**Health and Social Services Committee HSS-17-02(p7)**

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| Date: | Wednesday 11 September 2002 |
| Venue: | Committee Rooms 3&4, National Assembly for Wales |
| **Title:** | The Zito Trust |

## Overview of Response

This overview is supported by responses we put forward to earlier publications which we feel may be helpful to your Committee. These are:

- Our response to the Green Paper, *Reform of the Mental Health Act 1983*
- Our response to the joint Department of Health and Home Office consultation paper, *Managing Dangerous People With Severe Personality Disorder*
- Our letter to the Chair of the Health Select Committee on services for people with psychopathic disorder in the context of homicide statistics

The draft mental health bill introduces a new legal framework for the compulsory treatment of people with mental disorders in hospital and in the community. We support the new definition of mental disorder proposed and the proposal to remove the treatability test in the current Act which has meant that very few people with severe personality disorder will ever receive treatment from NHS services outside the special hospitals.

While there has been a good deal of criticism of the draft mental health bill, we believe that much of it has been misplaced and emanates to a large extent from organisations and commentators lacking the experience of working with, or dealing with the consequences of, mentally disordered offenders; that is, the interface between mental disorder, NHS services, social services and the criminal justice system.

The procedure for compulsion involves a single pathway with three distinct stages: a preliminary examination, a period of formal assessment lasting up to 28 days, and then treatment under a new Mental Health Act order which can only be authorised, and then directed, by a newly established mental health tribunal.

Four conditions must be satisfied before any compulsory powers can be used:

- There must be a mental disorder (defined as ‘any disability of mind or brain which results in impairment or disturbance of mental functioning’.)
- The mental disorder must be of a nature or degree warranting medical treatment
- Treatment must be necessary for the health or safety of the patient or the protection of others, and
- Appropriate treatment must be available for the disorder

We believe that these safeguards, including a new statutory right to advocacy, will provide the necessary framework to ensure that patients who are clinically assessed as posing a risk to themselves or others will be provided with treatment, thereby protecting themselves and/or members of the public from the risk of harm.

We would like to emphasise that compulsory powers may only be used if medical treatment is warranted. Medical treatment covers care, nursing, and rehabilitation; the latter includes education, training in and for work, and social and independent living skills. It does not include preventative detention. We would also like to point out that neither the word 'dangerous', nor the concept of 'dangerous severe personality disorder', are included at any point in the draft mental health bill.

The Zito Trust supports the proposal in the documents attached to the draft bill to extend the rights of victims of prisoners to victims of mentally disordered offenders, so that information about the proposed discharge of patients, and the circumstances of the discharge from hospital, may be given to victims and/or their families in the same way that the probation service includes victims of crime in the release process. This would remove the current anomaly experienced by victims in the context of patient confidentiality.

We have one concern about the mental health bill, which refers to the proposal to extend compulsory powers to prisons, so that NHS medical services can be given to mentally ill or disordered prisoners without their consent if the relevant criteria set out above are met. We take the view that was set out in the Reed Report some years ago, which stated that as far as possible mentally disordered offenders should be treated by health and personal social services, and not in prison. The incidence in prisons of mental illness and DSM-IV antisocial personality disorder is high, and while there are clearly resource issues to be considered in treatment options, we believe that offenders who suffer from a mental illness/disorder should be treated in hospital, returning to prison once treatment has been successfully provided, to serve out their sentences.

Finally, we would like to make it clear that while we believe a new Mental Health Act is essential to support a new framework for mental health provision, the emphasis being community rather than hospital, we do not believe new legislation will resolve many of the real difficulties faced by services on the ground in engaging and treating people who are in need of help. The 100 or so independent homicide inquiry reports which have been published in England since 1994 contain much valuable data about the consequences of a breakdown in communication between professionals, poor or absent note-taking, poor systems management, the lack of supervision of individuals, inadequate resources, overburdened caseloads, a refusal to listen to carers or family members etc., much of which will not be affected by a new legislative framework.

I do hope your Committee will find our observations helpful.

**Michael Howlett (Director)**

**Annex A**

Response to *Reform of the Mental Health Act 1983 : Proposals for Consultation*

**NOTE**

We have responded only to those parts of the consultation document where we have felt it appropriate to make some observations which alter or enlarge upon the consultation points published in the green paper. Where we have made no comment at all, it should be taken as read that The Zito Trust endorses the principles for reform put forward but has no preferred view as to the mechanisms described for implementing them.

