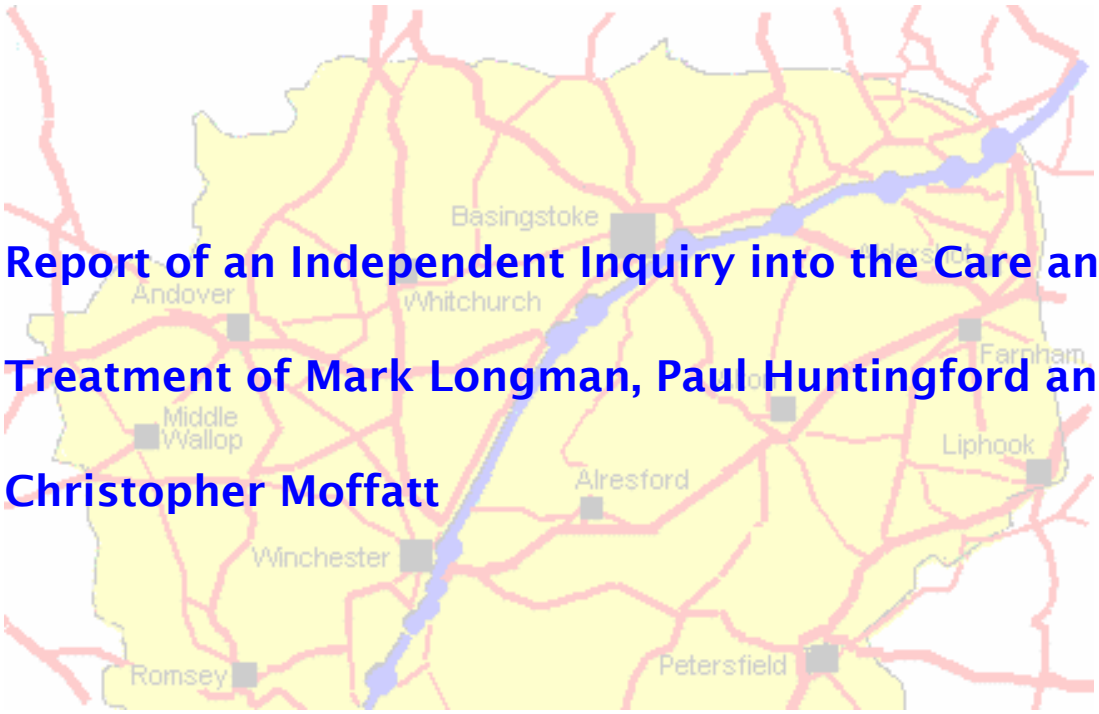
North & Mid Hampshire NHS Health Authority

Hampshire County Council Social Services



Report of an Independent Inquiry into the Care and Treatment of Mark Longman, Paul Huntingford and Christopher Moffatt

Commissioned by North & Mid Hampshire Health Authority and Hampshire County Council Social Services Department

June 2001

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PREFACE AND ACKNOWLEDGMENTS

xWe have independently reviewed the care and treatment of three patients in north and mid Hampshire who were charged with homicide.

Our review was a further source of distress for the bereaved, and for the families of the patients. We particularly wish to acknwledge the way in which they helped us, and the contributions made by their solicitors.

We also wish to acknowledge the way in which the professionals who cared for the patients worked with us. Their candour and commitment to providing the best possible service to local people was commendable. A constructive process is impossible without this willingness and commitment, but giving it, when many inquiries have been highly critical of individuals, took courage.

Such candour is to be encouraged, and is the ultimate test of professionalism. The mature professional who accepts that their practice, or local practice, can be improved upon thereby ensures that the future direction of the service is based, not on falsehood, but on a true understanding of its present state.

The function of an independent inquiry is thoroughly and objectively to review the patients' care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. We make no reference to individual professionals: the value of such a process lies not in apportioning blame, but in identifying, and then gaining support for, feasible improvements to services.

Our report is a short one. It concerns services provided to people in north and mid Hampshire and we wish it to be available to, and read by, local people and professionals. With this in mind we hope that the North & Mid Hampshire Health Authority will ensure that it is generally available.

As a final note, it needs to be emphasised that the enduring impression left after many years visiting psychiatric wards is for most people not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which may cause severe physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

Anselm Eldergill (Chairperson)

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1 INTRODUCTION

National Health Service Guidelines issued in May 1994 require that an independent inquiry is held when a person who has been in contact with mental health services takes another individual's life.

In this instance, the independent panel were asked to review the care and treatment of three patients who resided in north & mid Hampshire:

Mark Longman was discharged from Park Prewett Hospital on 10 January 1995. On 4 June 1996, he killed his father, Kenneth Longman, at their home in Basingstoke, by setting fire to him. He later pleaded guilty to manslaughter on the grounds of diminished responsibility, and is presently detained in hospital under the Mental Health Act 1983.

Paul Huntingford was admitted to Parklands Hospital in May 1997, and discharged home in June. During the afternoon of 23 December 1997, he was assessed at home by his consultant and an approved social worker, who considered that he required compulsory admission to hospital. However, his admission was delayed when it was discovered that a medical recommendation form had been incorrectly dated. On 24 December, his mother, Mrs Lena Huntingford, died during an attempt by him to exorcise her. He was subsequently found to have been insane at the time, and was not convicted of any criminal offence. He too is presently detained under the Mental Health Act.

Christopher Moffatt was admitted to Parklands Hospital in January 1997, where he was detained under section 3 of the Mental Health Act 1983. He left hospital without permission on 19 February 1998, and went to, and worked in, Andover. On 9 April 1998, he entered a private house in Hampshire and stabbed Anthony Harrison, killing him. He was later convicted of manslaughter on the grounds of diminished responsibility. Subsequently, he committed suicide in the hospital where he was detained under the Mental Health Act.

All three of the patients lived within the area served by the NORTH & MID HAMPSHIRE HEALTH AUTHORITY, HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES and the NORTH HAMPSHIRE LODDON COMMUNITY NHS TRUST, and received in-patient treatment in Basingstoke. They were not, however, cared for by the same mental health team. Mr Longman received in-patient treatment at the old Park Prewett Hospital, and was cared for in the community by the eastern sector team. Mr Huntingford and Mr Moffatt were treated in Basingstoke's new Parklands Hospital, and were cared for in the community by the southern sector team.

Patient	*Admitted to*	*Last left hospital*	*Community team*	*Date of homicide*
Mr Longman	Park Prewett	10 January 1995 (discharged)	Eastern team	4 June 1996
Mr Huntingford	Parklands	30 June 1997 (discharged)	Southern team	24 December 1997
Mr Moffatt	Parklands	19 February 1998 (absconded)	Southern team	9 April 1998

WHO CONDUCTED THE INQUIRY

The inquiry was undertaken by a panel of professionals from outside Hampshire. The care and treatment received by Mr Longman and Mr Moffatt was reviewed by Anselm Eldergill, Paul Bowden and Nick Welch.

Mr Huntingford's care and treatment was also reviewed by Anselm Eldergill and Paul Bowden, who were joined for this review by Claire Murdoch and Jeremy Walker.

Anselm Eldergill (Chairperson)	Solicitor. Former Chairman of the Mental Health Act Commission's Legal & Ethics Committee. Author of *Mental Health Review Tribunals, Law and Practice*.
Paul Bowden (Medical member)	Consultant Forensic Psychiatrist. Joint editor of *Principles and Practice of Forensic Psychiatry* and former editor of the *Journal of Forensic Psychiatry*.
Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
Jeremy Walker (Social work member)	Approved social worker, Mental Health Act Commissioner.
Nick Welch (Social work member)	Assistant Director, Oxfordshire Social Services.

PURPOSE SERVED BY THE INQUIRY

The function of an independent inquiry is thoroughly and objectively to review the patient's care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. This is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone.

Such inquiries serve important private and public needs. At a private level, individual tragedy requires a response, ideally determined by the individual circumstances: inquiries enable the bereaved to know that what happened is being fully and impartially investigated, and to be a party to that process. Equally, local people need to be reassured that the service is operating effectively. In such circumstances, it is wholly understandable, and wholly reasonable, that local people wish to be reassured that when family members come home, or friends or strangers return to their community, the risk of being seriously harmed is minimal.

Although agencies outside the locality may draw useful lessons from an inquiry report, the cost and usefulness of the exercise does not require national justification. The value of the process lies in systematically examining the way in which a particular service, and group of professionals, operate and co-ordinate *their* efforts.

GUIDING PRINCIPLES

The inquiry panel were guided by the following principles:

1. A health and social services inquiry is a form of service review, and its main function is to learn lessons and bring about necessary change. Retribution, and the expiation of wrong-doing, are matters for the courts and for professional bodies.

2. The process is not concerned with establishing whether the death was predictable or preventable, or who bears responsibility for it. Unless insane, the patient bears responsibility for it, and professional interventions and omissions only ever make certain events more or less likely.

3. Although always present, apprehension and fear on the part of those taking part should be minimised, so that the inquiry does not interfere with the service being provided to others.

4. The panel should seek to reduce the anguish and distress experienced by the bereaved and the patient's family by establishing early contact with them, sharing information, and, if requested, securing legal representation for them.

5. The personal nature of information about a patient and his family, plus the importance of an uninhibited dialogue and minimising stress, makes privacy desirable, and meetings should be held in private.

6. An adversarial approach is incompatible with a review process which attempts to bring about change through uninhibited dialogue, partnership and consensus, and within which culpability is not an issue.

7. The process should be as informal as possible, developing into a partnership with those providing the services, and avoid the usual terminology of inquiries ('inquiry', 'witness', 'evidence', etc).

8. Candour should be encouraged because it ensures that the future direction of the service is based on a true, comprehensive, understanding of its current state.

9. Procedural fairness remains important even when a review is not directed at establishing responsibility and culpability, and the panel should impose on itself a set of procedures designed to ensure this (see below).

10. The report should be short and accompanied by an abstract of the main points; not disclose personal information unnecessarily; concentrate on the terms of reference and local services; be confined to points on which the panel are agreed; set out what it is realistic for the public to expect in relation to psychiatric treatment, care, risk, and discharge planning; accept that all discharge decisions involve risk; make clear the legislative and other constraints to which practitioners are subject, so that decisions are measured against a realistic yardstick; recommend, or contain, a course of action for each significant problem (or explain why further improvement is not feasible); and contain as few recommendations as possible.

11. The report should be readily available locally.

12. The implementation of the action plans set out in the report should be audited by the Health Authority, and the panel should contribute to that process.

THE TERMS OF REFERENCE

The terms of reference, which were drafted and agreed by NORTH & MID HAMPSHIRE HEALTH AUTHORITY, were similar in all three cases, and required us to review each patient's care and treatment and related matters. In particular, we were to consider in each case:

1. the quality and scope of the patient's health, social care and risk assessments.

2. the suitability of their treatment, care and supervision in the context of

    — their actual and assessed health and social care needs

    — the actual and assessed risk of potential harm to himself or others

    — the history of medication and compliance with that medication

    — any previous psychiatric history, including alcohol and drug misuse

    — any previous forensic history

3. the extent to which their care complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, and relevant guidance from the Department of Health, including the care programme approach (see pp.17, 19, 20), and the guidelines on supervision registers (see p.18) and discharge planning (see p.18).

4. the extent to which their prescribed treatment and care plans were adequate, documented, agreed with the patient, carried out, monitored, and complied with.

5. the adequacy of the risk assessment training of all staff involved with the three patients;

6. the adequacy of the collaboration and communication between the agencies involved in each patient's care (LODDON COMMUNITY NHS TRUST, HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES and the general practitioners).

7. the adequacy of the support given to each patient's family by the community health team and other professionals.

Having done this, we were to prepare a report for the NORTH AND MID HAMPSHIRE HEALTH AUTHORITY, HAMPSHIRE COUNTY COUNCIL and the LODDON COMMUNITY NHS TRUST. That report was to contain our findings and recommendations concerning the care and treatment available to mentally ill people, and the safety of mental health users, the public and staff.

OVERVIEW OF THE PROCESS

The ideal of a constructive review, which seeks to develop a partnership with the services and individuals affected by the death, led to the following procedure being adopted:

1	**Introductions**	Pre-review meetings were held with family members and the teams, with the aim of allaying any fears they had about the process.
2	**Documents**	As the documents were received, they were indexed and a chronology was prepared.

3	**Induction**	An induction week was held, during which the panel visited relevant sites; received presentations concerning the organisation of local services and the implementation of legislation and departmental guidelines; and obtained a number of independent perspectives (from the Mental Health Act Commission, the Community Health Council, and user groups). Having read the documents, visited the sites, and drawn on local expertise, the panel members defined the issues, identified those persons whom they wished to see, or receive statements from, and commissioned further documents.
4	**Meetings**	Meetings were held with those involved in each patient's care, followed by informal meetings with managers, at which the panel communicated what they had read and heard, and any areas of concern.
5	**Action**	Following these discussions, action plans were drawn up for inclusion in the final report, and a steering group was formed, comprising the chairperson and a representative from each agency, in order to co-ordinate this process.
6	**Report**	The report was drafted, containing a brief history, the findings, and the action which had been, or is being, taken in response.
7	**Follow-up**	The panel will reconvene after nine months, in order to assess the extent to which the action plans have been implemented, and to report further to the Health Authority.

In our opinion, the benefits of such a process are:

- that it seeks consensus;
- that it is productive (capable of producing necessary change); *and*
- that action is part of the process.

TIMETABLE

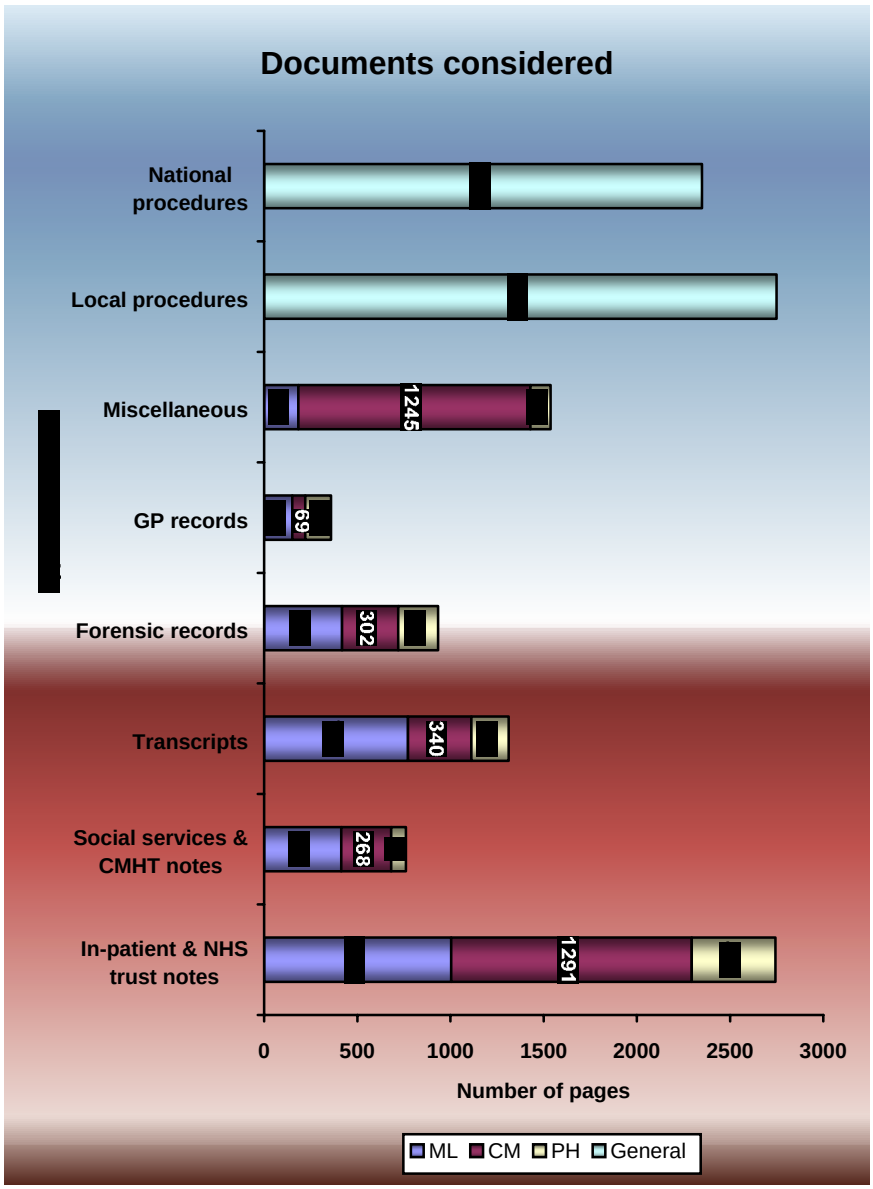
Mark Longman and Christopher Moffatt both consented to the release of their medical and other records to the panel. The panel members and local professionals then worked hard, and at short notice, in order to conclude their reviews as quickly as possible. By the end of July 1999, after six months, all of the documents concerning their care had been obtained and all of the hearings had taken place; and our preliminary findings had been fed back to the services.

Mr Huntingford refused to consent to the release of his records, and the Department of Health refused to confer on the panel chairman the necessary powers to subpoena the documents. This left the services in a difficult legal position, because of the risk that they might be liable for breach of confidence if they released the documents without his consent or a legal order. Having noted that, the panel and the Loddon Trust were willing to proceed, on the basis that the public interest served by an independent review outweighed the public interest in maintaining the patient's usual right to confidentiality. Eventually, following receipt of a confirmatory opinion from Queen's Counsel, it was decided to proceed. At this point, one of the panel members had to be replaced because of other commitments, the review having originally been scheduled to last a year. The remaining members had also started other undertakings, around which the third review in Hampshire had to be completed.

INFORMATION REVIEWED BY THE PANEL

During the course of the inquiry, the panel interviewed 92 professionals concerning the care and treatment received by the three patients. We also read almost 13,000 pages of documents concerning their care and treatment or the way in which local services are provided.

In order to keep our report short and readable, and so as not to disclose unnecessarily information about their families and professional carers, precise details do not appear in this report. However, it is important to emphasise that the inquiry was thorough and searching, and the following chart summarises the information received by us, upon which our findings are based.



PROCEDURAL SAFEGUARDS

Although not part of the terms of reference, the inquiry panel chose to adopt a set of procedures designed to ensure that those persons assisting them were treated fairly:

REVIEW PROCEDURES

1. Every professional who provided treatment or care to the particular patient prior to the death will receive a letter before meeting with the inquiry team. This letter will ask them to provide a written statement and inform them:

   a. of the terms of reference and the procedure adopted by the inquiry;

   b. of the areas and matters to be covered with them;

   c. that when they attend the meeting they may raise any matter they wish which they feel might be relevant to the inquiry;

   d. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another person who has been asked to meet with the inquiry team;

   e. that it is the person invited who will be asked questions and who will be expected to answer;

   f. that what they say will be transcribed and a copy of the transcription sent to them afterwards for them to sign.

2 Persons attending meetings with the inquiry team may be asked to confirm that what they have said in their statement and at the meeting is true.

3 Any points of potential criticism will be put to the individual affected, either verbally at the meeting with the inquiry team, or in writing at a later time, and s/he will be given a full opportunity to respond.

4 Written representations may be invited from professional bodies and other interested parties regarding best practice for persons in similar circumstances to the patient's, and as to any recommendations they may have for the future.

5 Those professional bodies or interested parties may be asked to speak with the inquiry team about their views and recommendations.

6 Anyone else who feels they may have something useful to contribute to the inquiry may make written submissions for the inquiry's consideration and, at the chairman of the panel's discretion, be invited to speak with the inquiry team.

7 All inquiry meetings will be held in private.

8 The draft report will be made available to North & Mid Hampshire Health Authority and Hampshire Social Services and, with their consent, to the Loddon NHS trust, for comments as to points of fact.

9 Information submitted to the inquiry either orally or in writing will not be made public by the inquiry, except insofar as it is disclosed within the body of the inquiry's report.

10 Findings of fact will be made on the basis of the information received by the inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

2 THE HUMAN FRAMEWORK

ABOUT THIS CHAPTER

The service which professionals can provide to people with mental health problems is influenced by resources and models of service delivery set nationally and locally. It is, however, also determined by many other factors, such as the chronic course of some mental disorders; the fact that severe mental disorders cannot be cured; the limited efficacy of available treatments; and the speculative nature of all assessments of a person's future behaviour. The purpose of this chapter is briefly to describe some of these problems, and what it is realistic for the public to expect in relation to psychiatric treatment and care, so that professional decisions are measured against a realistic yardstick.

MENTAL DISORDER

Psychiatry is that branch of medicine concerned with the study, diagnosis, treatment and prevention of mental disorder. The term 'disorder' is not an exact term but simply implies the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and interference with personal functions. In practice, the classification of certain disorders as mental or psychiatric is largely determined by the historical fact that these conditions have generally been treated by psychiatrists.

RISKS ASSOCIATED WITH MENTAL DISORDERS

The current emphasis in mental health practice is very much on public safety. Nevertheless, it needs to be emphasised that the enduring impression left after many years visiting psychiatric wards is for most people not one of fear or dangerousness, but of suffering and an often disarming kindness on the part of those who have lost their liberty. Although compelled to submit to the will of others, and forced to accept medication which can cause severe physical discomfort, most patients remain dignified and courteous, and retain the compassion to respond to the plight of others in a similarly unfortunate situation.

The risk of suicide

Serious mental disorder has a marked effect on lifetime suicide rates. They have been estimated at schizophrenia 10%, affective (mood) disorder 15%, and personality disorder 15%. Suicide rates amongst young men with no known occupation are nearly four times those in social classes I and II; and the suicide rate in men is three times that in women. On average, one patient on each GP's list will commit suicide every five years.

In statistical terms, the risk that a mentally ill person will kill her or himself is substantially higher than the risk that s/he will kill another person. According to one study, persons suffering from schizophrenia are one hundred times more likely to kill themselves than another person, and persons with a mood disorder are one thousand times more likely (Häfner & Böker, *Crimes of violence by mentally disordered offenders,* Cambridge University Press, 1982).

The risk of homicide and violence to others

There are about forty homicides per 100,000 psychiatric admissions, compared with ten maternal deaths in child-birth per 100,000 deliveries (Tidmarsh, *Psychiatric risk, safety cultures and homicide inquiries*, The Journal of Forensic Psychiatry (1997) 8(1): 138–151). Although the public have understandably been concerned about the closure of the old asylums and the discharge of patients into the community, the criminal statistics for England and Wales between 1957 and 1995 do not reveal any increase in the number of homicides committed by persons with mental health problems. There has, in fact, been little fluctuation in the number of people with a mental illness who commit criminal homicide over the 38 years studied, and a three per cent annual decline in their contribution to the official statistics (Taylor & Gunn, *Homicides by people with mental illness: myth and reality*, British Journal of Psychiatry (1999) 174: 9–14).

Although research findings tend to demonstrate a positive relationship between mental illness and offending, including violence, this must be seen against the general level of prevailing violence in homes and public houses, and on the roads. Mentally ill people contribute proportionately very little to the general problem of dangerous behaviour. Measured against the full range of modern social hazards, the contribution to public safety of preventively confining persons with mental health problems is tiny, as also is the likely impact on the rates at which serious offences are committed.

It must also be borne in mind that in-patients are themselves members of the public. Practitioners therefore face the difficult task of ensuring both that members of the public are not unnecessarily detained and also that members of the public are protected from those who must necessarily be detained. Balancing these different considerations is a formidable task.

GOOD PRACTICE AND RISK MANAGEMENT

There is much written and said nowadays about risk management, of which risk assessment is the first step. Risk management has become a sort of cure-all; as if, recently discovered, it holds the key to a safe future. In fact risk management has existed for years, simply as good practice. Good practice includes skills in communication and understanding; the capacities to listen, be flexible, and empathic; it is built on sound training, and effective supervision and support; it is not judgemental or discriminatory; it is broadly based, fair and thorough, and its policies and practices are the product of multi-disciplinary consensus. The same comments apply to the care programme approach (CPA) about which, again, much is said in this report.

WHY NO SERVICE CAN EVER BE TOTALLY SAFE

It is impossible for a mental health service to be totally safe. However, some of the principles which psychiatric practice takes account of, and which we have borne in mind, are that:

- there is tension within any resource limited service between the utilitarian ideal of producing the greatest good for the greatest number and the desire to perfect the care for individuals. A utilitarian service attempting to provide 'good enough' care for all will inevitably have some individuals experience a poor outcome. In practice, this usually means that there is subsequently a reworking of the poor outcome cases to a more thorough level.

- in-patients are members of the public, and at increased risk of being victims of violence for as long as they are detained on a psychiatric ward.

- risk cannot be avoided and even a very low risk from time to time becomes an actuality.

- every decision about the need to detain a person involves the assumption of a risk and, however careful the assessment, it is inevitable that some patients will later take their own lives or commit a serious offence.

- the purpose of compulsory powers is not to eliminate that element of risk in human life which is a consequence of being free to act, and to make choices and decisions; it is to protect the individual and others from risks that arise when a person's judgement of risk, or their capacity to control behaviour associated with serious risk, is significantly impaired by mental disorder.

- good practice relies on good morale and a feeling amongst practitioners that they will be supported if they act reasonably; it is unjust to criticise them when decisions properly made have unfortunate, even catastrophic, consequences.

- the occurrence of such tragedies does not *per se* demonstrate any error of judgement on the part of those who decided that allowing the patient their liberty did not involve unacceptable risks.

- an outcome often occurs as a result of a complex of events, and the choice of one particular causal factor may be arbitrary.

- small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.

- unless the individual's propensity for violence has a simple and readily understandable trigger, it is impossible to identify all of the relevant situations; some of them lie in the future and will not yet have been encountered by the patient.

- understanding the situations in which a person has previously been dangerous, and avoiding their repetition, can give a false sense of security about the future.

- although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction is therefore significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

- predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').

- a risk can in theory be measured and is the basis of actuarial prediction — in theory because in practice all of the critical variables never are known. While the risk depends on the situation, all of the situations in which the patient may find himself in the future can only be speculated upon.

- all violence takes place in the present, and the past is a past, and so unreliable, guide to present and future events.

- because future events can never be predicted, it is important to put in place an adequate system for supervising any individual whose own safety may potentially be at risk or who may pose a threat to the safety of others.

- this approach is not fail-safe: it is based on the assumption that most attacks do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.

- all human beings, regardless of their skills, abilities and specialist knowledge, make fallible decisions and commit unsafe acts, and this human propensity for committing errors and violating safety procedures can be moderated but never entirely eliminated.

- introducing the concept of 'hindsight bias' in a defensive way cannot justify a lack of reasonable foresight, or simple failure to think about what one is doing.

3 THE NATIONAL FRAMEWORK

ABOUT THIS CHAPTER

Local practitioners work within a context set nationally. The purpose of this chapter is to explain briefly the national legislation and guidelines which guide, and sometimes limit, how they practise. One of the tasks given to the inquiry panel was to report on local compliance with the Mental Health Act, and national and local policies and procedures.

OVERVIEW

- The delivery of mental health and community care from 1997 onwards has been governed by a number of Acts of Parliament, such as the *National Health Service Act 1977*, the *National Health Service and Community Care Act 1990*, and the *Health Act 1999.*

- The circumstances in which a person with mental health problems can be detained in hospital are set out in the *Mental Health Act 1983*.

- Under that Act, a *Code of Practice* is published periodically, the aim of which is to guide practitioners about what is, and is not, good practice.

- The Department of Health issues *Health Service Guidelines*, which require all health and social services authorities to manage or deliver a service provided by them in a particular way; such as care plans and discharge arrangements.

- The way in which the police and the prosecution should deal with persons with mental health problems is set out, in particular, in a *Code for Crown Prosecutors* and a circular called *Mentally Disordered Offenders: Inter-Agency Working*.

NATIONAL HEALTH SERVICE

Many different individuals and bodies may be involved in the detention, treatment or care of an individual.

Unless the hospital is a private establishment, it will form part of the National Health Service for which the *Secretary of State for Health* is accountable to Parliament. The Secretary of State has a duty to provide hospital accommodation and such other mental health services as he considers appropriate as part of the health service, and to such extent as he considers necessary to meet all reasonable requirements. The Department of Health's funding is negotiated annually with the Treasury, through the public expenditure survey.

The Secretary of State is not normally involved in the day-to-day management of the National Health Service. The *NHS Executive*, the headquarters of which is based in Leeds, provides the central management of the NHS, dealing with all operational matters. The size and complexity of the NHS means that it must operate through a regional structure, and there are eight NHS Executive regional offices. The regional office responsible for Hampshire was the South West and Wessex Regional Office until 31 March 1999, and is now the South East Regional Office.

NHS hospitals are managed by NHS trusts, and Parklands Hospital was managed by the *Loddon NHS Trust* until 31 March 2001. The core function of an NHS trust is to deliver health services according to the local Health Authority's specifications. Every trust has a board, consisting of a chairperson appointed by the Secretary of State, and executive (employee) and non-executive (non-employee) directors. All of the trust's directors are full and equal members of the board, and jointly responsible for carrying out the trust's functions.

Since 1993, local health authorities have purchased in-patient and other medical services from these trusts. However, as part of the current reorganisation of the NHS, responsibility for commissioning local health services is increasingly being transferred to Primary Care Groups (PCGs) and Trusts (PCTs). For people living in Basingstoke, Alton, Bordon and the surrounding areas, this responsibility now rests with the NORTH HAMPSHIRE PRIMARY CARE TRUST established on 1 April 2001.

Although the NHS Executive regional offices monitor the NHS trusts within their area, and approve their business plans, they do not generally become involved in detailed operational matters, which are the responsibility of the local health authorities and trusts.

SOCIAL SERVICES

The local authority responsible for people living in north and mid Hampshire is *Hampshire County Council*. Although some cities in Hampshire now have their own 'unitary' local authority, these changes did not affect Basingstoke.

Community care refers to the policy of providing services and support which people affected by mental health problems need in order to be able to live as independently as possible. The National Health Service and Community Care Act requires local authorities to prepare and publish a plan for the provision of community care services in their area. It also gives local authorities primary responsibility for co-ordinating the assessment of community care needs. In general terms, any community care services which may be provided by a local authority may also be provided by the independent sector. Just as the role of health authorities has become one of purchasing health services provided by NHS trusts, so local authorities are expected to seek out and purchase community care services from a range of public and non-public providers.

Section 117 of the Mental Health Act 1983 imposes a duty on the health authority and the local social services authority to provide after-care services for patients who have been detained in hospital for treatment and who then cease to be detained and leave hospital.

MENTAL HEALTH ACT 1983

The vast majority of people who receive psychiatric treatment in hospital are treated without resort to formal legal powers, and they are known as 'informal patients'. In a minority of cases, where the actions of an individual with mental health problems are seriously jeopardising his welfare or that of others, the law countenances detention and treatment without consent. The main statute which deals with the subject of mental disorder, the Mental Health Act 1983, includes powers which authorise such detention and restraint. All applications for a person to be detained are founded on medical recommendations, and most of them are made by an approved social worker (or ASW), that is by a social worker who has completed special training. The criteria for detention always comprise at least two grounds. The first of these grounds (*the diagnostic ground*) requires that the individual is suffering from a serious mental disorder. The second ground (*the risk ground*) requires that his detention is 'necessary' or 'justified' on his own account (specifically for his health, safety or welfare) or that of others (in order to protect them). Whether a person's detention is justified or necessary in a particular case will often depend in part on what

arrangements have been, or can be, made for his treatment outside hospital. The patient's willingness to accept appropriate treatment as an informal in-patient, and his capacity to adhere to any agreed treatment programme and discharge plan, will also be highly relevant.

Applications for assessment under section 2

Under section 2 of the 1983 Act, an individual's nearest relative or an approved social worker may apply for that person to be detained in hospital for up to 28 days, so that his mental state can be assessed, and any treatment given which is assessed to be necessary. Such an application must be founded on two medical recommendations.

Emergency applications under section 4

In urgent cases, obtaining two medical recommendations may lead to undesirable delay in effecting admission. Section 4 sets out an emergency procedure which enables a person to be admitted for assessment on the basis of a single medical recommendation. If this procedure is adopted, the authority to detain the individual ceases after 72 hours unless the second recommendation has by then been received.

Applications for treatment under section 3

Detention beyond 28 days is generally only permissible if a fresh application, made under section 3, has been accepted by the managers of the relevant hospital. Their acceptance of an application under this section authorises them to detain and treat the person in hospital for up to six months. Where necessary, that authority to detain the patient may be renewed for a second period of six months, and thereafter for a year at a time.

Applications which relate to care outside hospital

When a patient is detained in hospital for treatment, section 25A now provides that an application may be made for him to be supervised in the community upon leaving hospital. Alternatively, an application may be made under section 7 for a person to be placed under the guardianship of a local social services authority, or a private individual, for up to six months. As with section 3 applications, a supervisor's authority and a guardian's authority lapse after six months unless renewed for a further six months, and thereafter at yearly intervals.

Relationship between the different applications

The various powers just referred to are not mutually exclusive. In the first place, a person detained in hospital may be transferred into guardianship, and vice-versa. Secondly, it is common for one application to be replaced by another. For example, section 4 might be used to admit a person in an emergency. If the second medical recommendation required by section 2 is then received within the permitted 72 hour period, the patient may be detained for the remainder of the usual 28 day assessment period. A section 3 application will follow if, before the 28 days expires, it becomes clear that a more prolonged period of detention and compulsory treatment is necessary. If it then becomes apparent that the patient will require statutory supervision after he ceases to be detained under section 3 and leaves hospital, a supervision application may be made.

Short-term powers not exceeding 72 hours

The procedures just described require the presence of the individual whose mental health is in issue and the attendance of those persons who must interview and examine him.

Problems will occur where access cannot be obtained to a person's home in order to conduct an assessment of his need for admission; where the seriousness of a person's mental condition only becomes apparent at a time when no doctor or approved social worker is immediately available; or where an informal patient attempts to leave hospital in circumstances which suggest that it is necessary to make an application for him to be detained there.

The Act therefore includes a number of short-term powers of detention, which enable a person to be detained so that his mental state and situation may be assessed and/or any necessary application made.

Detention of in-patients under section 5(2)

If it appears to the doctor in charge of an informal in-patient's treatment that an application ought to be made under section 2 or 3, he may furnish a written report to that effect to the managers of the hospital. Once such a report is furnished, the patient may be detained in the hospital for a period of 72 hours.

Removal from a public place to a place of safety under section 136

If a police constable finds in a public place a person who appears to him to be suffering from mental disorder, and to be in immediate need of care or control, the constable may remove him to a place of safety, if he thinks it necessary to do so in that person's interests or to protect others. The individual may be detained there for a period not exceeding 72 hours, for the dual purpose of, *firstly*, enabling him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and, *secondly*, of making any necessary arrangements for his treatment or care. These arrangements not uncommonly involve making an application for the person's admission to hospital.

Powers of the Home Secretary

The Mental Health Act also contains various powers relating to patients involved in criminal proceedings. Under section 48, the Home Secretary can direct that a person who is in prison awaiting trial shall be transferred to hospital for treatment. This is known as a 'transfer direction'.

The use made of powers of detention

There were 12,990 patients detained in hospital under the Mental Health Act on 31 March 1999, compared with 12,680 a year earlier. Of, these 1,300 (10%) were detained in a high security NHS psychiatric hospital; 10,500 (80%) were in other NHS facilities, and 1,170 (9%) were in private mental nursing homes. Most of the patients (80%) were recorded as suffering from mental illness.

CODE OF PRACTICE

The Secretary of State publishes a code of practice concerning the use of the 1983 Act and the medical treatment of patients. The first and second editions of the code were in force when the three patients whose cases we reviewed were in hospital. A third edition replaced it in April 1999. According to this version, good practice now requires that greater emphasis is placed on risk assessment and management and less on the importance of individual liberty. For example, the new Code says that, 'Informal admission is usually appropriate when a mentally capable patient consents to admission, *but not if detention is necessary because of the danger the patient presents to him or herself or others*' (para. 2.7). It also states that, '*A risk of* physical harm, or serious persistent psychological harm, to others is an indicator of the need for compulsory admission' (para. 2.9).

HEALTH SERVICE GUIDELINES

The following guidelines concerning discharge planning, supervision, risk management, after-care and care programmes were issued between 1989 and 1997.

(a) Discharge of Patients from Hospital, Health Circular HC(89)5

The circular states that no patient may be discharged until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the care the patient will need in the community.

This includes making arrangements for any necessary follow-up treatment, travel to, and support in, the home or other place to which they are being discharged. They or their relatives must also be fully informed about such things as medication, lifestyle, diet, symptoms to watch for, and where to get help if it is needed. Important points must be confirmed in writing. Their ability to cope and access to emergency services and out-of-hours advice must be taken into account.

Responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given in one member of the staff caring for that patient. This person should have a check-list of what should have been done. If the completed check-list is filed in the patient's notes it will provide a permanent record of action taken before discharge.

In many cases the patient, family or friends, will be capable of making all the arrangements for the return home. All that will then be required of the nominated member of the hospital staff is to ensure that they and the general practitioner have been given all the information they need. In other cases much more will be required, a range of services will have to be organised in advance, and several agencies involved.

(b) Local Authority Circular LAC(89)7

Local Authority Circular LAC(89)7 draws the attention of local authorities to *Health Circular (89)5*, and asks them to review their existing procedures, so as to ensure that people do not leave hospital without adequate arrangements being made for their support in the community. The circular states that local authorities have a key role to play in ensuring that a range of services are available for patients who will need continuing care and support which cannot be provided by family and carers alone. Social workers can advise on the particular package of services available from statutory and non-statutory suppliers which will best meet the patients needs and preferences. Suitable accommodation is essential if people are to be able to resume independent living in the community. Social services departments should make sure that local authority housing departments are involved at an early stage in the planning process if the patient is not able to return to his or her former home.

(c) Care programme approach, Health Circular HC(90)23

The *care programme approach* applies to all patients who require psychiatric treatment or care, and it requires health and social services authorities to develop care programmes based on proper ‘systematic arrangements’ for treating patients in the community. The underlying purpose is to ensure the support of mentally ill people in the community, thereby minimising the risk of them losing contact with services, and maximising the effect of any therapeutic intervention.

All care programmes should include systematic arrangements for assessing the health care needs of patients who can potentially be treated in the community. A key worker should be appointed for the patient.

The key worker's role is to keep in close touch with the patient, and to monitor that the agreed health and social care is given. S/he should maintain sufficient contact with the patient, and advise professional colleagues of changes in circumstances which may require review and modification of the care programme. When the key worker is unavailable, proper arrangements should be made for an alternative point of contact for the patient and any carers. Every reasonable effort should be made to maintain contact with the patient and his carers, in order to find out what is happening, to sustain the therapeutic relationship, and to ensure that the patient and carer knows how to make contact with the key worker or other professional staff.

(d) Supervision registers, Health Service Guidelines HSG(94)5

Supervision registers were an extension of the care programme approach. The purpose of the registers is to enable NHS trusts, and other NHS provider units, to identify all individuals known 'to be at significant risk of committing serious violence or suicide or of serious self-neglect, as a result of severe and enduring mental illness.' Consideration for registration should take place as a 'normal part' of discussing a patient's care programme before he leaves hospital. The decision as to whether a patient is registered rests with the consultant, although other members of the mental health team, including the social worker, should be consulted. Judgements about risk should be based on detailed evidence, and the evidence be recorded in written form and available to relevant professionals.

(e) Guidance on Discharge, Health Service Guidelines HSG(94)27

The guidance seeks to ensure that psychiatric patients are discharged only when and if they are ready to leave hospital; that any risk to the public or to patients themselves is minimal; and that when patients are discharged they get the support and supervision they need from the responsible agencies.

According to the guidelines, the 'essential elements' of an effective care plan are systematic assessment, a care plan, the allocation of a key worker, and regular review. The professionals responsible for making discharge decisions must be satisfied that these conditions are fulfilled before any patient is discharged.

