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TRANSCRIPT OF "FILE ON 4" – "COMMUNITY MENTAL HEALTH CARE"

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O'REILLY: At Manchester Crown Court last week a paranoid schizophrenic was jailed for the manslaughter of a grandfather after hearing voices telling him to kill. It's one of a rising number of homicides by the mentally ill.

CHRISTINE: He turned up twice for his medication and he never got it, and then he asked them to come out on the Monday and they never came. And you don't leave people eight days without medication, you don't not give them assessments.

COLETTE: Their lack of care and treatment is to blame for my parents' death.

O'REILLY: Ten years after the Government laid out an ambitious framework for care in the community, File on 4 has found evidence of serious shortages in the front line staff delivering mental health treatment - increasing risk to both patients and the public.

BAMRAH: There are gaps within the teams, there aren't enough staff members, enough skills, recruitment has been a big problem. There just aren't enough staff to do the sort of work that is required for the level of illness there is in the community.

O'REILLY: And we can reveal doctors are bending the law rather than leave seriously mentally ill people in the community without medication. File on 4 has learned the unexpectedly high number of patients released from hospital under new Government legislation means a legal requirement to get a second opinion on their care is being disregarded.

ZIGMOND: These safeguards were put in place to ensure that patients weren't treated inappropriately and if the safeguard is deemed not to be necessary, then one is keeping the powers without the safeguards. Quite a number of us have been very concerned at that.

SIGNATURE TUNE

BARRETT: I've just brought some yellow roses to put down today on the grave.

O'REILLY: Where is his grave?

BARRETT: It's just over there at the back …

O'REILLY: Just there, oh I can see it - Sid Waller, yes.
What goes through your mind when you are walking down here?

BARRETT: I shouldn't have to be here really, should I? It's not a situation anybody wants to be in. I'm quite angry really that we are in this situation that we are in, but obviously pleased that we have got somewhere to come and see him and be close to him.

O'REILLY: At Sale Cemetery near Manchester, Gill Barrett is bringing flowers for her father. Gill and her family's loss was sudden. Her dad, Sid Waller, was killed by Paul Cusack, a mental health patient suffering from schizophrenia, who was being treated in the community. Cusack had had inadequate support and care from the team who were supposed to be treating him.
Why did you decide to have 'died tragically' on his stone?

BARRETT: For us I think it's important not to hide from the fact of how he died really and just sort of gloss over it. We don't want to shy away from that, you know. He went off to work one morning, we never saw him again, he never came back, that was it. Even now it doesn't seem quite real, certainly to myself. It could be like I'm talking about someone else sometimes, it doesn't always seem to sink in.

O'REILLY: Sid Waller had been a joiner all of his life. Although he was semi-retired, he enjoyed his job and didn't want to give it up entirely.

BARRETT: Well, he was actually working in an old Victorian house that was converted and so it had several flats inside it. He was working in one flat finishing off fitting a kitchen and Paul Cusack was in the flat above. He heard my Dad downstairs, obviously he was drilling and he was sawing and he was hammering, whatever he was doing to fit this kitchen. And Paul Cusack came down and confronted my Dad, had voices in his head telling him to attack my Dad and then attacked him with a knife in quite a frenzied attack. And my Dad would never have stood a chance. After he had actually killed my father he then went for his mobile phone and actually dialled 999. The police went round to the flat and they found him stood there with the knife in his hand and obviously my Dad was in the doorway of the flat.

O'REILLY: In the aftermath of the killing, a confidential report highlighted the mistakes made by carers, leading to Mr Waller's death. Although Paul Cusack was the responsibility of Manchester's Assertive Outreach - one of the community mental health care teams, set up under Government reforms of mental health services - he hadn't been referred to a psychiatrist. No action was taken when he told care workers he had a knife, or when he missed eighteen appointments with them.

BARRETT: Something like that, such a number of missed appointments surely is a concern, and the psychiatrist you would think would be the person that would be able to talk to him about his behaviour, why he's missing appointment. That would maybe have brought to light a change to his medication and then we might never be in this position today.

O'REILLY: His care worker was a member of an assertive outreach team.

