and does not address underlying causes (MH support, substance misuse, etc), and in many cases worsens situation for vulnerable clients who now have frightening court case and prospect of damaging criminal conviction for life, further hindering their recovery attempts. These kinds of clients are often unable to fully recall the incident/offending, leading to mistrust in CJS and little effect by way of rehabilitation.

One lawyer described someone with learning difficulties, personality disorder and post-traumatic stress disorder (PTSD):

Client was brought in an ambulance to hospital after an overdose/suicide attempt. Client spat on floor and a minute amount bounced off floor onto paramedics' protective trousers.

The man was charged with assaulting an emergency worker for this incident. Another charge was against a man with autism spectrum disorder who "bit the air" while being arrested, as described here by his father:

Rob thought that there were people in his house intent on killing him; police and ambulance were called. The arrest was forceful and painful: Rob's reaction was to lash out with an "air bite". He literally bit the air. For this he was charged with assault emergency worker – a breach of his suspended sentence which triggered him being sent to prison.[42]

In many cases defence lawyers use expert evidence to show that their client is not fit to plead, to persuade the prosecution the case is not in the public interest or to provide mitigation. In nearly all the cases cited to us by lawyers, they obtained expert psychiatric, psychological and/or neurological reports. Given the expense and difficulties in obtaining such reports, and the extra court hearings required, it is questionable whether prosecution is always in the public interest particularly when the assault has involved no physical injury.

Resolving crime without going to court

I've argued for diversion, multiple, multiple times, and had good grounds for diversion from the court system, and every time it gets rejected, which is disappointing, but also potentially very damaging to the health and recovery of the people caught up in this. (defence lawyer)

The case for diversion of those accused of assault emergency worker is in many cases strong, particularly for those who have mental health issues and/or are neurodivergent.

Diversion and out of court disposals can be rehabilitative and, in these days of court backlog, be a way to swiftly resolve the harm so that victims can move on. There are four main out of court options for dealing with the assaulting of a healthcare worker or a police officer:

- Caution. A simple or conditional caution is a formal criminal sanction which officially acknowledges the crime. A conditional caution involves the person who was violent or abusive agreeing to meet conditions such as completing a programme, paying compensation, or undertaking a restorative justice process in which they meet the person they harmed and agree how to make amends.

- Community resolution. This "on the street" sanction allows the person who committed the crime to agree to make amends in some way – for example by apologising or clearing up any damage done.

- Outcome 22. In cases where it is not in the public interest to take any more formal action, this option allows the police to record when they have referred someone voluntarily either to services, a course, or another type of intervention.

- Diversion from the criminal justice system. If the victim does not want to pursue a criminal justice route, the person alleged to have committed the crime might be diverted from the justice system altogether.

These options are hardly used for assaults on emergency workers – only 5% of assaults are dealt with via diversion or out of court disposals, compared to the 56% that go to court.[43]

One of the challenges in effectively diverting crimes of violence and abuse against police and NHS staff is that there are few programmes designed to deal with these crimes and even fewer which are designed to include those with mental health problems and who are neurodivergent. But there are green shoots. Avon and Somerset force is piloting a conditional caution for assault emergency worker (see below) and the Ministry of Justice has commissioned research on the use of out of court disposals with people with these disabilities.

Despite the lack of specialist programmes for this offence, we would still advocate resolving more such crimes by those who have mental health issues and/or are neurodivergent out of court. Under outcome 22, people can be referred to support services, or the condition for a conditional caution can be referral to liaison and diversion. Someone who is already on a mental health ward clearly cannot be referred to mental health services, but they can be asked to pay compensation via a conditional caution.

Resolving assault emergency worker crimes in Avon and Somerset without going to court

Avon and Somerset police were aware that many relatively low-level assault emergency worker offences were being charged. Even the local magistrates were suggesting that more could and should be diverted. The force was already using a conditional caution for some assault emergency worker cases but felt that the conditions used were often inappropriate. They consulted police officers, the Police Federation, Unison, the NHS, ambulance and fire services and then asked a local charity partner – Rise Mutual - to design a programme specific to this crime. Participants need to do two sessions of three hours each. The first is on values, beliefs, consequences, and victim awareness and the second on emotional awareness, de-escalation, decision making and emotional management skills.

Potential participants will be carefully screened. Only three designated detective inspectors can approve the referral and they will only sign off the caution if they are confident the victim has agreed to resolve the crime without going to court, and if the person admits the offence. The programme was designed to address the harm caused by this offence whoever commits it. But the force acknowledges that many of those who assault police and NHS staff have mental health issues and/or are neurodivergent. They will accept anyone onto the course who fits the criteria and they will make reasonable adjustments such as allowing a support worker to accompany the person. The programme is in its infancy, but has already inspired a lot of interest from other forces who would like to resolve more assaults out of court.