It is essential that arrangements for discharge and continuing care are agreed and understood by the patient and everyone else involved, including private carers. In particular, they should have a common understanding of the community care plan's first review date; information relating to any past violence or assessed risk of violence; the name of the key worker (prominently identified in clinical notes, computer records and the care plan); how the key worker or other service providers can be contacted if problems arise; and what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

There must be a full risk assessment prior to discharge, which involves: (1) ensuring that relevant information is available; (2) conducting a full assessment of risk; (3) seeking expert help; and (4) assessing the risk of suicide. A proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour. It is essential to take account of all relevant information, whatever its source. Too often, it has been the case that information indicating an increased risk existed but was not communicated and acted upon.

(f) Introduction of the departmental after-care form (February 1995)

In February 1995, the Department of Health circulated an after-care form designed to be used for all patients discharged from psychiatric in-patient treatment, including those subject to section 117. The use of the form, though not mandatory, was

strongly recommended as constituting good practice, and was devised in response to a recommendation in the *Report of the Inquiry into the Care and Treatment of Christopher Clunis (North West London Mental Health NHS Trust, 1994).*

The form contains a number of sections: (1) About the patient; (2) Patient's nominated contact; (3) Keyworker's details; (4) After-care plan; (5) Information to be included in the after-care plan; (6) Availability of information (7) Review; (8) Transfer of responsibility for patient's after-care; (9) Discharge from after-care.

(g) Building Bridges document (November 1995)

Building Bridges stressed that the care programme approach is the cornerstone of the Government's mental health policy. It also emphasised the need to adopt a tiered approach. The purpose of this is to focus the most resource-intensive assessment, care and treatment on the most severely mentally ill people, while ensuring that all patients in the care of the specialist psychiatric services receive the basic elements of CPA.

Patients with less complex needs should still receive systematic assessment, be assigned a key worker, and receive monitoring and review of a simple care plan. A minimal CPA would apply to patients who have limited disability/ health care needs arising from their illness and have low support needs which are likely to remain stable. They will often need regular attention from only one practitioner, who will also fulfil the key worker role.

Each patient's details should be entered on a CPA information system, and an initial needs assessment be carried out by a mental health professional ('pre-CPA assessment'). If a patient needs only a minimal CPA there will be no need for a multi-disciplinary meeting. It is important that the individual concerned and his or her carer(s) are involved as much as possible in the care planning process. All aspects of the care planning process should involve the user, his or her advocate, carers and/or interested relatives. A full assessment of risk, covering both risk to the patient and others, should be part and parcel of the assessment process. If the patient has been an in-patient, the keyworker should ensure before discharge that elements of the plan necessary for discharge are carried out. This will include the patient's needs for medication, therapy, supervision and accommodation. In particular, those taking decisions on discharge have a duty to consider both the safety of the patient and the protection of other people. No individual should be discharged from hospital unless and until those taking the decision are satisfied he or she can live safely in the community, and that proper treatment, supervision, support and care are available.

The keyworker is the linchpin of the CPA. S/he should be selected at the needs assessment meeting and, since s/he is vital to the success of the whole process, identified as soon as possible. This is particularly the case when patients are soon to be discharged from hospital. The decision as to who should be the key worker should take into account the patient's needs: if housing and financial concerns and family problems are uppermost, a social worker is likely to be the most suitable candidate. The patient will need to know that the key worker (or an alternative worker) is available when things are difficult. Therefore, the key worker should ensure that patients and their carers have a contact point which is always accessible. Keeping in touch must also be assertive and key workers should not rely on the patient contacting them.

(h) Subsequent guidance

In order to help the reader make sense of the recommendations and action plans set out in Chapter 9, it is necessary to refer to three important documents published since April 1998: *Modernising Mental Health Services, Modernising the care programme approach* and the *National Service Framework*.

Modernising Mental Health Services (December 1998)

In December 1998, the Government promised to modernise mental health services by providing safe, sound and supportive services:

Safe	***Sound***	***Supportive***
• Good risk management • Early intervention • Enough beds • Better outreach • Integrated forensic and secure provision • A modern legislative framework	• 24 hour access • Needs assessment • Good primary care • Effective treatment • Effective care processes	• Involvement of patients, service users and carers • Access to employment, education and housing • Working in partnership • Better information • Promoting good mental health and reducing stigma

Modernising the care programme approach (October 1999)

The booklet sets out important changes to the CPA which take account of available evidence and experience. Some of the key developments are the integration of the CPA and care management; the appointment of lead officers within each trust and local social services authority; the introduction of two CPA levels (standard and enhanced); the removal of the previous requirement to maintain a supervision register; and the use of the term 'care co-ordinator' in place of 'keyworker'.

National Service Framework (November 1999)

The *National Service Framework* is the single most important guide to the challenges ahead for mental healthcare (and the deployment of resources in general) over the next 5–10 years. It sets seven key standards in five areas, which are expected to be delivered from April 2000:

Standard 1	• Mental health promotion
Standards 2 & 3	• Primary care and access to services
Standards 4 & 5	• Effective services for people with severe mental illness
Standard 6	• Caring about carers
Standard 7	• Preventing suicide

Each standard is supported by a rationale, by a narrative that addresses service models, and by an indication of performance assessment methods. Each standard also indicates the lead organisation and key partners.

Standards four and five aim to ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible.

The following represent some of the most significant standards set out in the framework, in the context of the three patients' care and treatment:

Primary care	Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed; and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.
Access to services	Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.
Effective services (including CPA)	All mental health service users on the *Care Programme Approach* (CPA) should: • receive care which optimises engagement, prevents or anticipates crisis, and reduces risk. • have a copy of a written care plan which: i. includes the action to be taken in a crisis by service users, their carers and their care co-ordinators; ii. advises the GP how they should respond if the service users needs additional help; iii. is regularly reviewed by the care co-ordinator. • be able to access services 24 hours a day, 365 days a year. Each service user who is assessed as requiring a period of care away from their home should have a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.
Caring about carers	All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis; have their own written care plan, which is given to them and implemented in discussion with them.

Performance will be assessed at a national level by measures which include the national psychiatric morbidity survey; reduction in suicide rates; access to psychological therapies; access to single sex accommodation; reduction in number of prisoners awaiting transfer to hospital; implementation of the 'caring for carers' action plans; and reduction in readmission rates.

The *proposed outcome indicators* for cases of severe mental illness include the prevalence of severe illness; the number of patients discharged from follow-up; CPA plans signed by service users; the incidence of serious physical injury; in-patient admissions; patients lost to follow-up; admissions of longer than 90 days duration; the prevalence of side effects from antipsychotics; user satisfaction measures; mortality amongst people with severe illness; and the number of homicides.

CRIMINAL LAW SYSTEM

In 1994, the Crown Prosecution Service produced a *Code for Crown Prosecutors* in which mental health issues are discussed as a public interest factor which may mitigate against prosecution (section 6.5). The issues are also covered in Home Office Circular No. 12/95 *Mentally Disordered Offenders: Inter-Agency Working* (Home Office and Department of Health, 1995). The following extract from Circular No. 12/95 has a relevance to some aspects of our review:

> ***'When to consider charging***
>
> The police have a crucial role to play in determining whether a mentally disordered person enters the criminal justice process. The existence of mental disorder should never be the only factor considered in reaching a decision about charging. The need to protect the safety of the public may indicate that formal action is needed ….
>
> Determining when prosecution is the proper course can be a finely balanced judgement. To help reach a decision, the police will need to find out whether the person has any history of mental disorder or has had any previous contact with the criminal justice system. Good links with the local psychiatric and social services are essential to provide a ready source of advice about the person's current mental state and any previous psychiatric history.
>
> This information should help the police to determine whether an incident can be assessed as an isolated event, and to decide an appropriate way forward, taking account of the gravity of the offending and the potential risk to others if the behaviour recurs. Although an incident may be a minor matter in itself, it is important to establish whether it represents the latest in a developing pattern of dangerous behaviour which requires intervention by the criminal justice system for the protection of the public.'

4 THE LOCAL FRAMEWORK

ABOUT THIS CHAPTER

Chapter 3 explained the national framework for delivering mental health services. The purpose of this chapter is to explain the local framework, by summarising how local services were, and are, organised and delivered.

I. INTRODUCTION AND OVERVIEW

Hampshire is the largest county in southern England, with a population of 1,150,773 and an area of 380,000 hectares. The area is a mixture of rural, semi-rural and urban settlements, and is one of the most prosperous and healthy parts of the country. The main towns are Winchester, Basingstoke, Farnborough and Aldershot, with significant populations in Andover, Tadley, Alton and Bordon.

Mr Longman lived in Basingstoke, Mr Moffatt in Alton, and Mr Huntingford in Bordon. All three of them resided within the boundaries of the NORTH AND MID HAMPSHIRE HEALTH AUTHORITY, HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES DEPARTMENT, the SURREY HAMPSHIRE BORDERS NHS TRUST and what is now the NORTH HAMPSHIRE PRIMARY CARE TRUST.

It should be emphasised that the SURREY HAMPSHIRE BORDERS NHS TRUST and the NORTH HAMPSHIRE PRIMARY CARE TRUST assumed responsibility for local mental health services on 1 April 2001.

From 1 April 1993 until 31 March 2001, the LODDON COMMUNITY NHS TRUST provided community mental health services (in partnership with Hampshire County Council Social Services Department) and inpatient and specialist services to people living in Basingstoke, Alton, Bordon and surrounding areas. On 1 April 2001, the services provided by Loddon were transferred to other organisations as follows:

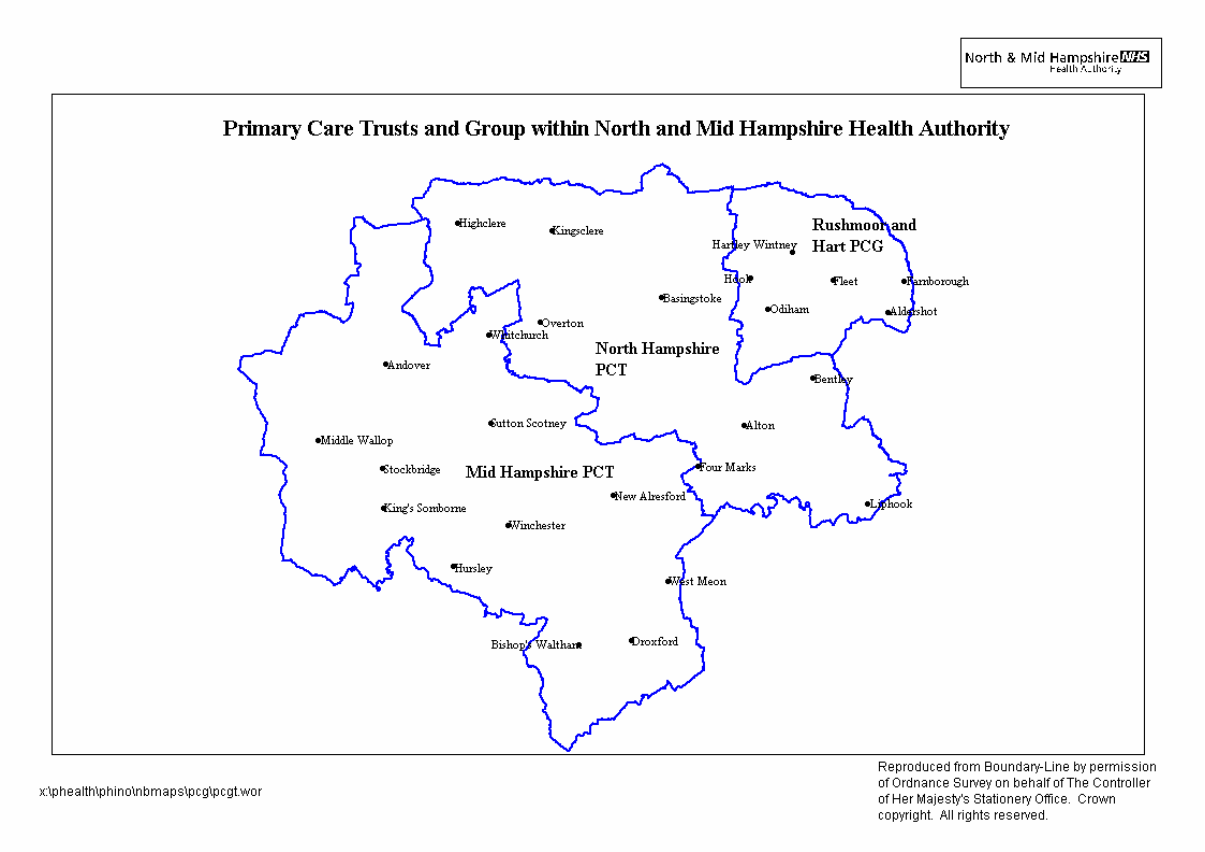
- mental health services, including child and adolescent mental health, were transferred to the SURREY HAMPSHIRE BORDERS NHS TRUST, a trust already providing mental health and community services to people living in North East Hampshire;

- other children's services were transferred to the NORTH HAMPSHIRE HOSPITALS NHS TRUST;

- most other community services, such as health visiting and family planning, transferred to the new NORTH HAMPSHIRE PRIMARY CARE TRUST, established on 1 April 2001 as the successor body to the NORTH HAMPSHIRE PRIMARY CARE GROUP. This trust is now the lead organisation for commissioning secondary care services, including mental health, for people living in Basingstoke, Alton, Bordon and the surrounding areas.

It should also be emphasised that this reorganisation of local mental health services is part of a national reorganisation of the NHS, and the decision to dissolve the Loddon Community NHS Trust was not performance-related.

The diagram below shows the configuration of Primary Care Trusts/Groups as at April 2001.



II. THE LOCAL POPULATION

Hampshire has a predominately rural image, centred on the historic county town of Winchester. However, north Hampshire has significant urban centres in Andover, Basingstoke and the Blackwater Valley.

The demography of the Basingstoke area is varied, with a large rural area spreading northwards and westwards from the town. Local mental health services have traditionally been centred in Basingstoke, because the old Park Prewett Hospital was there and it had the largest population. There are two other communities of significant size within the area: Tadley in the north and Kingsclere in the west.

The population of Hampshire is predicted to rise slightly between 1997 and 2001, with larger than average increases in the number of children and people aged over 85. The number of residents from ethnic minorities is relatively low, but includes a Sikh community in Basingstoke, and an Asian community in Alton.

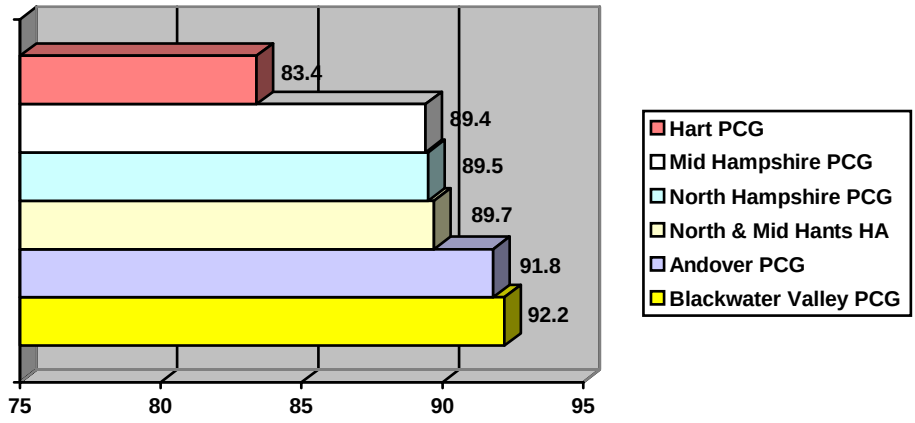
ECONOMIC AND SOCIAL CONDITIONS

Areas of high social deprivation correlate with increased prevalence of mental illness and use of services, such as admission to hospital. In the case of Hampshire, the county is relatively prosperous, and indicators of social need are slightly below the average for similar counties.

The Mental Illness Needs Index (MINI)

The *Mental Illness Needs Index* (MINI) estimates the level of mental illness expected within an area, using factors known to lead to poorer mental health, such as unemployment, homelessness and low income. The average score for England and Wales is 100. Areas with a score above 100 are likely to have higher levels of mental illness than average, those below 100 lower. North and mid Hampshire as a whole has a lower than average MINI score. Although there are wards with high scores within the area, such as Heron Wood in Aldershot, with a score of 107, even this compares favourably with areas such as Hackney in London, which scores 120.

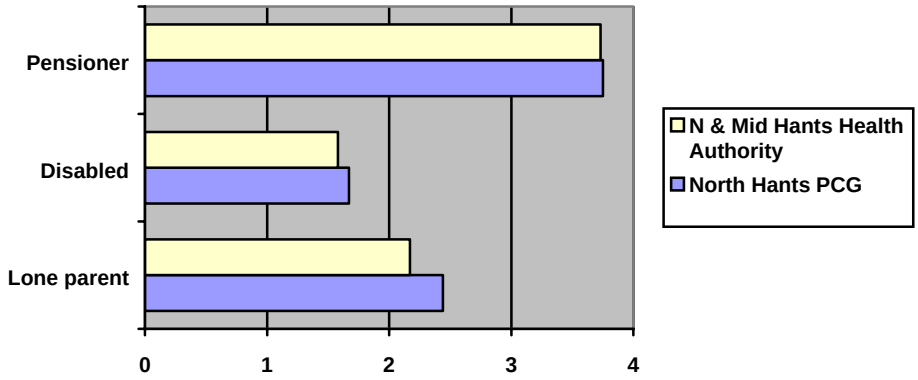
North & Mid Hampshire MINI Scores



Income support claimants

Poverty has a cumulative effect, and those particularly vulnerable to poverty include pensioners, lone parents, households with no earners, and families with children.

Households with income support claimants (%), August 1998



Rural disadvantage

Isolation, unemployment, poor transport links and sparse services affect rural communities and large estates in several built-up areas. Research commissioned by COMMUNITY ACTION HAMPSHIRE, and funded by HAMPSHIRE COUNTY COUNCIL, demonstrates that many rural parishes lack basic amenities: 92 per cent lack rail services; 67 per

cent lack evening bus services; 57 per cent lack daytime bus services; and 67 per cent lack a permanent or visiting GP. There are very few services in the Kingsclere Area, which means that people either travel to Basingstoke or receive little service at all.

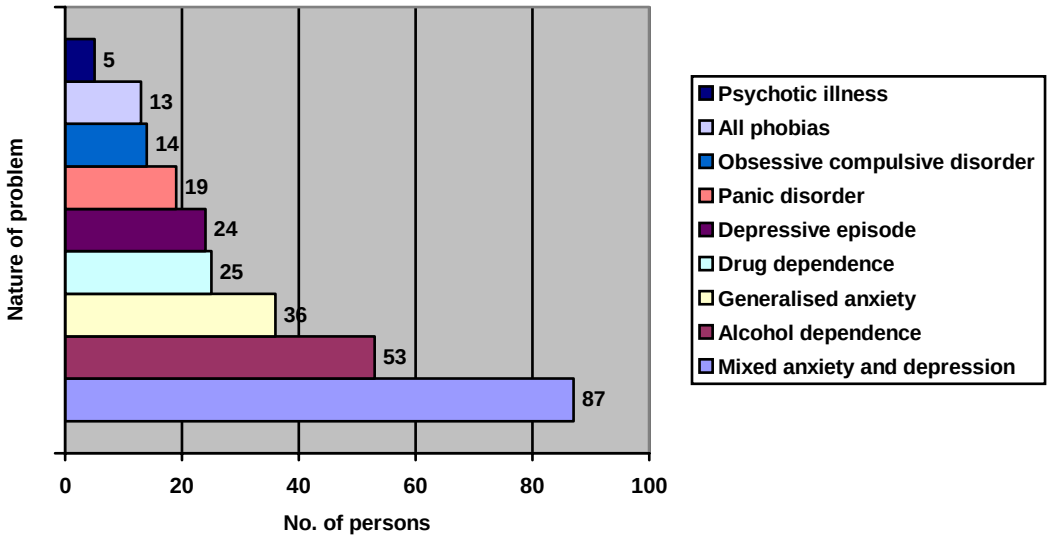
ADULT MENTAL HEALTH

National research suggests that some 10-25% of the general population annually seek help for mental health problems, usually from their GP. Between 2-4% of adults have a severe mental illness, and between 0.3 and 1.5% of them a severe and enduring mental illness.[1] The prevalence in rural areas is, however, significantly lower than that in urban areas.

A recent national survey of over 10,000 people aged 16-64 indicated that during the preceding year:[2]

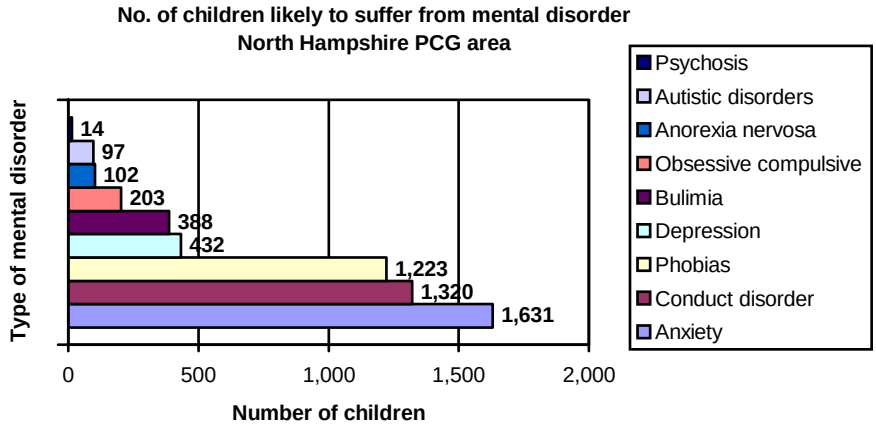
- functional psychosis (for example schizophrenia or manic depression) had a prevalence of 4/1000;
- the overall rate of alcohol and drug dependence was 47/1000 and 22/1000;
- men were three times as likely as women to be alcohol-dependent, and twice as likely to be drug-dependent;
- alcohol and drug dependence were most prevalent among young adults, particularly young men aged 16-24.

Applying this national data to adults aged between 16-64 in north & mid Hampshire gives an estimated prevalence of 2,206 cases of functional psychosis, with almost 26,000 people dependent on alcohol, and just over 12,000 dependent on drugs.[3] On the basis of this estimate, an average GP's list of 1,800 people aged 16 to 64 would include around 275 patients with the following range of mental health needs:[4]



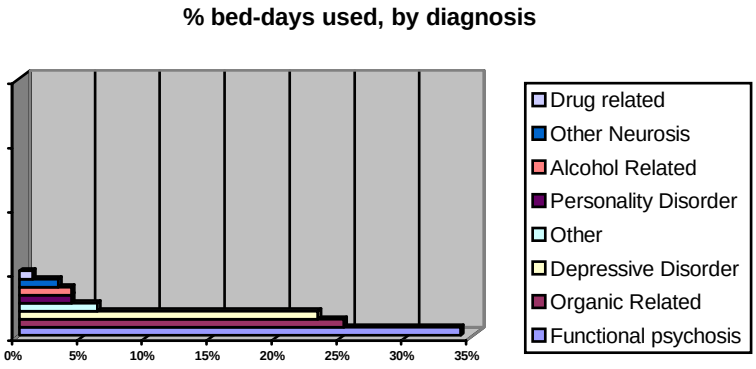
CHILDREN'S MENTAL HEALTH

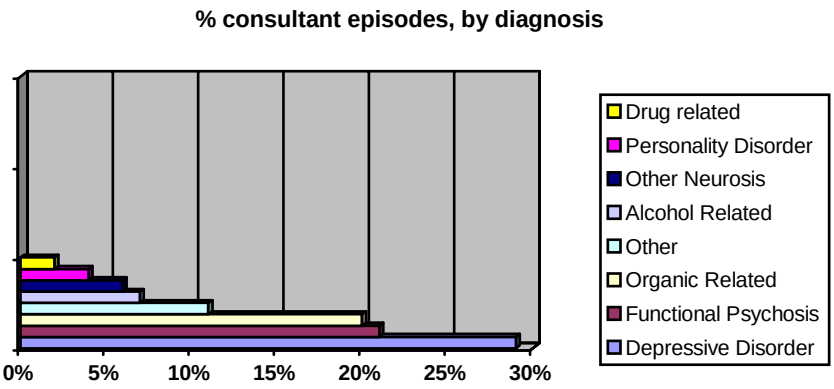
The rate of mental illness among young people has been rising, and rates of suicide in teenagers have increased nationally. The following table estimates the number of people aged under 18 in what until 1 April 2001 was the North Hampshire PCG area who are likely to have certain forms of mental disorder.[5]



IN-PATIENT AND CONSULTANT CARE

The following charts show the proportion of hospital bed days, and the proportion of consultants' finished cases, devoted to patients with different kinds of mental health problem.[6]





Within Hampshire, it appears to be the case that the rate at which people with a diagnosis of schizophrenia are admitted to hospital is falling. Such admission rates are influenced by the level of mental illness in the community, diagnostic habits, how readily consultants admit people to hospital, and the availability of beds and community care.[7]

Directly age-standardised hospital episode rate per 100,000 for schizophrenia

PCG	*Males*		*Females*	
	1997-98	*1998-99*	*1997-98*	*1998-99*
Andover	16.55	13.22	19.02	7.65
Blackwater Valley	23.20	17.80	22.08	8.61
Hart	20.96	8.63	24.74	5.74
Mid Hampshire	38.98	28.41	19.55	9.53
North Hants PCG	**36.77**	**15.96**	**22.48**	**8.76**
N&MH HA	**30.61**	**17.72**	**21.52**	**8.43**

Prescribing data

GP prescribing data reveal pockets of high usage of modern atypical antipsychotics in north and mid Hampshire, the highest use being in the Blackwater Valley area. This may reflect needs of the patients, or what local consultants choose to prescribe.

Readmission rates

National studies have raised concerns about the overall number of beds available, and the balance between different sorts of beds. There are concerns that bed shortages may lead to premature discharge and early readmission. One measure of the quality of community support and pressure on beds is therefore the rate of readmission to hospital.

Readmissions within 90 days of discharge, 16–64 year-olds

Primary Care Group	*1996/97*	*1997/98*	*1998/99*
Andover	33	5	16
Blackwater Valley	1	9	9
Hart	7	10	12
Mid Hampshire	97	19	29
North Hampshire	**40**	**40**	**76**
Total for NMHHA	**178**	**83**	**142**

Source CDS Inpatients from Business Objects

There have been insufficient intensive care beds in north and mid Hampshire, and some people have remained on acute psychiatric wards longer than necessary because suitable 'step-down' care is not available. At the end of March 1999, at least 14 adult mental health in-patients needed alternative care, and during 1998/99 over 1,000 acute psychiatric hospital bed-days were lost because suitable placements were not available. More local long-term medium-secure places are also needed for people who are being treated in private facilities, a long way from Hampshire.

The need for secure care

A recent study by the WESSEX CONSORTIUM FORENSIC PROJECT TEAM found that throughout the Wessex area there were 110 people who needed high or medium-secure psychiatric inpatient care. Of these, 20 were residents of north and mid Hampshire, nine of whom were in distant private placements, because local long-term low and medium-secure care was unavailable. Five were resident in high-secure hospitals.

SUICIDE

Suicide rates have been used as proxy indicators of mental health for some time, although they are not ideal for this purpose.

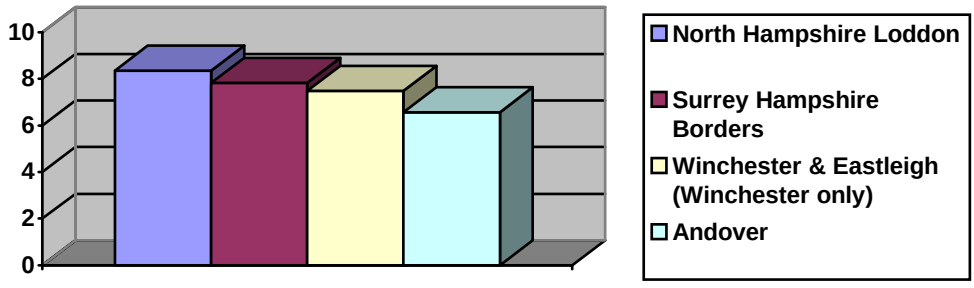
There are presently around 50 deaths from suicide each year in north and mid Hampshire.

In line with the national picture, an audit of the records of people who committed suicide in Wessex found a high incidence of previous contact with mental health services during the year prior to death. In addition, approximately 40% of the men and 60% of the women had seen a medical practitioner in the four weeks prior to their death (E King, *Wessex Suicide Audit* 1988-1993, 1996).

The rates of suicide and death from undetermined injury in the area have risen above those for similarly prosperous areas, and lie just below the rates for England and Wales. Furthermore, the age-standardised rates for males now appear to be above those both for England and more prosperous areas.

A joint review of suicides and undetermined deaths during the period from January 1995 to March 1998 was carried out recently. Confidence intervals were very wide, but the rate of deaths in the Loddon area was not significantly different from that for the other trusts in north and mid Hampshire. Of the 63 suicides and other unnatural deaths occuring in the Loddon area during the three years, 19 individuals (30%) had had contact with mental health services.

Average annual rates of suicide per 100,000 persons per year, by NHS trust area, Jan 1995 to Mch 1998



III. THE LOCAL SERVICES

During the period covered by our review, local mental health services were mainly the responsibility of three statutory bodies: North & Mid Hampshire Health Authority, the Loddon NHS Trust, and Hampshire County Council Social Services Department.

NORTH & MID HAMPSHIRE HEALTH AUTHORITY

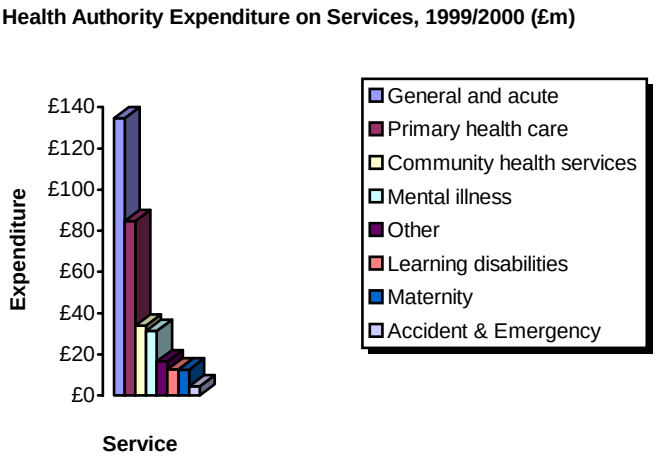
NORTH AND MID HAMPSHIRE HEALTH AUTHORITY was created on 1 April 1996. It assumed the functions previously carried out by NORTH AND MID HAMPSHIRE [DISTRICT] HEALTH AUTHORITY and HAMPSHIRE FAMILY HEALTH SERVICES AUTHORITY. Its creation established a single, statutory agency with responsibility for commissioning health care for north and mid Hampshire residents.

The health authority was responsible for implementing national health policy. Its strategic role included developing collaborative strategies to meet national and local priorities, and ensuring that national policy, and local strategy, was implemented effectively. It did this in part by monitoring the quality and standards of care of NHS trusts. Implementation of the National Service Framework was drawn together by the health authority, in consultation with individuals and organisations with an interest in the area.

During the period of our review, the health authority was responsible for trying to ensure that the needs of local people were met effectively and efficiently within available resources. Most of the expenditure on local mental health services was incurred by it, in the main through contracts with the NHS trusts that managed the services, such as the LODDON TRUST.

In 1999/2000, the health authority spent £330.7 million on healthcare and related services, which represented 98% of its total expenditure. Of this, some £31.3 million was spent on mental health.

The funding formula which sets health authority 'fair shares' targets is weighted for need. Because NORTH AND MID HAMPSHIRE HEALTH AUTHORITY has one of the wealthiest and healthiest populations in the country, its *weighted population* is only 81% of its *resident population.* It is considered to be £1.6 million over its fair shares target, and receives minimum amounts of new money coming into the NHS.



At the start of the 99/00 financial year, health services in North and Mid Hampshire faced a recurring deficit of £10 million a year (out of a total of £313 million). An external review was commissioned, to help understand the reasons for the financial pressures. The ways in which North and Mid Hampshire invests its money were compared with other Health Authorities, and the reviewers concluded that North and Mid Hampshire:

- spent proportionately more than other Health Authorities on acute and community hospitals;

- treated more patients than would be expected for the population's needs (based on a assessment of relatively low health needs when compared with other parts of the country);

- had too many organisations with consequent overhead costs.

A financial recovery plan was drawn up, in order to meet a governmental requirement to balance the authority's budget by 31 March 2002. Short-term actions were taken by trusts, some of which had had an impact on patient services. The recovery plan also involved a medium-term programme of action, which included reconfiguring local mental health services. The need to reduce overheads led to the dissolution of the LODDON TRUST on 1 April 2001, at which time SURREY HAMPSHIRE BORDERS NHS TRUST took over the management of its mental health services.

Public Health Report of 1999

The Annual Report of the Director of Public Health for 1999 focused on mental health in north and mid Hampshire, and it contains valuable information about the needs and circumstances of people living in the area. The report includes the following summary:

> 'For a long time there has been a false perception that 'not much can be done' to prevent mental health problems and improve the outcomes of treatment and care for individuals. This is far from the truth. There is now a wealth of research into what works to promote mental health and provide effective services. When people need them we need to put this into practice. We now also have a national framework within which we can do this and we will be expected to use it.
>
> It is clear that this will have to be a joint endeavour between local service users and carers together with local statutory and voluntary agencies.
>
> Compared with many parts of the country we are fortunate to have the mental health service we do. However some service developments are needed, in particular: assertive community outreach; alternatives to acute psychiatric inpatient care for people who need short tern crisis care or ... longer term supportive care; psychiatric intensive care beds; long-term low and medium-secure services; and community-based services for people with eating disorders.
>
> These service developments should be part of the Joint Investment Plan for Mental Health.'

The report made a number of recommendations, which reflected local concerns and the action needed to fulfil the standards set out in the National Service Framework. The recommendations included the following:

1. There should be no further disinvestment in mental health promotion services, especially those aimed at improving the mental health of young people.

2. The Health Authority, in conjunction with Mid Hampshire PCG and the Prison Medical Service should jointly develop a Health Improvement Programme for Winchester Prison, with mental health as a priority.

3. The Health Authority should support the development of a prison CMHT.

4. Together with partner agencies, the Health Authority and PCGs should investigate the most appropriate way to provide mental health and substance

misuse services to people who are homeless and who may find difficulty accessing regular services.

5. As alcohol misuse and drug misuse are becoming more common problems, local multi-agency strategies should be developed through the Drug Action Team and Drug Reference Groups, with appropriate links to local community safety strategies.

6. The Health Authority, PCGs and NHS Trusts should support local programmes for vulnerable children and families, for example through Sure Start schemes.

7. The Health Authority, PCGs and NHS Trusts should encourage the Education and Social Services Departments of Hampshire County Council to continue to give priority to their work to reduce school and social exclusion, for example through the Behaviour Support Plan.

8. The Health Authority, PCGs, NHS Trusts, Social Services and partner agencies should develop a more systematic approach to the involvement of local mental health service users and carers in the planning and development of mental health services.

9. PCGs and mental health service providers should consider the development of joint registers for people with severe and enduring mental illness.

10. The Health Authority, PCGs and NHS Trusts should support initiatives to minimise disadvantage in rural areas, including access to services.

11. The Health Authority and PCGs should consider the treatment of depression in primary care as a priority for clinical governance.

12. Mental health service providers and accident and emergency departments should develop guidelines for the referral and assessment by a mental health professional of people who self-harm.

13. Health and social services should ensure that all staff who work with clients who may be a risk to themselves or others have sound and regular training in risk assessment and management.

14. The Care Management and Care Programme Approach processes should be combined as soon as possible, taking account of the new guidelines for CPA.

15. Mental Health Services providers and PCGs should develop and agree referral and shared care protocols for the management of depression.

16. The Health Authority, PCGs, NHS Trusts and Social Services should develop:

    i. assertive community outreach, appropriate for a mixed urban and rural area, for people who are hard to engage in regular services;

    ii. alternatives to acute psychiatric inpatient care for people who may need short term crisis care, or longer term less intensive supported care;

    iii. a minimum of four local intensive care beds;

    iv. long-term low and medium-secure services.

HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES DEPARTMENT

The local authority responsible for providing social services to people in the Basingstoke area is HAMPSHIRE COUNTY COUNCIL.

On 1 April 1997, separate unitary authorities, with responsibility for social services, were created in Southampton and Portsmouth. The separation of the cities was viewed as a significant challenge for the county council, and was originally strongly contested. Many key services had been developed out of the cities to serve wider communities across the south of the county, and over 35 per cent of the social services budget was transferred to the new authorities, a higher proportion than that of other departments.

Departmental structure

The current departmental structure was introduced during 1996/97, when the number of local areas was reduced from 17 to seven, with an emphasis on establishing more consistent management arrangements across each area of the county.

Each area is managed by an Area Director, responsible for both adult and children's services, and for local commissioning, care management and the direct provision of services. Area Directors are members of the Departmental Management Team, and chair their own area teams of service managers, each responsible for a discrete area of service activity. The number of service managers varies slightly between areas.

The Deputy Director and four Assistant Directors based at headquarters in Winchester carry lead responsibilities for strategic commissioning, performance and resource management and for particular service areas. A number of support staff, reporting to Assistant Directors, lead commissioning and support work.

The Director therefore heads a large management team of 13, which meets two or three times a month. Area and headquarters staff work together on a large number of planning and policy groups, and items of new work are often commissioned on a project basis which may cut across management lines.

Hampshire Social Services is currently considering, together with NHS trusts, the opportunities for developing integrated, jointly managed, mental health services. More generally, the Social Services Committee decided in March 2001 that the department should develop specialist county wide management of locality services across all client groups. This is in response to the modernising health and social services agenda, and plans for this are now well advanced.

Finance and investment

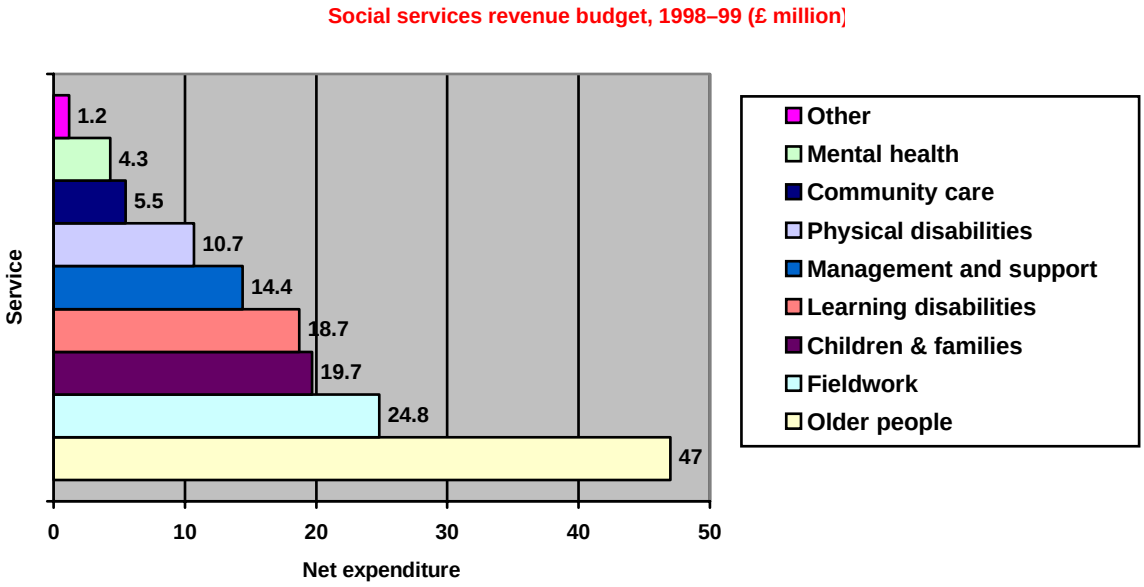
Local authority funds come from a variety of sources, including government grants and subsidies, local taxes, business rates, and charges for services, in varying proportions. Over half is government grants for specific items, and most local government finance is earmarked, so that in practice there is local discretion only at the margins as to how the money is spent.

The potential source of additional money for health projects is the net expenditure budget, though the likelihood of major shifts within this is small: public sector funding is tightly controlled and increased spending in one area can only be funded by reducing another.