The consultation points we would like to refer to in particular are as follows:

*Consultation Point H: The Government would welcome views on the practicality of the proposals outlined for compulsory care and treatment in a community setting.*

We accept the need identified to extend provisions for compulsory care and treatment to the community. Our experience of non-compliance with treatment, especially medication, by patients living in the community suggests that it continues to pose a serious problem for those patients, their carers, health professionals and the public. This view is endorsed by a recent postal questionnaire we commissioned during March 2000 of all 124 health authorities in the England, Scotland and Wales. It seems unnecessary to rehearse the arguments here in favour of extending powers of compulsion beyond the hospital into the community.

We would, however, like to reaffirm our view that while a compulsory order could and, in many circumstances, should be applied in the community without requiring the individual subject of such an order to be returned to hospital, we do want to see a situation develop where medication is given to an individual without that individual's consent in the community (by community we mean outside a recognised clinical setting), but that the law should unambiguously state that such powers of compulsory medication should only be given in a clinical setting. Thus, when a patient has become subject to a compulsory order in the community, which order stipulates the place of residence, the proposed care and treatment plan etc., and subsequently becomes non-compliant with some part of that order, then conveyance to 'a stipulated place for such care and treatment as is prescribed in their care plan' must in our view, if it is for the purpose of compulsory medication, be a designated clinical setting.

*Consultation Point N: The Government would welcome views on the Committees's proposals to ensure that people who have been arrested get early access to a gate-keeping assessment where necessary.*

The green paper makes the important point that there is a clear interface between health, social services and the criminal justice system in some cases of individuals with a mental illness/mental disorder. The point is also made that the police are often the first agency to come into contact with the mentally disordered.

While The Zito Trust agrees with the principle of gate-keeping assessments, we would also like to draw attention to a problem which has emerged in our work as common practice by the police in the way mentally disordered offenders are dealt with. That is, to attend an incident involving someone with a mental disorder, to take statements from the victim and witnesses, but not to pursue charges against the offender on the grounds of his/her mental state. The response to victims that 'we can't prosecute because the offender is mentally ill' is, in our experience, extremely common. In our view, this practice is contrary to the spirit of Home Office guidance on the prosecution of mentally disordered offenders issued in circulars 66/90 and 12/95, and to that which is contained in the Crown Prosecution Service Code of Practice (1994). There is an urgent need for greater clarity in the modus operandi of police forces in such cases, as the police have an increased role to play in their communities in this context.

*Consultation Point T: The Government would welcome views on whether the principles outlined by the Committee are the best way to achieve the right balance between confidentiality, the patients health and welfare and the protection of others?*

***Consultation Point U: The Government would welcome views on whether rights in the Victims Charter for victims and their families to be given information about detention and release of offenders should be extended to cover those restricted patients who have committed serious, violent or sexual offences.***

Information Sharing and Victims

The Zito Trust supports the recommendation that rights in the Victims Charter for victims and their families should be extended to cover those restricted patients who have committed serious or violent or sexual offences.

The Zito Trust also recommends that the remit for information gathering and information sharing should

be extended to carers, victims and secondary victims who have been affected adversely by the behaviour of a mentally disordered person, whether or not they have been charged with a criminal offence.

Rationale

There is still confusion and conflict about information gathering and information sharing not only between agencies, but between carers, victims and secondary victims who have in some way been adversely affected by the behaviour of someone with a mental disorder.

Information gathering and information sharing not only serve to ensure adequate health care for the patient but ensures protection and reassurance to carers, victims and secondary victims.

Evidence provided by the independent inquiry reports into homicide repeatedly describe situations where withholding information has had disastrous consequences. The current emphasis on the patient's right to confidentiality has ensured that carers,victims and secondary victims' rights have been disregarded:

'It is important to re-evaluate the concept of confidentiality [and] recognise the responsibility that professionals must accept in this difficult culture of community care for the mentally disordered offender, balancing the rights of the community to be safe while not riding roughshod over civil liberties.' (*Community Care Tragedies* : *a practice guide to mental health inquiries*. Margaret Reith. Venture Press 1998. Page 113)

Among the consequences of failing to address the rights of carers, victims and secondary victims both during the assessment process, and within the current practice of mental health review tribunals are the following:

- The history prior to and following the index offence is minimised.
- Inaccurate and/or incomplete assessments of a patient's mental health are made.
- Inaccurate and/or incomplete assessments of public safety are made.
- Carers, victims and secondary victims may be exposed to threats, and possible future contact with the offender, with no avenues for independent support or advocacy.
- Carers, victims and secondary victims experience undue distress due to the failure of mental health professionals to recognise their needs as equal to other victims of serious threat and assault.