BARRETT: Yes, that's quite interesting, assertive outreach team. It seems that they weren't very proactive in dealing with him and in my mind it was quite a laid back approach, so it does seem a contradiction in terms.

O'REILLY: Findings from the Manchester Mental Health and Social Care Trust 'Serious Untoward Incident Review' following Mr Waller's murder concluded that there was no 'evidence of a full and formal assessment of need' being carried out. Cusack was 'never raised as a concern with the consultant psychiatrist'. The last complete safety assessment on him was dated January 2008, so his condition went unassessed for five months. There was nothing in writing to show that there had been clinical discussions about him. Before the killing, Cusack told care workers he had a knife, but no emergency action was taken that day. He was left to return home and had no further contact until the killing. Sid's daughter Gill has no doubt where the fault for her father's death lies.

BARRETT: I think ultimately Paul Cusack was responsible for what happened, however it does appear he was crying out for help on several occasions over a period of time, so I also would say that those people who were giving him his care in the community would also have a responsibility, and they have failed Paul Cusack just as much as they have failed us and my Dad and lots of other victims and other people out there. They are responsible in some way.

O'REILLY: Could your Dad's death have been prevented?

BARRETT: Had the person that killed him, the care of that person been different, had certain things been acted upon, then I think yes, it certainly could have been avoided.

O'REILLY: Mark Spurrell is a psychiatrist and Clinical Director for the Manchester Mental Health and Social Care Trust, which was responsible for the care of Paul Cusack

O'REILLY cont: Explain how it could be that a patient with a serious mental illness, who admitted he was carrying knives, so on the face of it he would seem a danger, and yet he was allowed to return home without being seen.

SPURRELL: This is a man who had been troubled with mental health problems for a long time. He had moved in and out of services, so there were times when he was well, there were times when he was less well. Nevertheless we recognised that he was a very vulnerable, fragile man and we specifically assigned him to the assertive outreach team. This team has a lot of extra staff, a lot of concentration of resource to robustly follow up and try and engage with people.

O'REILLY: But of course they didn't do that in this case, did they? He never saw a psychiatrist in the months he was under their care.

SPURRELL: Let me say again, it's clear from looking into this incident that mistakes were made. Don't forget that mental health problems affect a large proportion of the population to some extent or the other, and the vast majority of people have good outcomes with the kind of services that we offer.

O'REILLY: But the death of Sid Waller was the latest in a long line of failings in Manchester. Just weeks before the killing, a review into the city's mental health care, chaired by John Boyington, Director of Mental Health for the NHS in the North West of England, highlighted extensive shortcomings. He said new services appeared to be bolted on to existing services without any evaluation of how they would work together, and staff were not aware of the existence of other teams in other parts of the system. Lack of communication between teams is one of the concerns of Terry, who works in mental health care in Manchester. Terry isn't his real name and we've disguised his voice to protect his identity, because he feared he could lose his job for speaking out.

TERRY: I'm what's called a care coordinator on a Community Mental Health Team, and the job of a care coordinator is to assess any risks that might be apparent with the person, to monitor their mental health and look towards recovery.

O'REILLY: Do you have enough people to help you do that work?

TERRY: No, I don't think we do have enough people. It's quite difficult to assess levels of contact and what you should be doing, but we are always under pressure.

O'REILLY: How under pressure?

TERRY: Under pressure enough to feel that pressure as a worker, to feel stressed and anxious yourself, to feel worried that perhaps we're not seeing somebody as often as we should, that it's very difficult to fit in all the different things that you feel should be being done at any one time for that person. There's still temporary staff, seconded staff, agency staff, so we don't know whether there's been an agreement to permanently staff the teams.

O'REILLY: What about communication between all these people? Does information get passed along?

TERRY: At the moment there isn't much communication at all. I think there is communication on managerial levels. Certainly on my level there isn't any communication at all.

O'REILLY: But Dr Mark Spurrell of Manchester Mental Health and Social Care Trust, denies there is a lack of communication between teams in the city. Workers have told us that teams don't talk to each other, they don't know who each other are. These are the folk who are responsible for coordinating care.

SPURRELL: We have recognised the need to refresh our organisation, to look at how we communicate more effectively. We are looking at restructuring in order to make it much more clear, much more accessible for staff to communicate. And on the strength of that initiative we are already seeing huge recognition and improvement in staff appreciation and we are very pleased at the way staff engagement is going.