Restorative justice

Restorative justice (RJ) is extensively used, partly to try to resolve the harm caused by assaults. Police use it "on the street" or in more formal settings when they use out of court disposals. Specially trained restorative justice practitioners use restorative justice techniques to deal with assaults that happen in hospitals.

There is no insuperable barrier to those with mental health issues and/or who are neurodivergent taking part, and some successful RJ work has taken place in forensic wards and hospitals. Dr Andy Cook, consultant clinical psychologist at Sussex Partnership NHS Foundation Trust, has pioneered this approach in a forensic ward in Sussex. Patients can stay on forensic wards for a long time, and these ongoing relationships between staff and patients can motivate both parties to find a way to repair the relationship after violence or abuse has occurred.

Victims and those who attacked them are supported to have a restorative meeting, where the victim describes the effect the incident has had on them, and the patient listens and apologises for the harm caused.

Professor Andy Cook has written up three case studies, all of which achieved some success[44]. The most positive involved Jessie, a patient, and Jen, a nurse. Jen was initially distrustful of the process and its ramifications and it took two years preparation from the assault to the restorative meeting. Both parties found it very helpful. Jen wrote that **"it really did feel that she [Jessie] was genuine and remorseful, and wanting to make good for the future"** and that **"she had forgotten that actually Jessie was just a young damaged woman and that she had expected someone much bigger and more intimidating to walk into the room.... She reflected that the incident is now part of her and part of her life story but that it no longer had the same power over her."** No-one wanted to involve the police at any stage to deal with the violent incidents (although the restorative process can occur in tandem with the criminal justice process). Staff either moved violent patients to a more secure ward and/or suggested restorative justice.

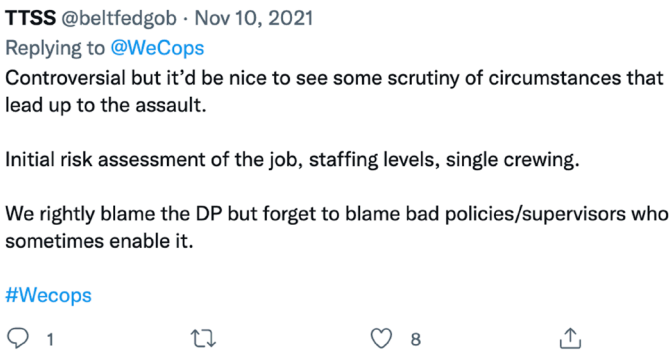
Though challenging to set up, it seems restorative justice can be a very effective approach to addressing the harm caused by mental health patients in hospitals. Currently there is little support for restorative justice amongst police - our survey and interviews suggest police officer victims are often reluctant to try it or may have heard about it done badly. Only a quarter of police survey respondents said more alternatives to prosecution (such as restorative justice) would be useful.

Restorative process allows the person to agree to accept the decision, apologise & forget about it, move on [but] it does not alter their future behaviour, there is no consequence or learning. The victim however, continues to live with it for ever. (police officer)

But there is good evidence that restorative justice leaves victims satisfied and can reduce reoffending[45] – that those who commit violence do learn from it. One police force regularly uses it to resolve the harms caused by assaults on officers:

If it's a "resist arrest" type assault while the person is in trauma or crisis, there's clearly other elements to it and, if the officer is in agreement, we will do [diversion]. We can often do restorative justice where the offender will apologise to the officer, and we have that conversation about the impact of their behaviour. We get the officer to come in and they explain to the offender the impact of what happened. The fact that they've got to go home and explain to the kids why they've got a black eye, and that they were stopped from going to a more serious job because they had to deal with that person. It is really impactive. We have a good outcome with those cases. (police officer)

Can assaults on emergency workers be avoided in the first place?



