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Psychiatrists and public dramas – a personal experience

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It has long been felt that there sometimes occur certain dire situations, often involving the police, where our special experience has been felt to be valuable. I am unsure how well established this claim is but wish to describe one recent occasion when I was called upon in this way, in the hope that it might help others in deciding what they might have to contribute.

On the morning of the day in question, I received an urgent domiciliary visit request through my secretary to visit a 39 year-old man in one of Swansea's most deprived areas. I had not met him before but the casenotes said that he had been admitted to our hospital in 1983 for alcoholism but not seen since. I rushed out in the lunch hour but found no one at home and the window of the front door was smashed and boarded up.

I returned to the hospital and half way through my clinic received a call from the police, through the duty nursing officer, saying that the man in question was standing on top of Swansea Castle threatening to jump off. Swansea Castle is a ruin about 50 ft high situated in the centre of Swansea opposite a small park, Castle Gardens, where vagrants frequently gather.

A large crowd of 100 or more people had assembled by this time and the fire service had blocked off one of the city's main streets leading to the area. The media, including television, were present, not surprisingly perhaps as the local regional paper's offices were a quarter mile in one direction and the Swansea studios of the BBC a quarter mile the other way. The man was on top of an unstable structure not open to the public and maintained in that state for conservation reasons.

I was then sent up in a fire service platform to try to talk to him. I was very glad it was a platform (such as is used to service street lights only bigger) rather than a ladder, but I coped. The fire officer put a fireman's yellow helmet on my head, for whatever good that might have done, and I held on to a rail like grim death as we were lifted up to the top of the ruin.

I spoke to the man and a few issues soon emerged regarding his mental state. He was somewhat intoxicated with alcohol but not grossly so. He said that he was depressed and that he had been unable to gain satisfaction when he visited his general practitioner's surgery that morning. It was evident that he was not hallucinated or in any other way psychotic. He appeared very angry and resentful of everyone, authority figures in particular. I explained who I was and later offered to take him into hospital. I was up on the platform about 20 minutes; all the while a crowd in the city centre plus TV and newspaper reporters looked on. I wasn't as frightened as I thought I would be but I held onto the platform's rail and didn't look down! We did not at that stage have full details of his background but it seemed as if he had had difficulties with his wife and he was also on probation for theft. Unfortunately, neither his wife nor his probation officer could be found while he was on the building. I had never met him before and it soon became apparent that we were getting nowhere. He regarded me as something to do with the police and had no wish to hear anything I had to say, and we eventually had the platform descend.

I came down and by this time the Police Superintendent in charge of the Swansea uniform branch had arrived at the scene. At his request, I gave him my assessment of the situation. I told him that I did not think that the man was hearing voices telling him to kill himself nor was he in any sort of similar psychotic state, but he was intoxicated with alcohol although not incoherent. I advised that he seemed very angry with everyone and appeared to be motivated by various ill defined grievances. I cautiously advised that he appeared to be enjoying the attention he was receiving from the large crowd. I said that I did not on balance feel that he was likely to deliberately commit suicide but that obviously he was at risk of coming to harm accidentally, either as a result of impulse or through losing his balance. I further advised that it seemed as if the incident could continue for a substantial period. I said that perhaps someone he already knew might have more success in persuading him to come down.

The Superintendent asked, in the light of my remarks, what I thought about withdrawal from the scene. I replied that in view of the risk of accident this seemed unwise but with my agreement, he decided to clear the 100 or so members of the public from the square and to get the press to hide in the bushes in order to deny the patient the attention he appeared to be seeking.

Some workers from a Christian missionary group who run a coffee bar for vagrants in central Swansea then arrived, one of whom had met the patient when he had called in there on a few occasions. This man then went up on the platform and actually clambered onto the ruin, something neither I nor the police

had done, though a fireman had. He was up there for about a half an hour and eventually much to my surprise, about three hours in total after the start of the incident, the patient got onto the fire platform and came down! He was then put in a police car and taken to the nearby police station. By this time, as can be imagined, the city's rush hour was in some state of chaos!

I then saw him at the police station and called the duty approved social worker and police surgeon with a view to implementing admission under Section 2. When he came down the patient was intoxicated with alcohol, very resentful of everyone, but could not give any reliable assurances that he would not do the same thing again. I took the view that the degree of suicidal risk implicit in his behaviour and his unpredictability and difficulty in explaining his actions constituted reasonable grounds for suspecting mental disorder for the purposes of the Mental Health Act, and that there was no way that he could responsibly be allowed free after the afternoon's events. However, he eventually agreed to informal admission and was brought to our closed high dependency unit.

I went back to our hospital thoroughly exhausted, though some degree of emotional arousal had overcome fear at some points. The incident appeared on that evening's BBC Wales regional television news and a curtailed account in the local newspapers, several of whose reporters had at various stages approached me. As it happened, and for which I was thankful, I had a lieu day's leave the next day but rang the hospital to check on the situation the next morning. It had been a day I will never forget!

I then went away on leave over the bank holiday. The patient settled rapidly when he sobered up and was allowed by the duty doctor to discharge himself a few days later. When I returned, I found another request to see him and he came to clinic where he was reasonably apologetic for his actions. I pointed out the risk he had caused to those trying to rescue him! He mentioned that he had done scaffolding work when he had been a builders' labourer and I then tended not to give as much credence to his assertion that he originally intended to jump. His history, not surprisingly, proved to be one of chronic alcoholism and petty criminality but there had never been any suggestion of psychosis. He assured me that he would go to Alcoholics Anonymous and had seen the error of his ways, but as he had apparently spent much of the last few years drinking with vagrants in Castle Gardens one did not hold out much hope of his continued abstinence.

What more general lessons can we draw from the involvement of psychiatrists in this sort of incident? Have we indeed any special skills to contribute over and above those of the police and other bodies involved?

There has been quite a tradition of such interventions including the involvement of the Institute of Psychiatry forensic department in advising the police in a number of dramatic sieges. How far do our and allied professions have special expertise, or are we only trying to "get in on the act"? I think perhaps it would be helpful here to define two main ways in which we as psychiatrists can be potentially involved.

The first and most obvious is when we already know the individual concerned. In that situation obviously the pre-existing rapport will often enable the mental health professional to persuade the individual to see reason and abandon self destructive plans. Unfortunately this was not the case in the incident I have just described but was why the religious worker from the voluntary body was able to prevail.

The second way is, of course, where we do, or hope we do, have some degree of specialised expertise. This probably in practice mainly means advising the police, and I think it was perhaps in this area, if any, that I was able to make a useful contribution to the afternoon's events. I think that being able to exclude psychosis and recognising the attention-seeking nature of the acts were helpful in enabling the police to plan their strategy in this case. Essentially, the man came down when his audience had been removed and when he was able to empathise with someone he already knew; I think our advice was of some help in both these areas even though I had not dealt with him previously.

Finally, I must say that I think it is mostly in these limited spheres that we can usefully assist. Physical heroism is best left to those like the fire service who are trained for it!!