O'REILLY: Workers have told us something completely different. Do you accept that you're underachieving in this area?

SPURRELL: I'd like to see where the information is from, because that's at odds with, you know, how I see things.

O'REILLY: Front line workers we've spoken to. You don't accept that you're underachieving in this area?

SPURRELL: What I would like to do is to see the information specifically that you're referring to and prepare, you know, a more considered response. I don't want to dismiss anything that anybody says, you know, out of hand, because this is not an area that I take lightly. But equally I'd like to do it justice.

O'REILLY: The Government spent over £1.2 billion on adult community mental health services in 2008/9. It's adamant there are sufficient teams in place to manage outpatient care. But Dr J S Bamrah, Chair of the British Medical Association's Psychiatric Sub-Committee, has surveyed his members to find out their experience. He says, while we may have the required number of teams, that doesn't mean they are adequately staffed.

BAMRAH: We're ostensibly in a good position, because obviously over the last ten years there has been a gradual increase in spend. And obviously on the outside it looks extremely good. The Government have set up crisis resolution and home treatment teams, which are wonderful really, they work extremely hard, but they can't actually plug the gap of the increase of workload in the community. The level of risk is more than many teams can bear. Also, there are gaps within the teams, there aren't enough staff members, enough skills. Recruitment has been a big problem in psychiatry for doctors, nurses and other professions too. There just aren't enough staff to do the sort of work that is required for the level of illness there is in the community.

O'REILLY: Two years ago, the Sainsbury Centre for Mental Health published a report which examined the progress of the Government's National Service Framework. This was the flagship strategy brought in ten years ago and aimed at raising the standard of community mental healthcare services, using newly modelled Early Intervention, Community Care, Crisis Resolution and Assertive Outreach teams to be the cornerstones of support. Using Government figures as a baseline, the Sainsbury Centre's

O'REILLY cont: long term analysis concluded that if the standards set out in the mental health framework were to be implemented successfully, an additional 18,000 community team care staff would be needed by 2010/11 - an increase of 50%. We asked the Care Services Minister, Phil Hope, whether these staff had been appointed.

HOPE: We've increased funding for mental health services by 50 – five zero – per cent. Some extra £2 billion over the lifetime of the National Service Framework. There are more staff providing better services to people in the community to help those patients who experience mental health problems.

O'REILLY: Have you taken those people on in the last two years?

HOPE: There has been a significant increase in the last few years, but this is over a period of time. The last eight years has been where the investment has increased by 50%.

O'REILLY: To deliver the policies that you wanted to deliver, the National Service Framework, then you would need 18,000 extra staff. That was in 2007. Have you taken on 18,000 extra staff in the last two years?

HOPE: Well, we have massively expanded mental health services. We are rolling out the investment in, for example, psychological therapists so that people can, we can improve people's access to it, and that figure will be climbing to, by 2010/11 an extra £173 million.

O'REILLY: After we'd spoken to the Minister, the Department of Health sent us additional information about staff figures. Initially they told us there were now a total of 26,316 staff employed in community care. When we studied the Sainsbury Centre figures, this appeared to be an increase of just 2.5%. The Department of Health then sent us additional clarification, with different figures this time, stating that 9% more staff had in fact been taken on. But this still represents an increase of just 4% on what the Sainsbury Centre said was required. Staff shortages were directly responsible for another killing by a schizophrenic patient in Liverpool

ACTUALITY WITH CHRISTINE AND COLETTE

O'REILLY: Colette McCormack and her sister Christine Walker are examining a series of incident reports following the death of their parents last year.

WALKER: We were very close. My mum and dad were just like lovely lovely people. They had loads of loyal friends, just dead down to earth, easygoing, just lovely.

O'REILLY: Alan and Stella Scott were stabbed to death by their son, a paranoid schizophrenic, also called Alan. With treatment, he had been able to live an independent life in his own flat and had established a good relationship with his carers, friends and family.
When Alan was taking his medication what was he like?