[The police officers] didn't realise or make allowances for his autism. He doesn't like to be touched. And they invaded his body space, not knowing or not appreciating his autism. He reacts to that, and that's an assault. (defence lawyer)

I've reviewed some pretty horrendous footage from body worn cameras, and had a different approach been adopted, things wouldn't have escalated to the point they did. (prosecutor)

People see us and think I'm getting arrested, I haven't done anything wrong, and then they get defensive, they don't necessarily understand that we're there to help them. (police officer)

I've never had a case where a mentally unwell person has just approached an officer and punched them for no reason. Like, that just doesn't happen. There's always this interaction first, and having watched the body worn footage, you can see it coming a mile off. Because the police officers aren't acting appropriately, either because they don't appreciate this person's mentally unwell, or there's a lack of any care to acknowledge that mental unwellness, or they've got different things that they're prioritising, which is, I don't know, get this person arrested in the back of your van. (defence lawyer)

Force begets force? Mental health, use of force and assaults

Just the arrival of the police can raise the temperature of a situation. People who may feel they have committed no crime see the police arrive and get annoyed. If the situation escalates and the officers feel an arrest is necessary, this can lead to the person lashing out. This is likely to be exacerbated if the person has a mental health condition that means they respond negatively to physical contact.

The College of Policing and researchers from the University of Exeter analysed over 45,000 police records to identify factors that increased the likelihood of officers being assaulted.[46] They found that police officers were more likely to be assaulted when they used force themselves (tactics such as Tasers, batons or physical force), and that this use of force was more likely when a person has a mental health condition:

People subjected to police force were more likely to have equipment or weapons drawn and physically used on them (but not unarmed tactics) when officers perceived them to be "mentally disabled"...Officers were more likely to manage encounters by drawing and using equipment, and using unarmed tactics, when "mental health" was considered to be an impact factor.[47]

This chimes with comments from lawyers working on assaults on emergency worker cases, who told us that more could be done to avoid incidents escalating to violence in the first place, particularly where the assault was against a police officer. They believed the police response often made things worse rather than better:

Frequently body-worn video shows police behaving in ways which demonstrate they have not considered neurodiversity when approaching/dealing with client, and resulting behaviour has caused avoidable negative reaction in client e.g. grabbing autistic client from behind unannounced, resulting in client hitting out. (defence lawyer)

Welfare call to police by neighbour. Police misread situation and handle situation badly assaulting the defendant repeatedly in order to contain her. Eventually the defendant retaliated with glancing blow to officer's arm causing no injury. Defendant is middle aged female. No previous convictions and obviously presents in an unusual way. Absolutely no public interest in prosecution.
(defence lawyer)

Remi's story

Remi is a young adult with autism who was charged with assault on emergency worker (a police officer). Police officers pulled Remi's car over after spotting an issue with his car insurance on the police database. Remi's passenger fled the vehicle, making the officers suspicious. The police approached the car and shouted at Remi to get out while also trying to pull him out of the car. He became confused about what to do as he was wearing a seatbelt, and was being restrained by the officers. An officer pointed a Taser at his face and kept trying to drag Remi from the car. In the process, it was alleged that Remi had scratched one of the officer's thumbs, inflicting a paper-cut sized injury. Remi sustained bruising and injuries all over his body.

Police mental health training

I think the police have a poor understanding of those with mental health conditions, or those who are neurodiverse. Particularly if you are Black/ Asian or an ethnic minority. Police mocked me during the arrest in November, 2018 and three out of the 7 officers in attendance were laughing at me as they dragged me out pulling my hair out of the flat.
(person accused of assaulting an emergency worker)

Frontline policing is by its nature unpredictable and, where a situation is uncertain, "restrain now, ask questions later" can feel like the safest option. But there is scope for police to approach people with mental health conditions with less aggression, good de-escalation skills and a better awareness of how to spot and respond to different mental health conditions. If they did, some of these assaults may not happen in the first place.

Police officers need to be better equipped to recognise neurodivergent behaviour when they encounter it, and to have the skills to respond in a way that calms rather than escalates the situation.

The joint inspection found a "variable picture" of police force mental health training. Officers recalled doing online learning modules and sitting through presentations, but very few remembered any of the content, particularly in relation to dealing with suspects with mental health conditions. In 2014 the then chair of the Police Federation described police mental health training as "woefully inadequate"[48], citing evidence that only 22 per cent of London response officers and 28 per cent of London borough mental health liaison officers thought that their training on mental health was sufficient.

A review of police officer safety conducted last year (2021) recognised that poor communication and conflict management on the part of the police can exacerbate the risk of assault. Officers agree – in a Hampshire survey of police officers quoted in the review, 40% felt that colleagues with poor communication skills were more likely to be assaulted.[49]

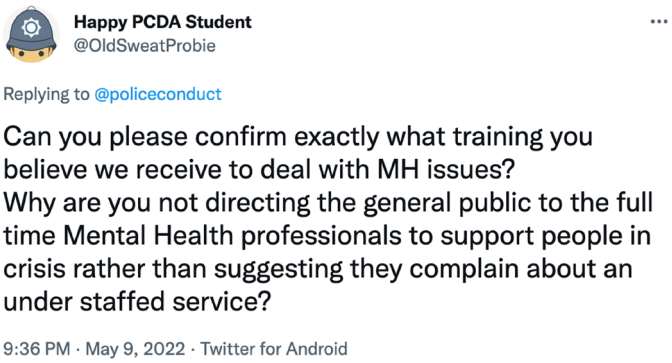
The review found that training in non-physical conflict management wasn't up to scratch. Only half (52%) of officers said they had been taught how to defuse confrontation, and under half (44%) said they had opportunities to practice these skills.