The total county council budget for 1998/99, the last year local services were provided to any of the patients whose cases we reviewed, was £737m. This was £14 million less than the council needed, and a strategy was put in place to meet the deficit. 63.6% of the budget was allocated to education and 18.2% to social services.

Compared with similar authorities, Hampshire spent the second lowest proportion of council resources on social services, and the least per head of population. For all client groups, the local authority spent less per head than the average.

Excluding government grants earmarked for specific developments (such as the mental illness support grant), the social services budget for 1998/99 was £146.3 million, compared with £140 million in 1997/98. The budget was allocated across six main user groups:



Since 1997/98, Hampshire County Council's expenditure on mental health services has increased by 24% (£2.8 million).

Since 1999, an additional £1.3 million has been made available by the county council for investment in mental health services across Hampshire. £600,000 of this relates to services in North and mid Hampshire.

Since 1999/2000, net expenditure per head has overtaken a neighbouring comparator authority, and is above the average for English counties (Source: CIPFA).

The Mental Health Service Review (November 1998)

An internal *Mental Health Service Review* reported to the departmental management team in November 1998. The objectives of the review were to evaluate the service, and to identify a form of mental health service which would meet the needs of service users and their carers, while providing effective protection for the public.

The review evaluated the mental health service against ten service criteria previously agreed by the departmental management team and the ADULTS' SERVICES SUB-COMMITTEE.

The review body stated that the strengths of the service included:

- the training, support and development of approved social workers;
- the development of multi-disciplinary community mental health teams in most parts of the county;

- a range of services to promote independent living, including advocacy, flexible day and employment services;

- the development of housing with support instead of traditional residential care.

Notwithstanding these strengths, the review found that the majority of the service criteria were not met, whilst two of the criteria were partly met, and concluded that the current service did 'not perform well against agreed criteria'.

There were concerns about inconsistent practice across the county and a shortage of ASWs in some areas.

The review group decided that the weaknesses of the current service were attributable largely to a lack of clear leadership; an insufficient specialist management resource to engage effectively with NHS trust management; the fact that the traditional team manager role was less relevant following the development of CMHTs; the variable quality of management of CMHTs across the county; the lack of effective joint protocols and standards for practice and inter-agency working; and an insecure resource base (financial, human and information).

According to the group, possible options for future service development should guided by the following principles (amongst others):

1. The need to ensure a consistent standard and quality of service delivery to users and carers, and to afford public protection across the whole of Hampshire according to national, county and departmental standards.

2. The need to have mechanisms to maintain this consistency in the context of joint/integrated working with three health authorities, 13 PCGs, seven NHS trusts and 17 CMHTs (including those in south east Hampshire).

3. The priority of ensuring a high standard of risk assessment and management to minimise self-harm and danger to the public. This required an investment in joint training and the development of an adequate ASW retention policy.

4. The need for effective links between substance misuse services and mental health teams across the county, to enable the consistent provision of services for people with dual diagnosis who present complex problems.

5. The need to focus the whole of the mental health resource, including provider services, to meet the requirements.

Joint Review of Social Services in Hampshire County Council (July 1999)

In July 1999, an independent SOCIAL SERVICES INSPECTORATE and AUDIT COMMISSION report concluded that overall the people of Hampshire were currently well served by their social services. The county had a distinguished record of innovation and of pioneering quality in service development. Many of the initiatives promoted increased user choice and involvement. There was a considerable track record of inter-agency co-operation and joint service development on which to build. Furthermore, the authority had considerable skills in project management, in managing performance and in service development. It also retained a commitment to research, evidence-based practice and staff training.

The joint review also considered that there were significant variations and some shortcomings across the county and across all care groups, including getting access to services; the range of support, advocacy and choice offered to users; managing risk

where vulnerable people are being supported at home; recording what is happening on a case; reviewing how things are going; and information management.

THE LODDON TRUST

The LODDON COMMUNITY NHS TRUST was established as a trust on 1 April 1993.

A need to reduce overheads resulted in its dissolution on 31 March 2001, when the management of its mental health services was taken over by the Surrey Hampshire Borders NHS Trust. This trust now covers those residents of North and Mid Hampshire Health Authority who previously received mental health services from the Surrey Hampshire Borders NHS Trust and the Loddon NHS Trust.

Acute in-patient psychiatric services for residents in the Basingstoke area are provided and managed at Parklands Hospital. This hospital opened in December 1996, and it includes two acute wards: Hawthorns 1 and 2. Prior to then, in-patient care was provided at Park Prewett Hospital, a large and old-fashioned asylum outside Basingstoke which opened in 1921. The villas in the asylum grounds included an acute admissions unit on two floors, which housed Pinewood 1 and 2 wards.

Prior to 31 March 2001, the Loddon Trust also provided a range of mental health services in the community. This is because a comprehensive service requires a range of different types of hospital beds (including secure beds, psychiatric intensive care and acute hospital beds) and different types of 'step-down' care, such as 24-hour staffed accommodation. Crisis houses, 24-hour staffed accommodation and more intensive home treatment may prevent people being admitted to acute wards unnecessarily.

Implementation of the care programme approach and discharge planning

The care programme approach was implemented in April 1991 (see p.17), and a year was spent preparing for it, and training all staff. Over the years it has been reviewed and updated twice a year. Developing the approach, changing the criteria, developing new paperwork and training staff has therefore been a challenge.

The LODDON TRUST broadly followed Department of Health and NHS Executive guidelines when implementing the care programme approach.

Following its inception, a CPA Monitoring Group was established, which was responsible for periodically revising the documentation and guidelines, overseeing and monitoring the introduction of CPA levels, and monitoring implementation.

The Loddon trust freely acknowledged that there had been problems with CPA documentation, and that its implementation had been under-resourced in terms of administration. It was audited rather better than it was administered during the period reviewed by us.

A revised care programme approach (CPA) was implemented by the Surrey Hampshire Borders NHS Trust in April 2001. For people on enhanced CPA, the revised care plan now includes identified needs and risks in relation to medical, social, employment, occupation, housing, finance and welfare benefits, family issues, forensic matters, substance misuse, treatment provided and crisis prevention/contingency.

A board level trust manager, the Director of Mental Health, has overall responsibility for ensuring that Health Service Guidelines are adhered to, and adherence is routinely monitored.

The Surrey Hampshire Borders NHS Trust also has a care programme approach development manager, whose sole task it is to ensure the effective implementation and delivery of the CPA across the trust, in keeping with NSF standards.

Monitoring is carried out through audit, user involvement and quarterly data collection. Quarterly data collection has been expanded since April 2001, and a user focused monitoring project was introduced in 2000.

The auditing of the revised CPA procedures introduced in April 2001 will include examining the quality of out-patient assessments of previously detained patients, and this will focus on the use of information from family members, in order to verify that:

- they have been seen;
- the range of issues considered within the assessment process (e.g. medical, social, employment, financial, family, forensic, substance misuse, etc.);
- the nexus between the treatment being provided and the needs which were identified;
- the way in which risks have been identified and managed.

North and Mid Hampshire Health Authority is enhancing its monitoring by way of regular random audits of compliance with the CPA.

Care management and the care programme approach is now an integrated process.

Implementation of the supervision register

The supervision register (see p.18) was introduced by the Loddon trust in accordance with Government guidelines. Training for medical and other staff was carried out, and the register of patients was held by the medical records department. The list of registered patients was fed back to consultants on a regular basis, for them to consider whether the patient should continue on, or be removed, from the register.

Inclusion on the register was viewed as a clinical decision to be made by the patient's consultant, as part of the CPA process. Monitoring revealed a great divergence in usage, as elsewhere in the country. We were told that two consultants each had 14 patients on the register (one of whom was Mr Huntingford's and Mr Moffatt's consultant). Mr Longman's consultant had registered three patients, and the other six consultants (who included learning disability and psychiatry for old age specialists) three between them.

The trust has recently satisfied the South East Regional Office that it has complied with the new guidance on the care programme approach (see p.20), which will result in the abolition of the requirement to keep a supervision register.

Implementation of the Code of Practice

The Code of Practice (see p.16) forms part of the trust's ongoing training on the application of the Mental Health Act. The training is overseen by a MENTAL HEALTH ACT MONITORING GROUP, comprising the Clinical Director and Directorate Manager for Mental Health, a non-executive director of the trust, and representatives of different clinical groups, and social services. This group supervises the general training of staff on the Mental Health Act, and addresses specific training issues that arise from recommendations made by Mental Health Act Commissioners.

A briefing day was held on 10 May 1999, to introduce staff to the third edition of the Code of Practice, and further briefings are organised from time to time (the last being in January 2001).

Monitoring by the Mental Health Act Commission

The Mental Health Act Commission visits local inpatient facilities, and in 1999 it noted that local services were moving forward:

> 'There are quite a few innovations. They now have a place of safety in the hospital, although it is only open during office hours – but they intend to extend that. There is a quick response team, and a good assessment team. Things seem to be moving. On the ward, the recruitment of nursing staff is better, and the use of agency staff has dropped. The occupancy remains high, with leave beds being used. Generally, however, there is quite an improvement in the morale of the nursing staff, and things seem to be moving forward.'

COMMUNITY MENTAL HEALTH TEAMS

Community care involves providing services and support which people affected by poor mental health need in order to be able to live as independently as possible in their own homes, or in 'homely' settings, in the community.

Community health teams existed in one form or another in the 1980s, although their development was very much down to the individual consultants, and the different localities worked in different ways. It was only around 1993 that there was reasonable consistency, by which time most of the current consultants were in post.

The plan for implementing the local mental health strategy published in November 1993 aimed to create a comprehensive, community mental health service based around five major components:

- four locality community mental health teams, composed of qualified and non-qualified health and social services staff, and led by locality managers responsible for managing all nursing and other therapeutic staff within the locality.
- community support services.
- supported community accommodation, provided by housing associations and staffed by independent sector agencies, to replace the continuing care (long-stay) wards, *e.g.* small houses, registered care homes and nursing homes.
- modern hospital in-patient services for admission and assessment.
- specialist services for mothers and young children, those misusing alcohol or drugs, etc.

In 1995, four community mental health centres were opened in Basingstoke (two), Bordon and Tadley, to accommodate the teams. Three of the new centres were situated within Hampshire County Council Social Services' Basingstoke Area: the eastern and western teams based at the Bridge Centre, and the northern team, based at Mulfords Hill in Tadley.

Each team has a consultant psychiatrist attached to it, and a variety of other professionals, such as occupational therapists, community psychiatric nurses, art therapists, support workers and social workers.

Since the end of 1995, the community mental health teams have continued largely unchanged. There have been some changes to the management structure, and there has also been further integration of the two teams within the Bridge Centre, as joint groups and activities are run for patients of both teams.

A further development has been the integration of psychologists within community mental health teams. Previously, they worked in a separate psychology department, which was managed and accommodated within a separate directorate of the trust (the community directorate). They were seconded to teams under a service agreement.

The NHS trust and Hampshire Social Services are integrating care management and CPA processes, and developing joint protocols for sharing information and risk management. A joint training programme on risk management is being developed.

Referrals and caseloads

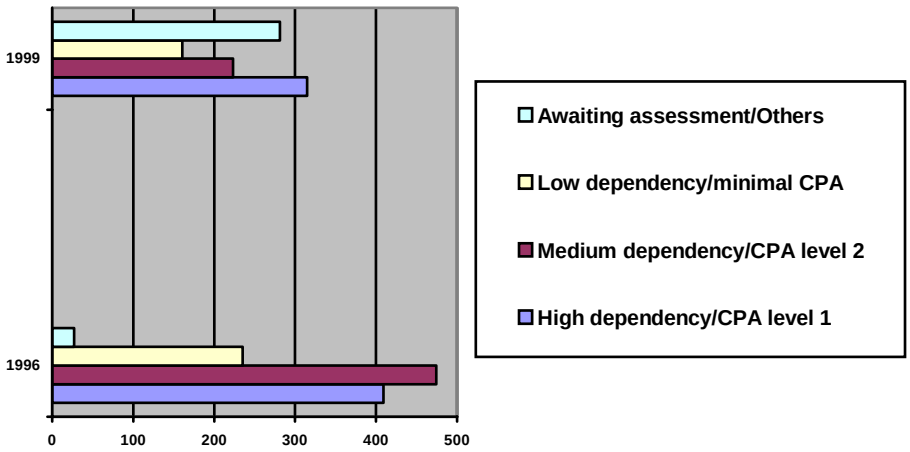
The following table shows the number of new referrals of north and mid Hampshire residents to, and discharges from, the different teams during the year to March 1999.[8] These numbers reflect the very different sized populations that the trusts each serve within north and mid Hampshire. It is important to realise that the number of referrals alone tells us nothing about the severity, duration or nature of the mental health problem, and the number of discharges tells us nothing about the outcome.

Referrals to CMHTs (March 1999)

NHS trust	*Initial referrals*	*Discharges*
Andover	497	398
North Hampshire Loddon	2,985	3,358
Winchester and Eastleigh	684	610
Surrey Hampshire Borders	903	652
Total	5,069	5,218

The caseloads of the four CMHTs in 1996 and 1999 are set out below (the figures do not include people seen only in outpatients).

CMHT caseloads, 1996 and 1999



Eastern community mental health team

Mr Longman lived in Popley, which lies within the area served by the eastern team. This team provides a service to many of the Park Prewett long-stay patients who resettled in the community. It serves a population of some 52,000 people.

When the Park Clinic closed in 1993, the CPNs who had been based there moved to one of the old wards at the hospital — Cherrydene — which became the embryonic community mental health team base.

The hospital-based social workers remained in the hospital social work department. This social work department had its own manager, and records and information technology system. It consisted of around eight social workers, some of whom were part-time. Social workers were, however, allocated to the local teams, and they attended ward rounds and community team meetings, and had a desk in Cherrydene. A half-time social worker covered the eastern locality until 1994, when the social work input was increased to two full-time workers.

For some time, members of the team continued to function relatively independently of each other. Community psychiatric nurses 'would see themselves as managing their caseloads in the sense of working separately', and often still discharged patients from their caseload without consultant or team approval. This reflected the fact that the nurses had been a separate service, accepting referrals from consultants, and discharging them from the nursing service when they decided that was appropriate.

There was little psychology input, again for historical and organisational reasons. The psychology service had also developed separately, and had its own site. They took their own referrals, and were not a close part of a mental health team.

Because the social workers and CPNs were based away from the Pinewood wards, the eastern team consultant was more involved with the in-patient unit. Before the Bridge Centre opened in December 1995, he had a room on Pinewood, where he would see out-patients, and also a clinic in the out-patient department of the general hospital. Within what was referred to then as 'the multi-disciplinary team', as often as the 'community team', team members tended to regard him as their leader.

The consultant's ward rounds were attended by ward staff, the senior house officer, and the social worker who, during this transitional period, attended both as the ward social worker and as the eastern community team's team representative, accepting referrals and feeding back to the rest of the team.

At this time, the in-patient service was managed by the in-patient service manager and the community team by a locality manager, although both ultimately reported to the Care Group Manager for adult mental health. This individual met weekly with all of the locality managers and the clinical director, to discuss operational issues and sometimes strategic issues. The manager of the hospital social work department had an open invitation to these weekly meetings, and regularly joined them, but she reported to Hampshire County Council's SERVICE MANAGER OF HEALTH.

During 1994/95, cases might be referred to the community mental health team or to a particular team member, who would take it back to the weekly community team meeting. Cases were allocated informally at these meetings, with the locality manager encouraging team members to take on clients or to consider them for discharge. The only guidance in terms of prioritising referrals was that the mental health strategy suggested that teams give priority to those with a serious mental illness. This put pressure on the team, who were looking after about 300 patients. The teams also took responsibility for some of the people being discharged from the hospital's long stay wards, which added to their workloads.

The eastern community mental health team moved to the Bridge Centre in December 1995. When the community mental health centre opened, the social workers moved from their hospital social worker base, and were based with the team. The integration of social work into the team at fieldwork level was now thought to be good, although the social workers' managers did not themselves move to the centre until 1997.

Unlike Pinewood, the Bridge Centre is a zoned secure building, with different levels of access. There is general access in the main reception areas, but the consulting rooms are locked off from the rest of the building, so it is not as easy to drop in and bang on the door. Following the move there, it became harder for patients to see their consultant without an appointment. According to one person, the Bridge Centre is not the sort of place where people hang around, 'and you get the feeling that people would be tidied up and moved along so if they did not have an appointment'. It may be therefore that the service lost something in the reconstruction.

In 1997, the eastern team comprised three social workers, six CPNs, one occupational therapist and one support worker; and CPNs had a typical caseload of 35–40. Services provided at the Bridge Centre included psychotherapy, art therapy, and help with occupational needs from Shaw Trust workers. Users and advocates told us that the greatest problem was a lack of treatment other than drug therapy. Although there were day centres and drop-in clubs which provided some activities, they were mainly sedentary and restricted by staff availability. There was also little activity at the weekends.

Team working and communication

We were told that:

1. The presence of all team members within the same building has improved contact and communication, although there is still relatively little in terms of joint day-to-day operational policies.

2. That liaison with 3 Vyne Road (see p.43) has improved. Vyne Road workers now attend out-patient clinics and CPA meetings. In addition, when the team moved to the Bridge Centre, a Vyne Road representative came to team meetings at least once a month, although that has now stopped.

3. It has been agreed that social work care managers will work to a CPA format and health staff to a care management format, so that there is no need for staff or clients to duplicate the processes, and all staff will look at health and social care needs. (However, before the two assessment formats are truly interchangeable, health staff must be trained and able to use social services' computerised assessment programme, and this has not happened.)

Southern community mental health team

The southern team serves a population of about 65–70,000 people, approximately 350–400 of whom will be in contact with mental health services. The area consultant has an out-patient caseload of about 600 people, and (proportionately) 10–12 in-patient beds.

The southern team covers a large rural area which includes Alton and Bordon (where Mr Huntingford and Mr Moffatt lived), and this presents difficulties in terms of transport and access to specialist services. The team is based at the Elizabeth Dibben Centre in Bordon. This is a single storey building with rooms available for interviewing clients. There is also a small therapy area, and Mr Moffatt attended an occupational therapy project there for a time.

OTHER SERVICES

Helplines, extended operating hours and alternatives to statutory services, such as crisis houses, are all potential options for easy access to the services. Studies carried out in Winchester and Andover of people accessing the out-of-hours helpline there indicated that evenings and weekends were the times when people were most likely to need help outside regular hours.

We were told that there was little out-of-hours support during the period embraced by our review. If a patient or carer telephoned the community mental health team base at the Bridge Centre out of hours, they would get an answer phone. Furthermore, although the North Hampshire Hospital operated a properly trained switchboard at all times, and access was excellent around the clock, Parklands Hospital had never had a properly trained switchboard service. Out-of-hours callers seeking help would generally be put through to one of the wards, and there was always a psychiatrist on call. Most often, patients were counselled over the telephone, and advised to contact their general practitioner. This advice did not help Mr Longman, who was struck off his general practitioner's list for telephoning three times a night, every night:

> 'one of the reasons why we had to remove him from the list because we could not cope with him, because he used to ring us regularly three or four times between ten o'clock in the evening and three o'clock in the morning, saying, 'My face is distorted', or 'my hands are hairy', or something or other, and what could you do? What could you do with only three or four of you trying to run a 24-hour rota ... 365 days a year? You cannot cope with that, you have 7,000 other patients.'

General practitioner support out of hours is now provided by HANTSDOC, the GP emergency cover service, although this sometimes consists only of telephone advice.

Although the Surrey Hampshire Borders Trust has a crisis response team operating out-of-hours, and it deals with some referrals from north east Hampshire, it is based in Guildford and most of its work is in Surrey. The CMHTs in north and mid Hampshire do not operate 24 hours a day, seven days a week, although there is a senior nurse bleep-holder available at night, who is part of the RAPID ASSESSMENT SERVICE.

Rapid Assessment Service (RAS)

A rapid assessment service, based within the area of Parklands Hospital originally designed as its intensive care area, was developed by the trust in April 1998. Its formation was part of the Loddon trust's response to assuming responsibility for all admissions, including extra-contractual referrals. Its functions included controlling access to beds by properly assessing requests for admission; helping to 'repatriate' local patients being treated in non-trust hospitals; and acting as a gateway to services provided by Loddon Alliance (such as home support and brief respite stays at its Base House). It guarantees to see within two hours any individual referred to it by the CMHT or a GP.

Since 1 February 1999, the Rapid Assessment Service base has been a place of safety patients detained under section 136 (see p.16) during office hours, subject to strict criteria agreed with the police concerning violent individuals.

The service initially consisted of a service co-ordinator, two grade G community nurses, and an administrative assistant. The service now comprises a service co-ordinator, seven nurses, two social workers, one mentally disordered offenders worker, one support worker and two administrators. It operates between 8am on 9.30pm during weekdays, and from 9am until 5pm at the weekend. Senior nursing staff on night duty are able to assist with assessment for admission and alternatives for admission out of hours.

Accommodation

The supported accommodation developed in the 1990s mainly focused on the need to resettle patients living on the long-stay wards.

Obtaining supported accommodation for patients on admission wards was said to be 'rather difficult', particularly if the individual is 'difficult to manage, unruly and challenging'. In practice, few patients are discharged from an admission ward to supported accommodation, and this sometimes results in individuals remaining in hospital after they are medically fit for discharge, which places further pressure on admission wards.

Specialist accommodation in the area includes the following homes: Normandy Street, Alton (6 places); Cliddesden Road, Basingstoke (7); Eastrop House, Basingstoke (8); Homefield House, Park Village (nursing home) (24); Old Worting Road, Basingstoke (7); Swiss Cottage, Basingstoke (6); Wavelly House, Basingstoke (6); Wellington Terrace Hostel (Stonham). Eastrop House is registered to take detained patients.

Beechwood Lodge is a long-standing 60-bed single male hostel situated near Partklands Hospital, managed by STONHAM HOUSING ASSOCIATION on behalf of Basingstoke and Deane District Council. We were told that the hostel is home to 'a number of quite disturbed and difficult clients'. It was thought that about one quarter of its residents had probably been patients at Park Prewett; and that around half of them had either been in the hospital or had an offending history. Beechwood Lodge is presently subject to a four year closure programme, and there are no plans to replace it with a similar hostel for the homeless. There are no bail hostels in Basingstoke.

Prior to March 1995, the council held the majority of public housing stock in the area of some 10,000 dwellings. The council then voluntarily transferred stock to two housing associations (Kingfisher and Oakfern), which now hold the majority.

The council also works with about 20 other housing associations which have pockets of accommodation, such as the GUINNESS TRUST and RAGLAN HOUSING ASSOCIATION. The council has 'nomination rights' with these housing associations, to meet particular needs. All of the associations provide general housing, and STONHAM in particular has a supply of supported housing.

If a person with significant mental health problems is nominated to occupy normal, run-of-the-mill, housing, the council will advise the relevant housing association that the tenant has special care needs and it will contact the key worker or social worker. The onus is then on the housing association to discuss what kind of care is necessary.

Until 1997, the council had a list whereby people would apply for housing and they would be assessed for rehousing on a category basis. The category that Mr Longman was given was 'NSPA', which meant that he was living in non-self-contained accommodation and a single person. That would not attract any priority in the general course of things, and he would not actively have been considered for housing.

The situation has now changed over to a points system, points being awarded for circumstances such as shared accommodation, social and medical needs. Single people living with their parents do now get quite a high number of points. However, single people comprise over a third of the housing list, so the wait is still quite considerable, around four to five years.

Day services

A day service at 3 Vyne Road in Basingstoke is provided by Hampshire County Council Social Services Department. The unit provides a service to people in their own homes, and in the community, as well as a sessional programme of activities at the centre. It

operates according to a social intervention model and aims to provide individualised care plans which build and maximise the independence skills of people with serious mental health problems. It was designed originally on the basis of 25 people per day, but can accommodate more, and now also opens on Saturday for a maximum of 15 people.

Substance misuse services

National figures for drug-taking are supplied by the regional drug misuse databases. In 1998 in Britain, around 30,000 people presented to drug-treatment services over a six-month period. Over half of these users were in their 20s (54%) and around 1 in 7 were aged under 20 (15%). The ratio of males to females was 3:1. Over half (55%) reported heroin as their main drug of misuse. Methadone was the next most frequently reported main drug of misuse with 13% of users, followed by cannabis and amphetamines, both with 9%.

Local drug treatment agencies reported 61 new attenders during the six month period ending in September 1998. However, this figure is an underestimate, because not all doctors who see drug users 'behaving in an addictive manner' report to the regional databases, although they are encouraged to do so. The age and sex distribution of local users are similar to the national data, although methadone was less frequently reported as a drug of addiction, ranking fourth after heroin, cannabis and amphetamines. Over 1 in 5 of the locally reported users were known to the criminal justice system, and around 1 in 5 of them were either homeless or their housing situation was considered precarious.

For 43 locally recorded addicts, information was available concerning the age at which their drug-taking first occurred. Nearly a third of them had taken an illicit substance before the age of 15, and 98% had first taken drugs before the age of 20. A survey of substance misuse among 14 to 16 year olds carried out by the LODDON TRUST COMMUNITY DRUGS SERVICE found that 39.2% of year 11 children had used drugs at some time, with cannabis being the most commonly used drug. There is a general trend of greater usage by males, and an increased frequency of both experimental and regular use in year 11 children in 1998 compared with year 10 children in 1997. After cannabis, the following drugs were used by the surveyed children in decreasing order: solvents, magic mushrooms, amphetamines, LSD, ecstasy, cocaine and heroin. More than half of them acquired the drugs through sharing with a group of friends.

The substance misuse service in Basingstoke started in 1985, in response to a department circular. It was initially a drug advisory service, staffed by a single individual and situated in a shared portacabin. If treatment was required, the patient had to be referred to the regional unit in Portsmouth, some 50 miles away. The majority majority of patients at that time were benzodiazepine users; there were very few heroin users using the service, primarily because there was little apart from advice that it could give.

The consultant who now heads the service took over in 1988, to provide medical support. The service began providing treatment in around 1990, when the biggest difficulty was agreeing a budget for methadone prescribing.

The service has grown significantly since 1990, when it had around 15 clients. It now has a purpose built alcohol unit (ROOKSDOWN HOUSE), and a drugs service with its own dedicated building situated in the community. The service has two full time social workers seconded from social services, one for drugs and one for alcohol. One of the service's team members always attends the ward rounds at Parklands, and is therefore available to accept referrals. Clients are also sometimes referred by the two hostels for homeless people. The service has close links with the youth offending teams, and recently seconded a worker from the alcohol and drugs team to work with them for a year.

The referral rate has risen to approximately 375 new referrals each year, with an incremental rise in the number of maintenance cases, including about 60 people on maintenance methadone. There continue to be problems agreeing a budget for methadone, which has been very limited in recent years (£40,000). A further £10,000–£15,000 is required in order to eliminate any waiting list, and this would enable methadone to be prescribed on a daily pick-up basis. Other limitations include the fact that the service only has five residential places; transport problems for would-be users, who must travel to Basingstoke; and insufficient resources to undertake active follow-up and outreach work.

There have been more young people using the service in recent years, most of them heroin rather than cannabis users, as was previously the case.

Approximately one-third of the service's clients have a psychiatric illness secondary to their alcohol or drug use. Being consultant-led, the service is able to treat individuals suffering from psychosis or depression (for example, following amphetamine use). However, if the primary diagnosis is thought to be a mental illness, the tendency is to refer the individual to the adult mental health services.

The incidence of co-morbidity appears to be increasing and the service has recently explored the possibility of appointing a dual diagnosis worker. However, two recent research bids concerning the development of a dual diagnosis service were unsuccessful, and it has not been possible to do this.

A jointly-funded voluntary agency called PHOENIX works in the Basingstoke area with people who have alcohol problems.

Offender services

A 1998 survey of all prisons in the Wessex area (Hampshire, Dorset and Isle of Wight) found that 21 individuals in prison needed additional psychiatric care. Fifteen of them were felt to need psychiatric hospital care, 9 of whom required medium secure provision. The majority had received psychiatric care in the past, had major drug and alcohol problems, had harmed themselves or made suicide attempts in the past, and classed themselves as homeless.[9]

The Loddon Trust's policy was that mentally disordered offenders should have access to the same range of services as everyone else, and that these services should be provided on a locality basis. Most mentally disordered offenders were therefore dealt with by their locality consultant and community mental health team, and had access to the usual in-patient services.

For those who could not be managed at Parklands Hospital, the trust had access to the OAK TREE CLINIC in Surrey and the RAVENSWOOD HOUSE REGIONAL SECURE UNIT outside Winchester.

In the case of persons in custody, local services liaise with the prison, usually through the locality consultant and the MENTALLY DISORDERED OFFENDER CO-ORDINATOR.

The co-ordinator's post has been jointly funded by the health authority and social services.

The co-ordinator covers Winchester, Andover and Basingstoke, and is based with the probation service in Basingstoke. Each morning, the co-ordinator contacts the custody sergeants in these areas, in order to establish if any arrested persons have a mental health problem (which includes a learning disability). This allows for the possibility of diversion at the point of arrest, although the role is more about liaison than diversion.

The co-ordinator presently accepts referrals from any source, including probation officers preparing pre-sentence reports and PREMIER PRISON SERVICE (the local private agency which conveys prisoners to and from court). Initially, there was a tendency for community mental health and learning disability teams to see the new co-ordinator as someone to whom challenging clients might be referred; whereas in fact the co-ordinator's role is to refer to them arrested persons, defendants and prisoners who require their services.

Relatively few people have been diverted. One reason for this has been the national shortage of secure beds. Ravenswood House has usually been full, and patients have ended up at secure units in Birmingham, Dorset and the south coast. In the opinion of the co-ordinator, there should be some secure provision locally; and this would enable more people to be diverted.

Many of the people seen by the co-ordinator are already known to the local community mental health team, having perhaps received a service in the past. As a group, they are not generally popular clients, and teams are all too often reluctant to accept the referral. Quite often, the reason given is that the individual has a personality disorder or needs which do not fit with the service provided by the teams. Ultimately, however, it seems that 'there are certain difficult and challenging people, and people will fight hard not to accept them .... the key thing is about ownership by the general services, and acceptance and understanding that if somebody ends up within the criminal justice system, they are still their business. That is possibly the key area'.

The need for community mental health teams to accept referrals from the co-ordinator has to be addressed, if the number of people diverted from custody is to increase. Written criteria need to be agreed which require CMHT involvement in specified circumstances.

The co-ordinator is part of the rapid assessment service, and therefore has access to its resources.

An appropriate adult scheme for Basingstoke is now operational, and a dual diagnosis worker has been employed.

HMP WINCHESTER contains a 36-bed hospital. Part of the hospital (what is called 'the lower hospital') caters for people who are acutely mentally ill, and it includes two unfurnished rooms. The majority of patients in the prison hospital have a psychiatric illness. Everyone received by the prison is seen by a doctor and, if the individual is mentally ill, a decision is taken as to whether to admit them to the hospital or just to see them in the clinic. Persons charged with murder are always admitted, so that their initial mental state can be assessed.

The staffing of the PRISON MEDICAL SERVICE comprises a psychiatrist and a doctor specialising in drug and alcohol problems (both on a sessional basis only) as well as one and a half primary care doctors.

In addition to this input, the prison medical service has a good relationship with the local regional secure unit (Ravenswood House). Staff from there attend three or four times a week. The support provided by local hospitals is more variable, but the Loddon Trust has always been supportive.

In the course of our review, we were told by the consultant psychiatrist who works at HMP Winchester that a prison-based forensic service, and more beds, are required: 'We should stop pretending that all mentally disordered people should be in NHS hospitals. And accept that some will be in prison, and provide services for them. They always are, and they always will be'.

The WESSEX PRISONS CMHT (formerly the WESSEX PROJECT) aims to identify prisoners with mental health problems within Winchester Prison, and to improve access to relevant community services, via the care programme approach, on release. This inter-agency project is supported by Hampshire County Council Social Services, Hampshire Probation Service, the Prison Service and the three Hampshire Health Authorities, via the Wessex MDO Consortium. Its development is overseen by a steering committee made up of the funding agencies.

The team includes professional staff from each of the agencies referred to above, who work with prison staff and community agencies to assess, liaise and plan care for the prisoners concerned. The team provide an important point of reference in respect of care and planning and mental health information for outside agencies, and act as the prison link between the courts, local social care and mental health agencies, and each of the local MDO court liaison schemes. It also has a significant role in training prison and community staff about the issues for mentally disordered offenders and their carers.

Advocacy and user services

BASINGSTOKE CITIZEN ADVOCACY was established in 1993 as the first dedicated advocacy scheme for the borough, providing a service for people who have a learning disability. The scheme, currently managed by HAMPSHIRE AUTISTIC SOCIETY, is run by one co-ordinator who is employed for 20 hours per week. The co-ordinator currently supports 20 partnerships run according to the principles of citizen advocacy. The scheme currently has 45 people awaiting pairing with a volunteer advocate.

BASINGSTOKE ADVOCACY FOR MENTAL HEALTH was established in September 1994, partly as an initiative to empower clients returning to the community with the closure of Park Prewett Hospital. It assists people aged between 16 and 65 who experience mental ill-health, other than a learning disability. The service was initially managed by Basingstoke Voluntary Services, but is now managed by its own management committee. It has a budget of £40,000 per annum, which funds one full-time advocacy co-ordinator, and one 2/3rds time outreach worker. A lottery bid for about £200,000 for three years has been made. The advocacy co-ordinator and outreach worker have not benefited from access to training or materials on the Mental Health Act.

The primary function of the full-time co-ordinator is to facilitate the delivery of 'citizen advocacy' to those living in the community who experience mental ill-health, but he is also responsible for promoting the organisation, and for furthering local people's awareness of the nature of mental ill-health. In addition, the co-ordinator provides time-limited crisis-advocacy where this is absolutely necessary. The training of potential advocates is offered by the co-ordinator, where appropriate, in conjunction with BASINGSTOKE CITIZEN ADVOCACY.

The main role of the outreach worker is to provide short-term advocacy support for those at Parklands Hospital. This may involve appeals against detention under the Mental Health Act, negotiating with creditors, providing assistance with state benefits forms, and helping with accommodation difficulties and potential homelessness. The outreach worker also provides crisis-advocacy for clients who have returned to the community.

The Basingstoke Users Group (now known as IMPACT) receives funding from social services. Users are almost always represented on the Loddon Trust's appointment panels.

5 THE HISTORICAL FRAMEWORK

ABOUT THIS CHAPTER

The three patients whose cases we reviewed received care in north and mid Hampshire over an eleven year period, from 1987 until 1998. This was a time of great change, associated with the closure of the old asylum, and the development of community services. The purpose of this chapter is to explain how the services developed during this period, and to draw together historical themes relevant to more than one review.

OVERVIEW

For many years, mental health services covering a wide area, embracing Andover, Basingstoke, Romsey and Winchester, were focused on Park Prewett Hospital. This hospital, which opened in 1921, with ten villas and capacity for 1300 patients, was a large, old-fashioned, institution spread across countryside outside Basingstoke. Four more wards were built in 1936, and by the 1950s the patient population had increased to 1600.

A plan for the contraction of the hospital was produced in 1985, but not implemented. By this time, the hospital had a central core of buildings on two or three floors, clustered around social facilities and administration. Villas in the grounds included an acute admissions unit on two floors, which was in a rather poor decorative state; rather empty and echoing. This housed Pinewood 1 and 2 wards.

In 1991, the old WESSEX REGIONAL HEALTH AUTHORITY decided that all of its old-style psychiatric hospitals should close within about five years; and, from 1993 until 1997, the emphasis of the mental health strategy was on providing local community services in their place.

Park Prewett Hospital finally closed in March 1997, after a complicated planning and implementation process.

HOSPITAL AND COMMUNITY BASED SERVICES

The following table contrasts the configuration of local mental health services in 1993 and 1996. Whereas mental health services in 1993 were very much asylum-based, by the end of 1996 modern acute facilities were in place, supported by more extensive community provision.

	1993	1996
In-patient services	336 beds at Park Prewett Hospital (including admission services for mid Hants, and continuing care services across north and mid Hants)	44 beds for adults, and 35 beds for older people, in Parklands Hospital.
	242 health funded staff	85 health funded staff

	1993	1996
Hospital-based day care	25 day care places at Cherrydene (which took over from the old Park Clinic when it vacated the site now occupied by the Bridge Centre). 25 day care places at Meadowside Day Hospital, which accepted up to 25 people a day for assessment, treatment and rehabilitation. Most users were over 65 years of age. 30 day care places at The Shrubberies (an industrial therapy unit housed in the old Villa 2 ward). 141 non-direct care staff	
	12 beds at Alton & Chase Community Hospitals.	8 beds at Chase Community Hospital.
Supported accommodation		Normandy Street, Alton : 6 places Cliddesden Road, Basingstoke (7) Eastrop House, Basingstoke (8) Homefield House, Park Village (nursing home) (24) Old Worting Road, Basingstoke (7) Swiss Cottage, Basingstoke (6) Wavelly House, Basingstoke (6) Peach Cottage, Tadley (7) Wellington Terrace Hostel (Stonham). Residential care for adults with serious mental health problems.
Day and community support services	3 Vyne Road day service. Home support in Alton/Bordon	3 Vyne Road day service. Adelphi Place, Basingstoke Clubhouse Alton, Bordon, Hook day services BRC ‘day care’ in Alton and Bordon NSF drop-in, Tadley NSF drop-in groups in Basingstoke, Worting, Popley and Westside. Loddon Trust clubhouse

	1993	1996
		Loddon Enterprise: A charity based industrial workshop.
		MACA employment worker, Alton.
		Shaw Trust employment workers in Tadley and Basingstoke.
		Shaw Homes 'Pavilion', Basingstoke.
		Mental Health Forum. A group for mental health service users, carers, and voluntary and statutory agency representatives in Basingstoke.
		Harmony Club, a social activity club run by the NSF and based at Chineham House. It operates 3 evenings per week and on Sundays.
		Two advocacy schemes for people with mental health problems.
Community teams	Community teams:	Community Mental Health Teams:
	Adults: 4 teams	Adults: 4 teams located at the Bridge Centre in Basingstoke; Elizabeth Dibben Centre, Bordon; Mulford Hills Centre, Tadley. Caseload of 1475.
	55 health funded staff.	48 health funded staff, 4.5 consultants, 11 social workers.
	Older people: 2 teams.	Older people: 2 teams based at Alton & Chase Community Hospitals and the Bridge Centre, Basingstoke. Caseload of 650.
	16 health funded staff.	18.5 health funded staff, 2 consultants.
Specialist Services	6 Mother & Baby service beds at Park Prewett with 9 health-funded staff.	3 Mother & Baby service beds ring-fenced for north & mid Hants patients.
	12 day care places x 5 days on Eastleigh Ward (community alcohol team).	Rooksdown House community alcohol team resource centre.
	Fairfields House community drugs team resource centre.	Fairfields House community drugs team resource centre.
		One co-ordinator operating a mentally disordered offenders scheme.

TIMELINE

This comparison of local services in 1993 and 1996 shows the enormity of the changes, but it does not reveal how the strategy was implemented, the difficulties encountered along the way, how they affected staff and patients, and how they were resolved (if at all). The following timeline summarises some of the developments, and illustrates the strategic and financial context within which individual professionals treated, and cared for, the three patients whose cases we reviewed.

1990

Management of the local NHS

At this time, there were three district health authorities in north and mid Hampshire:

- BASINGSTOKE AND NORTH HAMPSHIRE HEALTH AUTHORITY (Basingstoke, Alton, Bordon);
- WINCHESTER HEALTH AUTHORITY (Winchester, Eastleigh, Andover);
- WEST SURREY AND NORTH EAST HAMPSHIRE HEALTH AUTHORITY (Fleet, Farnborough, Aldershot).

The first two of these district authorities were overseen by WESSEX REGIONAL HEALTH AUTHORITY; the third of them by SOUTH WEST THAMES REGIONAL HEALTH AUTHORITY.

