Mental Health Bill House of Commons
Second Reading supplementary briefing:

Risk, violence and the amended Mental Health Act

1. The risk of homicide by people with mental health problems

There has been much debate about the risk of violence posed by people with severe mental illnesses. While people with the most severe mental health problems do have a higher risk than average of committing homicide, they are responsible for a very small proportion of such tragedies.

The facts are:

- About 5% of homicides are committed by people who have had contact with mental health services. The number of such cases has stayed the same (about 50 a year) for the past 50 years. Many more homicides are associated with drink and drugs than with mental illness.

- The number of homicides recorded by police by people currently with a mental health problem is lower still, and has remained at about 30-40 a year since 1997 (according to Home Office figures) while overall homicide rates have increased by around 30%.

- Mental illness is not a predictor of violence although for the small percentage with psychotic illness there is a modest increase in levels of violence.

- Some 630,000 people are today in contact with mental health services, the vast majority of whom live safely in their own homes. Only one person in 20,000 with schizophrenia commits homicide.

2. Findings from homicide inquiries

Every homicide by a person with severe mental health problems is followed by an independent inquiry. These provide important lessons about what can be done in future to reduce the risk of such tragedies happening again.

The Michael Stone inquiry found that despite much intervention by services on his behalf there were institutional and communication failures, including a lack of appropriate inpatient services that contributed to his commission of homicides. It did not recommend a change to the law. It found at no point was he refused a service: he was refused admission to an ordinary hospital ward because he would be a danger to other patients and there was a lack of secure beds available.

The John Barrett inquiry found that Barrett's care had been 'seriously flawed': the risk he posed was not properly assessed and he was given 'ground leave' at Springfield Hospital, from which he did not return. Neither a CTO nor the abolition of treatability would have made any difference in this case.

The Christopher Clunis inquiry found that his care was characterised by 'one failure or missed opportunity on top of another' and that a lack of resources was a key reason for this. In particular it was a failure of services to follow up with him or his family or to 'plan, provide or monitor' Section 117 aftercare, and a lack of secure

beds and sufficient trained social workers. Implementation of CPA and assertive outreach would have had more impact in this case than a change in the law.

3. Evidence from homicide reviews

Two recent government publications have reviewed evidence from a range of inquiries to draw wider lessons from their findings.

The National Confidential Inquiry *Avoidable Deaths* report examined 500 homicide cases (and 5,000 suicides) over 10 years. It concluded:

- 'The number of patient homicides has not changed' over time.
- 'It is… unrealistic to expect services to prevent all suicides and homicides.'
- The number of suicides by people using mental health services is 1,300 a year: many times higher than the number of homicides.
- 14% of homicides (seven a year) were found to have been 'most preventable'.
- The keys to preventing homicides and suicides were:

    1. Preventing people from absconding from inpatient wards
    2. Better care in transition from hospital to home
    3. Improved care planning and implementation
    4. Direct contact with people who do not comply with treatment after discharge (including home visits)
    5. Changing professionals' views about the preventability of deaths and their ability to do so
    6. Improved observation on inpatient wards
    7. Better physical ward environment
    8. Improved care for people with a dual diagnosis of mental health and substance use problems.

The Government's review of homicides by Prof Anthony Maden also reported last year on the small proportion of cases where the individual had behaved very violently before the tragedy took place. It stated that there was a case for some kind of compulsion in the community for the most dangerous individuals who consistently represent a high risk and do not comply with treatment.

4. Compulsory treatment in the community

Some commentators have argued that community treatment orders (CTOs) will help to reduce the risk of homicide.

CTOs are not common in European countries but they are used in New Zealand, Australia and at least 38 States in the USA. Despite over two decades of use, their effectiveness has not been established.

A detailed assessment of the impact of CTOs conducted in 8 States by the RAND Corporation in 2001 concluded there was better evidence for focusing resources 'on developing state-of-the-art community based mental health treatment systems' than for creating compulsory community treatment orders.

The most structured assessment of CTOs so far published (by the Cochrane Collaboration) found: 'little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices: health service use, social

functioning, mental state, quality of life, or satisfaction with care… In terms of numbers, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.'

The DH's own review of CTOs internationally has yet to be published, despite which it is pressing ahead with plans for CTOs that have much broader powers than any other country where they are now in use.

5. Implications for the Mental Health Bill

The Government proposes to improve public safety through increasing the scope of compulsory powers and bringing people into compulsion even if they cannot gain any therapeutic benefit from it.

This approach will not reduce risk, and could in fact increase it, because:

- It is based on the wrong model. The belief that it is possible to predict who, out of a population of people with a history of violence, will commit a violent offence is false. Using the most accurate risk assessment predictors it would require the detention in hospital of at least 2,000 people to prevent a single homicide[1]. This is impractical AND
- The added use of resources for compulsory care will diminish availability of other community services that could better avert crisis and danger. Dangerousness is not an enduring trait. It can be exacerbated by some factors (eg drugs and alcohol) and restrained by others and can be modified over time. There is evidence that quality of care rather than risk assessment makes the biggest difference to offending behaviour[2].
- Psychiatrists and service users make clear that a more coercive system will scare more people away from services, stopping them from seeking help early on for fear of excessive coercion.
- Only one person in 20,000 with schizophrenia commits homicide. This legislation must also work for the other 19,999, not drive them away from services or unnecessarily exclude them from the chance of an ordinary life.

'The only way that I can generally decide that somebody is a danger to themselves is because they have come to see me, I have interviewed them and they have told me what is in their mind. If they do not do that I will not know about it; and so any law that drives people away from service I have to say, increases risks for everybody and damages health.... we need to get people to come and see us.' Dr Anthony Zigmond, Vice President Royal College of Psychiatrists

The Government also claims the Bill could reduce the risk of suicide. According to official figures, there are 1,300 suicides by mental health service users annually

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[1] For instance Szmukler 2003, *Risk assessment: 'numbers' and 'values'* in Psychiatric Bulletin 27, 205-207

[2] Analysis of 40 homicide enquiries between 1988 and 1997 concluded that in 11 cases (27.5%) violence could have been predicted but in 72% there had been insufficient evidence to alert professionals. The findings state "more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would than would be averted by attempts at better risk assessment and management (11 cases)." Munro & Rumgay: 2000. *Role of risk assessment in reducing homicides by people with mental illness*.
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(2000-04), of whom 49% had been in contact in the previous week and 86% were judged to have a low immediate risk of suicide. The National Confidential Inquiry noted that the best ways to prevent such tragedies were: to improve inpatient care; better transition care from hospital to home; improved care planning; a more positive staff attitude to prevention. The Bill addresses none of these issues.

Changing the law will not in itself have a big impact on homicide or suicide rates. Continued efforts to invest in better services and effective treatments that people will want to use are the key. But the Bill could go some way to reduce risk by:

- Giving people a right to be assessed when they seek help: currently up to a quarter of people are turned away because they are not ill enough and because of a lack of available services.
- Requiring all people who have been sectioned to be given a comprehensive care plan when they leave hospital.
- Limiting the use of compulsion as far as possible to increase public confidence that if they seek help they will not be sectioned unless it is necessary and likely to help them.

The amendments passed by the House of Lords go some way to achieving this. They ensure community treatment orders are only imposed on those who are a risk to others. And by bring the scope of compulsory powers into proportion they will increase public and patient confidence in the system, encouraging those who need help to seek it without fear of unnecessary coercion. The task ahead is to amend the Bill further to create positive rights to better care.

The Mental Health Alliance, March 2007