The College of Policing has taken the cue to produce new guidelines on how to manage conflict: **"Officers and staff may inadvertently escalate conflict by the way they interact with people who find it difficult to communicate. These may include people with mental or physical illnesses, physical disabilities, learning difficulties or reduced mental capacity, or developmental or neurological differences (e.g. autism)."**[50]

The guidelines include practical advice for interacting with neurodivergent people or people with mental health conditions or cognitive impairments, such as avoiding physical contact unless necessary, adopting a non-threatening stance, and asking whether the person has any problems police may not know about. It remains to be seen if the new guidance will lead to changes in practice, but it is timely, given the influx of new police officers[51]: **"One issue is around the quality of training for these new recruits. Are they going to be better equipped to deal with people who have mental health conditions than their predecessors? Or are we looking at an escalation in the problem?"** (ex-police officer)

But there is reluctance amongst "rank and file" police officers to undergo training for something they do not see as part of their job. To them, a police force better trained to respond to mental health-related incidents would only increase reliance on police as a first port of call: **"The police could always have better training, but the issue of dealing with mental health is not a police issue. Providing training on the matter makes it a police issue"** (police officer).

Police officers recognise that particular skills are needed when interacting with people who are neurodivergent and/or have poor mental health or a cognitive impairment, but to them the solution lies in more funding for NHS and mental health services rather than training police officers to pick up the slack.



Officer reluctance aside, training an entire police force is a significant challenge, and some areas are instead trialling delivering mental health training to a smaller group of officers across the police force. These trained officers form "crisis intervention teams", available to be called on at any time. The approach was first trialled in Memphis, USA (see box). West Midlands and Avon and Somerset have introduced versions of this model in the past few years, although evidence on effectiveness has not been published.

Crisis intervention training – the Memphis model[52]

The Memphis police department's crisis intervention team was set up to improve how people with mental illness in crisis would be approached and dealt with by police officers. The scheme delivers a 40-hour training programme to a group of officers across the force. The training was designed and conducted in partnership with mental health providers and advocates, and teaches officers to identify people with mental health issues and divert them, where possible, from the criminal justice system. The trained officers are spread throughout the city on all shifts, performing their usual duties but available for immediate dispatch to "mental health crisis scenes". Their aim is to de-escalate the incident, thereby decreasing the likelihood of violence and injury to the person, police officers and other members of the public. The highly trained officers also help the police officers on the scene to assess the person and decide what to do next, referring to resources such as community mental health services or social services. The team is now made up of 200 trained officers and offers 24/7 coverage.

Research has found that officers trained in Crisis Intervention Training have a more positive attitude towards, and improved knowledge of, mental health issues; that they are more confident in working with people with mental health issues; and that they deliver higher rates of diversion from the criminal justice system.[53]

Street triage, crisis cars and control room advice

Another way to inject frontline policing with more mental health expertise is through closer collaboration with existing mental health services.

Street triage, or "crisis cars", pair a mental health professional with a police officer. They attend police call-outs together when someone seems to be experiencing mental health difficulties. The health worker can access the person's medical records, advise on how best to engage with them, and help make a more effective referral to services if needed.

Such schemes proliferated across England and Wales in the early 2010s, and live on in various police force areas, for example South Yorkshire's Street Med Worker (SMED) scheme. Despite this, evidence of their impact is relatively limited. The evaluation of an NHS England pilot found it reduced the use of detentions under the Mental Health Act, but the impact on assaults on police was not tested. A new street triage scheme is now being piloted in Greater Manchester[54, 55], and the results will be published later this year.

Greater Manchester has also introduced a team of mental health practitioners who police control operators can reach by phone.[56] The mental health team can access a person's medical record and provide information and telephone advice to officers at the scene. Police officers and call handlers can contact the service for support when they need to make a decision or refer to services.