Park Prewett Hospital

Park Prewett Hospital provided a service to north and mid Hampshire and was managed by BASINGSTOKE & NORTH HAMPSHIRE HEALTH AUTHORITY. The hospital's medical teams, community psychiatric nursing service, and art, occupational and physiotherapy departments, all had their own management structures. However, members of the different disciplines were mostly allocated to localities, and came together for team meetings to consider referrals and jointly held patients.

Development of NHS trusts

The National Health Service & Community Care Act was passed in 1990, and it provided for the creation of NHS trusts. The underlying aim was to create a 'competitive market' within the NHS. NHS trusts would manage mental health services and health authorities would purchase them.

As a result of this legislation, management of the local mental health services was devolved to a PRIORITY SERVICES UNIT. It was intended that this unit would become an NHS trust following a transitional period.

Service standards and concerns

The MENTAL HEALTH ACT COMMISSION were concerned about:

- the unsystematic implementation of section 117 of the 1983 Act (see p.14);

Mark Longman

Mr Longman was first seen as an out-patient, at Basingstoke District Hospital, in 1987, when a provisional diagnosis of schizophrenia was made. In October 1989, he was briefly admitted to hospital in a confusional state, and detained there under section 5(2) (see p.16). For much of 1990, he was attending the Park Day Clinic, to receive antipsychotic medication by injection from a community psychiatric nurse.

Paul Huntingford

Mr Huntingford was detained at Park Prewett Hospital between December 1981 and February 1982. He attended the Park Day Hospital in 1983 and 1984. By the beginning of 1990, he had been at home, well maintained on medication, for 7 years.

He lived at home with his mother during 1990, and was supported by his GP, a consultant psychiatrist, and a CPN (the latter until August). He continued to receive medication and was 'reasonably stable'. Nothing untoward is described.

Christopher Moffatt

Mr Moffatt celebrated his 19th birthday in 1990, and it was not until 1993 that he had his first episode of mental illness.

- the way in which patients whose behaviour was difficult to manage were removed from the patient group, into seclusion (usually a locked room) or 'time out' (physical separation from the rest of the patient group);
- the number of patients in night attire and the use of deprivation of daytime clothing to control misbehaviour;
- the standard of record-keeping (social workers' reports were seldom included in patient files; history sheets were not up to date; and patient files were very difficult to work through);
- pressures as a result of staff shortages.

Local approved social workers were concerned about a lack of community resources, which the county council dealt with by acknowledging that, 'as with most social services departments, the priority we have accorded to mental health services has historically been low'.

1991/92

The local mental health strategy

WESSEX REGIONAL HEALTH AUTHORITY'S mental health strategy, 'Developing Better Mental Health Services for the Community', which involved the closure of Park Prewett Hospital, was considered by the public.

Two of the local district health authorities (BASINGSTOKE AND NORTH HAMPSHIRE and WINCHESTER) formed a commission to lead the process of implementing this stategy (the NORTH AND MID HANTS HEALTH COMMISSION).

Two multi-disciplinary, and multi-agency, groups were set up to oversee implementation of the strategy. The MENTAL HEALTH STEERING BOARD provided overall direction and included representatives of the Health Commission, NHS providers, Wessex RHA, social services, the Community Health Council, users and carers. The MENTAL HEALTH TASK GROUP dealt with day-to-day issues, and included representatives from the Commission, RHA, social services and the project managers for the three NHS providers.

Service standards and concerns

The district health authority referred to enormous financial pressures, emphasising that 'without the bridging funding, both this year and 1993/4, there will be enormous pressures to reduce the number of available beds.'

The MENTAL HEALTH ACT COMMISSION was concerned that:

- the mental health strategy did not appear to include a comprehensive service for offender patients;
- there were few resources in the community for a patient who could not live at home, which often made it necessary to admit patients who could otherwise be cared for and treated outside hospital;

Mark Longman

In March 1991, Mr Longman was informally admitted to Pinewood 1 ward for four days. It was during this brief admission that he first told staff that his body was inhabited by two men who were using witchcraft to control him. He then fell out of contact with psychiatric services. On 26 November 1991, he was sentenced to 2½ years imprisonment, for attempted robbery.

On 25 September 1992, Mr Longman was released from prison. He was psychotic in October and November, and was informally admitted to Pinewood II ward on 2 December. He remained in hospital until 11 May 1993.

Paul Huntingford

Mr Huntingford remained reasonably well during 1991, and continued to receive medication. On 17 December, his new consultant elicited some mild paranoid thoughts (he believed that a friend's wife at the DSS could harm him, by interrupting his state

- the hospital was experiencing a 'critical mass problem', of how to maintain a level of service and support when large pieces of the service were suddenly moved out;
- patients with challenging behaviour were scattered across wards, and there was evident difficulty managing them on some wards. Such people needed to be tackled systematically;
- there was a long way to go to secure a real partnership between health and social services;
- there was an unequal distribution of resources, with under-development and under-funding of mental health services in the north of the county;
- section 117 priority was being given to patients who had been in hospital for six months.

benefits).

In March 1992, Mr Huntingford was described as being deeply depressed. He was given antidepressants and details of local voluntary organisations. In July, it was arranged that he would no longer see his consultant, because of the long journey, and his GP took over his treatment. He continued to receive an antipsychotic, and no psychotic phenomena were recorded.

Christopher Moffatt

It was not until 1993 that Mr Moffatt had his first episode of mental illness.

1993

Implementation of the mental health strategy

The plan for implementing the local mental health strategy was published in November 1993, having been agreed with HAMPSHIRE SOCIAL SERVICES and health service bodies.

The plan was thought to be 'revenue-neutral', that is, it would not require any significant additional expenditure.

It aimed to create a comprehensive, community mental health service based around five major components:

- four locality community mental health teams, composed of qualified and non-qualified health and social services staff, and led by locality managers responsible for managing all nursing and other therapeutic staff within the locality.
- community support services.
- supported community accommodation, provided by housing associations and staffed by independent sector agencies, to replace the continuing care (long-stay) wards, *e.g.* small houses, registered care homes and nursing homes.
- modern hospital in-patient services for admission and assessment.
- specialist services for mothers and young children, those misusing alcohol or drugs, etc.

Creation of the Loddon Trust

The NORTH HAMPSHIRE LODDON COMMUNITY NHS TRUST was established on 1 April, and it was responsible for providing and managing local mental health services, including Park Prewett Hospital.

Mark Longman

Mr Longman continued to receive in-patient treatment at Park Prewett, and he was detained under section 3 (see p.15) on 17 January. He was discharged from hospital on 11 May 1993, when he was referred to the day service unit at 3 Vyne Road, for 'supportive care'. He was still subject to supervision by the Probation Service.

In September, Mr Longman was twice informally admitted to Park Prewett, on each occasion for 3 days, because he felt suicidally depressed. The second of the admissions was to Chester Ward, a ward for Winchester patients. Following these admissions, he continued to receive a weekly injection, and to attend 3 Vyne Road, for the rest of the year.

Paul Huntingford

Mr Huntingord continued to see his GP, and to receive medication. No psychotic phenomena were recorded.

Reconfiguration of mental health services

The PARK CLINIC DAY HOSPITAL (situated on the Hackwood Road Hospital site where the Bridge Centre now is) was closed in June 1993.

The community nurses who had been based there, as part of the north, east and west locality teams, moved to a vacant villa at Park Prewett Hospital. This became the CHERRYDENE MENTAL HEALTH CENTRE.

Service standards and concerns

Part of the implementation plan involved moving 24 of the older patients from two of the wards to another ward by 31 March 1994, with a view to their discharge from Park Prewett by 31 December 1995. When it transpired that the two nursing homes identified for them could receive them in March 1994, most of the patients had their discharge dates brought forward, and a number of them died following the move. The SELECT COMMITTEE ON THE PARLIAMENTARY COMMISSIONER FOR ADMINISTRATION published a report on the discharge procedures in March 1997, and the matter was investigated by the SECRETARY OF STATE FOR HEALTH, the Rt Hon Frank Dobson, MP. Both were critical of the way in which the NORTH & MID HAMPSHIRE HEALTH AUTHORITY and the LODDON TRUST managed the discharge process.

The MENTAL HEALTH ACT COMMISSION commended the upgrading of Pinewood 1, and asked that this be extended to Pinewood 2. However, according to the Commission:

- there was no sign that the range of local community resources had improved, and there was a lack of independent sector provision in North Hampshire;
- the demand for acute admissions was high (107% occupancy), and nursing staff were concerned about the situation on Pinewood, and the therapeutic quality of life there. As occupancy pressures mounted, consultants 'had to be fairly brisk in their dealings, necessarily so'.
- Nursing staff ratios were low and, because of this and local practice, the hospital seemed to call very readily on police support, and the police seemed very willing to give it. It was not unusual for police to appear on the ward in the management of patients, including the forcible administration of medication, and handcuffing was used. These coping mechanisms appeared to be a response to the policy that seclusion should not be used, and that difficult patients should be distributed throughout the hospital.
- Staff reiterated the view that seclusion was not used and not wished for. However, 'the character of Basingstoke itself was changing considerably [and] ... it was not surprising from that point of view that there was close involvement with the police'. Proposals were being discussed for a special unit for difficult-to-manage patients.
- A pilot audit indicated that the care programme approach (see p.17), introduced by the government in 1990, was still not well established at Park Prewett.

Christopher Moffatt

Mr Moffatt's family became concerned about his mental state and behaviour during 1993. On 30 November, he was seen at home by a consultant psychiatrist, who arranged an informal admission to Pinewood 2. He remained in hospital for the rest of the year, but had periods of leave at home.

1994

Implementation of the mental health strategy

The implementation plan was submitted to WESSEX REGIONAL HEALTH AUTHORITY in January, and approved by it in principle in the spring. Later on in 1994, the WESSEX and SOUTH WESTERN REGIONAL HEALTH AUTHORITIES were amalgamated.

Reorganisation of mental health services

Managers were appointed to lead the four new community mental health teams and interim team bases were developed for the eastern, western and northern teams at the PARK PREWETT HOSPITAL'S CHERRYDENE CENTRE, (Mr Longman's team), and for the southern team at the LORD MAYOR TRELOAR HOSPITAL in Alton (Mr Huntingford's and Mr Moffatt's team)

Grayshott long-stay ward at Park Prewett was closed, its patients having been resettled in the community.

Service standards and concerns

According to the MENTAL HEALTH ACT COMMISSION:

- 'services in Southampton had terrific urban pressures to accommodate, and they were given priority because Park Prewett was evolving out of something that had always been solid, respectable, good and well-run. Probably, the penny dropped too late, that you could not trade on that. As it diminished, so its capacity to deal with pressures and handle the balance safely became less and less.'
- leave beds on Pinewood were in use, and the rate of occupation, and the number of detained patients, was high.
- The LODDON TRUST continued not to practise seclusion, commenting that it was an activity 'proscribed under adult mental health, and has been so for a number of years. The emphasis is on the use of sufficient numbers of staff, engaging their clients in therapeutic activities and the use of varying degrees of observation of the more severely ill client'. The Commission agreed with the philosophy, but did not believe that there were resources and systems in place which made it practical.

HAMPSHIRE COUNTY COUNCIL was a low spender on mental health, and after-care services were 'thin'.

Mark Longman

Having stopped medication, Mr Longman's mental state gradually deteriorated. On 25 January, he was 'very keen' to come back into hospital. According to his consultant, 'although we cannot take him at the moment, I will see if we can arrange this in the near future. It might help get his compliance to a more satisfactory level'.

On 28 January, he decided that he no longer wished to receive assistance from 3 Vyne Road, which closed his file.

On 19 May, he was informally admitted to Chester ward, having cut a wrist 'because of the voodoo'. Having absented himself, he was discharged on 11 June, after 3 weeks; following which he referred himself back to 3 Vyne Road.

From 7 until 20 July, he was again an informal patient on Chester ward, following an overdose. A clinical note made at the time records, 'Plan: short admissions.'

Mr Longman would not accept medication following discharge, but continued to attend Vyne Road.

On 20 October, he spoke 'of inexplicable physical pain and a desire to kill himself — determination (?) even soon'. On 22 October, he was informally admitted to Pinewood II, after buying rat poison. He was detained under section 3 (see p.15) two weeks later, and was not discharged until 10 January.

Paul Huntingford

Mr Huntingford continued to see his GP, and to receive medication No psychotic phenomena were recorded.

Christopher Moffatt

Mr Moffatt remained an in-patient for much of 1994. In June, he was referred to Vyne Road, which he attended for the rest of the year. In September, he was started on clozaril. On 21 November, he was discharged from in-patient care, and lived at a Stonham group home in Popley. He had regular contact with his key worker and CPN.

1995

Implementation of the mental health strategy

In April 1995, the NHS REGIONAL OFFICE announced the withdrawal of the long stay hospital replacement programme fund. This loss of £8m bridging support necessitated speeding up the timescale for the hospital resettlement programme by about a year. By this time, about 150 long-stay patients had been resettled.

In the autumn of 1995, the cost of implementing the mental health strategy of 1993 was reviewed by the local HEALTH COMMISSION.

It was estimated that the new community-based mental health service would in fact cost £2.35m more than had been allowed for in the implementation plan submitted in January 1994.

Providers were told that the level of expenditure planned in 1993/94 would not be increased. Thus it became clear that the available funding was less than that required to complete all of the planned service changes.

The effect was necessarily that the proposed new community services would be neither as comprehensive nor as responsive as the Loddon Trust had originally planned. It was given the target of scaling down its proposed investment by £850,000.

Reconfiguration of mental health services

Park Prewett Hospital closure programme

In August 1995, there were 100 acute beds at Park Prewett Hospital, half of which were for Winchester patients.

70 long-stay patients on four wards were awaiting resettlement. Seven homes in Basingstoke, and two in Winchester, were to accommodate 64 of them, in groups of six to eight, with the remaining six patients being individually resettled in nursing or residential homes.

Mark Longman

At the beginning of 1995, Mr Longman was an in-patient at Park Prewett Hospital. He was discharged on 10 January. The discharge plan was that he take clopixol, and attend 3 Vyne Road and out-patient appointments.

A CPA meeting (see p.17) was held on 20 January, but his CPN keyworker did not invite other professionals to attend it. He stopped medication in February, as a result of which his keyworker disengaged. On 6 March, after an overdose, he was admitted to a medical ward for overnight monitoring.

On 4 May, he told a Vyne Road worker of violent thoughts connected with buying a shotgun, and was reviewed by his consultant.

In August, staff shortages at Vyne Road led to the temporary suspension of his programme there.

On 27 October, he 'seemed again to be symptomatic and quite scared by his delusional ideas' and asked to be readmitted. After a lengthy attempt to find him a bed, he decided against it, agreeing to take chlorpromazine.

Development of Community Mental Health Centres

In February, the southern team (responsible for Mr Huntingford and Mr Moffatt) moved into the ELIZABETH DIBBEN CENTRE in Bordon, after several months at the LORD MAYOR TRELOAR. The centre was not purpose built, but was well furnished. It had a high skill mix, with six CPNs, occupational therapists, social workers and an art therapist.

In August, the MULFORD'S HILL CENTRE in Tadley opened (the base for the Northern CMHT).

In December, the BRIDGE CENTRE, which was purpose-built on the Hackwood Cottage Hospital site in central Basingstoke, opened; and the east and west teams moved there from Cherrydene. Prior to this, team social workers had worked from the social work department at Park Prewett. For the first time, all team members were accommodated in the same building, whatever their discipline.

Service standards and concerns

The MENTAL HEALTH ACT COMMISSION commented that:

- the building of Parklands Hospital had begun;
- bed occupancy at Park Prewett was in excess of 100%, and three additional beds had been put up on the day of the Commission's visit (which was unusual at the time);
- notwithstanding this, the new hospital would have 18 fewer acute beds;
- the problem of difficult-to-manage patients had not been addressed sufficiently (the trust did not want seclusion, but what was standing in its place?);
- staff were under considerable pressure and at risk of personal injury, and they should not be expected to cope with responsibilities 'which are reasonably judged to be beyond their capabilities';
- there was a significant risk of self-harm or harm by other patients;
- Pinewood should not have been allowed to deteriorate to such an extent.

The local COMMUNITY HEALTH COUNCIL were concerned that CPN caseloads at the ELIZABETH DIBBEN CENTRE were too high and needed to be reviewed, given the increasing number of clients with a serious mental illness. The availability of transport was also a concern, and it was felt that extra resources were required.

Similar concerns were expressed about CPN caseloads within the east and west teams, which ranged from 27/28 fairly chronically ill long-term clients to between 40 and 50 clients requiring less intervention.

The locality manager for the east team said that he was unable to regularly monitor staff caseloads until August, because he was managing two teams.

On 4 November, he went to the hospital ward 'demanding admission'. The duty doctor was too busy to see him until later that day, and he refused to go home to be assessed there by GP. A nurse asked him to leave the ward but he said that he could not walk; he was not admitted.

He saw his consultant for the last time on 29 November, when he continued to refuse regular appointments and medication, and he only went to Vyne Road twice in December.

On 13 December, his consultant wrote to Mr Longman's parents, stating: 'I don't know whether you are aware Mark has been down to the hospital recently (usually unannounced), making demands upon staff there about admission etc. Whenever he has a proper appointment to see me, he fails to attend. He struck me as being unwell once again, with his odd beliefs very much to the front of his mind once more. I wonder how you feel he is doing at the moment. If you have any anxieties, perhaps you could contact me ...' Mr Longman's parents did not reply.

Paul Huntingford

Mr Huntingford continued to see his GP, and to receive medication. No psychotic phenomena were recorded.

Christopher Moffatt

In March 1995, Mr Moffatt's placement at the Stonham group home broke down. He returned home to Alton in March 1995, to live with his mother and stepfather. He remained there for 17 months, during what was a relatively settled and stable period.

When the Bridge Centre opened, the local COMMUNITY HEALTH COUNCIL were concerned about whether there were sufficient community support services to enable people to remain well, noting that the HEALTH COMMISSION was only now putting the community work out to tender.

This was significant because the aim was to shift the focus of the service away from a day service/social care model to a targeted intervention model: patients would attend the Bridge Centre for therapies, and community support services would be provided at a separate location.

The 3 VYNE ROAD DAY SERVICE had almost a complete staff turnover around August. This resulted in a reduced service to users for a short time.

1996

Abolition of regional and district health authorities

On 1 April, regional and district health authorities were abolished, and the current NORTH & MID HAMPSHIRE HEALTH AUTHORITY came into being. It assumed sole responsibility for purchasing primary and secondary health services for those residing within its area. However, the new SOUTHAMPTON AND SOUTH WEST HEALTH AUTHORITY assumed responsibility for the entire borough of Eastleigh on this date, which involved the transfer of about 10% of the population of north and mid Hampshire.

Reconfiguration of mental health services

During the winter of 1995/96, Park Prewett Hospital changed from being predominately a long stay hospital to having only admission and assessment facilities. Seven homes, with a total of 46 places, were opened in Basingstoke, Tadley and Alton, and these were managed by the London & Quadrant Housing Association and MACA. There was also an eight bedroom home in Basingstoke for long-term NHS care.

In June, services for mid Hampshire patients were transferred to a new 36 bed unit in Winchester, called Melbury Lodge.

In December, the Pinewood I and II acute wards at Park Prewett moved to the new Hawthorns 1 and 2 wards at Parklands Hospital.

A new alcohol unit on the Hackwood Cottage Hospital site, Rooksdown House, replaced the old Eastleigh ward at Park Prewett.

The Basingstoke clubhouse, providing social care for people with mental health problems, was established at Adelphi Place in Basingstoke.

Service standards and concerns

In May, the BASINGSTOKE & NORTH HAMPSHIRE COMMUNITY HEALTH COUNCIL authorised a lay audit of the implementation of the mental health strategy agreed in 1993. The report of this audit was then presented to a public meeting in September.

Mark Longman

By 1 January 1996, Mr Longman had not been receiving injections for 11 months; nor was he regularly attending 3 Vyne Road or his out-patient appointments.

In January, he attended 'the day service a lot, 'making an inappropriately and unusually high use of the services'. His Vyne Road programme was reviewed on 13 February, when he refused to sign a contract drawn up for him; and he failed to attend an out-patient appointment that day.

On 12 March, Mr Longman's consultant wrote to his GP, telling him that he had failed to keep his appointment on 5 March: 'I wrote to his parents in December, to ask them about their opinion of his current mental state but I have had no reply ... He hasn't got an appointment to see me at the moment and I am not aware of any concern being expressed about him from other quarters.'

Mr Longman attended Vyne Road twice between 12 March and 30 April. On 3 May, he told Vyne Road that he 'felt better ... and 'did not need to come to Vyne Road'. He asked to leave the service on 22 May, and his file was formally closed on 4 June.

Concern was expressed about the need for local crisis beds, 24 hour cover for help and advice, a shortfall in staff posts in the community teams, and the non-appearance of satellite centres.

During the early hours of that morning, he poured a gallon of petrol over his father, and set light to him. His father died within minutes.

Paul Huntingford

Mr Huntingford continued to see his GP, and to receive medication. No psychotic phenomena were recorded.

Christopher Moffatt

Mr Moffatt lived with his mother and stepfather for most of 1996. In November, he went to live at a new MACA house in Alton.

This was a residential home with six residents and at least two staff on duty at all times. There was 24-hour sleeping cover, and Mr Moffatt's mother lived nearby.

1997

Implementation of the mental health strategy

Park Prewett Hospital closed in March 1997, and the 1993 mental health strategy was 'signed off'.

Reconfiguration of mental health services

On 1 April, separate unitary authorities, with responsibility for social services, were created in Southampton and Portsmouth. Many key services had been developed out of the cities to serve wider communities across the south of the county, and over 35 per cent of the social services budget was transferred to the new authorities.

A revised mental health services management structure was introduced. A new mental health & learning disabilities directorate and a directorate review group were established. LODDON ALLIANCE was formed, to provide all social care.

Community mental health teams

The Eastern CMHT at the Bridge Centre, serving 52,000 people, comprised three social workers, six CPNs, one occupational therapist and one support worker. Services provided by the Bridge Centre included psychotherapy, art therapy, and help with occupational needs from Shaw Trust workers. The social workers' managers moved to the Bridge Centre. CPNs had a typical caseload of 35–40.

In May 1997, the caseloads of 22 members of the four CMHTs were analysed. Of the total caseload of 1,006 clients, 28 were on the supervision register; 352 on CPA level 1; 211 on CPA level 2, and 200 on minimal CPA.

Paul Huntingford

On 3 March, Mr Huntingford asked his GP to increase the dosage of his antipsychotic (orap) from 2 to 3mg, saying that it inter- rupted the messages to his brain.

On 10 May, an out-of-hours GP found him lying in his bed, unable or unwilling to speak. He had been refusing to speak with his mother, or to eat with her, for 2 weeks, and had stopped taking medication.

On 14 May, he was admitted to Hawthorns 2 at Parklands under section 2 (see p.15). Catatonia was evident.

When the section expired, he stayed in hospital until he was discharged home on 30 June. He had a CPA meeting, was prescribed an anti-psychotic, was followed up weekly for two months by a CPN, attended out-patients, and received GP support.

30 full-time staff were required to manage this level of dependency, although there were only 27 team members (NHS EXECUTIVE CPA AUDIT WEIGHTING GUIDELINES; CLUNIS REPORT).

In August, there were five vacancies in the CMHTs, the north and west teams being particularly affected.

Service standards and concerns

Early in 1997, it became apparent that more north Hampshire residents were being referred to Hawthorns for admission than formerly, with the consequence that a significant number had to be admitted elsewhere.

On 22 July — one year after Mr Longman's death, five months before Mrs Huntingford's death, and eight months before Mr Harrison's death — a meeting was held to consider the state of the Adult Mental Health Service. It was said that certain aspects of the service were unsafe for both patients and staff, and a number of factors were identified. These included:

- an increasing number of acute admissions;
- the fact that patients were more disturbed, and an increasing number of them were being detained;
- the fact that more patients required visual observation;
- the reduction in the number of mental health beds;
- the fact that Parklands Hospital had been subject to more than 100% bed occupancy since it opened;
- the fact that at least five or six patients were inappropriately on the wards due to the lack of a rehabilitation facility;
- a lack of willingness on the part of the private sector to admit 'high-dependency' patients;
- inadequate staffing levels and numbers of trained staff;
- the problem that consultants were faced with choosing between admitting patients to an unsafe environment and leaving people in the community.

An action plan which sought to address this situation was agreed. This involved reviewing staffing levels and the mix of staff skills; daily monitoring of bed availability in the region; reviewing admission, observation and discharge policies and protocols; setting safe operational limits (*i.e.* closing to admissions); and formally writing to the Health Authority about the problems. Progress was to be monitored through the mental health review group.

At an EGM (extraordinary general meeting) of the trust board on 4 August 1997, it was noted that 5 minute observations were no longer practicable; that there were patients in Parklands who should be in secure units (two at that time); and that the effect of the changes was that in-patients would have a safer service, at the expense of some community patients, who would receive no service at all.

In July, weekly visits by a voluntary worker were added, and he was recorded as being depressed. His consultant discharged him to GP care at the end of September; and he was discharged from his CPN's case load at the end of November.

On 22 December, he seemed to be mute.

On 23 December he was visited by his consultant and an approved social worker, who agreed on admission to hospital under section 3. However, an error in the dating of one of the forms caused his admission to be delayed until the following day.

Mrs Huntingford died during the morning of 24 December, during an attempt to exorcise her.

Christopher Moffatt

Mr Moffatt's mental state deteriorated at the beginning of 1997. On 24 January, he was admitted to Hawthorns 2 ward at Parklands Hospital, under section 3 (see p.15).

On 15 August, he was transferred to the Burnham Unit, a medium secure facility in Epsom, mainly because he kept absenting himself from Parklands. He was transferred back on 11 November, and he remained at Parklands for the remainder of the year.

In the autumn of 1997, the trust described the gaps in the service as being the range of specialist services (*e.g.* a lack of psychological therapies); variations in assessment skills and response times between teams; and insufficient beds for all those requiring admission.

1998

Reconfiguration of mental health services

From April to July 1998, average bed occupancy was 113.6%, the situation being managed by the reuse of beds vacated by patients on home leave.

The number of beds on Hawthorns was increased to 53. This involved using accommodation previously used as offices, with over-crowding and lack of space during the day. However, only two patients had to be admitted to facilities other than Parklands Hospital. In effect, the trust financed this increase itself, the Health Authority being unable to commit itself to additional expenditure.

It was also agreed that the Loddon Trust, the WEHC Trust and Heathlands/Downlands would operate a 'knock for knock' arrangement with regard to acute inpatient treatment for Health Authority residents.

Three beds in a house in central Basingstoke, and a number of community support places to enable people to remain in their own homes, were provided by the newly established LODDON ALLIANCE HOUSING PROJECT. A team of nine staff were employed on a flexible basis.

Between April and July 1998, 18 people used the short-term bed for 107 nights between them, and 6 people stayed 86 nights in the two long-term beds. Community support, including sleep-overs, was given to 42 people, and almost 300 people received telephone support.

A RAPID ASSESSMENT SERVICE (RAS) was established, centred around three senior and experienced nurses based on Hawthorns 1. Their primary aim was to assist in identifying an admission bed and to secure the necessary support for people to remain in community settings (including close liaison with the Alliance Housing Project).

Between April and July 1998, the RAS received 107 referrals, resulting in 10 admissions.

Christopher Moffatt

By the beginning of 1998, Mr Moffatt had been an in-patient at Parklands Hospital for just under a year. On 19 February, he again absented himself from the hospital. He went to Andover and, on 9 April, he entered Anthony Harrison's home, killing him and seriously injuring his wife.

HISTORICAL THEMES

Two common themes emerged during our reviews of the treatment which Mr Longman and Mr Moffatt received. They were:

- difficulties associated with the implementation of the mental health strategy.
- difficulties associated with the lack of a local locked facility.

Implementation of the mental health strategy

The difficulties facing trust and social services practitioners during this period included the following:

1. The resources made available to mental health services in Hampshire did not permit the mental health strategy to be implemented, and the range of community resources was scaled down.

2. There was little additional investment in mental health services in north Hampshire until about four years ago.

3. Hampshire County Council was a relatively low spender on mental health services during the period reviewed by us.

4. Although the mental health strategy was 'revenue-neutral', its implementation involved developing a completely new range of services in Winchester, and this may have resulted in some disinvestment in north Hampshire.

5. The hospital closure programme was disruptive. Reducing the number of acute beds involved transferring in-patients to a day patient unit, which was then closed when a day programme was established at the Bridge Centre. The loss of the Winchester beds put additional pressure on the remaining beds in Basingstoke, by putting an end to creative bed management.

6. The three-bed intensive care area built into Parklands Hospital was not used, partly because the cost of staffing it safely would have caused disproportionate problems for the remainder of the in-patient unit, and the risks of not staffing it safely were unacceptable.

7. Because the trust was unable to guarantee no redundancies during the reorganisation, all of the nursing staff were required to compete for their own jobs, and to be interviewed in a competitive situation. Not surprisingly, this led to pressure and tension, and staff morale was not particularly good.

8. There was a very high concentration of trained staff on acute admission wards in the 1980s. As a result, there was a great deal of money tied up in acute admission wards, and the need to implement the mental health strategy led to skill mix reviews, which were thinly disguised financial reviews. At the same time, increased drug and alcohol usage was beginning to affect the client population, who became more prone to violence and aggression. So the ward became harder to manager, rather than easier, at the same time as staffing was being diluted.

9. The demands on community teams made by general practitioners, as a result of fund holding and the opening of CMHT centres, reduced the resources available to people with severe mental illnesses.

10. Both psychology and substance abuse services were poorly integrated with CMHTs.

11. Confidence in the implementation of the mental health strategy was affected by a House of Commons review concerning the discharge of a number of older patients, a review of local suicides, and three homicide reviews.

Findings

1. **Although consultants attempt to base their decisions on clinical considerations, budgetary constraints and bed availability do influence the treatment and care which patients receive.**

2. **The resources available to mental health services in north Hampshire did not permit the whole mental health strategy to be implemented.**

3. **Financial constraints and the implementation of the mental health strategy did compromise Mr Longman's treatment: on three occasions he had to be admitted to one of the wards for Winchester patients (in 1993 and 1994), and on three occasions it was not possible to admit him (in January 1994, October 1995, and November 1995). Furthermore, having regularly seen his consultant on Pinewood ward between January and November 1995, he did not see him thereafter, following his consultant's move to the Bridge Centre in December.**

4. **Financial constraints and the implementation of the mental health strategy also compromised Mr Moffatt's treatment, insofar as they contributed to (i) the lack of intensive care facility at Parklands Hospital; (ii) the lack of rehabilitation facilities for in-patients at Parklands Hospital; and (iii) the decision to discharge him to the Stonham group home.**

5. **There is no evidence that financial resources or the implementation of the mental health strategy compromised Paul Huntingford's treatment.**

6. **The LODDON TRUST inherited a difficult situation in 1993, and it showed great resolve in its attempts to modernise local mental health services. The services are now more efficient than they were during the period when the mental health strategy was being implemented, and are an improvement on those in place in 1990.**

Lack of a local locked facility

Park Prewett gave up its locked ward in 1975, operating an open service with no locked doors or seclusion rooms. The decision to dispense with a local locked ward led over the years to a lot of work being done on observation and other techniques for managing patients who would traditionally have been nursed in locked facilities.

Although the trust had access to locked facilities at the OAKTREE CLINIC in Surrey, and to the regional secure unit, these facilities were not always available in an emergency.

Considerable effort was put into the design of Parklands Hospital in order to eliminate some of the problems associated with the old Pinewood wards, by reducing the number of exits and making observation easier.

The design also included a small three bedded intensive care area, which could be locked, and would provide a degree of security as well as intensive nursing. Partly for staffing reasons, this area was never opened.

The lack of a local locked intensive care facility was, in our opinion, a weakness:

1. As a philosophy, the idea that patients should not be managed on locked wards has nothing to commend it if local people are simply admitted to out-of-area locked wards.

2. In-patients had the benefit of more space and more extensive occupational therapy at the old Park Prewett Hospital, and this may have made the management of disturbed behaviour easier.

3. There was evidence that staff working on the open wards had to resort at times to less than ideal ways of managing disturbed behaviour. Deprivation of daytime clothing was used at Park Prewett, and the police and hospital porters were sometimes called upon to restrain patients. Indeed, Mr Longman was given medication 'with the help of porters holding him down'. It also seems to be the case that informal, and hence unregulated, seclusion and 'time-out' were practised.

4. There was evidence that the use of observation was not always an effective means of detaining, or ensuring the safety of, patients. Five minute observations came to be seen as impracticable and were phased out in August 1997, and nursing levels were inadequate at times. When the use of the observation policy was audited against recommended staffing levels for the period 15 December 1997 to 22 June 1998, it was found that staffing levels were not met on about one-third of the shifts, 92% of these occurrences being on Hawthorn 2 ward.

5. Given recent increases in the level of substance abuse and behavioural disorders among the mentally ill, it may now be imprudent, and in some cases untherapeutic, to maintain an open policy.

Findings

1. **Local people did not benefit from a comprehensive mental health service during the period covered by our review.**

2. **'An inevitable consequence' of the coincidence of a non-functioning intensive care unit and more disturbed behaviour was 'that that there are people who the trust cannot manage, and there are more of them now than there have ever been. And it is likely to get worse.'**

3. **In Mr Longman's case, his in-patient treatment was compromised by the absence of a local intensive care facility.**

4. **In Mr Moffatt's case, his treatment was compromised by his absences from hospital, by the absence of a local intensive care facility, and by the use of continuous observation for long periods.**

5. **The lack of locked facilities at Park Prewett and Parklands limited the ability to deal with a small group of patients who presented with persistent absconding behaviour.**

6 MARK LONGMAN'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The main purpose of this chapter is to summarise the most important aspects of Mark Longman's personal history, care and treatment, and our findings concerning his care and treatment.

I. MR LONGMAN'S CARE AND TREATMENT

Mark Longman was born on 21 August 1969. On 4 June 1996, he killed his father, Kenneth Longman, at their home in Popley, by setting fire to him. Having initially been found unfit to plead, he later pleaded guilty to manslaughter on the grounds of diminished responsibility. He was sentenced on 5 May 1998, when hospital and restriction orders were imposed.

Mr Longman father was sixty three when he died, and had retired from work as a tool setter on the grounds of ill health. He and his wife had five children, but only Mark Longman was living with them at the time of his father's death.

Mark Longman left school with no or few qualifications. By the time he celebrated his 17th birthday, in August 1986, he had been in regular contact with the police, for minor property-related offences, and irregular employment. He was being supervised by the probation service. It was at this point that signs of mental illness first became obvious. He was convinced that he had contracted AIDS and that an infection had stunted his growth. Delusions regarding his body shape were recorded. He became increasingly self-conscious and withdrawn, giving up his job and undertaking a crash diet.

Mr Longman was seen by a psychiatrist on 2 April 1987, when it was noted that he had scared his face in order to slow down the facial changes. He was started on antipsychotic medication. Some moderate alleviation of Mr Longman's symptoms and distress was noted in July, which was maintained until he stopped medication in October.

In June 1988, he agreed to try a different drug, modecate, and he received the necessary injections from a community psychiatric nurse until October, when he looked 'remarkably well'. He then discontinued medication for seven months, until 1 May 1989, following which he again received it regularly until 16 October 1989.

On 21 October 1989, he was taken to the A&E Department at Basingstoke District Hospital, having been found in a confusional state. He was diagnosed as acutely psychotic and was detained in hospital under section 5(2) (see p.16), but discharged after two days. He then received regular injections until October 1990 when his consultant, who could not elicit any signs of mental illness, agreed to a drug holiday.

The position in October 1990 was therefore that Mr Longman had a serious mental illness, but one which responded to medication, and his record of compliance that year had been very good.

Unfortunately, Mr Longman's mental state began to deteriorate in November 1990 and, in January 1991, he was arrested for attempted robbery. In March, he attended the A&E Department, having taken an overdose. He believed that two men of African origin were residing in him, and that they were using witchcraft and black magic to control him. He also believed that a neighbour was spying on him and trying to frighten him, and he was worried 'that he was cracking up — 'my pupils were getting big. That's never happened before.' He asked his father to get hold of a shotgun, so that he could kill himself. On 8 March, he was informally admitted to Pinewood I Ward, at Park Prewett Hospital, and prescribed an antipsychotic. He left hospital on 11 March, and received two injections later that month. In April, he ceased attending out-patient appointments and taking medication. On 26 November, he was sentenced at Winchester Crown Court to 2½ years imprisonment, for the attempted robbery committed in January.

On 25 September 1992, Mr Longman was paroled. His then girlfriend was worried by his references to black magic and voodoo and she obtained an injunction against him. Matters came to a head on 2 December, when he was informally admitted to Pinewood II Ward. He received in-patient treatment there for five months, until 11 May 1993. He was particularly unsettled during December 1992 and January 1993, when he believed that a coven of witches inhabited his abdomen, controlling his thoughts, actions and physical appearance. On one occasion, he fell to the floor for no apparent reason, and was unresponsive to staff. On 17 January 1993, he was detained under section 3. By the end of April, it was thought that he had improved but remained odd, with his delusional beliefs 'just under the surface'. Nevertheless, he was discharged on 11 May.

Mr Longman received weekly injections of depixol for about seven months until 18 January 1994. During this period he attended the day service at 3 Vyne Road, somewhat erratically, and twice in November was informally admitted to Park Prewett for three days, because he felt depressed and suicidal.

In January 1994, Mr Longman stopped taking medication. According to his consultant, he was deteriorating, and was 'very keen to come back into hospital', but no bed was available. Notwithstanding this deterioration, the Vyne Road day service closed his case three days later, when he told them he was feeling 'much better' and asked for his case to be closed.

On 19 May 1994, Mr Longman attended the A&E Department at Basingstoke District Hospital, having cut his wrist with a razor blade, and was admitted to Chester Ward at Park Prewett. He described continually seeing black witches and rastafarians, which talked to him in a derogatory fashion, ate his insides, and controlled his speech and breathing. He remained in hospital until 11 June, when he discharged himself. On 23 June, he referred himself back to Vyne Road, where his attendances were described as 'aimless'. On 7 July, he took an overdose outside the hospital grounds and was again admitted to Chester Ward, where he remained until he discharged himself on 20 July. On 25 October, he purchased some rat poison and threatened to kill himself, and was again admitted. His behaviour during this admission was said to be 'very disruptive' and a section 3 application was made on 10 November. By December he was much improved and, on 10 January 1995, he was discharged from hospital.

In February 1995, Mr Longman stopped seeing his key worker and stopped receiving injections. He did, however, continue to see his consultant until November, missing only one appointment with him until then. His behaviour at Vyne Road was problematic. He was described as abusive, over-assertive and intimidating, and he was twice warned about the possibility of exclusion from the service. On 4 May, he told his Vyne Road worker that his only recourse was to buy a shotgun and to take his own life, and those of two others; he badly wanted attention, fame and success, and did not care if this was only achieved by the notoriety that such violence would bring. On 9 August, he saw a locum GP, complaining of a lack of muscle definition. On 27

October, he 'seemed again to be symptomatic and quite scared by his delusional ideas; for the moment, he is clearly wanting some help and support'. He asked for readmission but, after a convoluted attempt to find him a bed, decided against it, agreeing to take chlorpromazine instead. On 4 November, he went to the ward 'demanding admission'. The duty doctor was too busy to see him until later that day, and he refused to go home to be assessed there by his GP. A nurse asked him to leave the ward but he said that he could not walk; he was not admitted.

Apart from occasional visits, usually to discuss his programme, he stopped attending Vyne Road in November 1995; and he also stopped seeing his consultant. His consultant did not see him in 1996 and, between 12 March and 30 April, he attended the day service only twice, for 5–10 minute visits. On 22 May, he came to Vyne Road and said that he wanted to leave the service. Day service staff judged that he had remained reasonably stable for seven months, and formally closed his file on 4 June. During the early hours of that morning, he killed his father by throwing a bowl of petrol over him, and setting a match to him.

After Mr Longman's arrest, it emerged that he had built a small cardboard altar in his bedroom, which he adorned with little figures. This altar also contained candles and 'strange' pictures on the walls, in the nature of a shrine.

