Between 10% and 40% of patients commit assault before admission to hospital and 28% of discharged patients have been found to have committed at least one violent act within a year of discharge (Monahan, 1997; Steadman et al., 1998). As with intensive case management (Walsh et al., 2001), crisis intervention has not so far been demonstrated to reduce the frequency of violent episodes committed by patients. This is neither argument for nor against crisis intervention, but simply a statement that we just don’t know what the impact of crisis intervention is on violence.

Finally, with regard to issues relating to the detainment of patients under the Mental Health Act, the authors’ views may be too radical for liberal-minded UK psychiatrists. Our current system of detention of patients may be considered too slow and unwieldy by the authors, but the alternative proposal of a single individual (a crisis assessment and treatment team worker) alone being able to swiftly effect the deprivation of an individual’s liberty is surely much more open to abuse than the English and Welsh system: surely our more elaborate processes of application are meant to serve as a safeguard for patients.


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National Confidential Inquiry

Sir: Following the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby et al., 1999) we compared our services to the recommendations made for follow up of high-risk patients discharged from in-patient care. Of 158 admissions to our service between 1 August 1999 and 31 January 2000, 40 were identified as high risk because they required one to one continuous nursing supervision. Eleven were offered follow up within 48 hours, 25 between 48 hours and 4 weeks and one after 4 weeks after discharge. Three had no follow up arranged. Twenty-three patients had trial leave before discharge.

Care Programme Approach was completed in 38 cases and six patients had the risk assessment form completed at discharge. Thirty-seven patients had discharge summaries – one recorded the nature of risk and two the need for special observation during admission. Thirty-eight patients were discharged with medication supply of less than 14 days and one with 19 days (missing data n=1).

Following discharge, seven patients were involved in nine adverse incidents (seven overdoses, one suicide and one violence to property). Three of these adverse incidents occurred within 1 week of patient discharge and two of these patients had follow-up appointments within 48 hours, including the patient who committed suicide.

Seventy-three per cent did not meet the recommended guidelines for follow-up; 95% met the guidelines for 2-weeks supply of medication. There was a lack of documentation in discharge summaries of the nature of risk. Risk assessment forms were not completed on discharge in 85% of cases.

We have concerns that the recommendations are not being adhered to locally and suspect our service is similar to others nationally. To implement the recommendations considerable changes need to be made to existing practice.
Can deception be therapeutic?
Sir: We are gratified that the case we described (Sandford et al, Psychiatric Bulletin, June 2001, 25, 206–208) stimulated such interest and controversy. However, much of Dr Adshead’s commentary (Psychiatric Bulletin, October 2001, 25, 374–375) related to the general issue of deceiving patients and failed to take into account the particular features of the case that made it exceptional.

First, the case was not ‘ordinary’ insofar as we were dealing with a person with a pervasive developmental disorder whose communication and cognitive difficulties lay at the heart of this dilemma. Adshead wonders if it had been possible to talk to the patient about moving over a long period. As we described, the many previous attempts to do this had caused extreme anxiety that had precipitated assaultive behaviour and led to the potential placements falling through. Adshead appears to assume that the communication issues for our patient were the same as for the non-autistic majority, unfortunately this is not supported by the research evidence.

Second, Adshead was incorrect to describe this as a forensic case; the patient was detained under a civil section and had been for many years inappropriately placed in a forensic facility, hence the impetus to move her into an autistic friendly environment.

Third, again as detailed in the case, her suspicions around the time issue are unfounded, planning around the move took many months of careful negotiation. Fourth, at no point was false information given to the patient (i.e. the patient was not told a lie), we rather withheld information. Last, the concept of human dignity is now widely used in a variety of complex bioethical debates from care of children with behavioural disorders through palliative care to the patenting of DNA and xenotransplantation.

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Psychiatrists, stigma and unlimited responsibility
Sir: Howlett (Psychiatric Bulletin, August 2000, 24, 287–288) has an incontestable right to advance the concerns of those affected by homicides perpetrated by psychiatric patients, particularly if they are deemed to have occurred as a consequence of failed community care.

Nevertheless he appears unable to give nuanced and contextually relevant arguments as evidenced by his most recent commentary (Psychiatric Bulletin, November 2001, 25, 414–415). This, to my mind, illustrates the invidious position we straddle between the Government/pressure group instigated paternalism and the respect for autonomy so beloved of our patients. He appears to marshal point after point in pursuit of his central thesis that we as a group have not been called to account as frequently and severely as our perceived failings would suggest we deserve. And in the process convicts himself of an overarching stigmatising prejudice towards patients who kill and ourselves as their responsible medical officers. Casting them as if grotesques – medication- and supervision-free, roaming the streets looking for victims – and ourselves as overpaid incompetents. Surely the real issue is the rather low priority given to our patients by successive governments in the face of unemployment, poor housing, derisory benefit entitlement, badly resourced services and demoralised staff. All of the aforementioned occurring in a deeply fearful and prejudiced society, where the press continues to poison the atmosphere with sensational and jaundiced reportage. The gloves should come off and psychiatry needs to shout a lot louder, ‘more resources and less of the stigma’. Something I am happy to say has started in earnest!

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