In Denver, USA, their Support Team Assisted Response (STAR) programme allows the 911-control rooms to bypass police altogether and send a mental health professional and paramedic instead when appropriate. The team can provide medical assessment/triage, crisis intervention, de-escalation, and referrals. The programme has responded to over 2,000 calls that otherwise would have involved the police.[57]

We don't know how well crisis intervention teams, control room advice or joint health/police cars are working. In 2017, Professor Eddie Kane from the University of Nottingham conducted a review of published studies on police mental health interventions. He found some promising results, especially for the crisis intervention team model, but not enough evidence to be confident that any of these initiatives were worth the investment. Another review of mental health triage interventions found most evaluations of schemes to date were methodologically unreliable[58]. A full evaluation of existing schemes could usefully answer some of the following questions: Do they reduce the likelihood of incidents escalating to violence? Do they result in fewer injuries to the police or the individual involved? Are they leading to fewer people with mental health problems being detained in custody and charged?

There may be other, more straightforward solutions. One ex-police officer conducting research on assaults against police officers feels part of the answer could be greater use of plain-clothed officers. He thought that while uniformed police officers may boost feelings of safety, security and trust amongst some members of the public, for others it can prompt feelings of fear and intimidation which can make matters worse:

Uniforms & overt presence can provide triggers even when there's no initial resistance or animosity/ defensiveness. I'd certainly endorse a no uniform or 'plain clothes' tactic when dealing with people who are in crisis or known in the system to have MH conditions, cognitive impairment and neurodiversity. (ex-police officer)

The pros and cons of mental health flagging

The police would be able to approach situations with people experiencing mental health difficulties more effectively if they had access to better information about the situation in advance.

Most police forces try to keep information about people who they believe could have mental health problems or have engaged with mental health services via the police. This marker – known as "MH flagging" - alerts control room staff and police officers receiving calls that the person may have mental health problems. This is useful in theory as it lets the police know whether a person has any mental health needs. It can also give useful context to the incident to which they have been called. But such systems requires significant resources to maintain, and evidence indicates it can make things worse.

Research by Professor Eddie Kane[59] has shown that people with mental health flags are more likely to be charged, less likely to be cautioned, and spend on average longer in custody. This could be because of poor training of control room staff, or a feeling by police that they need to take extra caution (which in reality can mean deciding to arrest and detain in police custody).

Professor Kane also found that the flags were often inaccurate. Cases were tagged as mental health incidents which were actually not related to mental health at all, but to other issues such as homelessness and drug or alcohol abuse. He described a **"rather mixed and un-systematised categorisation [which] leaves too much room for un-evidenced claims and counter claims around demand, response and resources."**

In addition, previous plans to introduce police markers for autism – a flag on police records that alerts officers to a person's autism - have raised concerns that this would stigmatise and criminalise autistic people. The campaign group Autism Injustice opposed the introduction of such markers. They suggested instead that training for police should be improved and voluntary card schemes promoted: **"If the information is to remain under the control of autistics, then a much simpler mechanism is to carry a card briefly explaining that one is autistic and possibly including some basic interaction advice."**[60]

Operation Hampshire and reducing assaults – an opportunity missed

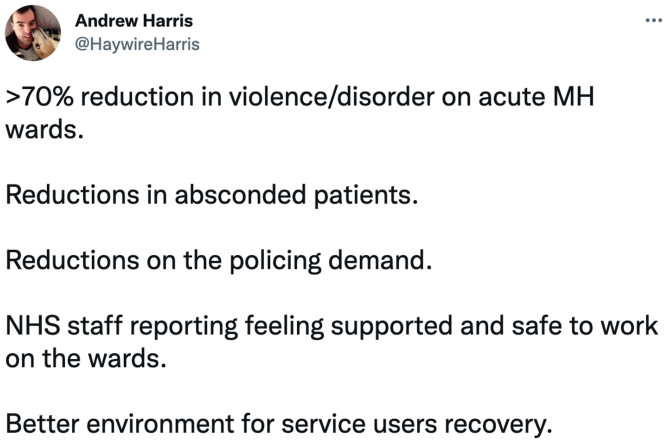
A new app launched in March 2022 by Operation Hampshire allows police forces to record incidents of assaults against officers and staff in a consistent way. Supervisors record who was assaulted, the type of call, the incident location, details of the injury, and whether an officer wellbeing check was carried out. The app will be useful for gathering force-level and national data on the scale and nature of assaults on police. But the data being collected won't shed much light on why assaults are occurring in the first place, and how they could be reduced. If, as lawyers claim, many assaults on police by people with mental health conditions occur because the police don't approach the situation effectively, this will not be picked up by the app. Other analysis has shown a link between single-crewing, police use of force, and assaults on police. If the police want to reduce assaults on police, are there ways to use this new app to better identify ways to stop these assaults happening in the first place?