II. FINDINGS

Our findings are presented in the following order, and under the following headings:

An individual's care is affected by the resources available for his care. When an individual's needs and behaviour are challenging, it is essential that adequate resources are available **(1)**, which are professionally applied within a plan that addresses his mental state, personality, behaviour **(2)**, and social circumstances **(3)**. Even then, as with any serious medical condition, the outcome may be unfavourable or only partially successful.

(1) RESOURCES

The availability of adequate resources is an important part of the context within which professional decisions are made. Mr Longman was treated and cared for during a period when local services were being closed and reformed. This reorganisation meant that it was no longer feasible to operate an 'open-door' policy for former patients who attended the hospital asking for admission; and financial constraints meant that the range of community care services originally planned had to be scaled down.

We have already noted that financial constraints and the implementation of the mental health strategy affected Mr Longman's treatment (see pp.62–63): on three occasions he had to be admitted to one of the wards for Winchester patients (in 1993 and 1994), and on three occasions it was not possible to admit him (in January 1994, October 1995, and November 1995). Furthermore, having regularly seen his consultant on Pinewood ward between January and November 1995, he did not see him after his consultant moved to the Bridge Centre in December of that year. Community facilities were limited, and many of the services now in place, such as the RAPID ASSESSMENT SERVICE, did not then exist.

These strategic and financial difficulties explain some of the shortcomings in the management of Mr Longman's treatment.

Findings

1. Inadequate resources had a significant impact on Mr Longman's care and treatment, and his health. This compromised his safety and the safety of his family, and required them, and professional carers, to accept risks which they ought not to have had to bear.

(2) MR LONGMAN'S PERSONALITY, ILLNESS AND BEHAVIOUR

Personality change can be the first evidence of severe mental illness, and occur before other symptoms and signs are present. In addition, severe mental illness often affects personality, and changes are mostly irreversible.

There was no professional consensus about the extent to which Mr Longman's behaviour reflected his personality or was a consequence of his illness or of the suffering caused by it. Nevertheless, it is possible to draw some conclusions from the information available:

- During his time in contact with local mental health services, Mr Longman was suffering from a devastating and disabling illness, and he had few (if any) social and economic advantages to mitigate its practical effects. He thought that he had AIDs; believed that he had an infection which had stunted his growth; suffered bizarre, false beliefs with respect to his body shape; believed he was going blind; and thought that his body was inhabited by two black men who were controlling him. This unshakeable belief that he was possessed made his life almost unbearable, and he frequently attended the Accident & Emergency Department following episodes of self-harm.

- There were many reasons why his medical condition and social circumstances were exceptionally difficult to treat and manage. His illness was a severe one, which almost certainly affected his personality and behaviour; the effect of his behaviour on other patients and clients had to be considered; he mostly did not believe that the services which were provided would benefit him, and most episodes of treatment came to an end when he failed to attend appointments and fell out of contact; his non-compliance with treatment and care plans made it impossible to sustain any improvement in his mental health or behaviour; eventually he was always non-compliant with medication outside hospital; he was an unreliable attender of outpatient's and other appointments; he was not a reliable informant and could be mischievous, so that it was often difficult to know what weight to attach to his statements or actions; his preference for

alcohol over medication compromised his treatment; and, although he was said to be good at drawing attention to his needs, he was incapable of following through any plan which addressed them.

- Mr Longman's mental health and demeanour deteriorated in prison, and he become quiet, withdrawn and miserable. Some of the behaviour which distressed him and others was a consequence of his severe illness and the torment it caused him.

- His mental state caused distress, arguments and divisions within his family, most of whom initially tried to help him, but came to view his behaviour as 'totally unacceptable.' Professional euphemisms aside, almost everyone who had regular contact with him felt provoked at times, and found his behaviour disruptive and distressing. Almost everyone felt some anger, and the chronicity of his condition taxed the skills, good will and patience of his family and professional carers, all of whom were often frustrated by the limited effectiveness of their interventions.

- Mr Longman's behaviour could put himself and others at risk.

- His mental state deteriorated some months before his father's death, from around September 1995 onwards.

THE MANAGEMENT OF MR LONGMAN'S TREATMENT

Mr Longman's consultant was praised by everyone with whom we spoke. He was described as 'super'; very open and approachable; flexible; easy to deal with; always willing to see relatives; happy to see people in the evenings or out-of-hours; well liked by patients and colleagues.

Mr Longman's consultant acknowledged that 'the difficulty was how do you work with and help to look after someone who kept you at arm's length.' It was decided that he was 'best engaged by allowing him the freedom to access the service as he chose and in the way he chose. That seemed to have kept him out of hospital and kept some degree of contact with him ...' He would be brought into hospital when floridly ill, would be discharged with the expectation that he would be non-compliant, would be picked up, access services, and again relapse. His schizophrenia would not go away.

Two key issues must be addressed. Firstly, whether, given resources, this strategy was that most likely to bring about and sustain an improvement in Mr Longman's health, and the best way to manage known risks. Secondly, whether the strategy was properly implemented, so that any chance it had of a favourable outcome was not reduced by indifferent practice.

WHETHER THE MOST APPROPRIATE STRATEGY

It seems to us that there were some inherent weaknesses in the strategy which was adopted, which make it difficult to support:

1. Whatever the contribution made by that immeasurable part of his personality which was not affected by his mental illness, Mr Longman also had a devastating mental illness which required intensive treatment but which, for many reasons, was not treated intensively.

2. Mr Longman's treatment in the community lacked clearly defined objectives.

3. The team lacked a clear strategy for following-up partially treated, non-compliant, out-patients; and the professionals waited for him to re-present.

4. There was little evidence that Mr Longman re-instituted contact, and it was most often the probation service or a crisis that brought him back into contact (the final crisis being the homicide).

5. The services relied on him to see his consultant if he felt that he had a problem, and on his parents to report disturbed behaviour. However, Mr Longman and his family had little or no understanding of his illness, and they rarely confided in professionals. Because Mr Longman thought that his son's behaviour was wilful, rather than the result of an illness, it was illogical to rely on him to contact mental health services if he was concerned about it. Similarly, because Mrs Longman found it impossible or difficult to acknowledge her son's illness, or its severity, it was illogical to rely on her to contact the services in times of crisis.

6. Since Mr Longman was referred to Vyne Road by his consultant because of the risk of isolation, it was illogical to wait for him to represent when he stopped medication, and stopped attending out-patient appointments and 3 Vyne Road; his isolation should have been the trigger for more action, not less. Attempts should have been made to follow him up, to find out why he had isolated himself, whether his mental state was deteriorating, and so forth. It seems paradoxical that, at a time when a person's need for supervision and contact is possibly greater than ever, it should be withdrawn, which is what happened.

7. Mr Longman was encouraged to use the service when he turned up but the service did not go to him. However, his mental state was such that it was at times unrealistic to expect him to attend out-patient appointments, and there is no evidence that his professional carers actively considered whether alternative ways of seeing him by appointment were feasible.

8. Even if compliance 'in the short term' was the only realistic goal, the period of compliance could have extended by discharging Mr Longman from hospital under section 17 leave, with appropriate conditions attached. (That this did not happen may, it seems, have been because of a misunderstanding of the case law.)

9. There was some evidence that Mr Longman was better managed by imposing formal requirements on him. His performance and behaviour at school improved enormously during his final year there, as a result of daily supervision and support ('now that his examinations are finished, he would benefit from some form of regular contact with someone in a position of authority, who could keep a check on his activities'). He responded to formal supervision from the probation service, completing the requirements of his attendance centre and supervision orders; and was not breached with regard to the probation orders: 'In general, response to his probation orders has been very satisfactory. Attendance at the day centre was excellent and group participation good.'

10. Although the significance of particular incidents of self-harm or threats to others were reviewed, there is no evidence of any systematic assessment of the risks, or of any plan for managing them. If an individual with a serious mental illness has harmed himself on a number of occasions, and threatened grave harm to others, it is difficult to justify a strategy which allows him to determine his need for treatment unless the risks of such a strategy have been systematically assessed.

11. As part of this risk management strategy, proper consideration should have been given to the need to place his name on the supervision register. The purpose of registration at that time was to ensure that a team followed up a patient whose behaviour put himself or others at significant risk.

12. When Mr Longman was in hospital, he would typically accept injections, which had a reasonably prompt effect, and 'you could certainly guarantee that he would have some medication at that time.' However, most individuals have a preference for

not being detained, and those with limited 'insight' a preference for not being treated. Following discharge, they will inevitably choose not to access the services much of the time, and this will keep them out of hospital; but not necessarily well.

13. The lack of physical security in the local in-patient service, and high levels of bed occupancy, made in-patient management and treatment difficult.

14. The strategy was driven as much by frustration as by any belief that it was that most likely to bring about and sustain an improvement in Mr Longman's health. This growing frustration led to a less tolerant and accepting approach being taken to his behaviour, and boundaries on contact with professionals being imposed. However, he had a serious, untreated, mental illness and was incapable of observing treatment and care plans, boundaries and contracts.

Findings

2. Mr Longman had a devastating mental illness which required intensive treatment but which, for many reasons, was not treated intensively.

IMPLEMENTATION OF THE STRATEGY

The implementation of the strategy was compromised by deficits in the following areas: (a) inadequate implementation of the care programme approach; (b) inadequate implementation of section 117; (c) inadequate communication between professionals; (d) inadequate record-keeping; (e) inadequate supervision; (f) insufficient attention to Mr Longman's family circumstances (see p.75 *et seq.*); and (g) inadequate resources (see p.62 *et seq.*).

(a) Implementation of the care programme approach

The care programme approach was not fully operational at the time. There was anxiety about the CPA, and its consequences in terms of resources and recording. Some consultants implemented it idiosyncratically, so that out-patients' clinics and ward rounds might be designated as the CPA meeting. The expectations of provider units, such as Vyne Road, were quite low, and there was no systematic care programme approach audit.

Proper implementation of the care programme approach requires a central administrator who can co-ordinate reviews, supervision register patients, check documentation, and so forth. The lack of a care programme approach administrator within the trust was acknowledged to be a weakness.

In Mr Longman's own case, it was common ground that the care programme approach had not been effectively carried into practice, and that professionals did not have a systematic approach to it.

There was no evidence that Mr Longman had a care programme before his final admission to Park Prewett in September 1994. During that admission, a community psychiatric nurse member of the eastern team was appointed as his key worker. On 20 January 1995, ten days after his final discharge from hospital, a care programme approach meeting was held at Mr Longman's home, at which only he and his key worker were present. Vyne Road staff, his family, his general practitioner, and other professional carers were not invited.

The key worker recorded that Mr Longman joined his caseload on 20 January 1995 (the date of his care programme approach meeting with Mr Longman), and was discharged from it on 26 May 1995, the last contact between them having been on 17 February. His input lasted barely a month and included only four contacts.

As soon as Mr Longman became non-compliant, his key worker therefore discharged him from his caseload, and his consultant became the unofficial *de facto* key worker. This was a paradoxical response, and the complete reverse of what one would expect in such a case, that non-compliance would increase contact.

The key worker did not discuss with Mr Longman's consultant whether it was appropriate to remove him from his case load, or how the difficulty might be resolved. Nor was there any discussion within the team, although the procedures in force at the time meant that there should have been.

Having unilaterally discharged Mr Longman, his key worker did not further enquire about his welfare.

The key worker was not properly trained or prepared for the role, seeing his job as being to ensure that Mr Longman was medicated: he had a 'one-track mind in terms of his getting his medication'.

Vyne Road did not receive care programme approach information on clients referred to it, partly because the then locality manager did not believe that it was appropriate that they receive it.

The key worker did not establish contact with 3 Vyne Road, in part because he was told by Mr Longman that he did not want to be involved with the day service. His 'primary thought was ... that the client is empowered to make decisions about their own care, and I had to get his signature for the care plan.'

The needs and views of Mr Longman's relatives were not taken into account; and we were told that this was not unusual at the time.

The development of multi-disciplinary work within the Eastern CMHT emphasised the identification of core skills and team consensus, possibly at the expense of professions exercising their particular, traditional, areas of expertise.

Although the locality team manager was responsible for care programme approach processes, no one we spoke with could recall being asked for evidence of its implementation.

Findings

3. In Mr Longman's case, it was common ground that the care programme approach was not implemented effectively, and professionals did not have a systematic approach to it at this time.

(b) Implementation of section 117

Section 117 after-care is to be provided until the relevant authorities are satisfied that the patient no longer requires it (see p.14).

We were told that section 117 was 'not formalised' at this time, despite the fact that the duty had existed since 1983.

There were management weaknesses in the way in which the hospital social work department implemented section 117. In particular, no one within the social work department was responsible for ensuring that patients detained under section 3 were seen by a social worker, or that after-care arrangements had been made, prior to discharge.

There were also management weaknesses in the trust's implementation of section 117. Although Mr Longman's consultant completed a section 117 notification form following his detention under section 3 in November 1994, this was not seen by any of the hospital-based social workers during that admission, which was apparently the norm.

It was common ground that there was no evidence that section 117 was implemented in Mr Longman's case.

Professionals took unilateral decisions which were incompatible with the duty imposed on the health and social services authorities to provide after-care services until they were satisfied that Mr Longman no longer required them.

Mr Longman's CPA key worker 'was not aware what section 117 was': nor, therefore, was he aware that it might be necessary to refer the issue of whether to close Mr Longman's case to the trust and social services before making a decision.

Vyne Road closed his case without taking section 117 into consideration. This decision should have been taken within a care planning framework, but it was not operating effectively at the time.

It was 'evident' that when Mr Longman isolated himself, this should have led to some kind of action plan involving health and social services jointly deciding how to proceed, rather than simple case closure on both their parts.

The hospital social work department demonstrated a lack of will or initiative to involve itself in his need for after-care, and to carry out the local authority's duties under section 117.

Family members, carers and professional carers from outside the hospital were not routinely invited to section 117 meetings.

Findings

4. Section 117 was 'not formalised' at this time, despite the fact that the duty had existed since 1983. It was common ground that there was no evidence that section 117 was implemented in Mr Longman's case.

(c) Communication between professionals

The quality of Mr Longman's care and treatment was undermined by inadequate communication between members of the community mental health team and other individuals and services.

There were many failures of communication, of recording, and of understanding others' roles and responsibilities.

The letter of referral to 3 Vyne Road, which was written the day after Mr Longman's discharge from hospital on 11 May 1993, was extremely short and failed to communicate crucial information about his history, condition, care and treatment. It

failed to inform 3 Vyne Road of his unpredictable mental state and behaviour during the recent admission; of the fact that he had been detained under section 3; of the fact that he was therefore entitled to after-care from social services under section 117; of the fact that he had a community psychiatric nurse; of his record of offending; or of his many visits to A&E, generally for overdoses and other episodes of self-harm.

Similarly, important developments following the initial referral were not shared with staff there. For example, Vyne Road staff closed his case in January 1994, when he said that he was feeling much better in himself, unaware that three days earlier his consultant had recorded that he had gradually been deteriorating and talking about wanting to die, and was very keen to come back into hospital, but they could not take him.

Although discharge letters, and letters following out-patient appointments were sent to his general practitioner, and copied to his CPN, they were not also copied to Vyne Road staff, who often relied on clients to give them this information. This was particularly unfortunate because the trust believed that the Vyne Road key worker was monitoring his overt mental state and would communicate any adverse developments.

Important information obtained by Vyne Road was not shared with his consultant. For example, although his key workers recorded despair and suicidal thoughts at various times, these observations were most often not passed on.

Mr Longman's consultant trusted his community psychiatric nurse, and other professional carers, to tell him about any significant developments. However, good communication requires more than trust, however well placed, particularly when staff have heavy caseloads. The evidence suggests that the weekly community team meetings were very informal and that communication was inadequate. People came or did not come. There was no formal administration of record-keeping. Minutes were neither written up nor circulated. Rather, there was an informal expectation that people would keep a record of their own action points.

Liaison with the Accident & Emergency Department was inadequate. Mr Longman made seventeen visits there following his first psychiatric referral. On some occasions, when he attended A&E for help with a somatic symptom of mental disorder, he would be discharged home without seeing a psychiatrist. Following each visit, the A&E department sent a note or letter of the attendance to his general practitioner, but not to his consultant at Park Prewett Hospital (or, through him, to other members of the team).

Findings

5. The quality of Mr Longman's care and treatment was undermined by inadequate communication between members of the community mental health team and other individuals and services.

(d) Record-keeping

The standard of record-keeping was inadequate in some respects, and this must have made it unnecessarily difficult for busy practitioners to plan and co-ordinate his treatment and care.

Mr Longman's in-patient records were 'a real jumble'. There were separate medical, nursing, and occupational therapy records, and it took the internal trust reviewers two days to put them into some sort of order.

The completion of the prescription card by a community psychiatric nurse was considered at the time to be an adequate record of the visit unless a significant change in the client's mental state was observed. Furthermore, nurses' records were not generally seen by managers, who were 'quite oblivious to the standards of record-keeping'. Although records were audited in the in-patient services, 'the community service had always resisted that.'

Findings

6. The standard of record-keeping was inadequate in some respects and Mr Longman's in-patient records were disorganized. There were separate medical, nursing, and occupational therapy records, and it took the internal trust reviewers two days to put them into some sort of order.

(e) Supervision

Clinical supervision within the trust was in its infancy at the time Mr Longman received care and treatment. Some services, such as substance misuse services (which was part of a separate directorate, called speciality services), had an active programme. In other areas, including some of the acute services, there was nothing; and it was not until May 1996 that a more formal process was introduced.

The internal review of Mr Longman's care and treatment reported that an adequate system of clinical supervision still did not exist. In reality, the supervision consisted of little more than a rebadging of existing 'weekly catch-up and feedback' meetings. It tended to concentrate on the number of clients on the practitioner's caseload and the way in which s/he used her time. There was little reflection, in the sense of examining cases, how they were being managed, issues arising from them, and what alternative strategies might be deployed. Clinical supervision was used as a management tool, rather than as a tool for clinicians to improve their skills, and one of the reasons for this was that a more effective system requires a reduction in caseloads.

The systems to monitor and review the ways in which community nursing staff planned and delivered care were not in place, and supervisory processes do not appear to have been in place or directed at ensuring that basic procedures were followed and standards applied.

Findings

7. An adequate system of clinical supervision did not exist. There was little reflection, in the sense of examining cases, how they were being managed, issues arising from them, and what alternative strategies might be deployed.

(3) MR LONGMAN'S SOCIAL CIRCUMSTANCES

Many professionals place great emphasis on the significance of the patient's relationship with her or his relatives, in terms both of the occurrence of the disorder and relapse. Two protective factors have been identified where the family environment is difficult: regular maintenance treatment with antipsychotic drugs and low social contact between relative(s) and patient.

MR LONGMAN'S HOME CIRCUMSTANCES

The information available to us indicates that:

1. Mark Longman sometimes held delusional beliefs which involved family members.

2. His parents struggled to understand, and cope with, his illness and behaviour, and he found it difficult to confide in them.

3. The domestic situation was such that the family home was the last place Mr Longman should have been, given his serious mental illness. His illness and behaviour, and his parents' different ways of dealing with his and their distress, were the source of much ill-feeling and frequent arguments. This intolerable situation affected the health of all of them.

4. Mr Longman was usually reluctant to talk about his family or to involve them in his care and treatment, and his parents were similarly reluctant to volunteer information about the situation at home. There was, nonetheless, considerable information, dating back to 1987, which indicated that he ought not to remain at home.

5. Although Mr Longman's observed behaviour outside the home was known to be disruptive, provocative, and disturbing, the professionals did not properly address the probability that, if he could behave in this way on the ward when unwell, this might also be the behaviour which his family had to contend with at home. It had no, or insufficient, impact on their thinking.

6. There was almost no contact between mental health services and Mr Longman's family during periods when they were caring for him at home, and no real support was given to them. There was no strategy for reducing family tension, or for alleviating the effect of this tension on Mark Longman's mental state and treatment.

7. The hospital social work department failed to allocate his case, or to take any long-term interest in him. Little priority was given to his need for alternative accommodation, and the interventions of Hampshire Social Services employees in this area were time-limited, inconclusive and of little help.

8. Underlying all of this was a failure to implement the care programme approach, section 117, and care management. Despite the requirements of the care programme approach, there was at the time no clear or consistent approach on the wards to involving the families of in-patients.

Findings

8. The domestic situation was such that the family home was the last place Mr Longman should have been, given his serious mental illness. Unfortunately, there was almost no contact between mental health services and Mr Longman's family during periods when they were caring for him at home, and no real support was given to them. There was no strategy for reducing family tension, or for alleviating the effect of this tension on his mental state and treatment.

(4) 3 VYNE ROAD DAY SERVICES

The statement of purpose in the service's business plan for 1993–1996 referred to upholding the client's 'right to self-determination and choice,' and included the ambiguous statement that the 'the individual is expert.'

We were told that the phrase 'the individual is expert' was meant to convey the idea that the individual was probably the best person to make judgements about whether the services being provided there were working for her or him. Likewise, the best way of determining the services which clients needed was to involve them centrally in the decisions. In short, the user was more expert than others about their level of satisfaction with services. This, it was said, reflected the reality that Vyne Road was a voluntary service, and the individual had to want to come.

While this approach has much to commend it, there are practical limits to 'a voluntary service dedicated to self-determination and choice' because some illnesses, such as severe schizophrenia, strike at the heart of voluntariness, and of self-determination and choice.

The service was also defined as being 'needs-led versus resource-led', by which was meant that Vyne Road would ascertain from the client what service he or she needed and then try to satisfy that need, rather than merely ask the client to choose a service from a pre-determined range. The service therefore aimed to be ever-changing, changing both for the individual and for groups, to meet assessed need. In short, the service was to be fitted to the people using it, rather than the clients being fitted into the service.

Vyne Road's role was to provide a service which the professionals referring a client to them, and they on assessing the client, felt would benefit the individual. It was a service which, in theory, would be identified as part of a care programme or through care management. Although it was not Vyne Road's function to assess the range of services which a client required, or to commission them, it did offer an outreach service to clients assessed to need it, which was 'mostly a home visiting service'. It also 'did quite a substantial amount of ... work concerning housing and welfare benefits.'

Expectations of the care programme approach were low at this time, and it was Mr Longman's consultant who referred him there, in the absence of a CPA framework. Care management 'was [also] not in at this point ... so that ... you had a system [of] in-house reviews, which would be looking at possibilities and programmes and areas of development and communication at Vyne Road.' A transition to care management was on the horizon, as a result of which 'the day service was losing part of its autonomy in terms of who it took and how they were managed.'

Following Mr Longman's referral, subsequent health service contact with Vyne Road was mainly through his designated key worker there.

It was accepted that health and social service professionals did not adequately co-ordinate Mr Longman's medical treatment and social care, and this was a weakness. We were told that, 'if there had been a closer working and awareness within the services involved with his care ... there may well have been things we would have picked up in that process of talking that through and reflecting on that together. When I look back on it, when we closed Mark's file, we closed it without any apparent concerns.'

A number of other factors also undermined Vyne Road's effectiveness:

1. There was a major upheaval at Vyne Road in the autumn of 1995, and all of the practitioner staff left within a short period of time. As a result, only the minimum drop-in type facility was kept going during this period: 'There was nothing — no programme, no kind of process by way of programme that had been formulated for any of the service users. There was just a kind of slightly more structured drop-in.' Not surprisingly, many of the service's users at the time described feeling confused, unsupported and disorientated. Mr Longman was angry about the loss

of his key worker and the suspension of his programme; angry about not being allowed to access the service early in the morning, after his parents locked him out of their home; and in conflict with at least two staff members, against whom he made a formal complaint.

2. This upheaval affected the service's ability to offer the outreach service:

> 'The Vyne Road remit was to have an outreach service, to work with people within the community, and not just with those who came to Vyne Road. There was certainly an emphasis placed on that when I started employment there. However, you also have to look at the particular time when I came into post. There was a completely new staff team, started from scratch almost. For the period of time we are talking about, that was not realistic ...'

3. Partly as a result of poor communication with health colleagues, a view seems to have been taken that Mr Longman's behaviour was wilful. After Kenneth Longman's death, a senior Vyne Road worker wrote that, 'His demeanour deteriorated and his level of verbal aggression increased. This would take the form of assertive domination and determination to have his own way, to attend when he wished and do what he wanted ... None of his behaviour was apparently a psychiatric illness as such. It seemed more to do with a determined desire to lead his life as he wished, and to trample over other people's feelings.'

4. The way in which Vyne Road twice closed Mr Longman's case was unsatisfactory, given that he had originally been referred there because of the risk of social isolation:

- His case was first closed on 28 January 1994. On that occasion, it transpired that he had recently stopped taking his medication, and had stopped seeing his consultant and community psychiatric nurse. Within two months, he was complaining to his GP of depression for the past three months; and within three months, he had been readmitted to hospital following cutting his wrists with a razor blade.

- When his case was closed in May 1996, his day service officer was unaware that his case had already been closed by his community psychiatric nurse/care programme approach key worker, and that he had not been seeing his consultant. This was unsatisfactory, as was the fact that no link was made with the previous case closure in January 1994, and the fact that Mr Longman tended to disengage when his health was deteriorating. In saying this, we accept that some of the medical history was unknown to Vyne Road, and this contributed to taking Mr Longman's statement, that he was well and no longer in need of the service, at face value.

Findings

9. The contribution made by Vyne Road was affected by staffing difficulties in the autumn of 1995, unsystematic liaison with health service colleagues, unsatisfactory closure mechanisms, and a misunderstanding of the effect of Mr Longman's mental illness on his behaviour. He was not a client who was able to make expert decisions about the services which he needed.

(5) THE NON-INDEPENDENT REVIEWS

Following the death of Kenneth Longman, both the Loddon Trust and Hampshire County Council Social Services Department initiated internal reviews of the way in which his care had been provided and managed.

THE TRUST'S INTERNAL REPORT

The trust's internal review panel was chaired by a non-executive director of the trust, although not the non-executive director whose particular sphere of interest was mental health. She was assisted by a consultant psychiatrist, specialising in learning disabilities, and by the trust's Complaints Quality Facilitator.

In our opinion, there were weaknesses in the process:

1. The fact that the trust and Hampshire County Council Social Services Department conducted separate reviews left the trust with only 'part of the story,' and vice-versa. The internal review panel did not have access to social services files, and the report of the social services review was only received at the end of the trust's review process.

2. The probation service were not invited to speak with the trust review panel; which again meant that relevant records were not seen; that the panel's understanding of his mental state, offending, and family circumstances was partial; and that the quality of inter-agency working and communication could not easily be ascertained.

3. The fact that the panel's medical member was chosen because she had never seen Mr Longman, and she did not clinically assess him, meant that she was unable to give an opinion as to whether his non-compliance and behaviour were signs of partial treatment or negative symptoms of schizophrenia. This was a crucial issue.

4. Some records were mislaid, for example those relating to a complaint which was investigated.

5. The report contained errors of fact, statements which cannot be supported, and judgements with which it was difficult to agree. For example, the report stated that it was 'entirely possible that drug abuse was the cause of his schizophrenic illness'; that he 'received the best treatment available without application of coercion from Adult Mental Health; and that the two services appeared to have liased appropriately throughout.'

SOCIAL SERVICES INTERNAL REPORT

An internal review was completed by Hampshire Social Services in August 1996. Here too, there were significant weaknesses in the process and in the report:

1. The review was confined to examining available documents.

2. Almost the whole of the report prepared by the service manager at 3 Vyne Road was incorporated within the internal review report, and almost nothing else.

3. The report did not identify or address social services' failure to fulfil its obligations under section 117 during and following his various admissions to hospital.

4. The report did not address how Mr Longman's family and accommodation problems were dealt with, or the fact that these needs had been overlooked by the hospital social workers who saw him.

5. The report did not address the fact that communication could have been improved; failures in the care plan; or the lack of any evidence of a systematic risk assessment.

6. The report failed to tackle the closure mechanisms in operation at Vyne Road.

7. The report failed to address the problems at Vyne Road in the autumn of 1995, and their effect on Mr Longman.

8. There was a failure to investigate the issues flagged up by a senior member of social services, and indeed those flagged up by the reviewer herself.

Findings

10. The internal reviews were inadequate in many respects.

11. The Department of Health ought to postpone its plans to replace independent reviews of homicides and untoward incidents with non-independent local reviews until there is more evidence that mental health services are better able to review shortcomings within their services.

7 PAUL HUNTINGFORD'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The main purpose of this chapter is to summarise the most important aspects of Paul Huntingford's personal history, care and treatment, and to set out our findings concerning his care and treatment.

I. MR HUNTINGFORD'S CARE AND TREATMENT

On 24 December 1997, Mrs Lena Huntingford died as a result of an attempt by her son, Paul Huntingord, to exorcise her. He was later found to have been insane at the time, and was not convicted of having committed any criminal offence. The judge made an order for his admission to a secure hospital, and a second order restricting his discharge from hospital without the consent of either a specially convened mental health review tribunal or the Home Secretary.

Paul Huntingford was born at Guildford, Surrey, in January 1941. He was an only child. He spent some of his childhood with his parents in the Republic of Ireland and completed his education at an independent school. He was an average scholar who shared his parents' interest in music, a subject which he studied at college. He held three positions as a music teacher, at least two of which were terminated in his mid-20s by his developing mental illness.

In 1966 Mr Huntingford was first admitted to a psychiatric hospital with a illness which was diagnosed as schizophrenia. In the three decades between the advent of his illness and the his mother's death Mr Huntingford was admitted to psychiatric hospitals on a further five occasions, always as a detained (formal) patient, and usually in similar circumstances: following non-compliance with medication over a period of weeks; increasing isolation; developing paranoid ideas associating him closely with forces of good and evil; marked negativism and hostility.

Mr Huntingford mostly did not accept that he was mentally ill, and felt stigmatised. When relatively well, he believed that his inability to lead a normal life was a consequence of others' actions; when ill, that it was part of a plot to harm him. Following the death of his father in 1980 Mr Huntingford lived with his mother in the family bungalow. Their relationship was mutually supportive, although not so when Mr Huntingford was ill. They shared an observance of the Catholic faith.

Mr Huntingford's intelligence, his sceptical attitude to the benefits of medication, which often has highly unpleasant side-effects, and his personality made him a challenging person to manage medically. Later, the development of diabetes complicated his treatment because of his tendency to blame his psychiatric medication for symptoms which were a consequence of diabetes. As with the majority of mentally ill persons, the type and dosage of drug which he would accept had to be negotiated and agreed by him.

Mr Huntingford had behaved aggressively when his illness was relapsing on two occasions: in the late 1960s towards his father; in 1981 when he chased his mother while holding a knife.

Between early 1982 and mid-1997 Mr Huntingford was treated in the community by psychiatrists and his general practitioner. In May 1997 his illness relapsed, probably because he stopped his medication. He was admitted to Parklands hospital where he remained for about six weeks. When plans were made for his discharge he made it clear that he did not want to be seen by a community nurse; in addition he was dissatisfied with his medication. Within a matter of weeks he had severed contact with his consultant psychiatrist, CPN and support worker, although they had never intended to provide long-term care. Mr Huntingford's problems were compounded by the temporary suspension of his driving licence following admission and the loss of his position as organist at his church.

Unknown to others Mr Huntingford stopped his medication in October 1997. Subsequently his paranoid ideas developed into delusions (false beliefs) concerning forces of good and evil in which he, and later his mother, were intimately involved. Alerted that Mr Huntingford was unwell the GP visited the family home on 19 and 22 December but Mr Huntingford was unable to cooperate with an assessment. The GP contacted Parklands Hospital indicating that admission was probably indicated. On the afternoon of 23 December, a consultant psychiatrist and two social workers, one of whom was a trainee ASW, visited the Huntingford home. Mr Huntingford was considered by them to require compulsory admission, so the trainee ASW attended the local surgery to obtain a recommendation from his general practitioner. The latter noticed an error in the dating of the medical recommendation completed by the consultant, who had left by then and was no longer contactable. The trainee returned to the Huntingford household, and the social workers left with the intention of completing the application the following day. On the morning of 24 December, Mrs Huntingford was killed, seemingly during an exorcism undertaken by her son.

II. OBSERVATIONS

1. Mr Huntingford was not found guilty of having committed a criminal offence, and we saw no evidence that he intended to harm his mother. Rather, the intensity of his belief that she was possessed by Satan, and of his wish to exorcise her, made him unaware that her life or safety was in danger.

2. The circumstances of Mrs Huntingford's death are therefore highly unusual. The panel's medical member had not come across a similar case, where death was caused seemingly inadvertently during the pursuit of psychotically-driven actions, despite having assessed some 1500 homicide suspects, about 200 of whom were mentally abnormal.

3. Mr Huntingford was an only child, and little is known of the quality of his upbringing or of family relationships. We know of no family history of mental illness or substance abuse.

4. When ill, Mr Huntingford's disorder was characterised by negativism, and a paranoid delusional system associating him closely with forces of good and evil. While the signs of negativism may have been obvious (although its origins may not have been), he had the ability not to disclose his overvalued and delusional ideas.

III. THE PANEL'S FINDINGS

Our findings are presented in the following order, and under the following headings:

(1) ASSESSMENT

It is axiomatic that health professionals need full personal and family histories of their patients/clients. They also need to know something of the views and circumstances of any carers in the community.

Findings

1. **Given Mr Huntingford's long psychiatric history, it is remarkable how little information was held in his current hospital/CMHT file. The medical files contained very little information concerning his psychiatric and personal histories, and his social circumstances. The importance to him of both the suspension of his driving licence and the schism with his church were not known or understood.**

2. **Because Mr Huntingford was not considered a risk to others (although there was evidence available that he was) his views prevailed as to what, and how much, prophylactic medication he would take, and which health care professionals he would see, and under what circumstances. Although his consultant encouraged him to take newer ('atypical') anti-psychotic drugs, for sound clinical reasons, they disagreed about his medication ('that was really the battle that was going on').**

3. **The purpose and effect of the 'quality assessment tool' used in his case are unclear. Many aspects were considered but seemingly not identified as a problem, *e.g.* social networks, occupation, isolation, poor compliance.**

4. **At some stage during Mr Huntingford's long contact with services, his mother should have been seen, perhaps quite formally, on her own. Too many assumptions were made about her relationship with her son, and more attention should have been given to the nature of this relationship, and its effect on the course of his illness. There is, for example, some evidence that Mrs Huntingford found it difficult to acknowledge his illness, may not have fully understood the importance of medication, and was sympathetic to the negative effect that previous admissions had had on him.**

5. Important information held by the GP was not sought by or made available to the hospital and community mental health services.

(2) ADMISSION TO HOSPITAL

Mr Huntingford's status under the Mental Health Act should have been reviewed soon after his admission to hospital under section 2 in 1997. In general, section 2 applications should not simply be allowed to lapse.

(3) AFTER-CARE AND FOLLOW-UP

In the months following his discharge from hospital Mr Huntingford succeeded in terminating contact with his consultant psychiatrist (25.09.97), his Stonham project worker (08.09.97), and his CPN (28.08.97 last home visit, case closed 27.11.97).

The decision to discharge Mr Huntingford back to his GP was his consultant's and not, as was suggested, his GP's. The case was handed over to the GP through correspondence.

For three months before the death of his mother, during which time both his consultant and CPN discharged him, Mr Huntingford believed his mother was possessed by Satan.

Findings

6. Formal (CMHT, *etc*) and informal (relatives) systems worked in parallel: those with the expertise didn't have the knowledge of him and his social networks, and those with the knowledge didn't have the expertise. More contact between the two would have helped both.

7. The care plan devised in July 1997 was over-inclusive and unfocused, and not enough attention was paid to properly engaging Mr Huntingford.

8. The notion that Mr Huntingford need only have a key worker for a period of two months played a part in his breaking off contact.

9. Mr Huntingford required an experienced, assertive, CPN.

10. Stonham's policy of seeing only Mr Huntingford as their client, and not allowing his mother to be appropriately involved in visits, was unhelpful and played a part in the family breaking off contact. Since, however, the contract was with Mr Huntingford, his mother should not have been allowed to end contact.

11. We were struck by the different way in which Mr Huntingford was described by his general practitioner (religious, kind, considerate, intense, serious) and members of the community mental health team (haughty, dismissive, narcissistic, difficult, opinionated, prickly). This might have accounted in part for the GP's greater success in engaging him.

(3) THE STATUTORY ASSESSMENT ON 23 DECEMBER 1997

Following Mrs Huntingford's death, the fact that one of the medical recommendations had been incorrectly dated received considerable attention. The consultant who completed the form was criticised for the error; and the approved social worker was criticised for not ignoring it, proceeding with the admission, and relying on section 15 of the 1983 Act. This section allows defects on the forms to be rectified during the fortnight following admission.

In support of this view, it can be said that a valid medical examination had taken place and that section 15 is a type of 'slip-rule', the purpose of which is to enable errors of recording to be corrected provided that the formalities were actually complied with.

While this view would probably prevail if the issue was argued in court, the matter is not quite as clear-cut as those who criticised the social worker assumed. In particular, the view does not acknowledge the ambiguity introduced by section 6. This section, insofar as relevant, provides as follows:

> *Effect of application for admission*
>
> **6.**—(1) An application for the admission of a patient to a hospital under this Part of this Act, **duly completed** in accordance with the provisions of this Part of this Act, shall be sufficient authority for the applicant, or any person authorised by the applicant, to take the patient and convey him to the hospital at any time within ....
>
> (a) ... the period of 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation for the purposes of the application ...
>
> (3) Any application for the admission of a patient under this Part of this Act **which appears to be duly made** and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given or of any matter of fact or opinion stated in it ...

In this context, 'an application' comprises the application *in toto*, and includes the medical recommendations. Apart from the fact that the case law demonstrates this, if it were otherwise the patient could be detained once an application form was correctly completed, notwithstanding that the medical recommendations were absent or wholly defective. This would, of course, not be a valid 'application'.

Because it is only a 'duly completed' application which authorises a social worker applicant to take the patient into her custody and to convey him to hospital, this creates a problem once she is aware that the application in her hands has not been, and is not, 'duly completed'.

Does she simply ignore the fact that the application has not been duly completed, and proceed with the detention; and, if the social worker can lawfully do that, what purpose is served by the requirement? Why did Parliament insert the phrase there in section 6?

To proceed in such circumstances might expose the applicant to criticism that she was exercising her power of detention in bad faith and without reasonable care. This is because, although section 15 allows defects to be rectified following admission, one cannot automatically infer from that that an applicant who knows that the application is not 'duly completed' can therefore ignore that fact. According to Laws J:

> 'Section 6(1) and (2) confer authority to convey or detain the patient in hospital where the application is "duly completed in accordance with the provisions of this Part of this Act". In my judgment that is an objective requirement and means that the application must not only state that the relevant provisions ... have been fulfilled, but also that it be the case that they have actually been fulfilled.'
>
> *Per Laws J in R v South Western Managers, ex p.M*

Accordingly, once the approved social worker (the prospective applicant) knew that she was not in possession of a duly completed application for Mr Huntingford's detention, and that to this extent she therefore lacked authority to convey him against his will to Parklands Hospital, it was not unreasonable for her to decide that admission required a substitute recommendation which was duly completed.

Whether proceeding in the knowledge that the application is not duly completed can be justified by a patient's circumstances or section 15 may be disputed; and no doubt in practice depends on the professional assessment of whether the patient's safety or that of others will be endangered if admission is delayed. In this case, the decision was that the application should be completed the following morning.

In theory, this means that the prospective applicant decided that there were no grounds for making or seeking an emergency application under section 4, based on a single medical recommendation from the GP; and nor did the circumstances require seeking a replacement section 3 medical recommendation from the duty psychiatrist. 'In theory' because it is not documented that these alternative options were considered at this point in the assessment process.

It seems therefore that there were three points at which the assessment process broke down:

> *Firstly*, the medical recommendation was incorrectly completed, and both the approved social worker and her trainee did not properly scrutinise it before she left the premises, and became uncontactable. Had the recommendation been properly completed or properly scrutinised, the planned admission would have occurred, and none of the other following considerations would have arisen.
>
> *Secondly*, when the error was pointed out by the patient's general practitioner, the need to proceed under section 4 or to obtain a replacement recommendation should have been explicitly discussed and the outcome recorded.
>
> *Thirdly*, it was undesirable, and perhaps unsafe, that the two social workers had to decide whether the risks involved in delaying admission until the following day were acceptable. The consultant assumed that immediate admission was taking place, and her opinion of the risks involved in delayed admission could not be obtained when the decision fell to be made.