The Zito Trust feels that the current proposals in *Reform of The Mental Health Act 1983* fail to address the following failures of practice:

- The emphasis on the patient's right to consent as a means of avoiding the passing on confidential information to a third party.
- The failure of staff to consider public safety issues or the distress and concern of a third party, be they carer, victim or secondary victim.

- The failure of the staff to assess the circumstances where information should be passed on in 'the public interest'.
- The failure of staff to assess when information should be passed on in a 'need to know' situation.

The Zito Trust is concerned that the current proposals in the Government's green paper to provide guidance only for good practice will not be sufficient to prevent the undermining of the importance of proactive information gathering and information sharing.

Recommendations for Consultation Points T and U

We therefore recommend that:

1. *each health authority be required by law to include the carer, victim and secondary victim within its obligations to the patient under the Care Programme Approach*
2. each health authority be required by law to appoint an advocate with responsibility for the assessment of the needs of carers, victims or secondary victims, and that such assessments are made available as a matter of course to the CPA multidisciplinary patient teams.
3. the assessment and information sharing duties by the advocate and multidisciplinary teams should override objections by the patient in cases where significant physical or verbal threats have taken place.
4. these requirements to be enshrined in law and in the Mental health Act code of practice.
5. in the event of homicide, the patient forgoes all rights to withhold consent to the disclosure of information to interested parties, including independent inquiry panels.
6. each health authority be required to share basic information about a patient, if that patient has made a significant physical or verbal threat, to a member of the public, basic information to include information to acknowledge whether or not the person is a patient at the hospital in question, what further course of action is to be taken concerning the patient, and when the decision has been taken to discharge the patient.
7. a legal obligation to be placed on mental health review tribunals to give notification to carers, victims and secondary victims of proceedings due to take place.
8. an opportunity be given to interested parties to make representations to mental health review tribunals, assisted by legal counsel if required.
9. a legal requirement that a statement by the individual health authority concerned in tribunal proceedings has placed before the hearing a statement concerning public safety issues with regard to the possible discharge of a detained patient.
10. that the new Code of Practice to the Mental Health Act clearly defines the expressions 'confidentiality', 'need to know' and 'public interest' in the context of information gathered about the patient which is or is not to be made available to carers, victims and secondary victims.

The Zito Trust
Green Paper response
March 2000

**Annex B**

**Home Office**

*Department of Health*

**MANAGING DANGEROUS PEOPLE WITH SEVERE PERSONALITY DISORDER**

**Proposals for Policy Development**

**A RESPONSE FROM THE ZITO TRUST**

**December 1999**

The consultation paper addresses significant problems with the management and treatment of those individuals diagnosed as having a severe antisocial personality disorder. While these problems have been around for a number of years, and a number of proposals have been put forward for tackling them (without much success), the trial in October 1998 of Michael Stone at Maidstone Crown Court did much to bring the issues into the public and political domain once again. Having gained some significant experience in providing support and advice to people who have contacted The Zito Trust concerning the diagnosis of personality disorder, and having examined some of the literature on mental disorder, risk and violence, we feel able to respond to the individual questions in the Home Office/DH consultation paper, as follows:

**Policy Options**

1. We endorse the proposal outlined in Option B, as we favour therapeutic treatment for DSPD, following appropriate risk assessment in small units specially set up for the purpose. This treatment should be provided under the auspice and authority of a new single organisation working closely with all other relevant agencies, including local authority departments. We do not exclude the possibility of the private sector developing appropriate services, as long as they are properly audited and inspected. Any new service should be adequately funded and resourced with properly trained and committed personnel (social therapists?) before new powers of compulsory detention are implemented. We firmly believe that new powers of detention followed by the patchy, half-hearted provision of therapeutic treatment will not work and will not substantially improve upon the current problems.