Reducing assaults on NHS workers – can we design out crime?

Opportunities to prevent assaults happening in the first place exist in NHS settings as well. Andrew Harris, a police officer in Bedfordshire, recently won an award for his violence reduction work on in-patient mental health wards.

As a mental health investigation officer, he is visibly present on wards (Bedfordshire has one forensic mental health hospital and a number of community mental health wards), available to staff and patients, and a first port of call for mental health inpatient teams to investigate any incidents of violence, abuse or other antisocial or criminal behaviour. When it does occur, the focus is on dealing with incidents through a restorative conversation rather than jumping to a criminal justice response.

These are informal chats with the staff member to understand what happened and what's needed to put things right, as well as a conversation with the patient. If violence or abuse reoccurs a community resolution is considered, with an action plan, and only if that fails to stop violent behaviour would conditional cautions or prosecution be considered.



Since the introduction of the role, the number of crime reports for damage or disorder on the acute wards had reduced from 53 in July 2020 to 13 in January 2021.

Andrew Harris also reviewed health and safety reports to identify any patterns as to when violence and abuse was occurring. He found monthly spikes in assaults on benefits payment days (thought to be related to some of the patients with substance abuse problems wanting to leave the ward to buy drugs) and so suggested the ward teams staggered their breaks on these days so that there were enough staff on duty at any one time.

Police presence in non-criminal justice settings should not be taken lightly. Campaigns such as No Police in Schools[61], which advocates against the introduction of schools-based

police officers in Manchester, argue that police officers in schools stigmatises students, makes children feel less safe and exacerbates the risk of children being criminalised. Many of these concerns also apply to greater police presence on mental health wards – any expansion of this approach should consider how these risks could be mitigated.

NHS mental health training

Mental health specialists in the NHS receive detailed and ongoing training in caring for patients with poor mental health. However, mental health training for most NHS workers is basic, even though all NHS workers are likely to come into contact with people struggling with their mental health on a regular basis.

I deal with a few mental health crises a week. My training for this has been inadequate. I've had a knife held at me and I honestly had no idea how to de-escalate the situation or why it was happening. I'm learning on the job, but would love to learn how to deal with MH issues.
(ambulance worker)

Ambulance workers and A&E staff are especially likely to be responding to incidents that result in violence or abuse, many of which will involve people with poor mental health. Assaults can happen while the person is being restrained. It's understandable that staff may need to be "hands on" with patients in emergency medical situations, but there is room to improve training about physical contact with patients and members of the public, and how to communicate when physical contact is necessary.

Conclusion and recommendations

Assaults on NHS workers and police cause huge harm and have lasting effects on staff morale, absences and retention. Unions and employers have turned to the criminal justice system, successfully calling for harsher sanctions to send a message that emergency workers are valued by society and that attacks on them are taken seriously.

But their belief that harsher punishments will deter people from violence and abuse is not backed up by evidence. The number of assaults on emergency workers have actually increased as sentences have got harsher. Harm can be addressed in better ways than police enforcement, prosecution and criminal sanctions, particularly in the case of those who have mental health conditions, cognitive impairments and/or who are neurodivergent (by our estimates, the majority of assaults). Employers can deal with staff who've been victims of violence and abuse much better with supervision, counselling, and restorative justice. Police and the NHS can improve training of staff to prevent incidents happening in the first place.

Where a criminal justice response is used, the latest inspection shows we need to improve how mental health conditions, cognitive impairments and/or neurodivergence are identified and factored into the decision to prosecute. There are many effective options for resolving the harms of assaults on emergency workers without going to court – through bespoke diversion courses and restorative justice – which should be used and expanded.

To reduce the use of prosecution for assaults on emergency workers by people with mental health conditions, cognitive impairments and/or who are neurodivergent, police, CPS, employers and the government should:

1. Improve the support employers give to emergency worker victims of violence or abuse, to tackle the dissatisfaction amongst emergency workers with how incidents are handled and to address harm. This includes making sure debriefings take place and any needs identified are addressed.

2. Introduce a screening tool to all police forces so that a mental health and neurodivergence assessment by a health professional is available to all who need it.

3. Make health assessment results available to police and prosecutors and give clear guidance for how mental health should be factored into the decisions to charge and prosecute. This guidance should match the level of detail provided in sentencing guidelines.

4. Increase availability and use of effective ways to resolve crime without going to court (such as cautions and community resolutions) for people with mental health conditions, cognitive impairments and/or who are neurodivergent who commit violence and abuse towards emergency workers.