Two points must be re-emphasised. Firstly, a trainee working with an approved social worker has no responsibility for any decision taken during the assessment process; it is the prospective applicant who remains responsible throughout. Secondly, the error in the dating of the medical recommendation is, in reality, something of a 'red herring'. The key issue is whether it was reasonable to delay admission until the following day. Had immediate admission been necessary, the approved social worker could have proceeded under section 4 (relying on a single recommendation from the general practitioner), or waited and obtained a second section 3 recommendation (assuming that they could have regained access to the Huntingford household). The view was taken that it would be safe to delay admission, and it is this assessment of the risks — necessarily taken without any input from the patient's consultant, who had departed — which was the most critical factor in terms of the timing of the admission.

Findings

12. There are some disparities in the accounts given by the four professionals involved in the assessment (the consultant psychiatrist, general practitioner and two social workers). These disparities cannot be accounted for by the passage of time or forgetfulness. Because of the disparities, it remains unclear or uncertain whether Mr Huntingford's GP told the trainee ASW that he wished to visit again on 24 December, and what the purpose of that visit would have been had it taken place.

13. The visit on 23 December should have been better planned, although staff should be praised for responding promptly to the request for an assessment. It was unsatisfactory (although common practice) that two social workers, who had never met Mr Huntingford and his mother before, were left to arrange and manage his admission. More thought should have been given to whether it would have been better to find a time when Mr Huntingford's GP (who knew him best) could have joined in the assessment. The panel heard from the GP that he was willing and able to do a joint visit.

14. Mrs Huntingford was relied on as an informant although she was not given the opportunity to speak in confidence about any concerns which she may have had. If any of the extended family had been seen it would have been clear that she could not be relied upon in terms of either notifying relapse or accurately reflecting its effect. We do not know that any attempts were made to educate her to understand the nature of her son's illness and the purpose and effects of the treatments he received.

15. Absence of information, in the form of past records and a mute patient, was viewed complacently.

16. In some respects, the trainee approved social worker acted as the approved social worker. The practice of delegating the interviewing of patients to a social worker who is training to be an ASW, though understandable, is questionable.

17. Although there was no evidence that Mr Huntingford intended to harm his mother when the approved social worker was asked to leave his home on the evening of 23 December, she left a situation destabilised by their visit. It was unfortunate that the patient's consultant was unavailable for consultation, and that there was therefore no medical opinion of the risks involved in deferring admission until the following day.

18. There is some case law that supports the approved social worker's interpretation of the effect of the incorrectly dated recommendation and therefore, even if this view was incorrect, she cannot properly be criticised for taking the view she did.

(4) PARKLANDS HOSPITAL

Parklands Hospital staff continued to have problems accessing secure intensive care and regional secure unit beds.

(5) SUPPORT FOLLOWING THE DEATH

The commitment of Mr Huntingford's relatives to him and his mother was exemplary. However, his cousins and their families, who held the roles of extended carers, were not contacted by mental health services following the homicide.

8 CHRISTOPHER MOFFATT'S CARE AND TREATMENT

ABOUT THIS CHAPTER

The main purpose of this chapter is to summarise the most important aspects of Christopher Moffatt's personal history, care and treatment, and our findings concerning his care and treatment.

I. MR MOFFATT'S CARE AND TREATMENT

On 9 April 1998, Christopher Moffatt entered a dwelling in Hampshire and stabbed Anthony Harrison, a retired civil servant, killing him. Mr Harrison's wife was then stabbed seven times in the head and body before their son came downstairs and managed to overpower Mr Moffatt.

Having been charged and remanded in custody, Mr Moffatt was transferred to a secure hospital in July 1998, so that he could have urgent treatment for his mental illness. He later pleaded guilty to manslaughter (on the grounds of diminished responsibility) and attempted murder, as a result of which the court ordered his indefinite detention in hospital, subject to hospital and restriction orders imposed under the Mental Health Act. On 10 December 1998, Mr Moffatt took his own life in hospital.

Christopher Moffatt was born on 6 June 1971. His childhood and development were normal, although he was considered to be a sensitive and vulnerable child. His parents separated when he was about nine years old, and he remained with his mother while continuing to have regular contact with his father. His mother remarried in 1987.

Mr Moffatt was an above average scholar and he obtained three A-level GCE passes. In his final year at college his mother was concerned at his cannabis use and sought advice from the family GP.

After college Mr Moffatt travelled for a year before enrolling at an agricultural college. He did not complete the course, and in 1992 transferred to university to read English. By mid-1993 he had left university and was living on a farm. For several months his family had been concerned about his appearance, behaviour and thinking, which they considered irrational.

On 30 November 1993 Mr Moffatt was seen by a consultant psychiatrist at his GP's request. He was thought to have a severe psychosis, marked by delusional ideas (false beliefs) centred on messianic themes. He agreed to accept admission to Park Prewett Hospital, and with vigorous treatment his illness remitted by early February 1994. There were, however, concerns that he was using illicit drugs during periods of leave from hospital.

Mr Moffatt's progress was interrupted by a depressive illness in March 1994, and then by a return of his psychosis. In May plans were being made for his placement in a group home in Basingstoke combined with day centre attendance. His rehabilitation

was impeded by continuing cannabis use, which was thought to be associated with adverse changes in his mental state. In October 1994, his medication was changed with beneficial effect. The drug advisory team assessed him and on 21 November he was discharged to a group home, subject to special supervision in the community.

Mr Moffatt's delusional ideas remained but they now seemed to have little effect on his day-to-day living, although his cannabis use caused management problems in the group home. In early 1995 he stopped his medication and, although he restarted it, he was not managing. By April he was back at home, following which he attended a day centre and Parklands hospital as a day patient. He was more compliant with medication, while continuing to use cannabis, and his acceptance that he was mentally ill was variable and superficial.

Mr Moffatt continued to have contact with the mental health team and by September 1996 plans were being made to admit him to a new hostel. In October his cannabis use brought him into contact with the police, putting him under considerable pressure, but by the end of the year he was settled in the hostel. On 10 January 1997 he disappeared from the hostel, and it transpired that he had hired a car and visited the town of Hungerford. After presenting himself at a police station he was returned to the hostel. Clearly severely ill, he refused to take medication, and on 24 January he was admitted to Parklands Hospital under section 3.

Mr Moffatt absconded from Parklands on the day of his admission, but he returned, and later revealed that he had had thoughts of serious violence before admission and while away from the hostel. Despite energetic treatment he remained very ill. In early April he left the ward without permission, returning on his own. On 27 April he absconded again, this time breaking into a house where he was found by the police. He was returned to Parklands Hospital on 5 May, where he admitted to having had homicidal thoughts whilst away from hospital. On 17 May he absconded from the first floor window of his hospital room. He was away for one day but on his return again spoke of homicidal thoughts. He absconded on 25 July and was brought back to Parklands by a female friend, and on 15 August was then transferred to a secure psychiatric unit in Epsom.

Mr Moffatt returned to Parklands Hospital in mid-November 1997, his mental state clearly improved. Throughout December and January discussions centred on placement in the community, although he remained only partially compliant with treatment, and had no insight into his illness and the need for treatment. On 13 February a mental health review tribunal refused to discharge him on the ground that he would not take medication if he was not in hospital. On 19 February the final absconding occurred, Mr Moffatt having been allowed 30 minutes unescorted leave in the hospital grounds. It appears that this absconding was planned, and on 9 April 1998 he killed Mr Harrison.

Following her husband's brutal death, Mrs Harrison said of Christopher Moffatt, 'I don't hate the lad. I think he should have been better looked after. I feel very sorry for his family and what they must have had to cope with. I pray for them every night.' She described her late husband as a 'true gentleman'. She added: 'He was very kind and thoughtful and never did anything to hurt anyone. I just wish I had been able to do more to save him.'

II. THE PANEL'S FINDINGS

Our findings are presented in the following order, and under the following headings:

(1) GENERAL FINDINGS

1. Mr Moffatt was a kind and popular man, who formed many close friendships. He suffered a devastating illness which, in the short space of five years caused two homicides, the second being the killing of himself.

   'He just presented as a very gentle laid-back sort of man.'

   'But generally he just presented as a very gentle caring man.'

   'My impression was of a quiet and withdrawn very pleasant intelligent young fellow, highly articulate, tormented by his delusions, his Son of God and so on.'

   'Christopher Moffatt was very quiet, shy and gentle even ... He used to sit in his room strumming his guitar, looking out the window, quite dreamy, very polite, very friendly, a good sense of humour.'

2. Mr Moffatt received, and benefited from, tremendous support from his mother, stepfather and sister, all of whom had an excellent understanding of his kindness, his illness and his needs. We were impressed by their humane and constructive approach, and their hope that the outcome of our review would be, not blame, but improvements to mental health services.

3. He remained psychotic during the entire period that he received treatment. Even when he was in Ireland with his parents, taking medication and not using any illegal drugs, he believed that he was the Messiah, and that he was there to save them; and, at other times, that God was displeased with him and that he would be punished.

4. He sometimes experienced violent thoughts, which greatly troubled him: 'he used to say "Oh thank God", how relieved he was — his thoughts, he had such bad thoughts that it was lucky he didn't hurt anyone or harm anyone in any way. I read the notes and I said to him, 'Did you know you used to have such-and-such thoughts', and, 'Oh God, yes I have been told and I know, I am aware of it but it is good that I haven't harmed anyone when I was feeling like that'. After Mr Harrison's death he was asked what had happened in the past when these thoughts came. He said: 'I kept them inside and they just messed up my mind ... I never thought it would go that far. Why did it have to go that far?'

5. Because Mr Moffatt consistently believed that he was Jesus Christ, obtaining his compliance with a care plan which was about him being ill was always going to be unlikely. There is, quite obviously, a dissonance about accepting a care plan and clozapine when you believe you are Jesus Christ.

6. The in-patient unit at Parklands Hospital found it difficult to manage him.

7. Mr Moffatt was in Andover for some weeks before Mr Harrison's death, having absented himself from hospital without leave. He had a job in a warehouse on one of the industrial estates, but was unable to continue with it. This was because of auditory hallucinations, and his belief that he was Jesus Christ, and that at times the Devil took over.

   'On the last occasion, he had worked for a few weeks for a firm in Andover and it was heartbreaking to hear him because he was saying "I was trying to get it all together, I had to get out of that place, I wanted to show that I could hold down a job."'

8. It later transpired that Mr Moffatt was seen in Andover by someone who used to work at Parklands Hospital as a student nurse. This individual could not place him at the time, and he commented to a colleague, 'I keep seeing this bloke about and I know him from somewhere.'

(2) RESOURCES

The resources made available to mental health services in Hampshire did not permit the Mental Health Strategy to be implemented, and the range of community resources was scaled down.

There was little additional investment in mental health services in north Hampshire until about four years ago.

Hampshire County Council was a relatively low spender on mental health services during the period reviewed by us.

Although the mental health strategy was 'revenue-neutral', its implementation involved developing a completely new range of services in Winchester, and this may have resulted in some disinvestment in north Hampshire.

The hospital closure programme was disruptive. Reducing the number of acute beds involved transferring in-patients to a day patient unit, which was then closed when a day programme was established at the Bridge Centre. The loss of the Winchester beds put additional pressure on the remaining beds in Basingstoke, by putting an end to creative bed management.

The three-bed intensive care area built into Parklands Hospital was not used, partly because the cost of staffing it safely would have caused disproportionate problems for

the remainder of the in-patient unit, and the risks of not staffing it safely were unacceptable.

Because the trust was unable to guarantee no redundancies during the reorganisation, all of the nursing staff were required to compete for their own jobs, and to be interviewed in a competitive situation. Not surprisingly, this led to pressure and tension, and staff morale was not particularly good.

There was a very high concentration of trained staff on acute admission wards in the 1980s. As a result, there was a great deal of money tied up in acute admission wards, and the need to implement the mental health strategy led to skill mix reviews, which were thinly disguised financial reviews. At the same time, increased drug and alcohol usage was beginning to affect the client population, who became more prone to violence and aggression. So the ward became harder to manager, rather than easier, at the same time as the staff were being diluted.

The demands on community teams made by general practitioners, as a result of fund holding and the opening of CMHT centres, reduced the resources available to people with severe mental illnesses.

Both psychology and substance abuse services were poorly integrated with CMHTs.

Findings

1. The resources available to mental health services in North Hampshire did not permit the whole mental health strategy to be implemented.

2. Financial constraints and the implementation of the mental health strategy compromised Mr Moffatt's treatment, insofar as they contributed to (i) the lack of intensive care facility at Parklands Hospital; (ii) the lack of rehabilitation facilities for in-patients at Parklands Hospital; and (iii) the decision to discharge him to the Stonham group home.

(3) PARKLANDS HOSPITAL

During his admission to Parklands Hospital, Mr Moffatt was detained on the acute Hawthorns 2 ward. The hospital had just opened, and staff were still adjusting to working with clients in individual rooms. There were nursing shortages, and tremendous pressure on beds:

> 'It was a very busy pressurised ward environment. We were discharging patients as soon as we could, and using leave beds ... On occasions we had to contact patients at home, following discussions with their consultants of course, to ask them to extend their home leave.'

Mr Moffatt's previous admission had been to the acute Pinewood II ward, at the old Park Prewett Hospital. This had been a massive ward, with lots of space. Parklands 'was a very small environment with individual rooms, and he felt quite trapped in that type of environment.' This seems to have been one reason for his attempts to leave, which he did several times despite intensive nursing. As a result, he was transferred to the Burnham Unit in Epsom, a close supervision unit for mid-Surrey patients.

Mr Moffatt's mental state improved during the period he was detained on the Burnham Unit in Epsom. This reflected consistent medication with clozapine, the fact that he was not taking cannabis and, linked to both these things, the fact that his treatment

was not disrupted by periods of absence from hospital (which gave access to cannabis and no access to prescribed medication):

> 'During first seven or eight months before he went to the Burnham Unit, he did lack a lot of insight to his illness'.

> 'When he came back, he was definitely better and that convinced me more that not absconding, not using illicit drugs and his partial compliance with clozapine were all important factors.'

> 'Why do you think that Chris did improve here? It is the close supervision; it is being with people on the one-to-one basis, your own member of staff, in an area from which you cannot escape, you cannot go away, and their encouragement to take the medication and their availability to talk to you at all times when you are tormented, when you are sad and so on. The fact is that we exclude from that any visitors we think might be carrying illicit drugs; they are not allowed in. That is it.'

This improvement raises the important issue of whether the lack of a secure intensive care unit at Parklands Hospital compromised his treatment.

NEED FOR A LOCAL INTENSIVE CARE FACILITY

The lack of a functioning intensive care unit at Parklands Hospital meant that staff had to resort to quite intrusive policies of continuous observation, as a way of managing Mr Moffatt's absences. For some people, particularly if it is for a long time, this is impossible to bear. As one person we spoke with put it:

> 'Literally like you and I sitting this far apart from each other 24 hours a day. For some patients that level of observation becomes intolerable, even though clinically it is thought to be necessary.'

Following Mr Moffatt's admission to Parklands in January 1997, he was thereafter subject throughout to observation. Given the limited space on the ward, this may well have increased his thoughts of absconding:

> 'One can argue that having someone for a long period of time under continuous observation caused more harm to someone like Chris who felt that he was trapped in the hospital. He was also too long on the acute ward.'

> 'For Christopher during the long period of five weeks continuous observation, he felt he was imprisoned, he was trapped. He was having a claustrophobic reaction with people following him everywhere and being there all the time with him. If you have a secure unit ... they do not need people to follow them around.'

We were told that financial constraints affected the way in which he was managed, insofar as he would have been easier to manage had a low security unit been available locally. The acute wards at Parklands make 'it very difficult to manage young people like this. We used to have a rehabilitation facility in which you could move people like this and take a long-term view of making changes slowly, and you could make it a more homely environment rather than a ward environment.'

The evidence which we received compels us to conclude that the absence of a local intensive care unit is a deficit which urgently needs to be remedied:

> 'The Parklands unit was not appropriate, given the way it was built, to maintain a disturbed patient who sometimes knew how and when they wanted to abscond.'

> 'If they had a secure ward in the hospital where you could maintain people with severe mental illnesses, who thought of harming people ... there would need to be an adequate staff level on the other wards.'

'When we actually went to the hospital unit, I was very concerned that there was no system for people that needed a higher degree of supervision .. I took it back to the meeting and actually opened it up ... The answer was that the management do not like locked doors.'

'There are times when there is nothing definite but you just get the feeling that you do not know where everyone is ... Sometimes there is just too much going on and not enough staff to watch that. The other patients tend to suffer as well because everyone is working with the particularly unwell ones.'

'Even in the in-patient unit we could not control the use of drugs because they were still filtering into the in-patient unit. I had to call in the drug dog-handling team to search through and they found some in the rooms.'

'I would feel that it would be really good for us to have our own intensive care unit. For our services to have one on site so that we were not at the beck and call of other clinicians.'

Findings

3. **Local people did not benefit from a comprehensive mental health service during the period covered by our review.**

4. **During the period covered by our review, it was often difficult to arrange a patient's admission to the Oaktree Clinic, which was short of beds.**

5. **The lack of locked facilities at Park Prewett and Parklands limited the ability to deal with a small group of patients who presented with persistent absconding behaviour. In Mr Moffatt's case, his treatment was compromised by his absences from hospital, by the absence of a local intensive care facility, and by the use of continuous observation for long periods.**

6. **A locked intensive care unit can be a less restrictive way of managing some people than lengthy periods of close observation on an open ward. What appears at first blush to be a libertarian policy was, for a patient like Mr Moffatt, quite coercive; and it may have exacerbated his thoughts of absconding.**

7. **The use of observation was not always an effective means of detaining, or ensuring the safety of, patients. Five minute observations came to be seen as impracticable, and were phased out, in August 1997, and nursing levels were inadequate at times. When the use of the observation policy was audited against recommended staffing levels for the period 15 December 1997 to 22 June 1998, it was found that staffing levels were not met on about one-third of the shifts, 92% of these occurrences being on Hawthorn 2 ward.**

8. **The lack of access to secure facilities required ward staff to look at what they could do within available resources. When treating someone with Mr Moffatt's needs, they might have no real option except to carry on trying to provide the treatment, and manage any risks, within the local acute in-patient unit'.**

9. **As a philosophy, the idea that patients should not be managed on locked wards has nothing to commend it if local people are simply admitted to out-of-area locked wards.**

OCCUPATIONAL THERAPY AND REHABILITATION

The OT department at Parklands has grown, and staff there have worked hard to provide the best possible service within available resources. Everybody is assessed when they come into Parklands by someone from the team, and a therapy programme is devised for them individually, as part of their care plan. The department offers individual and small group focused work, and therapies such as anxiety management, stress management, and concentration skills. There is a community group, a writing group and computer work. However, we believe that there were deficits in the range of therapies and diversional activities provided to people in Mr Moffatt's situation.

One reason why Mr Moffatt remained relatively well during the period he was living with his mother (who was an occupational therapist) was that she and his step-father arranged a structured day for him. He similarly benefited from having a structured programme of activities at the Burnham Unit.

Almost everyone we spoke with told us that the in-patient services are now caring for a new group of people with enduring mental illnesses whose needs were not anticipated when Parklands Hospital was planned. A particular problem in meeting their needs is a lack of hospital-based rehabilitation and occupational therapy:

> 'We had an expert OT department in Park Prewett, and I think it was the best OT department they could have had that time, when we first moved there.'
>
> 'There was a good facility in Park Prewett and obviously a larger facility because there were more patients. Non-ward-based, in a totally separate building, which was nice, because patients could walk to it. When they built Parklands Hospital, the actual facility was not as large as the one at Park Prewett. The amount that they could offer was less simply because of the lack of space ... The patients tend to spend a lot of time on the ward, definitely in the winter months ...'
>
> 'With our wards and our hospital ... it is just an acute setting, an acute admission ward.'
>
> 'It is very different from the way Park Prewett used to be. It is a short stay, acute unit and so what can happen is that when somebody is on the ward for a long time, they will have gone through the entire programme.'
>
> 'It was a problem that Parklands was in a sense designed for a quick throughput, high turnover, and then we were developing a new long-stay population. Christopher spent quite long periods in hospital.'
>
> 'At the moment in the acute in-patient setting, the culture is still heavily containment and pharmacological. OT has traditionally been about sending patients to go and do something, as opposed to recognising that as a valuable therapeutic intervention.'
>
> 'I believe it was a great mistake to cut our rehab service. We have had an accumulation of chronic patients on the ward ... and we have to be focused towards meeting their needs. In the transfer from Park Prewett to Parklands, the position of the new long-term mentally ill like Christopher was not understood clearly enough. I am not sure if it is being addressed.'
>
> 'I would recommend a 24-hour rehabilitation unit. For people who stay a long time on the acute ward it exacerbates their illness. Maybe Christopher was getting better, but being in that environment where other severe mentally ill people were coming in with these florid symptoms may have exacerbated other people's illnesses. So it actually slows down their progress. I can see a rehabilitation unit could benefit people who have been in the hospital for a long time, especially who have no placement at all, no accommodation has been available on the acute ward for some time.'

Findings

10. The occupational and recreational facilities at Parklands Hospital were not adequate for those patients who required a long period of in-patient treatment at Parklands Hospital.

SUBSTANCE USE

Mr Moffatt's use of cannabis complicated the management of his condition. He believed that 'cannabis made him feel good, relaxed and calm, and would fight the demon inside, because the demon was there all the time making him cause harm to people.' He used it as a self-medication, while regarding prescribed medication as a type of poison. He believed that cannabis was going to cure him, and felt strongly about this.

The opinion of his professional carers was rather different. However, ultimately, it is impossible to know what contribution cannabis made to his mental state. Although he seemed better when he was using less cannabis, it is possible that he used more cannabis when he was less well. In other words, increased violent thoughts led him to increase his use of cannabis, rather than cannabis exacerbating the violent thoughts. Similarly, although his mental state improved when he was treated in a secure setting, this may primarily be because he was receiving regular medication, rather than abstaining from cannabis.

Whatever the truth, the DRUG ADVISORY SERVICE'S philosophy virtually precluded it from helping people like Mr Moffatt: 'If a client does not want contact with our service ... that is seen as their responsibility, and it is respected. That has not changed over a number of years.' Which means that if a patient has a serious mental illness, and believes that smoking cannabis fights the devil in his head, he will never seek, nor therefore receive, help from the service:

> 'It is a very helpful service but not for the co-morbid patients. They very much do the motivational interviewing which is great, but we also have to look at the process of schizophrenia, and how it affects people's cognition and behaviour, and the other aspects. The whole process is based on individual motivation. It is the last thing he would need.'

The issue is important for a second reason, which is the amount of illegal drugs which are still filtering into the in-patient unit: 'I had to call in the drug dog-handling team to search through and they found some in the rooms.'

Mr Moffatt did not abuse alcohol.

Findings

11. The philosophy of the substance abuse service, which was based on a motivation to give up illegal drugs, made it impossible for the service to help someone like Mr Moffatt, whose illness involved seeing the drug as bringing about an improvement in mental state.

COGNITIVE BEHAVIOURAL THERAPY

Although cognitive behavioural therapy was not available at the time, Mr Moffatt's mother was keen that he should receive it, because of the possibility that it might improve his understanding of his illness, and his compliance with treatment. This is an important issue and, fortunately, a clinical psychologist has now been recruited to work with in-patient and CMHT staff.

(4) THE MANAGEMENT OF MR MOFFATT'S ILLNESS

After such a tragedy, there is a natural tendency to judge the quality of the patient's care according to the outcome. On reflection, however, it is obvious that even the best available treatment of a devastating illness, such as cancer or schizophrenia, does not preclude a devastating outcome. Conversely, natural remission may mask poor treatment; and while poor treatment usually reduces the chances of a favourable outcome, most often it does not lead to loss of life.

In every other branch of medicine the tragic outcome is the loss of the patient's life. In psychiatry, it may be that a person who has no connection with the patient, and has not consented to any risks taken in treating the illness, loses their life. That is uniquely tragic, but is no more proof that the patient's treatment was poor than the death of a patient with cancer.

These points are important because our belief is that, *given available resources*, the overall quality of Mr Moffatt's care and treatment was high. In reaching this finding, we have at all times tried to be independent, thorough and objective. We hope that the individuals who have been personally affected by this tragedy will accept that, even if they do not accept our finding or everything in the report.

Mr Moffatt's mother highlighted for us a number of limitations in the care he received. For example, that he would have benefited from more support and supervision, more extensive occupational therapy, access to a clinical psychologist, cognitive behavioural therapy, continuing drug counselling, more appropriate accommodation, and secure supervised accommodation.

However, these concerns and reservations were shared by professional staff:

> 'His mother visited Chris a great deal and took him out a great deal. She was so supportive and if she went on holiday, she would tell us and give us the address, please contact me, which was sadly rather unusual ... She did want more for Chris than perhaps we were able to offer ... which was a shame ... it was kind of philosophical, this is all we have to offer, it is a shame. It is what everyone felt. Obviously, you could always do with more, people always want more.'

A comprehensive range of mental health services, meeting all needs, was not, and is not, available locally; nor, sadly, anywhere else in the country. Mr Moffatt did receive the full range of services available locally, and a high standard of professional care:

- He was admitted to the local acute service, and the Health Authority paid for him to be admitted to an out-of-area secure unit.
- He received hospital day-patient care, and day services from 3 Vyne Road and the Elizabeth Dibben Centre in Bordon.
- He had the full use of such occupational therapies as were available at Parklands Hospital.
- He was treated with one of the new atypical antipsychotics (clozaril).
- Places were found for him in specialist, supported, accommodation provided by Stonham Housing and the Mental After-Care Association (funding for the latter was £650 per week, which was a high care package).
- He had two highly experienced, and highly regarded, key workers allocated to him.

- He had an experienced and very able consultant psychiatrist who took an intensive and assertive approach to his severe illness:

  '[Mr Moffatt's consultant] ... has quite high standards and wants it done, this is the meeting, it will take place at this time, such and such a person will be there and it will be documented very clearly in the notes.'

  'Once you have known her for a long time, you just know how [Mr Moffatt's consultant] works, and she has very strict guidelines and very high standards and high expectations, which I do not believe is unreasonable.'

  GP: 'I was very impressed with [his consultant's] care which was, as far as I could see, beyond the call of most psychiatrists. She took a personal interest in these patients, she was brisk, thorough and yet warm, and she was always willing to help us. From that point of view she was very efficient. When Christopher finally had to be sectioned, she got there before I did — she was so quick off the mark — I was very impressed with the care and consideration. I have also seen her at work in meetings and in discussions about patients. I felt that she was on top, she knew what she was doing. She was very impressive, I liked her and the patients certainly liked her.'

  Another GP: 'The service we get is actually very good. [His consultant] is an excellent psychiatrist and if we ever have any problems she is always on the end of a phone, you can always get in touch with her. It is usually very easy to get hold of the CPNs as well, through the Elizabeth Dibben Centre.'

- The treatment provided by the staff on Mr Moffatt's ward and within his community mental health team was well integrated.

- His consultant liaised effectively with the out-of-area secure unit during the time he was placed there:

  '[His consultant] was jolly good. She was always on the phone. We had long conversations. We really did keep in touch. She was very concerned about Christopher.'

- Full appraisals were done and clinical supervision was carried out.

- The care programme approach was fully implemented, as were the supervision register guidelines: there were very frequent reviews; opportunities were taken at ward rounds to review and record the CPA; and the record-keeping was excellent.

- Social services care management was good.

- There were structured discussions within the community mental health team about patients with particular problems and cases which had reached an impasse.

- Resignation was not allowed: having tried a group home, and then the most highly supported home in his area, it was intended to move up to a hospital-hostel, where he would reside under section, or a Richmond Fellowship placement.

- Following his arrest, his consultant visited and examined him in the police station (when the duty doctor refused to attend), and was very active in trying to get him transferred from prison to a special hospital. All of his hospital notes were faxed to the two prisons where he was in custody.

Findings

12. We cannot support the view that there was a general failure to treat Mr Moffatt adequately and in fact, as a general statement, we feel the opposite.

(5) RISK MANAGEMENT

COMMUNICATION OF RISKS

A search of Mr Moffatt's room at Normandy Road was conducted by MACA staff when he went missing in January 1997. Several magazines were found in which he had circled advertisements for rifles, and staff were sufficiently concerned to pass this information to the police. However, the information was not shared with Mr Moffatt's consultant, or his key worker; or the GP and approved social worker who assessed him for compulsory admission to hospital on his return to the hostel. They were given some information about possible risks (for example, that he might have a knife), which caused them to ask the police to assist in his removal to hospital.

Mr Moffatt had violent and sexual thoughts about his project worker at Normandy Road and this information was also not shared.

The general practitioner who examined Mr Moffatt and recommended his compulsory admission to Parklands Hospital observed that he was sitting reading a book on knives; and he told the doctor how interesting he found the book. No one can recall that this information was shared with his consultant.

Findings

13. Important information about the risk to others known to staff at the MACA hostel in Normandy Street was not shared with his consultant, or with the other professionals who assessed him for compulsory admission to hospital. This placed them at unnecessary risk.

14. This failure also undermined the assessments of risk performed by his consultant during his time at Parklands Hospital, and therefore the management of risks.

ABSCONDING AND RISK

There were several reasons why Mr Moffatt absented himself from hospital: the need to be free and resentment at being detained; a feeling that he was a prisoner, and that staff were against him ('I am Jesus Christ, why am I being kept here?'); dejection at not being released by the tribunal combined with a desire to get on with his life and prove that he could live independently; and so as to obtain cannabis to treat his violent thoughts. On yet other occasions, the act of leaving seems to have been compulsive (voices said that he had to go, and it was his mission to go) or impulsive ('He would just keep walking and walking, or he would meet up with a friend and they would say "let's go"'). On only one occasion (and this not during his last absence) did he telephone his mother, to let her know that he was all right.

Apart from when Mr Moffatt was at the Burnham Unit, the risk that he would abscond was managed by placing him under observation. Just before the final absconsion, he spent a period of five weeks on continuous observation. This management strategy was at times undermined by nursing shortages. The use of the observation policy was audited by the trust against recommended staffing levels for the period 15 December 1997 to 22 June 1998. Staffing levels were not met on about one-third of the shifts, 92% of these occurrences being on Hawthorn 2 ward.

> 'At one time, we had about six to eight day patients on my ward alone, so the nurses were under tremendous pressure.'

> 'Basically the ward was so short of staff that a staff member on the ward had to ask the social worker that I was with if they would stand in for them whilst they went to the toilet. There were grave concerns about patients that may abscond. I brought it up at the team meeting at Bordon with the co-ordinator who had some input as management of the unit.'

It was suggested to us that his absences were not treated with appropriate concern. This we cannot accept, bearing in mind the level of observation to which he was subject, his transfer to the Burnham Unit, and the public appeal following his last disappearance.

His consultant was 'extremely concerned', because he was without medication, the risk of suicide was felt to be very high, and it was known that he experienced violent thoughts. It was she who raised the possibility of a public appeal, and she who discussed this with the police.

Both the consultant and a senior manager informed the police that he was felt to be potentially dangerous to others, and that he was certainly a danger to himself. Furthermore, the longer he was off medication, the greater the risks.

The trust's managers took advice from their solicitors and took soundings within the executive; and came to the view that a public appeal should be made. This appeal was transmitted by Meridian, a local television station, but there were only a few small items in local papers, which was unfortunate.

In retrospect, other local trusts and social service offices should have been alerted and a description circulated to them, and this is now trust policy. However, one cannot assume from this that Mr Moffatt would have been identified in Andover had this happened, because the evidence suggests that his demeanour and behaviour were not such that he drew attention to himself:

> 'he hid his symptoms so well and to an outsider you would look at him and think why is here. Look at him – what is wrong with him?' It would not surprise me that Christopher could live in Andover and work for a number of weeks without people knowing that he had symptoms. Even visitors went up to him thinking that he was a member of staff or a relative, he did not strike you as a patient.'

> 'He hid his mental health symptoms very well and would come across as very able.'

The trust has subsequently revised its procedures concerning patients absent without leave. Social services and the patient's GP are now alerted; and the police attend the ward to complete the missing persons form with staff, and to talk with them about the risks. The general manager and the director must be informed after three days, or earlier if there are felt to be special risks. The director must then review the procedures that have been put into place, to see if there are any special risks and whether additional agencies need to be involved or informed.

Ultimately, however, once a patient absents himself from hospital, staff have lost control of the situation, and the patient's ingenuity and matters of chance will determine whether, when and where he is found. The management of absences without leave must therefore concentrate on preventing unauthorised absences.

This raises two issues in this context, one general and one specific. The general issue has already been mentioned, and it concerns managing such risks by observation. The particular issue is whether it was appropriate to grant Mr Moffatt 30 minutes ground leave on the day of his final absconsion. Given that he had not absconded since 25 July the previous year, and given the need to build some sort of therapeutic alliance with him, the decision cannot be faulted as irrational.

Findings

15. Once a patient absents himself from hospital, staff have lost control of the situation, and the patient's ingenuity and matters of chance will determine whether, when and where he is found. The management of absences without leave must therefore concentrate on preventing unauthorised absences.

16. The decision to try to establish a therapeutic rapport with Mr Moffatt, by allowing him 30 minutes ground leave, was justifiable.

(6) MEDICATION

Mr Moffatt made an excellent response to clozaril, and there were times when his psychotic symptoms receded, so that they had to be probed for. The difficulty was that it is an oral medication and, for long periods, he was not taking the prescribed dose. Moreover, there is some evidence that people relapse very quickly when they stop taking clozaril; and that it may be selectively less effective with recurrent trials. Since Mr Moffatt was reliably unreliable taking medication, remaining psychotic and partially treated throughout, this raises the issue of whether it would have been more productive to treat him with a long-acting drug given by injection.

The dilemma was that he had not responded in the past to conventional anti-psychotics, and the choice therefore appeared to be between oral medication which, when taken, was effective and injections which were not, albeit that one knew he was receiving medication ('of everything we had poured in, nothing else had worked'). Furthermore, given the present law, once he was in the community and not on section, he could not be compelled to take it. Given that conventional drugs at best only moderately alleviated his symptoms, voluntary compliance would then be unlikely.

Findings

17. The decision to prescribe clozaril was a considered one, made for good reasons, and it cannot properly be criticised.

(7) SUPPORTED ACCOMMODATION

THE STONHAM GROUP HOME

Mr Moffatt took up a place at a Stonham group home in Popley in November 1994. Prior to his discharge from hospital, it was obvious that he had a serious mental illness, and would need some form of supported accommodation. The issue was what level of support.

Suitable supported accommodation was not available in Alton at the time, which is where he wished to live; and an occupational therapy assessment, undertaken as part of the care management process, indicated that he had the ability to live at this group home.

The alternative was a totally structured environment, which was felt not to be appropriate at this stage; and, in any case, was not available. More particularly, the 24-hour MIND hostel, run by Stonham at Wellington Terrace, had no vacancies.

Because he needed plenty of support, he was referred to the Vyne Road day service and Pinewood about three times a week. There was also regular contact with his key worker and community psychiatric nurse.

The group home was a maisonette on the second and third floor, and was ex-council accommodation. There were two other men there. One of them was physically unwell, and he was admitted to hospital, and died not long afterwards; the other was a young man who was quite reclusive.

Unfortunately, Mr Moffatt's residency lasted only a matter of months, ending in eviction. He became ill and his behaviour became problematic. It later transpired that he had hidden his clozaril tablets in a bag underneath the bin; and that this practice started quite soon after he moved there.

Mr Moffatt's mother was concerned that her son did not have sufficient support and supervision: the supervision was not 24-hours a day, and 'the local heavies' moved in on benefit day.

The support during the day, and some evenings, involved cleaning, helping with chores around the house, cooking meals, and other basic day-to-day tasks. Sometimes staff would be present in the morning, to try and get him up, and to remind and encourage him to take his medication.

We were told that when it became apparent that Mr Moffatt was having difficulties coping, consideration was given to arranging a befriender for him, but he was not keen. An attempt to get Stonham to increase the amount of supportive and supervisory time spent with him was unsuccessful.

Findings

18. We doubt the morality and wisdom of placing people with severe mental illnesses in ex-council accommodation which is hard to let.

RETURN HOME TO ALTON

Mr Moffatt went home to Alton in March 1995, to live with his mother and stepfather. They monitored his medication, and provided a structured lifestyle. He became stable, and all of them enjoyed some happy times. It was a positive period. He took his medication on a fairly regular basis, and attended the health centre for blood tests, and medical appointments:

> 'Home was best ... I suspect home was providing a non-threatening, liberal, tolerant yet loving and caring environment, within which Chris had the freedom to operate.'

Mr Moffatt remained at home for 17 months, before going to a new MACA house which had opened in Normandy Street, Alton.

MACA HOUSE (NORMANDY STREET)

The house in Normandy Street was a residential home with six residents. Residential care homes aside, it had the highest staffing ratio of the available local placements. There were always two staff on duty, one a senior member of staff, the other another senior or a project worker. There was 24-hour sleeping cover arranged at the time, and Mr Moffatt's mother lived quite close by.

Findings

19. **The hostels which were developed as part of the mental health strategy were for long-stay hospital patients, in order to enable the closure of the old Park Prewett hospital, and the strategy took insufficient account of the new long-stay population.**

20. **An attempt by the Loddon Trust to set up a hospital hostel in Tadley was unsuccessful. This was partly because of Health Authority financial constraints, and partly because of 'the most nasty public demonstrations against it, including a public meeting in Tadley with the police.' Those who demonstrated against the development must accept some responsibility for the lack of secure provision locally.**

21. **Mr Moffatt's very limited compliance with medication, and his use of cannabis to relieve his distress, meant that it was not feasible for him to live independently in the community. He needed a community facility which could provide the intense support and supervision but such a facility was not available.**

22. **The staff then at Normandy Street had a limited understanding of risk management. They did not inform the professionals who visited to detain Mr Moffatt under section 3 that he had been experiencing violent and sexual thoughts about his project worker, and that staff had found magazines in his room in which adverts for rifles were circled.**

23. **There were management problems at this time in relation to ensuring the implementation of patients' care plans.**

24. **There were also difficulties almost immediately with Mr Moffatt's compliance with medication, about which a robust approach was not taken:**

> **'Because we are a residential care home we have to show that we are working within the standards of Hampshire registration authority, and that would have been monitoring someone's medication. Where the balance comes, though, in our philosophy is about choice ...'**
>
> **'I was always quite open in my discussions with him, talking about the pros and cons of all forms of treatment. I tried never to advocate one above the other, just to keep it purely to giving people the information with which to make informed choices ... He tapped into the feeling that I was never pro-medication as strongly as the rest of the team, so there was some discussion.'**

(8) FAMILY SUPPORT FOLLOWING THE HOMICIDE

Mr Moffatt was initially remanded in custody, but was quickly assessed to need a secure hospital bed. Unfortunately, he remained in prison for about four months because of a lack of available beds. His mother's MP wrote to the Chief Executive of the Loddon Trust about this and other anxieties, and received a reply through her MP, dated 27 May 1998. This reply made her quite cross and she felt that it was it inaccurate and offensive. It made her think that, 'nobody is going to speak about anybody like that, certainly not my son, or anybody else in such a dismissive fashion'.

Findings

25. In our opinion, certain passages in the Chief Executive's letter of 27 May 1998, which made no reference to his schizophrenia and the context of his cannabis use, were insensitive. For example, 'Once he had been back at Parklands for a short time, the man reverted to his previous behaviour of absconding to buy and use street drugs.'

(9) OTHER MATTERS

POLICE STATION PROCEDURES

Following Mr Moffatt's arrest, the duty psychiatrist refused to attend the police station to examine him and provide any treatment he might require.

Findings

26. The trust needs to address the issue of whether duty psychiatrists should be permitted to refuse to attend.

STAFF SUPPORT

The health service professionals who cared for Mr Moffatt all said that they felt supported following Mr Harrison's tragic death, and also that they felt supported in relation to our review:

> 'There was a lot of discussion that took place on the ward and we were offered counselling outside of the ward ... We dealt with it as a team, we dealt with it well and there were opportunities to meet up ...'