2. Answered above

**Service Provision**

3. There would initially seem to be a problem in meeting therapeutic and security needs for DSPD individuals, as the two concepts do not readily go hand-in-hand. Yet, therapeutic treatment is provided in high security and medium security hospitals, as well as in Grendon Underwood prison (and, formerly,

in Barlinnie). If the physical environment is designed appropriately, there is no reason why therapeutic treatment and management cannot be effectively implemented.

4. Much can be learned from the therapeutic community movement about the need for properly trained and skilled management, committed to the treatment of DSPD. In practice this means supervision at every level of the organisation, and on a regular basis. The organisations should be small and should receive supervision from external consultancy organisations experienced in this field of work (for example, the Tavistock Institute and/or Portman Clinic). Every member of staff should receive supervision individually and in groups. There should be opportunities for honest feedback by staff at all levels to their seniors and to each other, but this feedback must be facilitated independently. Training programmes should be robust and meaningful with plenty of external input, and with meaningful opportunities to attend external courses and conferences and to gain valid and relevant qualifications. The point about this emphasis on supervision and training is to ensure that organisations working with such complex issues as are presented by DSPD individuals are in danger of becoming isolated, inward-looking, hostile to the outside world, unable to work with external agencies and dysfunctional over time. There are opportunities here for a sophisticated and innovative pilot and the development of a model which is transferrable to other institutions in the UK and abroad.

5. The evidence for interventions which are effective points to a service driven and managed by psychologists and psychotherapists – but only those who are committed and appropriately trained to work in this field. There is a wealth of experience within these professions which is currently under-utilised, and both professions have their forensic sub-specialties. We recommend, additionally, the establishment of a new clinical worker for DSPD inviduals, probably called *social therapists*, who would benefit from appropriate training, supervision, validated qualifications etc. They may come from existing professions – psyciatrists, social workers, probation officers, community psychiatric nurses – following advertising. Or they may come from graduates seeking to work in this field. It would be important to develop at the very least a diploma course (see the Diploma in Forensic Psychotherapy offered by University College London at the Portman Clinic), in either Psychology or Psychotherapy. It would be important to ensure that those who are currently working in, say, the special hospitals, do not 'drift' across to the new service, bringing with them inappropriate beliefs and expectations and/or remnants of a stale, pessimistic culture which is not conducive to working therapeutically with DSPD individuals.

6. This question has been addressed in Q.4. In terms of which government department should be responsible, we believe that this new service should be the (actively) joint responsibility of the Home Office *and* the Department of Health.

7. There is a shortage of staff generally within forensic services. Clinical Psychology training courses take only a few of the number who apply to train for three years. Few of these who qualify commit themselves to forensic work. A multi-disciplinary service will be able to draw on personnel from different professions and train them for the purpose, but clinical psychology and psychotherapy training must develop quickly in order to respond to the needs of the new servcice being provided. Overall leadership must come from psychology/psychotherapy, not just because these are the professions with

the skills necessary to deliver effective, therapeutic tretaments, but also because there is less chance of the kind of multi-disciplionary breakdown which we see so often within mental health services within the NHS.

8. The new service will need to be financed from the Home Office and the Department of Health (notwithstanding comment above concerning the role of PFI and the private sector). Agreements will have to be drawn up between other agencies relevant to the service to ensure that perverse financial incentives are not beneficial options. There must be free flow of patients between the criminal justice, health and community-based systems, in every case determined by individual need which has been assessed clinically.

**Assessment Procedures**

9. As already stated, we recommend that clinical psychologists and psychotherapists be given overall clinical responsibility for the assessment and treatment process. There is some merit in adopting a multi-disciplinary panel system for the process of assessment but we recommend that psychologists and psychotherapists should have ultimate responsibilty for the report. There is no doubt that some forensic psychiatrists are interested in working with DSPD individuals, but it is now clear that, in general, psychiatrists do not possess the commitment, desire, time or necessary skills, to work with these individuals in a way that is meaningful and effective. The psychiatric profession has been quick to criticise the current consultation paper (see, for example, *Psychiatric Bulletin*, vol 23 No 12 December 1999), but as a profession it has signally failed to offer individuals with anti-social personality disorder, or psychopathic disorder, much more than a diagnosis followed by a statement about untreatability. The numbers of those diagnosed as psychopathic under the Mental Health Act 1983 receiving treatment from psychiatrists within the NHS has decreased significantly over the past 15 years. It is now virtually impossible for such a person to receive inpatient care under current arrangements. We recommend that purchasing and legal powers vis a vis DSPD individuals be removed from psychiatrists and given to psychologists etc, as described. While this may seem a radical shift of responsibility, we believe that a new service requires a new intellectual and clinical approach, one which accepts the significant shift in psychiatry towards the medical model of treatment, which is not the treatment of choice for personality disorders of any kind, apart from, perhaps, borderline pd.