5. Fast track the introduction of training for police and NHS workers in how to respond to people with poor mental health, to reduce the risk of incidents escalating to violence.

6. Gather data on the circumstances in which assaults on emergency workers occur, to identify opportunities for interventions to prevent violence and abuse occurring in the first place. The new Operation Hampshire app could gather this information nationally for police assaults. NHS trusts could review this at a local level.

7. Evaluate the impact of mental health interventions such as street triage and mental health tactical advisors on violence and abuse towards police officers.

8. Review the application of the CPS public interest test for prosecution of assaults on emergency workers, particularly the consideration of whether the suspect is or was affected by a significant health issue.

9. Research how violence and abuse towards emergency workers could be prevented and addressed, including research with people who have been accused of assaults.

10. Mainstream the use of restorative justice as a first port of call for dealing with assaults on emergency workers, building on the learning from forensic mental health settings and Bedfordshire mental health community wards.

Appendix

Stakeholders engaged with as part of the research

Association of Special Constabulary Officers

Autism Injustice

Bedfordshire Police

Broadmoor Hospital/West London NHS Trust

Centre for Mental Health

College of Policing

Crime in Mind

Crown Prosecution Service

Exeter University/Centre for Clinical Neuropsychology Research

Hospital Consultants and Specialists Association

Mark Brown, policing commentator

Met Police

National Police Chiefs Council

National Survivor User Network

NHS England

Nottingham University Institute of Mental Health/Centre for Health and Justice

Operation Cavell

Operation Hampshire

Oscar Kilo

Pharmacists' Defence Association

Police Federation

Police Superintendent's Association

Prison Reform Trust

Royal College of Nursing

Sussex Partnership NHS Foundation Trust

Thames Valley Police

UK Acquired Brain Injury Forum

Endnotes

1. https://www.legislation.gov.uk/ukpga/2018/23
2. See table on page 1 of the Joint agreement on offences against emergency workers for a list of roles under the emergency worker definition https://www.npcc.police.uk/Offences%20against%20em%20workers.pdf
3. Including private and independent sector care providers delivering NHS services
4. https://uknip.co.uk/Breaking/News/breaking/being-assaulted-as-a-frontline-worker-whether-thats-police-fire-health-or-prison-must-not-be-tolerated-and-those-who-do-so-must-feel-the-full-weight-of-the-criminal-justice-system-come-do/
5. Sentencers can consider an offence as more serious if it is committed against those working in the public sector or providing a service to the public https://www.sentencingcouncil.org.uk/explanatory-material/magistrates-court/item/aggravating-and-mitigating-factors/
6. Section 89(1) of the Police Act 1996 https://www.legislation.gov.uk/ukpga/1996/16/section/89#:~:text=(1)Any%20person%20who%20assaults,standard%20scale%2C%20or%20to%20both.
7. An FOI request for the consultation responses was made by independent prison consultant Rob Allen. The request was refused on the grounds that releasing the consultation responses was not in the public interest.
8. https://hansard.parliament.uk/lords/2021-10-20/debates/A3954398-16DA-4A16-8AB4-35B67A52586C/PoliceCrimeSentencingAndCourtsBill
9. The offences of unlawful marketing of knives as suitable for combat, or in ways likely to stimulate or encourage violent behaviour, and administering drugs to obtain intercourse, both carry maximum sentences of two years https://www.thelawpages.com/court-cases/maximums.php
10. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/967767/MOJ_Sentencing_IA_-__Assault_on_Emergency_Workers.pdf
11. This document is cited in the government's impact assessment https://nij.ojp.gov/topics/articles/five-things-about-deterrence
12. https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021-equality-statements/assault-on-emergency-workers-in-the-police-crime-sentencing-courts-bill-equalities-impact-assessment
13. https://committees.parliament.uk/event/13615/formal-meeting-oral-evidence-session/
14. https://www.lawgazette.co.uk/news/tougher-criminal-sentences-contributing-to-the-courts-backlog-new-bar-chair/5111014.article
15. https://twitter.com/HudsonKerry/status/1450140162399293440
16. UK lawyers plan further protest over legal aid rates https://www.ft.com/content/b38ed146-b262-456e-945e-0ad4c268f269
17. Police recorded crime and outcomes – Outcomes open data year ending March 2021 https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables
18. https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables
19. Story taken from original Times article by Shanti Das https://www.thetimes.co.uk/article/a-teen-dies-behind-bars-why-was-she-there-in-the-first-place-lbb77jkr7
20. Common assault on emergency worker sentencing guidelines https://www.sentencingcouncil.org.uk/offences/crown-court/item/common-assault-racially-or-religiously-aggravated-common-assault-common-assault-on-emergency-worker/ and Sentencing guidelines for offenders with mental disorders, developmental disorders, or neurological impairments https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/
21. Gravity matrix (Adult) https://www.npcc.police.uk/2019%20FOI/Counter%20Terrorism/061%2019%20Gravity%20Matrix.pdf
22. https://www.npcc.police.uk/Mental%20Health/Nat%20Strat%20Final%20v2%2026%20Feb%202020.pdf
23. Joint agreement on offences against emergency workers https://www.cps.gov.uk/sites/default/files/documents/publications/Joint%20Agreement%20on%20Offences%20against%20Emergency%20Workers.pdf

