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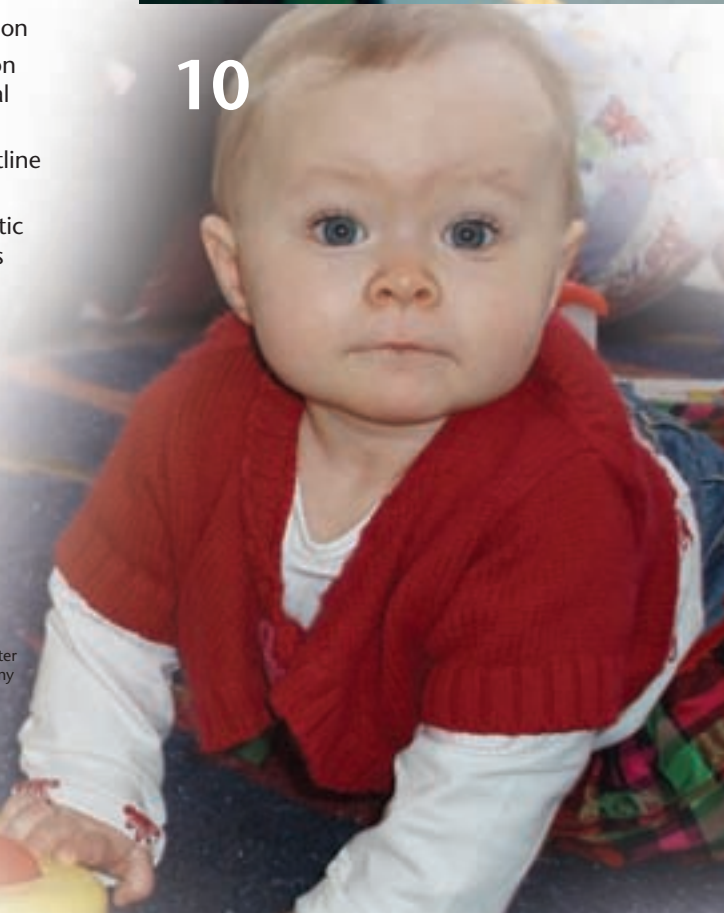


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'Focusing on homicide is a mistake. They are freak events'

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Adam James reports on the government's plans for managing high-risk patients

# Mind the

# gaps

Some 5–10% of homicides (equivalent to 55–60 of the total 600–800 homicides committed annually) are by people who are known

It's 14 years almost to the month since Christopher Clunis stabbed to death musician Jonathan Zito in an unprovoked stranger-killing on a London tube station platform. The inquiry into the attack, published two years later in 1994, revealed a catalogue of errors in Clunis's care and treatment. The 23-year-old had a diagnosis of schizophrenia, and had a history of violence and non-compliance with medication. He had been seen by 43 different psychiatrists in five years, and had moved home, from one side of the London to the other, on four occasions.

Jonathan Zito's death, and the murder by Michael Stone (who had a history of drug abuse and personality disorder) of Lin Russell and her daughter Megan 10 years ago, directly influenced the shape and intent of the draft Mental Health Bill and the government's determination to introduce compulsory community treatment orders aimed at ensuring people like Clunis and Stone do not fall out of the mental health system. Although the draft bill has been dropped, following a vociferous and effective campaign by almost every organisation and profession concerned with mental health, including psychiatrists and service users, the government intends to press ahead with the introduction of compulsory community treatment.

A promised new 'streamlined' bill, which would simply bolt compulsory community treatment powers onto the current Mental Health Act, has yet to be published. In the meantime the Department of Health has announced a new initiative to tighten up on procedures for assessing and managing the risk of violence posed by psychiatric patients. The proposals are based on an independent review commissioned by the Department of Health from Tony Maden, professor of forensic psychiatry at Imperial College London. He examined a small number (25) of the most florid cases of homicides by people diagnosed with a severe mental illness in the period 1995–2002. The review seeks to draw out the common, preventable high-risk factors in these homicides.

to the mental health services. Interviewed by MHT, Tony Maden says that if all his recommendations (see box) – including the introduction of CTOs – are implemented, it would be 'reasonable' to expect the homicide rate to be cut by 10% in five years. This equates to between five and six fewer homicides by psychiatric patients per year, and an overall reduction in homicides of 0.7–1.2%.

Critics say that Maden is way over-optimistic, even with these very modest figures. Tom Fahy, professor of forensic mental health at the Institute of Psychiatry, accepts Maden's recommendations could reduce incidence of violence. But, he says, they are 'very unlikely' to achieve any reduction in homicide rates by people diagnosed with a mental illness. Indeed, he argues, the Department of Health is focusing on the wrong target. 'Every homicide is a disaster and tragedy,' says Fahy. 'I support the notion of improving risk assessment. But at the same time one needs to be realistic about what that might deliver. Focusing on homicides is a mistake. They are freak events.'

Questions have also been raised about the validity of implementing a costly national policy change on the basis of Maden's analysis. 'It's going to create a lot of burden on clinicians, and all from an analysis of just 25 homicides,' says consultant psychiatrist Sashi Sashidharan, co-director of the National Centre for Research in Ethnicity and Mental Health at the University of Warwick.