> 'We had plenty of support in doing our statements.'

PRIORITISING SERVICES

Members of the Southern CMHT expressed views similar to those expressed by their colleagues in the eastern team as concerns to the need to prioritise their work:

> 'I would like to see an owned statement – by "owned" I mean by purchasers as well as providers – a statement of priority of who we should be working with. The climate is changing. Chris is a typical person who should be the core business of the community mental health service. We are looking at dual diagnosis. It is always CMHTs can do everything. I am involved in a mentally disordered offenders steering group, a dual diagnosis steering group, an eating disorders steering group, and the message always from the purchasers is: that's okay, that can fit into a CMHT. There is no recognition that that means extra people with extra skills.
>
> At the moment we have everything from cat phobia to people like this referred. It has been the blight of CMHTs ever since they were conceived. ... We have to prioritise people now and really focus on giving them a quality service, and move away from face-to-face contacts of activity. Measuring outcomes and looking at what is effective, and training our staff and valuing our staff to provide that.'

9 SUMMARY OF FINDINGS AND ACTIONS

ABOUT THIS CHAPTER

The purpose of this chapter is to collate our findings, and to set out the consequential recommendations and action plans. The various matters are dealt with under the following headings:

Main findings	Action

1 INVESTMENT IN MENTAL HEALTH SERVICES

During the period covered by our review, the NHS resources available in north and mid Hampshire did not permit the whole mental health strategy to be implemented.

Hampshire County Council was a 'low spender' on social services during this period. Compared with similar authorities, it spent the second lowest proportion of council resources on social services, and the least per head of population.

Financial constraints and bed availability influenced treatment and care decisions, and skewed the management of risks, by requiring staff to accept risks which they would prefer not to accept.

Inadequate resources had a significant impact on Mr Longman's care, treatment and health. This compromised his safety and that of his family, and required them, and professional carers, to accept risks which they ought not to have had to bear.

On three occasions, Mr Longman had to be admitted to a ward for Winchester patients (in 1993 and 1994); and on three occasions it was impossible to admit him (in January 1994, October 1995, and November 1995).

Inadequate resources compromised Mr Moffatt's treatment, insofar as they contributed to the lack of an intensive care facility at Parklands Hospital; the lack of rehabilitation facilities for in-patients there; and his placement at the Stonham home. His mental state improved during the period he was detained in a close supervision unit at Epsom. This reflected consistent medication with clozapine, the fact that he was not taking cannabis and, linked to both these things, the fact that his treatment was not disrupted by periods of absence from hospital (which gave access to cannabis and no access to prescribed medication).

The government and county council of the day must accept responsibility for consequences arising from, or associated with, their funding decisions.

At the start of the 1999/2000 financial year health services in north and mid Hampshire faced a recurring deficit of £10 million a year (out of a total budget of £313 million). An external review concluded that:

- North and mid Hampshire spent proportionately more than other Health Authorities on acute and community hospitals;
- treated more patients than would be expected for the population's needs;
- had too many organisations, with consequent overhead costs.

North and Mid Hampshire Health Authority and Hampshire County Council are committed to investing in adult mental health services.

Hampshire County Council's expenditure on mental health services has increased by 24% (£2.8 million) since 1997/98. Since 1999/2000 net expenditure per head has overtaken a neighbouring comparator authority and is above the average for English counties (Source: CIPFA).

Since 1999, an additional £1.3 million has been made available by the County Council for investment in mental health services across Hampshire. £0.6 million of this relates to services in North and mid Hampshire.

North and Mid Hampshire Health Authority have allocated the following additional funding to adult mental health services in the current financial year:

- £500,000 for the development of low secure services, with a further £240,000 released from the closure of the Oaktree Clinic to support this;
- £47,000 towards the continued development of medium secure services;
- £500,000 (and a £60,000 social services contribution) towards the initial development of assertive outreach.

The number of beds at Parklands Hospital available to north Hampshire adults has been increased from 40 in December 1996 to 44 in April 1997, to 48 in late 1997, and then to 53 in April 1998. There is also access now to a supported living scheme for up to 7 people at any one time, which provides an alternative to hospital admission.

The formal risk assessment procedure, established by the Surrey Hampshire Borders NHS Trust and Hampshire County Council Social Services Department in April 2001, is an integral part of the revised care programme approach for people on enhanced CPA. When a formal risk assessment indicates that an individual requires admission, a bed is always found. If this is not available locally then a placement outside the area is used.

Main findings	Action

2 LACK OF A LOCKED FACILITY

During the period covered by our review, it was often difficult to arrange a patient's admission to the Oaktree Clinic in Surrey, which had only five beds designated for north and mid Hampshire residents, and this clinic has now closed.

The lack of secure facilities, or access to them, required ward staff to look at what they could do within available resources. In other words, it skewed the management of risks. Risks 'might have to be accepted which the staff would prefer not to accept, and that inevitably lead to accepting risk locally.'

Mr Longman absented himself from hospital on many occasions, and his treatment was compromised by the lack of a local intensive care facility.

Mr Moffatt's treatment was likewise compromised by the lack of such a facility. He was absent from hospital on several occasions and subjected to a very lengthy period of continuous observation.

Mr Huntingford's treatment was compromised, after his mother's death, by problems accessing secure intensive care and regional secure unit beds.

The two wards at Parklands Hospital have been reorganised in order to provide more security. While Hawthorns II functions as an open ward, Hawthorns I now operates a locked door policy. The main criterion for admission to Hawthorns I is perceived risk to self or others, and it has a higher nurse/patient ratio. In practice, all assessments are done on Hawthorns I, with patients moving to Hawthorns II when their clinical condition makes it appropriate.

Out-of-area placements are used for those who require assessment and treatment in a more secure setting. Annual expenditure on such placements has increased from £200,000 in 1997 to a projected £800,000 in the current year.

A national shortage of secure facilities means that it sometimes remains necessary to provide temporary treatment in the local acute in-patient unit (with increased staffing levels and additional security measures) pending transfer to a more secure facility. In order to overcome this difficulty, the services plan to provide eight low secure places for north and mid Hampshire residents by April 2002. A team led by the North and Mid Hampshire Health Authority is in the process of finalising the details.

Main findings	Action

3 IN-PATIENT NURSING LEVELS

There was, it seems, a higher concentration of trained staff on the acute admission wards in the 1980s.

The need to implement the mental health strategy led to 'skill mix reviews', which were thinly disguised financial reviews.

At the same time, increased drug and alcohol usage was beginning to affect the local population, who became more prone to violence and aggression.

The ward therefore became harder to manage and, at the same time, staffing was being diluted.

An audit of the observation policy in 1997 and 1998 revealed that staffing levels were not met on one-third of shifts, 92% of the occurrences being on Hawthorn 2 ward.

A senior nurse referred to there being times when 'you just get the feeling that you do not know where everyone is', and a social worker spoke of being asked to stand in for a nurse so that the latter could go to the toilet.

Nursing levels in in-patient units are presently reviewed daily, and the Surrey Hampshire Borders NHS Trust seeks to match the staffing and the skill-mix levels with the needs of patients, staff and members of the public at all times.

A review of ward nursing levels and skill mix levels was completed in February 2001. This was followed by a comparative review of local and national nursing and skill-mix levels in May 2001.

The first review indicated that Parklands adult inpatient services met baseline staffing levels set for the South West and South East Regions. Baseline staffing levels were met on 100% of shifts, with bank or agency staff being used when additional patient observations were required.

The second review found that meeting baseline staffing requirements *inclusive* of all the additional observations necessary for safe patient care would require an extra 12 full-time posts (trained and untrained). The trust is now considering how best to deal with this finding.

In order to enhance clinical leadership in ward settings, and to develop professional practice, team leaders have completed a 12-week leadership development programme.

Main findings	Action

4 THE SERVICE ETHOS

In 1990, Gallwey described some of the limitations of operating a regional secure unit alongside a parallel open-door policy.

Drawing in particular on the work of Bowden, his predecessor, he wrote that, 'there was an uneasy feeling that staff wanted to work in open, unrestricting environments but that patients who were unable to attain the required standards of conduct would be excluded irrespective of their diagnosis or their need for treatment, so that psychiatric patients would have to fit the nature of the facilities rather than the facilities be designed to suit a realistic spectrum of patients' needs ...'

The local mental health in-patient service has run 'a completely open service' since 1975, with no locked doors or seclusion rooms. In our opinion, this philosophy — which was a prevalent one at the time — contributed to the decision not to open the intensive care area built into Parklands Hospital, and contributed to the difficulties experienced in treating the patients locally.

The Health Authority and the Surrey Hampshire Borders NHS Trust fully accept that in the interests both of safety and therapy local in-patient facilities must be designed to suit the full spectrum of mentally ill patients' needs, including the needs of those whose conduct militates against effective, humane or safe treatment in an open setting. To this end:

- within Parklands Hospital, Hawthorns I ward now operates a locked door policy.
- plans are in progress to commission low secure services for people living in north and mid Hampshire by April 2002.
- Surrey Hampshire Borders NHS Trust and Hampshire County Council Social Services Department have developed a Rapid Assessment Service for people in crisis.

Main findings	Action

5 HOSPITAL SECURITY AND ABSENCE WITHOUT LEAVE

There was evidence that the security of Parklands Hospital was inadequate during the period covered by our review.

Both Mr Longman and Mr Moffatt absented themselves from hospital on a number of occasions, and these absences interfered with their treatment.

However, the decision to grant Mr Moffatt 30 minutes ground leave on the day of his final absconsion in February 1998 cannot properly be faulted, given that he had not absconded since 25 July 1997.

Mr Moffatt's absences were treated with appropriate concern:

- He was transferred to a more secure unit for a period and placed under continuous observation on his return.
- Following his last disappearance, a public appeal was made at the initiative of his consultant.
- Both Mr Moffatt's consultant and a senior manager informed the police that he was felt to be potentially dangerous to others, and that he was certainly a danger to himself. Furthermore, the longer he was off medication, the greater the risks.
- The trust's managers took advice from their solicitors and soundings within the executive; and came to the view that a public appeal should be made.
- This appeal was transmitted by Meridian, although there were only a few small items in local papers, which was unfortunate.

In operational terms, other local trusts and social service offices should have been alerted, and a description circulated to them, following his final absence.

Hawthorns 1 at Parklands Hospital is now locked and short-term low secure facilities are being developed.

The Surrey Hampshire Borders NHS Trust accepts that once an inpatient absents herself or himself, the patient's ingenuity and matters of chance may determine whether, when and where s/he is found. Consequently, managing absence without leave must concentrate on preventing unauthorised absences. The trust has a policy in place to minimise the occurrence of unauthorised absences.

It is now trust policy that social services, the patient's GP, and neighbouring trusts are alerted when a patient is absent. The police attend the ward to complete a missing persons form with staff, and to talk with them about any risks. The general manager and the director must be informed after three days, or earlier if there are felt to be special risks. The director must then review the procedures that have been put into place, to see if there are any special risks and whether additional agencies need to be involved or informed.

New guidelines concerning public appeals for information are in place. As part of the guidelines, the Director of Mental Health has responsibility for deciding whether a public appeal should be made.

The number of residents who are absent without leave from Parklands Hospital is continuously monitored by Surrey Hampshire Borders NHS Trust. Reports are made on a quarterly basis to the Directorate Clinical Governance Forum, which decides what action should be taken to improve security.

During the year to 31 March 2001, 42 inpatients absented themselves without leave, of whom 22 returned or were returned within 24 hours.

The trust recognises that there has been concern about security arrangements at Parklands Hospital. It is satisfied that security at Parklands Hospital is appropriate, and security there will periodically be reviewed by an independent organisation approved by the local health authority.

Main findings	Action

6 MANAGEMENT OF DISTURBED BEHAVIOUR IN HOSPITAL

A lack of local intensive care facilities, pressure on beds, nursing pressures, an open service ethos, and the need to manage increasing numbers of men with disturbed behaviour, led in the early 1990s to the use of various techniques for managing risks. Informal, and hence unregulated, seclusion and 'time-out' were occasionally practised. Deprivation of daytime clothing was used, and the police and hospital porters were sometimes called upon to restrain patients. Mr Longman himself was given medication 'with the help of porters holding him down'.	The care and treatment of patients complies with the Mental Health Act 1983 Code of Practice. It is trust policy that non-care staff, including porters, are not to be involved in the management of aggressive behaviour. Compliance with the code is externally monitored through routine visits by the Mental Health Act Commission. These visits include interviews with people who are detained under section as well as with staff. There is a regular and mandatory programme of Mental Health Act training for all in-patient staff. Additionally, the Mental Health Act Commission provides annual Code of Practice seminars for senior managers.

Main findings	Action

7 IN-PATIENT ASSESSMENT

Given Mr Huntingford's long illness, it was remarkable how little information was held in his hospital/CMHT file. The file contained little information about his psychiatric and personal history, or social circumstances. The importance to him of the suspension of his driving licence and the schism with his church were not known or understood.

The purpose of the 'quality assessment tool' used in his case was unclear. Many issues were considered but not identified as a problem: social networks, occupation, isolation, poor compliance.

Assessing and managing potential violence and levels of dangerousness posed by patients' behaviour is the purpose of the formal risk assessment procedure.

A competency framework introduced for health and social services qualified staff requires them to demonstrate that they are competent to carry out this formal risk assessment procedure by April 2002.

Notes of admissions and treatment outside the Surrey Hampshire Borders NHS Trust are routinely obtained as part of the formal risk assessment procedure introduced in April 2001.

Each patient has one current record, which is held by the team that is currently providing care and treatment for the patient (for example, by the Community Mental Health Team if the patient is receiving care in the community).

In-patient summaries (known as 'Communication Sheets') are completed at every ward round. To ensure that all teams have up-to-date information about patients, these are routinely copied to the Community Mental Health Team and the Rapid Assessment Service as well as to the current file.

All correspondence about the patient is kept in the current file.

As part of clinical governance, staff involvement in clinical audit projects (including record-keeping) has enabled a greater awareness of the importance of good and accurate record-keeping, which is now reflected in clinical practice. The programme of audit is on-going and is monitored through the Trust Clinical Governance Committee.

A tool is in place to audit the quality of assessments on admission. As part of a review taking place in July 2001, clinical audit of the quality of assessments on acute wards will include a focus on:

- the use of information from family members, in order to verify that they have been seen;
- the range of issues considered within the assessment process (e.g. medical, social, employment, financial, family, forensic, substance misuse, etc.);
- the nexus between the treatment being provided and the needs which were identified;
- the way in which risks have been identified and managed.

Main findings	Action

8 OCCUPATIONAL THERAPY AND REHABILITATION

The in-patient services now care for a new group of people with enduring mental illnesses whose needs were not anticipated when Parklands Hospital was planned.

During the period reviewed by us, the effect of this was that the occupational and recreational facilities at Parklands Hospital were insufficient for patients who required a long period of in-patient treatment.

The effect on Mr Moffatt was described by one professional carer in the following way: 'For people who stay a long time on the acute ward it exacerbates their illness. Maybe Christopher was getting better, but being in that environment ... actually slows down their progress.'

From June 2001, all patients receive a therapy assessment on admission.

The trust is now well placed to provide occupational therapy following the expansion of the Parklands Hospital therapy team from two to seven full-time posts, including occupational therapists, art therapists, and therapy support workers.

The directorate constantly review the provision of rehabilitation and on-going care within the hospital to in-patients who require longer-term treatment. The increase in therapists based at Parklands is an example of the action taken. In addition, supported access to Adelphi Place, Basingstoke Clubhouse and other community support facilities ensures that people remain in contact with their usual support networks whilst they are in-patients.

9 ASSESSMENTS FOR COMPULSORY ADMISSION TO HOSPITAL

It was unsatisfactory that two social workers who had never met Mr Huntingford and his mother before were left to arrange and manage his admission.

Once the prospective applicant (the ASW) knew that she lacked a duly completed application authorising his compulsory admission, and to that extent lacked authority to convey him to hospital, it was not unreasonable for her to decide that admission required a substitute medical recommendation.

There were three points at which the assessment process broke down:

Firstly, the medical recommendation was incorrectly completed, and the approved social worker did not properly scrutinise it before the doctor left the premises, and became uncontactable.

Secondly, when the error was pointed out by the GP, the need to use section 4 or to obtain a replacement was not explicitly discussed, and the outcome recorded.

Thirdly, it was undesirable, and perhaps unsafe, that the two social workers had to decide whether the risks involved in delaying admission until the next day were acceptable. The consultant assumed that immediate admission was taking place, and her opinion of the risks involved in delayed admission could not be obtained when the decision fell to be made.

Two points must be emphasised:

Firstly, a trainee working with an approved social worker is not responsible for decisions made during the assessment. The prospective applicant remains responsible throughout.

Secondly, the error in the dating of the recommendation was, in reality, something of a 'red herring'. The key issue is whether it was reasonable to delay admission until the next day. The view was taken that it would be safe to delay admission; and it is this assessment of the risks, necessarily taken without any input from the patient's consultant, which was the most critical factor in terms of the timing of the admission.

Although there was no evidence that Mr Huntingford intended to harm his mother when the approved social worker was asked to leave his home on the evening of 23 December (and indeed Mrs Huntingford died during an attempt to 'save' her), she left a situation destabilised by their visit.

Following Mr Moffatt's arrest, the duty psychiatrist refused to attend the police station to examine him, and provide any treatment he required.

As a matter of local policy, the agencies are agreed that, until such time (if ever) as the courts rule otherwise, ASWs conducting Mental Health Act assessments and trust staff should rely on the rectification provisions in section 15 of the 1983 Act in any case where a date is incorrectly entered on a medical recommendation.

The roles and responsibilities of approved social workers (ASWs) and trainees are clarified in the third edition of Hampshire County Council's Mental Health Practice Handbook, published in April 2001.

The handbook, which complies with the 3rd edition of the Mental Health Act Code of Practice and takes account of the findings of inquiries, has been disseminated to all ASWs and their managers.

Revisions to the handbook include:

- Specific guidance on the scrutiny of documents and a requirement to rely on the rectification provisions of Section 15 of the Mental Health Act 1983.
- Guidance on the role of trainees, including explicit clarification that they must not undertake Mental Health Act assessment work unless accompanied by an experienced ASW. The experienced ASW must be present, actively oversee the assessment process, and sign the statutory documents.
- A requirement that the ASW informs the patient, the nearest relative, the doctors, and the CPA care co-ordinator (if applicable) of any delayed admission, together with the reasons. The ASW must consider the impact of the delay on anyone whose welfare may be affected by it, and ensure that alternative care planning arrangements are made where necessary.

It is now local trust policy that:

- If a doctor who provides a recommendation has to leave the scene before the application procedures have been completed, s/he must remain available for consultation until those procedures have been concluded.
- duty psychiatrists may not refuse to attend police stations when a psychiatric assessment is required.

Main findings	Action

10 RISK MANAGEMENT AND INFORMATION SHARING

Because Mr Longman had a serious illness, and had harmed himself and threatened grave harm to others, allowing him to determine his need for treatment could not be justified unless the associated risks had been systematically assessed. Although the significance of particular incidents of self-harm and threats to others were reviewed, there is no evidence of any systematic assessment or plan for managing them.

Mr Longman's treatment was undermined by inadequate communication between CMHT members and others.

The consultant's referral letter to Vyne Road was unduly brief and failed to give a proper history. Discharge and out-patient letters were sent to Mr Longman's GP, and copied to his CPN, but not to Vyne Road staff, who often relied on clients to give them information.

Important information obtained by Vyne Road was not shared with his consultant.

CPN records were inadequate. The completion of the prescription card was considered to be an adequate record of the visit unless a significant change in the client's mental state was observed. Nurses' records were not generally seen by managers, who were 'quite oblivious to the standards of record-keeping'.

Weekly community team meetings were not properly managed. Minutes were neither written up nor circulated. There was no common record of action points.

Liaison with the Accident & Emergency Department was inadequate. Mr Longman made 17 visits there. On some occasions, when he attended with a somatic symptom of mental disorder, he was discharged without seeing a psychiatrist. Following each visit, the A&E department sent a note or letter of the attendance to his GP, but not to his consultant (or, through him, to other members of the team).

In Mr Huntingford's case, important information held by the GP was not available to the hospital or community mental health services.

If any of Mr Huntingford's extended family had been seen, it would have been clear that his mother could not be relied upon to notify professionals of relapse or its effect.

Formal (CMHT, etc) and informal (relatives) systems worked in parallel: those with the expertise did not have the knowledge of Mr Huntingford and his social networks, and those with the knowledge did not have the expertise. More contact between the two would have helped both.

On admission, all patients are assessed using the formal risk assessment procedure. This includes assessing each patient in terms of the immediate and potential risks of going missing, suicide, self harm, harm to others and self neglect, taking into account their social and clinical history. An individual care plan is then devised, which includes the measures required to manage those risks appropriately.

The formal risk assessment procedure includes an assessment of the risk of dangerousness, and this is included in the discharge summary.

Signs and symptoms that may indicate that the patient is likely to relapse are included in the revised care plan for people on enhanced CPA.

Before discharging or granting leave of absence to a patient who is liable to be detained, the responsible medical officer is now formally responsible for ensuring both that a proper assessment is made of the risks to the patient or others and that the individual's care programme sets out the measures required to manage risks safely. This assessment specifies

- the likely effect on the patient's mental state, behaviour and treatment of the environment to which it is proposed to discharge him;
- having regard to the particular risk to carers, the extent to which the safety of each person with whom the patient will be living is thought to be at risk and the way in which those risks are to be minimised.

All community staff undertake mandatory training on risk assessment, which includes identification of the risk of violence and dangerousness.

All service level agreements with voluntary sector providers require that training in the assessment and management of risk is provided to staff. This is reviewed during quarterly contract review meetings.

All social care providers have received written instructions from Hampshire County Council Social Services Department stating that no referral should be accepted without adequate risk assessment. When a client is referred to 3 Vyne Road, the letter of referral will contain a detailed history, including information about the care programme, the patient's mental state, previous violence and warning signs.

ASWs leave an outline report at the hospital when a patient is admitted, and this requirement is reiterated in the Mental Health Practice Handbook. Outline reports include the reasons for the admission and information concerning risk.

Guidelines between Accident and Emergency and Mental Health services for the referral and assessment of people who attempt self-harm are in place.

As required in the NHS Plan, a shared protocol to support the sharing of information is being agreed and will be in place by April 2002. This will ensure that CMHTs and in-patient facilities have access to information about in-patients held by GPs.

Main findings	Action
When Mr Moffatt went missing in January 1997, a search of his room by MACA staff revealed magazines in which he had circled rifle advertisements. This information was not shared with his consultant or key worker; or with the professionals who assessed him for compulsory admission to hospital on his return to the hostel. The fact that he had violent thoughts about his project worker at the MACA home was similarly not shared. The GP who examined him in January 1997, and recommended compulsory admission, observed that he was sitting reading a book on knives; and Mr Moffatt told the doctor how interesting he found the book. No one can recall that this information was shared with his consultant. These omissions placed the professionals who assessed him for admission at unnecessary risk; and undermined the risk assessments later undertaken at Parklands Hospital. They also, therefore, undermined the management of risks.	MACA acknowledges the important lessons to be learnt through this inquiry. The events occurred in the early days of a new service and a new team which was not as confident in, and familiar with, good practices and local relationships as is now the case. MACA now has effective systems and policies in place which promote and guide good practice in communications and risk management. These emphasise the need for collaborative work with local mental health teams and for a rigorous approach to: • Risk assessment and management. MACA's policy is to involve users, carers and key professionals in risk assessment and plans, and it supports any move to integrate the process locally. Normandy Street staff have attended a training course in risk management. • Sharing and communicating information. • Recording information, when and with whom shared (a basic practice which was not adequately followed in this case).

Main findings	Action

11 CARE PROGRAMME APPROACH AND SECTION 117

The eastern team did not have a systematic approach to the care programme approach, which was completely ineffective in Mr Longman's case.	A revised care programme approach (CPA) was implemented in April 2001. For people on enhanced CPA, the revised care plan now includes identified needs and risks in relation to medical, social, employment, occupation, housing, finance and welfare benefits, family issues, forensic matters, substance misuse, treatment provided and crisis prevention/contingency.
Family members, carers, and professional carers from outside the hospital, were not routinely invited to CPA meetings or involved in CPA processes.	A board level trust manager, the Director of Mental Health, has overall responsibility for ensuring that Health Service Guidelines concerning the care programme approach are adhered to, and adherence is routinely monitored.
The Vyne Road day service did not receive care programme approach information on clients referred to it.	The trust also has a care programme approach development manager, whose sole task it is to ensure the effective implementation and delivery of the CPA across the trust, in keeping with NSF standards.
As soon as Mr Longman became non-compliant, his keyworker discharged him from his caseload. This key worker was not properly trained or prepared for the role.	Monitoring is carried out through audit, user involvement and quarterly data collection. Quarterly data collection has been expanded since April 2001, and the User Focused Monitoring Project was introduced in 2000.
Although the eastern locality manager was responsible for CPA processes, no one could recall being asked for evidence of its implementation.	The auditing of the revised CPA procedures introduced in April 2001 will include examining the quality of out-patient assessments of previously detained patients, and this will focus on the use of information from family members, in order to verify that they have been seen; the range of issues considered within the assessment process (e.g. medical, social, employment, financial, family, forensic, substance misuse, etc.); the nexus between the treatment being provided and the needs which were identified; the way in which risks have been identified and managed.
The lack of a trust CPA administrator was a weakness.	North and Mid Hampshire Health Authority is further enhancing its monitoring of the trust's compliance with Health Service Guidelines, by way of regular random audits, in particular of compliance with the CPA and discharge planning.
Section 117 was 'not formalised' at the time (although the duty had existed since 1983), and it too was not implemented in Mr Longman's case.	The Social Services Department introduced a new procedure in November 1999, to ensure that it meets its responsibilities under Section 117. This places a responsibility on mental health service managers to ensure that appropriate arrangements are in place with each trust, for planning, monitoring, reviewing and discharging people subject to section 117.
Mr Longman's key worker did not know what section 117 was and did not refer the issue of whether to close his case to the trust and social services. Vyne Road similarly closed his case without taking section 117 into consideration.	Care management and the care programme approach is now an integrated process.
The hospital social work department failed to involve itself in Mr Longman's need for after-care, and failed to carry out the local authority's duties under section 117. No one in the department was responsible for ensuring that after-care was arranged for section 3 patients prior to discharge.	A protocol for the transfer of care from secondary to primary services is being developed with PCTs and a clear policy, which is workable and realistic, will be drawn up. This will ensure periodic review by the mental health service of patients with a severe mental illness who are being cared for by primary services. Decisions to transfer care will be multi-disciplinary and discussed in advance with the GP.
The care plan devised for Mr Huntingford in July 1997 was over-inclusive and unfocused, and not enough attention was paid to properly engaging him.	
The case was handed over to the GP through correspondence.	
The decision that Mr Huntingford need only have a key worker for two months played a part in his breaking off contact.	

Main findings	Action

12 AUTONOMY, PATIENT EMPOWERMENT AND ASSERTIVE CARE

Misplaced ideas about patient autonomy and empowerment contributed to a lack of (assertive) care for Mr Longman and Mr Moffatt.

Mr Longman's key worker's primary reason for not establishing contact with 3 Vyne Road was 'that the client is empowered to make decisions about their own care, and I had to get his signature for the care plan'. He said that he 'respected' his decision not open up and to keep their meetings as brief as possible.

Mr Longman's consultant had a similar philosophy. He was 'best engaged by allowing him the freedom to access the service as he chose and in the way he chose. That seemed to have kept him out of hospital and kept some degree of contact with him ...' However, most individuals have a preference for not being detained, and some a preference for not being treated. The latter will choose not to access the services much of the time; and this will keep them out of hospital, but not necessarily well.

Mr Moffatt's compliance with medication was poor at MACA's Normandy Street home. His worker there said: 'Where the balance comes, though, in our philosophy is about choice ... I was always quite open in my discussions with him, talking about the pros and cons of all forms of treatment. I tried never to advocate one above the other, just to keep it purely to giving people the information with which to make informed choices ... He tapped into the feeling that I was never pro-medication as strongly as the rest of the team.'

Vyne Road's statement of purpose in its business plan for 1993-1996 included the statements, 'the individual is expert' and 'upholding their right to self-determination and choice.' This was at best ambiguous.

Mr Longman had a devastating mental illness which required intensive treatment but which, for many reasons, was not treated intensively.

When he isolated himself, this should have led to some kind of action plan, involving health and social services jointly deciding how to proceed, rather than simple case closure.

Because he had a severe mental illness, behaviour which disrupted his treatment, and lack of compliance, should have resulted in more, rather than less, care.

The period of compliance could have extended by discharging him from hospital under section 17 leave, with appropriate conditions attached.

Hampshire County Council and North & Mid Hampshire Health Authority have committed themselves to implementing safe, sound and supportive services, the cornerstone of which are integrated care management and care programme approach services, risk assessment and management.

The revised care plan for people on enhanced CPA:

- includes a statement of the objectives of treatment and care.
- considers the relationship between the patient and her/his consultant and the action to be taken should the patient not maintain this contact.
- identifies needs and risks and plans for crises and contingencies.
- considers how best to plan care and treatment around the patient's needs and circumstances.

Two assertive outreach workers have been appointed for north Hampshire, and funding and proposals have been agreed to extend this service across North and Mid Hampshire during the current year.

Assertive outreach training, purchased from the Sainsbury Centre, and available to staff across north and mid Hampshire from September 2001, is developing expertise in this area. The training emphasises, and will continue to emphasise, that teams must have a clear strategy for following-up partially treated, non-compliant, out-patients, which does not involve waiting for the patient to re-present.

The system of clinical supervision now in place seeks to promote a culture of active engagement, and provide the skills necessary to achieve this.

The above expertise in interventions which encourage engagement will be shared with the voluntary sector.

3 Vyne Road's business plan no longer refers to 'upholding the [client's] right to self determination and choice', nor does it state that 'the individual is the expert' (although this is a strongly held view among service users, and self-determination and choice continue to be important values in mental health care).

The Vyne Road service is delivered in accordance with the departmental risk assessment and management policy agreed by Hampshire County Council's Social Services Committee in January 2000. This:

- recognises the importance of good risk assessment and management, and makes protecting individuals from serious harm, whether to self or others, the primary consideration.
- recognises the importance of working in partnership and using existing planning and review mechanisms e.g. CPA, section 117 planning, potentially dangerous offender conferences.

Main findings	Action
Because Mr Huntingford was not considered a risk to others (although there was evidence available that he was), his views prevailed as to what, and how much, medication he would take, and who, and under what circumstances, he would see the various health care professionals. The notion that Mr Huntingford need only have a key worker for two months played a part in his breaking off contact. In the months following discharge from hospital, Mr Huntingford ended contact with his consultant psychiatrist (25.09.97), his Stonham project worker (08.09.97), and his CPN (28.08.97 last home visit, case closed 27.11.97). Stonham's policy of seeing only Mr Huntingford as their client, and not allowing his mother to be appropriately involved in visits, played a part in the family breaking off contact.	❖ aims to ensure that effective communication and information sharing protocols are in place and are effective. ❖ makes a commitment to ensuring that its staff receive adequate training, guidelines and support. MACA wishes to emphasise that it was their staff who requested and arranged Mr Moffatt's assessment for admission to hospital under the Mental Health Act, and he had been in hospital for over a year prior to Mr Harrison's death. MACA's procedures involve two staff administering medication wherever possible, one always being a senior worker; and it is fully committed to supporting patients' care and treatment plans.

Main findings	Action

13 SUBSTANCE MISUSE

The philosophy of patient autonomy and empowerment also compromised what the Drug Advisory Service could offer Mr Longman and Mr Moffatt.

Mr Longman's preference for alcohol over medication affected his treatment, and his use of illegal drugs, though probably exaggerated, was unhelpful. He refused help from the Drug Advisory Service.

Mr Moffatt's use of cannabis complicated the management of his condition. However, the Drug Advisory Service's philosophy virtually precluded it from helping him: 'If a client does not want contact with our service ... that is seen as their responsibility, and it is respected. That has not changed over the number of years.' The reality for a patient who has a serious mental illness, and believes that smoking cannabis fights the devil in his head, is that he will never seek, nor therefore receive, help from the service. 'It is a very helpful service but not for the co-morbid patients.'

The philosophy of the substance abuse service, which is based on a motivation to give up illegal drugs, made it impossible for the service to help someone like Mr Moffatt, whose illness involved seeing the drug as bringing about an improvement in his mental state.

The philosophy of the Substance Misuse Services has changed.

Risk assessments are carried out on all users of substance misuse services, and assertive outreach is conducted with users who are deemed to be at risk and are difficult to engage.

There are now much closer working relationships between the adult mental health and substance misuse services:

- Since April 2001, the substance misuse service has been managed within the same Mental Health/Learning Disabilities Directorate.
- Since June 2001, both services have been using a common Patient Information System. Therefore, any member of the adult mental health service will be aware that a patient is also accessing the Drugs/Alcohol Service.

Joint working with people in need of both services is now a matter of course. Integrated CPA and care management procedures are implemented in both services, and are fully operational for people with mental health problems who use drugs and alcohol.

All substance misuse staff receive at least monthly clinical supervision from a psychiatrically qualified member of staff. Conversely, consultation and training are provided by the Substance Misuse Services to the Mental Health in-patient and CMHT services.

The substance misuse services now employ more mental health qualified staff.

Drug use is not tolerated in MACA services. Use of illicit drugs off the premises is a cause for concern and is addressed as a care and health issue, but is not necessarily an issue for staff control.

Misuse of Drug policies are now in place in MACA services which make it clear that suspicion of drug use or supply on the premises is reported to the police and can result in termination of the placement.

Main findings	Action

14 APPROACHES TO PEOPLE WITH DISRUPTIVE BEHAVIOUR

Mr Longman was variously described by professional carers as being 'certainly quite criminal'; 'none of his behaviour was apparently a psychiatric illness issue as such but seemed more to do with a determined desire to lead his life as he wished and to trample over other people's feelings. This would take the form of assertive domination and determination to have his own way, to attend when he wished, do what he wanted'; 'his behaviour had a knowing quality; there was a lot of attitude behind it which was difficult to associate with mental illness (e.g. ridiculing others).'

Mr Huntingford was described by his general practitioner as being religious, kind, considerate, intense, and serious; and by members of the community mental health team as being haughty, dismissive, narcissistic, difficult, opinionated, prickly. This may have accounted in part for the GP's greater success in engaging him.

Linked to this, many people seen by the mentally disordered offenders' co-ordinator were already known to their local CMHT. As a group, they were not generally popular clients, and teams were all too often reluctant to accept the referral. Quite often, the reason given was that the individual had a personality disorder, or needs which did not fit with the service provided by the teams. Ultimately, however, they are 'difficult and challenging people, and people will fight hard not to accept them .... the key thing is about ownership by the general services, and acceptance and understanding that if somebody ends up within the criminal justice system, they are still their business'.

Eastern and southern team members expressed a need to prioritise the work done by CMHTs: 'It is always CMHTs can do everything. I am involved in a mentally disordered offenders steering group, a dual diagnosis steering group, an eating disorders steering group, and the message always from the purchasers is: that's okay, that can fit into a CMHT. There is no recognition that that means extra people with extra skills. At the moment we have everything from cat phobia to people like this referred. It has been the blight of CMHTs ever since they were conceived'.

The trust is committed to the implementation of the mental health National Service Framework — and its key components of a safe, sound and supportive service. This has required staff to concentrate on each patient's need for treatment and how best to provide it, and to develop alternative ways of caring for individuals whose disturbed behaviour and non-compliance have frustrated attempts to treat them in an accepting, open, environment.

In accordance with this, the revised care plan for people on enhanced CPA is intended to ensure that a comprehensive care and treatment package is planned around a patient's needs and circumstances. This focuses care and treatment on what treatment the patient needs and how this can best be provided.

Personality disorder will not be used as a criterion for acceptance or rejection from CMHT services. Other indicators of severity and disability associated with mental health problems will be applied, including psychiatric history.

It is trust policy that a multi-disciplinary review should be conducted before any patient is excluded from a service. In all cases a strategy will be agreed for the patient's future care.

A clear model of caring for mentally disordered offenders in the community will be agreed locally, by June 2002, so that there is a common understanding of who is responsible for providing care to them.

The trust will work with the SSD and others to audit services against the Department of Health Guidance recently issued. In particular, the functions and skills required for assertive outreach and crisis resolution are currently being audited against those available.

Main findings	Action
Mr Longman's delusional beliefs involved his family. His parents did not understand the nature of his illness, or the importance of treatment. The domestic situation was such that the family home was the last place Mr Longman should have been given his serious mental illness. There was considerable information, dating back to 1987, which indicated this. His behaviour outside the home was known to be disruptive, provocative, and disturbing. However, no one properly addressed the likelihood that this might also be the behaviour which his family had to contend with at home. No support was given to them during periods when they were caring for him. There was no strategy for reducing family tension, or for alleviating its effect on Mr Longman's health and treatment. Because of the circumstances at home, regular maintenance treatment, and low social contact between Mr Longman and his parents, were important. There was no clear or consistent approach on the wards to involving the families of in-patients in care programmes. Inviting a patient's family or friends to CPA meetings was the exception, not the rule. Mr Huntingford's mother should have been seen, perhaps quite formally, on her own. Too many assumptions were made about her relationship with her son, and more attention should have been given to the nature of this relationship, and its effect on the course of his illness. There is some evidence that she found it difficult to acknowledge his illness, may not have fully understood the importance of medication, and was sympathetic to the negative effect that previous admissions had had on him. The commitment of Mr Huntingford's relatives to him and his mother was exemplary. However, they were not contacted by mental health services after the homicide. After Mr Harrison's death, Mr Moffatt remained in prison for about four months because of a lack of secure hospital beds. His mother's MP wrote to the Chief Executive of the Loddon Trust about this and other anxieties. In our opinion, certain passages in the Chief Executive's reply, which made no reference to his schizophrenia or the context of his cannabis use, were inaccurate and insensitive.	It is trust policy that the views of the immediate family must be sought and considered as part of the CPA assessment, when taking the history or assessing a patient's current condition, especially if the patient is being cared for outside hospital and is not attending out-patient appointments or taking medication. The revised risk assessment procedures and training emphasise the importance of considering the following matters: ❖ who (if anyone) is most at risk of violence from the patient; ❖ whether individuals known to be at risk are aware of the risks, the history of violence, the context within which it occurred, and any warning signs; and (if not) ❖ whether maintaining the patient's confidence, and not sharing this information about the risks with those bearing them, can be reconciled with the legal duty to take reasonable care to protect third parties from reasonably foreseeable risks; ❖ where discharge information concerning risks or their management is provided to professional carers, but not to non-professional carers, why professional carers require the information in order to provide care safely but not non-professional carers — this must be specified. A training programme has been in place since November 2000 to ensure that care co-ordinators are competent to assess carers needs. Local organisations are working to meet the target set in the NHS Plan to ensure that all regular carers of people on enhanced CPA have a written care plan by March 2002. More particularly, all individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs repeated on at least an annual basis; and they should have their own written care plan, which is given to them and implemented in discussion with them. A procedure for handling serious incidents has been developed by the trust and the Social Services Department (see p.127). When a person commits a homicide, the needs of the immediate family of both the deceased and the patient must be ascertained, and they must be offered appropriate professional support.

Main findings	Action
16 DAY SERVICES AND 3 VYNE ROAD	
The Vyne Road remit included an outreach service, to work with people within the community, and not just with those who came to Vyne Road. However, this service was not available to Mr Longman, and Vyne Road did not contact his family or visit him at home. The way in which Vyne Road twice closed his case was unsatisfactory, given that he had originally been referred there because of the risk of social isolation.	3 Vyne Road's remit continues to include an outreach service in the community, and these services are now made available as part of the CPA and risk assessment processes described above. Services for users provided by Vyne Road are now only ended following explicit agreement in the formal CPA process.