MCCORMACK: He was funny, he had a great sense of humour. Everyone had a lot of time for Alan. The support workers he had had in the past took Alan under his wings, and you know, they'd gave him plates for his flat or take him running round the park. One of the support workers, she used to take him out with her boyfriend and her friends. And so he was a very sociable person and he was a likeable person. He came to Mum and Dad's every Sunday, we all met up in my Mum and Dad's house and had a big Sunday roast dinner and talked about what we had done all week. So we were a really close family.

O'REILLY: Alan had been a drug user in his teens. Unknown to his family, he was taking cannabis and cocaine. Gradually his behaviour became strange and erratic, leading to him being diagnosed with schizophrenia when he was 21.

WALKER: He had this book which he had got off the internet delivered, and he just thought that it was like a cult, he thought he was a Russian soldier and that my Mum and Dad weren't his parents basically, so he used to march everywhere and he carried this book around with him everywhere. He had to cook his food as well because he said that, you know, they were poisoning him, stuff like that.

O'REILLY: At the beginning Alan wouldn't accept he was ill. He was living at home with his parents and had become very difficult to manage. They did everything they could to stop him taking illegal drugs, but in the end they were forced to have him sectioned to a secure hospital.

WALKER: What they had to do was they had to bring someone from Broadgreen hospital to come and see him, which was a doctor, and then they done an assessment and they were taking Alan in, but Alan realised what they were doing, jumped out my Mum's window, the back window and run off, so then they had to bring the police and take him in because he didn't want to go in himself, which, that was terrible. And then he was in Broadgreen then for quite some time.

O'REILLY: During the decade which followed, Alan was treated as an outpatient. He had monthly injections of the drug Depixol at the Moss Clinic in Liverpool. For most of this time he managed well, and never showed any signs of violence. Then on 24th March last year he missed an appointment, but later went to the clinic hoping to still get his injection.

MCCORMACK: He turned up, staff were in a meeting, told him to come back the next day. He came back the next day, he was too early and there was no qualified member of staff to give him his needle. And then he left a message for his care coordinator to come to his house on the Monday, which was the 31st, which was eight days late now without medication. And his care coordinator didn't turn up that day. On the 31st March in the evening time, at half eight, he was talking to spirits, and they told him to go round to my Mum and Dad's house, and he killed my Mum and Dad. And the care coordinator came round on the Tuesday afternoon, on the ninth day and Alan had been arrested that morning.

O'REILLY: Christine and Collette have seen a confidential report into their parents' death which shows what went wrong in their brother's care. They say it clearly identifies a shortage of skilled staff as one of the factors which led to Alan's mental deterioration in the crucial days before he killed his parents. Of most significance was the fact that for a long period before that Alan had been allowed to lower his medication without his family knowing and without a vital assessment of his condition first.

O'REILLY cont: Having looked at the report leading up to your brother killing your parents, where do you think the key failings were?

WALKER: Well, him not having a psychiatric assessment for over three years, you know, with three and a half years him being allowed to lower his own medication as well and nothing being noted on any systems as to why he was allowed to lower his medication. And obviously that medication just wasn't enough for him, so you know, he's done what he's done.

MCCORMACK: The care programme approach wasn't followed in regards to Alan's care and treatment. Working practices of community mental health team, care coordination.

O'REILLY: But that sounds like everything to do with his care?

MCCORMACK: Yes yes, he was let down in many areas.

WALKER: Because his care coordinator had a lot of sickness leave, Alan really should have been passed on to another team, which he never was.

O'REILLY: Was Alan assessed at all, was he risk assessed?

MCCORMACK: No, when he got his medication lowered, he wasn't assessed, and he hadn't been seen by a psychiatrist for three and a half years.

O'REILLY: Alan Scott pleaded guilty to the manslaughter of his parents and was sentenced to be detained indefinitely under the Mental Health Act. He is now in the top security Ashworth Hospital. His medication has been increased, and he's responding well. Collette and Christine can't say whether they will want to see their brother again. The body responsible for supporting Alan in the community, Mersey Care NHS Trust, refused to give us a breakdown of current staffing levels, saying it was confidential, but in a statement they said:

READER IN STUDIO: Alan Scott was a long term patients of the Trust's community service and had received ongoing care and treatment over many years. Issues governing patient confidentiality make it difficult for us to go into the exact details of his condition or treatment.