But it is the spectre of CTOs that campaigners feel most uneasy about. Andy Bell, chair of the Mental Health Alliance, the group of 78 mental health professional, human rights and service user organisations whose combined opposition defeated the draft Mental Health Bill, fears CTOs could end up being implemented purely as a form of social control – a mental health ASBO – without bringing any health benefits to patients. CTOs do have the potential to benefit some so-called revolving door patients (people who suffer repeated relapses and

hospital readmissions), Bell argues, but 'we have to make sure there are safeguards and clear conditions. Compulsion in the community is only likely to be useful for a very small group of people in strictly limited conditions. The government proposals are too broad, too restrictive and too lengthy.'

Maden is keen to stress that '99.9% of patients would be unaffected by CTOs'. But, such orders, he says, would provide professionals with desperately-needed additional powers to ensure medication compliance from these high-risk, revolving door patients who have a history of violence and non-compliance, without having to detain them in hospital. 'The lack of such powers discredits the whole enterprise of risk management,' he says.

In Scotland community compulsory treatment orders (CCTOs) have been in place since October last year. So far a total of 144 have been issued between October 2005 and March 2006, according to initial findings from review to be published later this year by the King's Fund. It is too early to say whether CCTOs have helped reduce the risk of homicides. But, says Simon Lawton-Smith, senior fellow at the King's Fund and author of the review, patients in Scotland say CCTOs are 'fairer'. This is because, he says, they are linked with a better resourced mental health system (for example, wider availability of talking treatments) and a new tribunal system that gives patients more say in their treatment orders. 'In Scotland CCTOs are not being implemented on the basis of kicking down someone's door and injecting them on the kitchen table,' Lawton-Smith says. 'No one has reported any horror stories.'

But mental health professionals in Scotland are less happy, he says, mainly because of the added administrative burden of the new Act, and particularly the paperwork associated with the tribunal process. 'A lot of people in Scotland feel that implementing CCTOs is putting more pressure on them,' Lawton-Smith says.

Scotland's legal framework is vastly different to that planned for England and Wales, points out Tony Zigmond, vice-president of the Royal College of Psychiatrists. In Scotland, a patient must at least have a treatable mental disorder (ie. pass the so-called treatability test) and lack decision-making capacity before they can be subjected to compulsory treatment, whether in hospital or the community. In England and Wales, to the fury of most mental health groups, the government has dropped these safeguards, along with the rest of the draft Mental Health Bill. 'If you are going to give people more powers to deprive someone of their civil liberties, you have to be very clear when drawing up any legal framework,' says Zigmond.

Zigmond supports CTOs 'in principle', but says they are 'probably pointless'. He points to a Cochrane international review of the effectiveness of CTOs, published earlier this year, which found that 85 would have to be imposed before one hospital admission was prevented, and 238 to prevent one arrest.

Maden, while admitting to not having read the Cochrane review, argues CTOs would, in effect, simply extend the supervised discharge orders currently in use that allow high-risk patients to be readmitted to hospital quickly, without having to go through the full sectioning process. 'These are well-recognised as being effective with high-risk patients,' Maden argues.

Some fear, however, that in the long term CTOs will achieve the exact opposite of what they are intended for: they will simply alienate high-risk, hard-to-engage patients further from mental health services. Sashidharan says: 'I've never seen evidence that CTOs work. We need to look at this issue of ensuring compliance from the other side. There needs to be more emphasis on engaging patients more, and giving services resources to do this, such as improving the staff/patient ratio and looking at what needs the patient has other than just medication. Successful psychiatry, wherever you look, is about the level of engagement with patients.'

Maden, nevertheless, continues vigorously to defend his review and recommendations: 'I believe homicides by mentally ill people are preventable,' he asserts. 'The argument that the overall homicide rate will not be significantly reduced is perhaps valid for those working in public health. But it is a terrible point for psychiatrists to make. Doctors working with cancer do not assume

## Managing risk

The Maden recommendations include:

- implementation of community treatment orders (CTOs) for patients with serious mental illness and history of violence and non-compliance
- CTO conditions to include ban on patients using drugs or alcohol where this is a risk factor
- mental health teams to use structured clinical assessment tools and risk management plans
- early assessment of violence risk
- early intervention when behaviour of patient with a history of violence deteriorates, with clear criteria for intervention agreed through CPA
- forensic teams to manage very high-risk patients in the community, and intervene earlier
- concerns about risk of violence to be shared openly with patients and carers, wherever possible
- assessment of risk to be reviewed 'whenever the carer appears more worried than the team'
- the Department of Health to recognise that serious violence by patients 'is sometimes inevitable and [to] offer support to staff as well as reassurance to the public'.

The Department of Health has asked CSIP (the Care Services Improvement Partnership, which now includes NIMHE) to produce a 'national evidence framework' to improve risk assessment and management by mental health teams, and new guidance on information sharing between health, social care and criminal justice agencies about high-risk patients. It will also carry out a review of staff training needs. The Department of Health is to consult on the reform of the 'cumbersome' care programme approach (CPA) before the end of the year. Specifically, it wants to find ways to 'cut the red tape', strengthen the role of the care co-ordinator, and ensure patients have a greater say in their treatment and are given more information.

that they cannot do anything about cancer. They presume that if they work hard, they will get somewhere. I am not concerned about the overall homicide rate; I am concerned about the homicide rate by the mentally ill.' ■