**Outcomes**

10. Outcomes are difficult to evaluate in the treatment of personality disorders. It is often stated that the most effective treatment is time. However, standardisation of the mechanisms and protocols for assessment and report-writing can be achieved, as they can for training and supervision as well as for the effective working of multi-disciplinary teams. The purpose of treatment is not simply to reduce convictions but to treat disorders which are debilitating and which have consequences for the sufferer and his/her family and, potentially, for the wider society. While reconviction rates can assist in achieving outcome measurements, it would be just as important to measure take-up of the service in terms of numbers and also in terms of reciprocity during treatment. Reciprocity is notoriously difficult to achieve on a one-to-one basis (which is why group therapy is also important) but can be monitored and audited using specially designed protocols for the purpose.

**Prevention**

11. The most important work in this field must be directed at childhood and parenting. This is where these complex disorders take root, and yet we still resist the notion that there is any connection between childhood experiences and problems in later adult life. Research must be encouraged on the developing brain of the infant – at birth, the least differentiated organ in the infant's body. The impact of the environment during these early months and years, particularly from the primary care-givers, is substantial. To reverse the process of damage in later life is costly, time-consuming and – currently - unrewarding work. Not every infant damaged will become personality disordered; it would seem that genetic predisposition has a vital part to play, but until we have the tools for predetermining those at risk we must ensure that interventions take place early on where there are signs of abuse and/or deprivation. This is where the medical model and the therapeutic model could and should work together. In terms of intervention, this should mean an increased role for community midwives, educational psychologists, GPs and the old child guidance clinics. To cater for those young people who slip through the net, we recommend a resurgence in the democratic therapeutic community facilities which have closed down over the years (eg Peper Harow), i.e. those which take young children (eg Mulberry Bush, Standlake, Oxford), rather than just those which cater for an older client group such as the Henderson Hospital, which is currently expanding. It is essential to tackle these problems as early as possible.

**Michael Howlett**

**Director, The Zito Trust**

**December 1999**

**Annex C**

David Hinchcliffe MP

Chair, Health Committee

House of Commons SW1A 0AA

9 June 2000

**INQUIRY INTO PROVISION OF NHS MENTAL HEALTH SERVICES**

I realise the Health Committee has now completed its oral evidence sessions for the inquiry into the provision of NHS mental health services. I want to write to you, however, to clarify a point that was raised during the final session on 24 May by Simon Burns MP. Jayne Zito, who attended the session, reported a point raised by Mr Burns to the Secretary of State for Health, which concerns the numbers of homicides committed by the mentally ill.

While our concerns about the provision of services for the severely mentally ill in the community are not based on a view as to whether there has been any significant fluctuation in the number of homicides committed by mentally ill people in the last two decades, I do feel, however, it is important to correct an impression about these statistics which is now current among some professionals, MPs and representatives of the voluntary sector.

I believe Mr Burns stated that the number of homicides committed by mentally ill people has fallen in recent times. While this may indeed be true, it is not a statement that can reliably be made from an analysis of the statistics currently available from Home Office publications, nor from any interpretation made of those statistics. I am thinking, in particular, of a paper published by professors Pamela Taylor and John Gunn in the *British Journal of Psychiatry* in 1999 which is, from time to time, relied upon to support the view that such a fall in the numbers has indeed taken place.