24. McKinnon and Grubin 2013 and 2014, cited by NAAN
25. https://www.nice.org.uk/guidance/ng66/evidence/full-guideline-pdf-4419120205
26. https://www.nice.org.uk/guidance/ng66/evidence/full-guideline-pdf-4419120205
27. Joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders, November 2021 https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf
28. https://www.appropriateadult.org.uk/policy/research/theretohelp3
29. p55 https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf
30. Eddie Kane, forthcoming
31. https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/07/Neurodiversity-evidence-review-web-2021.pdf
32. https://www.polfed.org/campaigns/protect-the-protectors/
33. https://www.uhcw.nhs.uk/news/no-excuse-for-abuse-campaign-launched-at-uhcw-nhs-trust-to-protect-staff-and-patients-from-violence-and-aggression/
34. https://www.policecare.org.uk/wp-content/uploads/PoliceCareUK_TJTL-Report-.pdf
35. https://www.polfed.org/media/16072/cop-npcc-officer-staff-safety-review.pdf
36. https://www.sussex.police.uk/SysSiteAssets/foi-media/sussex/policies/investigation-of-assaults-and-hate-crimes-on-police-officers-police-staff-and-volunteers-whilst-on-duty-policy-9032021.pdf
37. https://www.nationalhealthexecutive.com/articles/operation-cavell-safety-frontline-nhs-staff
38. https://www.cps.gov.uk/cps-london-north-london-south/news/london-wide-launch-operation-convict-those-who-assault-nhs-staff
39. https://www.leicspart.nhs.uk/wp-content/uploads/2021/06/Violence-Prevention-and-Reduction-Policy-exp-May-24.pdf
40. https://twitter.com/dadwithahat1/status/1529132966680711169
41. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814177/impact-short-custodial-sentences.pdf
42. https://www.transformjustice.org.uk/a-different-understanding-how-the-cjs-discriminates-against-those-with-autism/
43. Police recorded crime and outcomes open data tables year ending March 2021 https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables
44. https://www.tandfonline.com/doi/abs/10.1080/14789949.2019.1637919
45. https://restorativejustice.org.uk/resources/moj-evaluation-restorative-justice
46. https://whatworks.college.police.uk/Research/Documents/Use_of_force_report.pdf
47. This term was used on the monitoring form at the time and referred to any perceived sensory impairment, fluctuating or recurring impairment (e.g. epilepsy), developmental impairment (e.g. autistic spectrum disorders), learning disabilities, or mental health condition or mental illness.
48. https://www.police-foundation.org.uk/2017/wp-content/uploads/2014/09/policing_and_mental_health_resp.pdf
49. https://www.polfed.org/media/16072/cop-npcc-officer-staff-safety-review.pdf
50. https://www.college.police.uk/guidance/conflict-management/conflict-management-skills
51. The government has committed to recruiting 20,000 additional police officers between 2020 and 2023
52. https://www.memphistn.gov/government/police-department/crisis-intervention-team/

53. Research cited in Police Foundation 2014 consultation response https://www.police-foundation.org.uk/2017/wp-content/uploads/2014/09/policing_and_mental_health_resp.pdf

54. https://twitter.com/i/web/status/1488832400910131203

55. https://www.theoldhamtimes.co.uk/news/19891213.crisis-mental-health-scheme-launches-oldham/

56. https://www.gmmh.nhs.uk/mental-health-tactical-advice-service/

57. https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program

58. https://pubmed.ncbi.nlm.nih.gov/31162918/

59. https://onlinelibrary.wiley.com/doi/10.1002/cbm.2078

60. https://gizmonaut.net/blog/uk/2015/02/police_marking_of_autistics.html

61. https://nopoliceinschools.co.uk/

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