Main findings	Action
17 HOUSING AND SPECIALIST ACCOMMODATION	
The hostels developed as part of the mental health strategy were for long-stay hospital patients, and the strategy took insufficient account of the new long-stay population.	Assessments of housing need are an integral part of the revised care programme approach.
Mr Longman required alternative housing on medical grounds, and this was also necessary for his parents' health.	The trust now manages two community-based 'hospital-hostels' in Basingstoke and Farnborough. This enables patients to be placed in settings outside the main hospital which are staffed by skilled and experienced practitioners and within which medication can be given without consent.
Little priority was given to his need for alternative housing, and the interventions of Hampshire Social Services employees were time-limited, inconclusive and of little help. Applications were made for housing, which were never followed up.	The Social Services Department has employed its own housing support officer for some years. This person's remit includes assisting mental health staff and service users with applications for priority housing, and she will advocate for them at resource panel hearings.
Mr Moffatt's very limited compliance with medication, and his use of cannabis to relieve his distress, meant that he needed a community facility which could provide hospital hostel support and supervision, but such a facility was not available.	Health and social services are undertaking a review of 24-hour staffed accommodation, which will report in October 2001.
The panel doubted the morality and wisdom of placing people with severe mental illnesses in ex-council housing which was difficult to let.	

Main findings	Action
18 CLINICAL SUPERVISION	
The problems identified above were not identified at the time because clinical supervision was inadequate. Supervision was more used as a management tool, rather than as a tool for clinicians to improve their skill. It did not centre on examining cases, how they were being managed, the issues arising from them, and what alternative strategies might be deployed. One of the reasons for this was financial: a more effective system would have required a reduction in caseloads.	A clinical supervision training programme is in place. Attendance at, and the frequency of, this training is monitored through the trust's Clinical Governance Forum. The Clinical Governance Forum will continue to address the issue of effective supervision. Clear standards will be established and audited, which ensure that all clinical staff receive effective and regular clinical supervision. Such standards will include frequency of supervision, those responsible for providing it, and methods for auditing its effectiveness. Hampshire County Council Social Services Department introduced specialist mental health management in July 1999, in order to enhance the quality and effectiveness of staff supervision and professional development.
19 HEALTH EDUCATION	
An attempt to set up a hostel in Tadley as a hospital hostel, under trust management, was unsuccessful, partly for financial reasons, and partly because of nasty public demonstrations, including a public meeting in Tadley with the police in attendance. The consequence was that local people were less, not more, safe; and the demonstrators bear some responsibility for the lack of secure provision locally.	Noted.
20 PRESS REPORTING	
Local reports of the deaths of Mr Longman, Mrs Huntingford and Mr Harrison, and the subsequent court proceedings, were mostly sensitive and informative. However, some of the language cannot be supported. For example, the headline, 'Widow's Plea as Killer is Caged', and using the word 'schizophrenic' to describe a person, rather than an illness. Representatives from the Health Authority, the trust and the local media should seek to agree guidelines as to the reporting of public appeals concerning absent patients and the way in which mentally ill people are described.	Local media are reminded of the benchmarks of professional and ethical standards set by the Press Complaints Commission's Code of Practice. This includes the entitlement to privacy under article 3, the sensitive handling of grief and shock under article 5, and the avoidance of pejorative or prejudicial references to a person's mental illness under article 13. When sensitive information is released to the media (e.g. concerning appeals for public information about absent patients) this will be accompanied by guidance on the appropriate reporting of the information.

Main findings	Action

21 THE INTERNAL REVIEWS

The Loddon Trust review of Mr Longman's treatment was chaired by a non-executive director of the trust. The trust review panel did not have access to social services files, and the report of Hampshire Social Services' own internal review was only received at the end of the trust's review process.

The probation service were not invited to speak with the trust review panel; which also meant that relevant records were not seen; that the panel's understanding of the circumstances was partial; and that the quality of inter-agency working and communication could not easily be ascertained.

The panel's medical member was unable to give an opinion as to whether his non-compliance and difficult behaviour were signs of partial treatment or negative symptoms of schizophrenia. This was a crucial issue.

Some important hospital records were mislaid.

The trust report contained errors of fact, statements which could not be supported, and judgements with which it was difficult to agree. For example, the report stated that Mr Longman 'received the best treatment available without application of coercion from Adult Mental Health; and that the two services appeared to have liased appropriately throughout.'

The internal review completed by Hampshire Social Services in August 1996 was even less adequate:

The review did not progress beyond an initial documentary review, and relied far too heavily on Vyne Road's Service Manager's own report.

The review report did not address compliance with the CPA process, including case closure; risk assessment; family and housing issues; and the Social Services Department's statutory duties under Section 117.

In Mr Huntingford's case, there were disparities in the accounts given by the four professionals involved in the statutory assessment. These disparities could not be accounted for by the passage of time or forgetfulness.

Surrey Hampshire Borders Trust agreed a revised serious untoward incident policy in February 2001 that complies with new NHS Regional Guidance. This procedure makes provision for external investigation.

Hampshire County Council Social Services Department introduced a more rigorous internal inquiry procedure in October 1998. This procedure:

- introduced improved quality checks and independent expert investigation in the inquiry process.
- incorporated requirements for joint working with Health Authorities and trusts to comply with national guidance regarding inquiries.
- introduced additional reporting requirements to the Social Services Committee.

A separate social services procedure continues to be required, to set departmental standards of joint working across a number of NHS trusts. The procedure has been reviewed and revised with Surrey Hampshire Borders Trust, in order to ensure:

- early joint investigation and reporting.
- a requirement to develop and agree a chronology of events and to note any discrepancies with reasons.
- the offer of support to relatives of victims and the patient.
- compliance with NHS Regional Office Guidance.

10 SUMMARY OF THE REPORT

National Health Service Guidelines issued in May 1994 require that an independent inquiry is held when a person who has been in contact with mental health services takes another individual's life.

In this instance, the independent panel were asked to review the care and treatment of three patients who resided in north & mid Hampshire:

Mark Longman was discharged from Park Prewett Hospital on 10 January 1995. On 4 June 1996, he killed his father, Kenneth Longman, at their home in Basingstoke, by setting fire to him. He later pleaded guilty to manslaughter on the grounds of diminished responsibility, and is presently detained in hospital under the Mental Health Act 1983.

Paul Huntingford was admitted to Parklands Hospital in May 1997, and discharged home in June. During the afternoon of 23 December 1997, he was assessed at home by his consultant and an approved social worker, who considered that he required compulsory admission to hospital. However, his admission was delayed when it was discovered that a medical recommendation form had been incorrectly dated. On 24 December, his mother, Mrs Lena Huntingford, died during an attempt by him to exorcise her. He was subsequently found to have been insane at the time, and was not convicted of any criminal offence. He too is presently detained under the Mental Health Act.

Christopher Moffatt was admitted to Parklands Hospital in January 1997, where he was detained under section 3 of the Mental Health Act 1983. He left hospital without permission on 19 February 1998, and went to, and worked in, Andover. On 9 April 1998, he entered a private house in Hampshire and stabbed Anthony Harrison, killing him. He was later convicted of manslaughter on the grounds of diminished responsibility. Subsequently, he committed suicide in the hospital where he was detained under the Mental Health Act.

All three of the patients lived within the area served by the NORTH & MID HAMPSHIRE HEALTH AUTHORITY, HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES and the NORTH HAMPSHIRE LODDON COMMUNITY NHS TRUST, and received in-patient treatment in Basingstoke. They were not, however, cared for by the same mental health team. Mr Longman received in-patient treatment at the old Park Prewett Hospital, and was cared for in the community by the eastern sector team. Mr Huntingford and Mr Moffatt were treated in Basingstoke's new Parklands Hospital, and were cared for in the community by the southern sector team.

Patient	*Admitted to*	*Last left hospital*	*Community team*	*Date of homicide*
Mr Longman	Park Prewett	10 January 1995 (discharged)	Eastern team	4 June 1996
Mr Huntingford	Parklands	30 June 1997 (discharged)	Southern team	24 December 1997
Mr Moffatt	Parklands	19 February 1998 (absconded)	Southern team	9 April 1998

It should be noted that a need to reduce NHS overheads resulted in the Loddon Trust's dissolution on 31 March 2001, when the management of its mental health services was taken over by the Surrey Hampshire Borders NHS Trust. This decision was in no way performance related.

WHO CONDUCTED THE INQUIRY

The inquiry was undertaken by a panel of professionals from outside Hampshire. The care and treatment received by Mr Longman and Mr Moffatt was reviewed by Anselm Eldergill, Paul Bowden and Nick Welch. Mr Huntingford's care and treatment was also reviewed by Anselm Eldergill and Paul Bowden, who were joined for this review by Claire Murdoch and Jeremy Walker.

Anselm Eldergill (Chairperson)	Solicitor. Former Chairman of the Mental Health Act Commission's Legal & Ethics Committee. Author of *Mental Health Review Tribunals, Law and Practice*.
Paul Bowden (Medical member)	Consultant Forensic Psychiatrist. Joint editor of *Principles and Practice of Forensic Psychiatry* and former editor of the *Journal of Forensic Psychiatry.*
Claire Murdoch (Nursing member)	Executive Director of Nursing, Brent, Kensington, Chelsea & Westminster NHS Trust; Director of Operations, Kensington & Chelsea. Co-author of *Psychopathy, the law and individual rights*.
Jeremy Walker (Social work member)	Approved social worker, Mental Health Act Commissioner.
Nick Welch (Social work member)	Assistant Director, Oxfordshire Social Services.

PURPOSE SERVED BY THE INQUIRY

The function of an independent inquiry is thoroughly and objectively to review the patient's care and treatment, in order to ensure that the services provided to persons with such needs are safe, effective and responsive. The purpose is to learn any lessons which may minimise the possibility of further tragedies. This is why the report is made to the bodies that have power to change the way the service is provided. The outcome should be that any feasible improvements are made, for the future good of everyone.

NATURE OF THE INQUIRY

The inquiry panel sought to achieve consensus with regard to its findings and recommendations, and to agree with the Health Authority and the service providers action plans designed to enhance the delivery of local services.

The inquiry panel commended the constructive and measured way in which the families helped them, and the contribution made by their solicitors.

The panel also commended the candour and professionalism of the individuals involved in the patients' care and treatment, and their commitment to providing the best possible service to local people.

GENERAL FINDINGS

The panel's findings included the following:

1. The LODDON COMMUNITY NHS TRUST was resolute in its attempts to close the old local asylum and modernise local mental health services, but these efforts were hampered by inadequate resources.

2. The resources made available to mental health services in Hampshire did not permit the mental health strategy of 1993 to be implemented, and the range of community resources was scaled down.

3. There was little additional investment in mental health services in north Hampshire until about four years ago.

4. Hampshire County Council was a relatively low spender on mental health services during the period reviewed by us.

5. Although the mental health strategy was 'revenue-neutral', its implementation involved developing a completely new range of services in Winchester, and this may have resulted in some disinvestment in north Hampshire.

6. There was a high concentration of trained staff on acute admission wards in the 1980s. Which is to say, there was a great deal of money tied up in acute admission wards. The need to implement the mental health strategy led to skill mix reviews, which were thinly disguised financial reviews. At the same time, increased drug and alcohol usage was beginning to affect the client population, who became more prone to violence and aggression. So the wards became harder to manage, rather than easier, at the same time as staffing was being diluted.

7. There was evidence that inadequate nursing levels meant that the use of observation was not always an effective means of detaining, or ensuring the safety of, patients.

8. Because the trust was unable to guarantee no redundancies during the reorganisation, all of the nursing staff were required to compete for their own jobs, and to be interviewed in a competitive situation. Not surprisingly, this led to pressure and tension, and staff morale was not particularly good.

9. The three-bed intensive care area built into the new Parklands Hospital was never opened, partly because the cost of staffing it safely would have caused disproportionate problems for the rest of the in-patient unit, and the risks of not staffing it safely were unacceptable.

10. The local mental health in-patient service run an open service, with no locked doors or seclusion rooms. This philosophy, which was a prevalent one at the time, contributed to the decision not to open the intensive care area, and contributed to the difficulties experienced in treating patients locally.

11. As a philosophy, the idea that patients should not be managed on locked wards has nothing to commend it if local people are simply admitted to out-of-area locked wards.

12. The security of the new Parklands Hospital was inadequate during the period covered by the review.

13. Although the trust had access to locked facilities at the Oaktree Clinic in Surrey, and to the regional secure unit, these facilities were not always available in an emergency.

14. The lack of secure facilities, or access to them, required ward staff to look at what they could do within available resources. In other words, it skewed the management of risks.

15. During the period reviewed by us, the occupational and recreational facilities at Parklands Hospital were insufficient for patients who required a long period of in-patient treatment. There had been more space and more extensive occupational therapy at the old Park Prewett Hospital, and this may have made the management of disturbed behaviour easier.

16. Misplaced ideas about patient autonomy and empowerment contributed to a lack of assertive care. A philosophy of patient autonomy and empowerment also compromised what the Drug Advisory Service could offer.

17. The lack of a local intensive care facility, pressure on beds, nursing pressures, an open service ethos, and the need to manage increasing numbers of men whose behaviour was disturbed, led at times to the use of inappropriate techniques for managing risks. Deprivation of daytime clothing was used, and the police and hospital porters were called upon to restrain patients. Informal, and hence unregulated, seclusion and 'time-out' were occasionally practised.

18. The demands on community teams made by general practitioners, as a result of fund holding and the opening of CMHT centres, further reduced the resources available to people with severe mental illnesses.

19. The hostels developed as part of the mental health strategy were for long-stay hospital patients, and the strategy took insufficient account of the new long-stay population.

20. An attempt to set up a hospital hostel in Tadley was unsuccessful, partly for financial reasons, and partly because of nasty public demonstrations. The consequence was that local people were less, not more, safe; and the demonstrators bear some responsibility for the lack of secure provision locally.

21. The consequence of all of this was that local people did not have the benefit of a comprehensive or adequate range of mental health services during the period covered by our review.

22. Although consultants and other mental health professionals attempt to base their decisions on clinical considerations, budgetary constraints and bed availability influence the treatment and care which patients receive.

23. In our opinion, inadequate resources required families and professional carers to accept risks which they ought not to have had to bear.

24. The government and the county council of the day must accept responsibility for consequences arising from, or associated with, their funding decisions.

25. Confidence in the implementation of the mental health strategy was affected by a House of Commons review concerning the discharge of a number of older patients, a review of local suicides, and three homicide reviews.

26. Local reports of the deaths and the subsequent court proceedings were mostly sensitive and informative. However, some of the language could not be supported. For example, the headline, 'Widow's Plea as Killer is Caged', and using the word 'schizophrenic' to describe a person, rather than an illness.

PARTICULAR FINDINGS

These findings included the following:

Mark Longman

1. Mr Longman had a devastating mental illness which required intensive treatment but which, for many reasons, was not treated intensively.

2. Mr Longman's treatment and care were compromised by inadequate resources; a lack of assertive care, inadequate implementation of the care programme approach and section 117; inadequate communication between professionals; inadequate record-keeping; inadequate supervision; and insufficient attention to his family circumstances.

3. Inadequate resources had a significant impact on his care and treatment, and his health. This compromised his safety and the safety of his family, and required them, and professional carers, to accept risks which they ought not to have had to bear.

4. The care programme approach was not effectively carried into practice, and professionals did not have a systematic approach to it.

5. There was no evidence that section 117 was implemented.

6. Communication between members of the community mental health team and other individuals and services was inadequate.

7. The standard of record-keeping was inadequate in some respects and in-patient records were disorganized. There were separate medical, nursing, and occupational therapy records, and it took the internal trust reviewers two days to put them into some sort of order.

8. An adequate system of clinical supervision did not exist. There was little reflection, in the sense of examining cases, how they were being managed, issues arising from them, and what alternative strategies might be deployed.

9. There was considerable information, dating back to 1987, which indicated that the family home was the last place Mr Longman should have been, given his serious mental illness. His illness and behaviour, and his parents' different ways of dealing with his and their distress, were the source of much ill-feeling and frequent arguments. This intolerable situation affected the health of all of them.

10. Although Mr Longman's observed behaviour outside the home was known to be disruptive, provocative, and disturbing, the professionals did not properly address the probability that, if he could behave in this way on the ward when unwell, this might also be the behaviour which his family had to contend with at home. It had no, or insufficient, impact on their thinking.

11. There was almost no contact between mental health services and Mr Longman's family during periods when they were caring for him at home, and no real support was given to them. There was no strategy for reducing family tension, or for alleviating the effect of this tension on his mental state and treatment.

12. The hospital social work department failed to allocate his case, or to take any long-term interest in him.

13. The contribution made by the Vyne Road day service was affected by staffing difficulties in the autumn of 1995, unsystematic liaison with health service colleagues, unsatisfactory closure mechanisms, and a misunderstanding of the effect of Mr Longman's mental illness on his behaviour. He was not a client who was able to make expert decisions about the services which he needed, and this sat uneasily with their philosophy.

14. The internal reviews were inadequate in many respects; and the Department of Health ought to postpone its plans to replace independent reviews of homicides and untoward incidents with non-independent local reviews until there is more evidence that mental health services are better able to review shortcomings within their services.

Paul Huntingford

1. Mr Huntingford was not found guilty of having committed a criminal offence, and we saw no evidence that he intended to harm his mother. Rather, the intensity of his belief that she was possessed by Satan, and of his wish to exorcise her, made him unaware that her life or safety was in danger.

2. The circumstances of Mrs Huntingford's death were therefore highly unusual. The panel's medical member had not come across a similar case, where death was caused seemingly inadvertently during the pursuit of psychotically-driven actions, despite having assessed some 1500 homicide suspects, about 200 of whom were mentally abnormal.

3. Given Mr Huntingford's long psychiatric history, it is remarkable how little information was held in his current hospital/CMHT file. The medical files contained very little information concerning his psychiatric and personal histories, and his social circumstances. Important information held by the GP was not sought by or made available to the hospital and community mental health services.

4. At some stage during Mr Huntingford's long contact with services, his mother should have been seen, perhaps quite formally, on her own. Too many assumptions were made about her relationship with her son, and more attention should have been given to the nature of this relationship, and its effect on the course of his illness. There was some evidence that she found it difficult to acknowledge his illness, may not have fully understood the importance of medication, and was sympathetic to the negative effect that previous admissions had had on him.

5. Formal (CMHT, *etc*) and informal (relatives) systems worked in parallel: those with the expertise didn't have the knowledge of him and his social networks, and those with the knowledge didn't have the expertise. More contact between the two would have helped both.

6. The care plan devised in July 1997 was over-inclusive and unfocused, and not enough attention was paid to properly engaging Mr Huntingford. The notion that Mr Huntingford need only have a key worker for a period of two months played a part in his breaking off contact.

7. Because Mr Huntingford was not considered a risk to others (although there was evidence available that he was) his views prevailed as to what, and how much, prophylactic medication he would take, and which health care professionals he would see, and under what circumstances.

8. In the months following his discharge from hospital in June 1997, Mr Huntingford succeeded in terminating contact with his consultant psychiatrist (25.09.97), his Stonham project worker (08.09.97), and his CPN (28.08.97 last home visit, case closed 27.11.97).

9. For three months before the death of his mother, during which time both his consultant and CPN discharged him, Mr Huntingford believed his mother was possessed by Satan.

10. We were struck by the different way in which Mr Huntingford was described by his general practitioner (religious, kind, considerate, intense, serious) and by members of the community mental health team (haughty, dismissive, narcissistic, difficult, opinionated, prickly). This might have accounted in part for the GP's greater success in engaging him.

11. The visit on 23 December 1997 should have been better planned, although staff should be praised for responding promptly to the request for a Mental Health Act assessment. It was unsatisfactory (although common practice) that two social workers, who had never met Mr Huntingford and his mother before, were left to arrange and manage his admission.

12. There are some disparities in the accounts given by the four professionals involved in the assessment (the consultant psychiatrist, general practitioner and two social workers). These disparities cannot be accounted for by the passage of time or forgetfulness.

13. Mrs Huntingford was relied on as an informant although she was not given the opportunity to speak in confidence about any concerns which she may have had. If any of the extended family had been seen it would have been clear that she could not be relied upon in terms of either notifying relapse or accurately reflecting its effect.

14. In some respects, the trainee approved social worker acted as the approved social worker. The practice of delegating the interviewing of patients to a social worker who is training to be an ASW, though understandable, is questionable.

15. Although there was no evidence that Mr Huntingford intended to harm his mother when the approved social worker was asked to leave his home on the evening of 23 December, she left a situation destabilised by their visit. It was unfortunate that the patient's consultant was unavailable for consultation, and that there was therefore no medical opinion of the risks involved in deferring admission until the following day.

16. Following Mrs Huntingford's death, the fact that one of the medical recommendations had been incorrectly dated received considerable attention. This ought to have been properly scrutinised before the doctor who completed it left the Huntingford household. However, there is some case law that supports the approved social worker's interpretation of the effect of the incorrectly dated recommendation; and therefore, even if this view was incorrect, she cannot properly be criticised for taking the view she did.

17. The commitment of Mr Huntingford's relatives to him and his mother was exemplary. However, his cousins and their families, who held the roles of extended carers, were not contacted by mental health services following the homicide.

Christopher Moffatt

1. Mr Moffatt was a kind and popular man, who formed many close friendships. He suffered a devastating illness which, in the short space of five years caused two homicides, the second being the killing of himself.

2. Mr Moffatt received, and benefited from, tremendous support from his mother, stepfather and sister, all of whom had an excellent understanding of his kindness, his illness and his needs.

3. He remained psychotic during the entire period that he received treatment. Because he consistently believed that he was Jesus Christ, obtaining his compliance with a care plan which was about him being ill was always going to be unlikely. There is, quite obviously, a dissonance about accepting a care plan and clozapine when you believe you are Jesus Christ.

4. Mr Moffatt's mental state improved during the short period he was detained on a locked close supervision unit in Epsom (the Burnham Unit). This reflected consistent medication with clozapine, the fact that he was not taking cannabis and, linked to both these things, the fact that his treatment was not disrupted by periods of absence from hospital (which gave access to cannabis and no access to prescribed medication).

5. Financial constraints and the implementation of the mental health strategy compromised his treatment, insofar as they contributed to the lack of an intensive care facility at Parklands Hospital; his absconding; a lack of rehabilitation facilities for in-patients; and his placements in the community.

6. The lack of an intensive care unit at Parklands Hospital meant that staff had to resort to quite intrusive policies of continuous observation, as a way of managing his absences. For some people, particularly if it is for a long time, this is impossible to bear.

7. The lack of access to secure facilities required ward staff to look at what they could do within available resources. When treating someone with Mr Moffatt's needs, they might have no real option except to carry on trying to provide the treatment, and manage any risks, within the local acute in-patient unit.

8. The occupational and recreational facilities at Parklands Hospital were not adequate for those patients who required a long period of in-patient treatment there.

9. The philosophy of the substance abuse service, which was based on a motivation to give up illegal drugs, made it impossible for the service to help someone like Mr Moffatt, whose illness involved seeing the drug as bringing about an improvement in his mental state.

10. After such a tragedy, there is a natural tendency to judge the quality of the patient's care according to the outcome. On reflection, however, it is obvious that even the best available treatment of a devastating illness, such as cancer or schizophrenia, does not preclude a devastating outcome. The point is important because our belief is that, *given available resources*, the overall quality of Mr Moffatt's care and treatment was high. In reaching this finding, we have at all times tried to be independent, thorough and objective. We hope that the individuals personally affected by the tragedy will accept this, even if they do not accept the finding or everything in the report.

11. Mr Moffatt's mother highlighted for us a number of limitations in the care he received. For example, that he would have benefited from more support and supervision, more extensive occupational therapy, a clinical psychologist, cognitive behavioural therapy, continuing drug counselling, and secure supervised accommodation. However, these concerns and reservations were shared by professional staff. A comprehensive range of mental health services, meeting all needs, was not, and is not, available locally; nor, sadly, anywhere else in the country. Mr Moffatt did, however, receive the full range of services available locally, and a high standard of professional care. We cannot support the view that there was a general failure to treat him adequately and in fact, as a general statement, we feel the opposite.

12. Important information about the risk to others known to staff at the MACA hostel in Normandy Street was not shared with his consultant, or with the other professionals who assessed him for compulsory admission to hospital in January 1997. This placed them at unnecessary risk. It also undermined the assessments of risk performed by his consultant during his time at Parklands Hospital, and therefore the management of risks.

13. Apart from when Mr Moffatt was at the Burnham Unit, the risk that he would abscond was managed by placing him under observation. It was suggested to us that his absences were not treated with appropriate concern. This we cannot accept, bearing in mind the level of observation to which he was subject, his transfer to the Burnham Unit, and the public appeal following his last disappearance. Furthermore, given that he had not absconded since 25 July the previous year, and given the need to build some sort of therapeutic alliance with him, the decision to grant him 30 minutes ground leave on 19 February 1998 was justifiable.

14. Mr Moffatt made an excellent response to clozaril, and there were times when his psychotic symptoms receded, so that they had to be probed for. The dilemma was that he had not responded in the past to older anti-psychotics. The choice was between oral medication which, when taken, was effective and injections which were not, albeit that one knew he was receiving them. Furthermore, given the present law, once he was in the community and not on section, he could not be compelled to have injections. Given that they at best only moderately alleviated his symptoms, voluntary compliance would then be unlikely. Accordingly, the decision to prescribe clozaril was a considered one, made for good reasons, and cannot properly be criticised.

15. Mr Moffatt's very limited compliance with medication, and his use of cannabis to relieve his distress, meant that it was not feasible for him to live independently in the community. He needed a community facility which could provide intense support and supervision but such a facility was not available.

16. The morality and wisdom of placing people with severe mental illnesses in ex-council accommodation which is hard to let must be doubtful.

17. The staff then at MACA'S Normandy Street house did not take a robust approach to Mr Moffatt's medication, and they had a limited understanding of risk management. They did not inform the professionals who visited to detain Mr Moffatt under section 3 that he had been experiencing violent and sexual thoughts about his project worker, and that staff had found magazines in his room in which adverts for rifles were circled.

18. Following Mr Moffatt's arrest, the duty psychiatrist refused to attend the police station to examine him and provide any treatment he might require.

19. The health service professionals who cared for Mr Moffatt felt supported following Mr Harrison's tragic death, and supported in relation to our review.

ACTIONS

The following action has been, or is being, taken by local mental health services to address these matters:

1. Hampshire County Council's expenditure on mental health services has increased by 24% (£2.8 million) since 1997/98.

2. North and Mid Hampshire Health Authority have allocated the following additional funding to adult mental health services in the current financial year:

   - £500,000 for the development of low secure services, with a further £240,000 released from the closure of the Oaktree Clinic to support this;
   - £47,000 towards the continued development of medium secure services;
   - £500,000 (plus a £60,000 social services contribution) towards the initial development of assertive outreach.

3. The number of beds at Parklands Hospital available to north Hampshire adults was increased from 40 in December 1996 to 53 in April 1998. There is also access now to a supported living scheme for up to 7 people at any one time, which provides an alternative to hospital admission.

4. When a formal risk assessment indicates that an individual requires admission, a bed is always found.

5. The two wards at Parklands Hospital have been reorganised in order to provide more security. While Hawthorns II functions as an open ward, Hawthorns I now operates a locked door policy. In practice, all assessments are done on Hawthorns I, with patients moving to Hawthorns II when their clinical condition makes it appropriate.

6. Annual expenditure on out-of-area placements has increased from £200,000 in 1997 to a projected £800,000 in the current year.

7. The services plan to provide eight low secure places for north and mid Hampshire residents by April 2002. A team led by the North and Mid Hampshire Health Authority is in the process of finalising the details.

8. Ward team leaders have completed a 12-week leadership development programme.

9. Surrey Hampshire Borders NHS Trust and Hampshire County Council Social Services Department have developed a Rapid Assessment Service for people in crisis.

10. The Surrey Hampshire Borders NHS Trust has a policy in place designed to minimise the occurrence of unauthorised absences.

11. It is now trust policy that social services, the patient's GP, and neighbouring trusts are alerted when a patient is absent. The police attend the ward to complete a missing persons form with staff, and to talk with them about any risks. The general manager and the director must be informed after three days, or earlier if there are felt to be special risks. The director must then review the procedures that have been put into place, to see if there are any special risks and whether additional agencies need to be involved or informed.

12. Security arrangements at Parklands Hospital are to be periodically reviewed by an independent organisation approved by the local health authority.

13. It is now trust policy that non-care staff, including porters, are not to be involved in the management of aggressive behaviour.

14. Assessing and managing potential violence and levels of dangerousness posed by patients' behaviour is now subject to a formal risk assessment procedure introduced in April 2001.

15. A competency framework introduced for health and social services qualified staff requires them to demonstrate that they are competent to carry out this formal risk assessment procedure by April 2002.

16. Notes of admissions and treatment outside the Surrey Hampshire Borders NHS Trust are routinely obtained as part of the formal risk assessment procedure.

17. Each patient has one current record, which is held by the team that is currently providing care and treatment for the patient.

18. In-patient summaries are completed at every ward round. To ensure that all teams have up-to-date information about patients, these are routinely copied to the Community Mental Health Team and the Rapid Assessment Service as well as to the current file.

19. All correspondence about the patient is kept in the current file.

20. As part of a review taking place in July 2001, clinical audit of the quality of assessments on acute wards will include a focus on: the use of information from family members, in order to verify that they have been seen; the range of issues considered within the assessment process; the nexus between the treatment being provided and the needs which were identified; and the way in which risks have been identified and managed.

21. Since June 2001, all patients receive a therapy assessment on admission, and the Parklands Hospital therapy team has been increased from two to seven full-time posts.

22. ASWs conducting Mental Health Act assessments, and trust staff, now rely on the rectification provisions in section 15 of the 1983 Act in any case where a date is incorrectly entered on a medical recommendation.

23. The third edition of Hampshire County Council's Mental Health Practice Handbook, published in April 2001, includes guidance on the role of trainees. They must not undertake Mental Health Act assessment work unless accompanied by an experienced ASW. The experienced ASW must be present, actively oversee the assessment process, and sign the statutory documents.

24. The handbook also requires that the ASW informs the patient, the nearest relative, the doctors, and the CPA care co-ordinator (if applicable) of any delayed admission, together with the reasons. The ASW must consider the impact of the delay on anyone whose welfare may be affected by it, and ensure that alternative care planning arrangements are made where necessary.

25. It is now local trust policy that if a doctor who provides a recommendation has to leave the scene before the application procedures have been completed, s/he must remain available for consultation until those procedures have been concluded.

26. Duty psychiatrists may not refuse to attend police stations when a psychiatric assessment is required.

27. On admission, all patients are assessed using the formal risk assessment procedure. This includes assessing each patient in terms of the immediate and potential risks of going missing, suicide, self harm, harm to others and self neglect, taking into account their social and clinical history. An individual care plan is then devised, which includes the measures required to manage those risks appropriately.

28. The formal risk assessment procedure includes an assessment of the risk of dangerousness, and this is included in the discharge summary.

29. Signs and symptoms that may indicate that the patient is likely to relapse are included in the newly revised care plan for people on enhanced CPA.

30. Before discharging or granting leave of absence to a patient who is liable to be detained, the responsible medical officer is now formally responsible for ensuring both that a proper assessment is made of the risks to the patient or others, and that the individual's care programme sets out the measures required to manage risks safely.

31. All service level agreements with voluntary sector providers require that training in the assessment and management of risk is provided to staff.

32. All social care providers have received written instructions from Hampshire County Council Social Services Department stating that no referral should be accepted without adequate risk assessment.

33. ASWs leave an outline report at the hospital when a patient is admitted, and this requirement is reiterated in the Mental Health Practice Handbook. Outline reports include the reasons for the admission and information concerning risk.

34. Guidelines between Accident and Emergency and Mental Health services for the referral and assessment of people who attempt self-harm are in place.

35. As required in the NHS Plan, a shared protocol to support the sharing of information is being agreed and will be in place by April 2002. This will ensure that CMHTs and in-patient facilities have access to information about in-patients held by GPs.

36. MACA now has effective systems and policies in place which promote and guide good practice in communications and risk management. These emphasise the need for collaborative work with local mental health teams and for a rigorous approach to:

- ❖ risk assessment and management;
- ❖ sharing and communicating information;
- ❖ recording information, when and with whom shared (a basic practice which was not adequately followed in this case).

37. A revised care programme approach (CPA) has been implemented (in April 2001). For people on enhanced CPA, the revised care plan now includes identified needs and risks in relation to medical, social, employment, occupation, housing, finance and welfare benefits, family issues, forensic matters, substance misuse, treatment provided and crisis prevention.

38. A board level trust manager, the Director of Mental Health, has overall responsibility for ensuring that Health Service Guidelines concerning the care programme approach are adhered to, and adherence is routinely monitored.

39. The trust also has a care programme approach development manager, whose sole task it is to ensure the effective implementation and delivery of the CPA across the trust, in keeping with NSF standards.

40. Monitoring is carried out through audit, user involvement and quarterly data collection.

41. North and Mid Hampshire Health Authority is enhancing its monitoring of the trust's compliance with Health Service Guidelines, by way of regular random audits, in particular of compliance with the CPA and discharge planning.

42. The Social Services Department introduced a new procedure in November 1999, to ensure that it meets its responsibilities under section 117.

43. Care management and the care programme approach is now an integrated process.

44. A protocol for the transfer of care from secondary to primary services is being developed with PCTs and a clear policy, which is workable and realistic, will be drawn up. This will ensure periodic review by the mental health service of patients with a severe mental illness who are being cared for by primary services. Decisions to transfer care will be multi-disciplinary and discussed in advance with the GP.

45. Two assertive outreach workers have been appointed for north Hampshire, and funding and proposals have been agreed to extend this service across North and Mid Hampshire during the current year.

46. Assertive outreach training will be available to staff across north and mid Hampshire from September 2001. The training emphasises, and will continue to emphasise, that teams must have a clear strategy for following-up partially treated, non-compliant, out-patients, which does not involve waiting for the patient to re-present.

47. The system of clinical supervision now in place seeks to promote a culture of active engagement, and provide the skills necessary to achieve this.

48. 3 Vyne Road's business plan no longer refers to 'upholding the [client's] right to self determination and choice', nor does it state that 'the individual is the expert' (although social services emphasise that self-determination and choice continue to be important values in mental health care).

49. The Vyne Road service is delivered in accordance with the departmental risk assessment and management policy agreed by Hampshire County Council's Social Services Committee in January 2000.

50. MACA's procedures involve two staff administering medication wherever possible, one always being a senior worker; and it is fully committed to supporting patients' care and treatment plans.

51. The philosophy of the substance misuse services has changed. Risk assessments are carried out on all users of substance misuse services, and assertive outreach is conducted with users who are deemed to be at risk and are difficult to engage. There are much closer working relationships between the adult mental health and substance misuse services, and both services now

use a common Patient Information System. Therefore, any member of the adult mental health service will be aware that a patient is also accessing the Drugs/Alcohol Service.

52. Personality disorder will not be used as a criterion for acceptance or rejection from CMHT services. Other indicators of severity and disability associated with mental health problems will be applied, including psychiatric history.

53. It is trust policy that a multi-disciplinary review should be conducted before any patient is excluded from a service. In all cases a strategy will be agreed for the patient's future care.

54. A clear model of caring for mentally disordered offenders in the community will be agreed locally, by June 2002, so that there is a common understanding of who is responsible for providing care to them.

55. It is trust policy that the views of the immediate family must be sought and considered as part of the CPA assessment, when taking the history or assessing a patient's current condition, especially if the patient is being cared for outside hospital and is not attending out-patient appointments or taking medication.

56. A training programme is in place to ensure that care co-ordinators are competent to assess carers' needs.

57. Local organisations are working to meet the target set in the NHS Plan to ensure that all regular carers of people on enhanced CPA have a written care plan by March 2002.

58. A procedure for handling serious incidents has been developed by the trust and the Social Services Department. When a person commits a homicide, the needs of the immediate family of both the deceased and the patient must be ascertained, and they must be offered appropriate professional support.

59. Services for users provided by Vyne Road are now only ended following explicit agreement in the formal CPA process.

60. Assessments of housing need are an integral part of the revised care programme approach.

61. The trust now manages two community-based 'hospital-hostels' in Basingstoke and Farnborough. This enables patients to be placed in settings outside the main hospital which are staffed by skilled and experienced practitioners and within which medication can be given without consent.

62. The Social Services Department employs its own housing support officer, who assists mental health staff and service users with applications for priority housing, and can advocate for them at resource panel hearings.

63. Health and social services are undertaking a review of 24-hour staffed accommodation, which will report in October 2001.

64. A clinical supervision training programme is in place. Attendance at, and the frequency of, this training is monitored through the trust's Clinical Governance Forum.

65. Surrey Hampshire Borders Trust agreed a revised serious untoward incident policy in February 2001 that complies with new NHS Regional Guidance. This procedure makes some provision for external investigation.

66. Hampshire Social Services introduced a more rigorous internal inquiry procedure in October 1998. This procedure introduced improved quality checks and independent expert investigation in the inquiry process; incorporated requirements for joint working with Health Authorities and trusts to comply with national guidance regarding inquiries; and introduced additional reporting requirements to the Social Services Committee.

CONCLUSION

The resources made available to mental health services in Hampshire did not permit the mental health strategy of 1993 to be implemented, and the range of community resources was scaled down. There was little additional investment in mental health services in north Hampshire until about four years ago.

The modernisation of mental health services in north and mid Hampshire has been, and continues to be, circumscribed by resources. The action which has been taken therefore represents part of an ongoing process of improving the range of services.

Given resources, the way in which the North & Mid Hampshire Health Authority, the Loddon Community NHS Trust and the Surrey Hampshire Borders NHS Trust have sought to develop services deserves support. Their staff are committed to providing the best possible service, and they have throughout this difficult process been open and professional with us.

Although it is common to select professionals for criticism following such tragedies, there is only so much that individuals can achieve within any given level of resources. Further significant improvements, and in particular more developed and localised secure intensive care facilities, will require additional investment from the NHS Executive South East Regional Office.

Since the resources available to it, and to social services, are determined by decisions made at national and local government level, any remaining concerns about the range of services available to patients, families and professionals, as opposed to their management, can only be dealt with at this level.

In a democracy, decisions made at this level are, of course, determined by the decisions of local and national electors about levels of taxation and spending on public services, so that the quality of mental health services, and the deaths of Mr Longman, Mrs Huntingford and Mr Harrison, must be seen as a national responsibility.

Accordingly, it would be unjust to select for criticism those who have committed their lives to supporting individuals with serious mental health problems, and we hope that others will likewise refrain from doing so.

11 ENDNOTES

[1] Sainsbury Centre for Mental Health 1999, *A Workbook for Primary Care Groups:* OPCS Surveys of Psychiatric Morbidity in Great Britain.

[2] H Meltzer, B Gill, M Petticrew, K Hinds, OPCS *surveys of Psychiatric Morbidity in Great Britain: Report 1: The Prevalence of Psychiatric Morbidity among Adults Living in Private Households,* 1995.

[3] OPCS Survey of Psychiatric Morbidity (1995). Note: Prevalence figures are based on national average rates. Actual prevalence could be lower than the above figures.

[4] The Sainsbury Centre for Mental Health 1999, A *Workbook for Primary Care Groups: OPCS* Surveys of Psychiatric Morbidity in Great Britain

[5] Prevalence data: Rutter 1994; Goodman & Scott 1997; Wallace et al. 1995; Goodman 1998. Attendance: estimated from literature, expert opinion at the institute of Psychiatry, and local clinicians. *ADHD = Attention deficit hyperactivity disorder.

[6] Mental health activity for occupied bed-days (OBDs) by diagnosis groupings for the period April 1998 March 1999. Source: CDS inpatients received though Clearnet. Total number of occupied bed days and finished consultant episodes for mental illness by diagnosis. Right-side table: Mental health activity for finished consultant episodes (FCEs) by diagnosis groupings for the period April 1998 March 1999. Source: CDS inpatients received through Clearnet.

[7] CDS Inpatients. Notes: Age on admission 15-74. North & mid Hampshire residents only (QD1). Schizophrenia = Primary diagnosis codes of F20, F21, F23.2, F25. See the original publication for information about confidence intervals.

[8] CDS Activity, Community Mental Health Teams.

[9] PJ Vaughan, M Kelly & N Pullen, *Wessex Consortium Forensic Project Team Prison Survey,* 1998.