Without going into the paper at great length, I would appreciate the opportunity to make one or two important observations about it. The figures collated by Taylor & Gunn begin in 1957 when the defence of not guilty of murder but guilty of manslaughter on the grounds of diminished responsibility (gmdr) was first introduced in the Homicide Act of that year. Although gmdr disposals are the most common outcomes in cases of homicide by mentally ill people, they by no means cover all disposals in such cases. What some people appear to have done is to look at the Taylor & Gunn figures for gmdr disposals, note that the number of such disposals has fallen

slightly in recent years, and then state with some confidence that homicide by mentally ill people has declined. As Professor Louis Appleby pointed out in his article in the *British Medical Journal* (8 May 1999), which accompanied publication of the report of the National Confidential Inquiry, '[t]he rate of verdicts of diminished responsibility reflects the processes of the criminal justice system rather than the true rate of mental disorder, particularly when perpetrators have a personality disorder.'

This is a vital point which appears to have been overlooked by some commentators on this issue. It is worth noting that what Taylor & Gunn have done is take the gmdr figures, add numbers for those who committed suicide before trial, those convicted of infanticide, and those found unfit to plead or not guilty by reason of insanity, and call their overall figure the '[t]otal *mentally disordered*' (my italics). But their total figure predominantly represents those who have been diagnosed with a mental *illness*, most commonly schizophrenia. It is rare, in our experience, though admittedly not unknown, for anyone with a legal diagnosis of psychopathic disorder, within the meaning of the Mental Health Act 1983, to succeed with the defence of diminished responsibility, which is usually followed by a hospital order.

The exclusion of a separate category for psychopathic disorder in the Taylor & Gunn figures is understandable, given that these figures are not available in the annual statistics published by the Home Office and, importantly, given some of the findings which emerged in debate following the trial of Michael Stone in 1998 – two factors which are inextricably related. You will no doubt recall that the Home Secretary drew attention to the fact that these days very few 'patients' with a diagnosis of psychopathic disorder will get treatment from psychiatrists within the NHS, and are more likely to go to

prison if they commit an offence. In his letter to *The Times* of 31 October 1998, Jack Straw quoted some figures which highlight the extent to which psychiatric practice has changed since the Mental Health Act was passed in 1983. These Home Office figures show that as a proportion of all restricted patients admitted for hospital treatment under the 1983 Act, the number who are psychopathically disordered has declined, from 14% in 1994 to 3.6% in 1997. Furthermore, it is clear from Department of Health statistics that most of the 3.6% are in one of the three special hospitals. The point is that the great majority of those with a diagnosis of psychopathic disorder who have committed homicide are included in the overall total figures for homicide (the annual rate of which has increased substantially during the last three decades). As Home Office annual statistics do not separate out this category we are ultimately unable to rely on these statistics to say with any degree of certainty how many mentally *disordered* people commit homicide.

The closest we have come to an accurate assessment of homicide and mental disorder is to be found in Louis Appleby's National Confidential Inquiry report. Mental disorder is defined there to include mental illnesses (such as schizophrenia and manic depression), and other disorders, such as personality disorder and alcohol and/or drug abuse. The Inquiry found that 44% of all homicides were committed each year by people with a diagnosed mental disorder, the majority suffering from alcohol or drug dependence, or personality disorder, rather than schizophrenia or affective disorder. The total number of offences recorded by the Home Office as homicide in 1967 is 354 (44%=156); in 1997 the total is 618 (44% =272).

In conclusion, my point is that we need to be more careful in presenting statistics about homicide and mental disorder when in fact we mean homicide and mental illness. I recognise, of course, that there is a separate debate about diagnostic categories and classifications, in addition to the debate about what are the appropriate services for them. For example, the incidence of alcohol and drugs in conjunction with a mental illness or personality disorder leads to an increased propensity to violence, and 'dual diagnosis' is now rightly recognised as highly significant – this week's publication of the Report of the All Party Parliamentary Drugs Misuse Group on dual diagnosis is timely in this respect. It is quite common to read academic papers, and some textbooks, where the expressions mental illness and mental disorder are used interchangeably. This highlights just some of the current confusion at the heart of the debate about treatability.

I would like to emphasise that I have not gone into this subject at some length because what we do and what we represent as an organisation are in some way dependent on a particular interpretation of homicide statistics. Whether the figures have gone up or down, the event itself is a trauma for those involved in every individual case, including the mentally disordered offender and his or her family. Homicide is, of course, the tip of an iceberg which hides a much larger number of suicides and untoward incidents related to community care breakdown, some of which we continue to deal with on a daily basis at The Zito Trust.

**Michael Howlett**
**Director**