O'REILLY: Alan Scott is just one of a growing number of mentally ill patients who go on to kill at the rate of over one a week. Research published by Manchester University in the summer shows a rise in the number of homicides committed by people with mental illness. It went up from 54 in 1997 to over 70 in 2004/5. Professor Louis Appleby, National Director of Mental Health In England, compiled the figures.

APPLEBY: The rise is particularly in people who are subsequently found to be mentally ill at the time of the homicide. It's a rise of about twenty to thirty cases a year between 1997, when we started collecting data, and 2005, which is the most recent year.

O'REILLY: Does that rise concern you?

APPLEBY: Well, it does concern us because at the moment it is unexplained. It's a rise which appears to be particularly in people who are not under mental health care. I think there are several possible explanations. One of them is that mental health services could do more than traditionally they have done to make themselves available at an early point in a person's illness.

O'REILLY: So that is a factor, an important factor in this trend?

APPLEBY: No, no I am not saying that, we don't know what the cause is for the trend. What I'm saying is that that's a possible part of the picture and therefore that's one area where safety could potentially be improved.

O'REILLY: Are you saying then that there is nothing that people like yourself could have done about it?

APPLEBY: It is possible, of course, that they declared their illness in some way to other people and for whatever reason it either wasn't picked up or the seriousness wasn't recognised or they didn't feel it was necessary to involve specialist mental health care. The rise that we are talking about is up to 2005. Since 2005, community care services have greatly changed. We have assertive outreach teams now, we have early intervention services which came in in the later part of this decade, and we have new mental health law which allows people to be treated in the community, and at times required to take their treatment, so three very important changes to the way services operate.

O'REILLY: The new mental health law for community treatment mentioned by Professor Appleby is perhaps the most controversial piece of mental health legislation in recent years. Community Treatment Orders were introduced just ten months ago as a way of easing public fears after a series of high profile murders by schizophrenics. CTOs are a part of a package of reforms which have revolutionised care in the community for the seriously mentally ill. But already they too are being hit by shortages in key staff.

ACTUALITY AT CLINIC

KUMAR: This is Tamworth Road reception.

O'REILLY: Your clinic?

KUMAR: Yes, I have to be there every fortnight for my injection, every Friday at two o' clock. I don't want to be in hospital.

RECEPTIONIST: Can I help you?

KUMAR: Yes, I've come for my injection.

O'REILLY: On a sunny autumn afternoon in Croydon, South London, Kumar is attending his local outpatients' clinic for an injection which controls his symptoms.

KUMAR: I've been diagnosed with paranoid schizophrenia.

O'REILLY: When were you diagnosed?

KUMAR: I was diagnosed when I was eighteen, which is going back years now. And I actually was hearing voices from a godly being, you know, I felt at the time, which is pretty much unrealistic, but, you know, it was probably my own mind imagining too much and I was working really hard, you know. In a way it is quite positive, and sometimes I was quite enjoying the voices because I didn't feel lonely, you know, when I'm alone, and it was pretty much good, good company. Because I was diagnosed with this disability I was medicated and taken to a mental hospital several times.

O'REILLY: Kumar has been on a Community Treatment Order for five months now. These orders are aimed at so-called revolving door patients who have a history of not taking their medication. CTOs give psychiatrists the power to require patients to take their drugs. If they refuse they can be taken straight back into hospital. Kumar feels his CTO is too restrictive.

KUMAR: The Community Treatment Order, I really hate it, to be honest, I don't feel comfortable having a treatment order where I am controlled in the community, and I have been told that I will be taken back to hospital if I don't attend the appointments with the doctor or don't take the injection.

O'REILLY: But surely that's for your own good?

KUMAR: I understand that taking regular medication is good for my health and I do understand the consequences of me not taking the medication, but I also feel that as an adult they should have less control over patients, you know, they should be allowing the clients to just get on with their lives. They come to see me every two weeks anyway so I don't see a reason why they should actually put me on a Community Treatment Order.

O'REILLY: Although Kumar is complying with the terms of his CTO, he's appealing to a tribunal to have it revoked on the grounds that his medication causes debilitating physical side effects, including incontinence and nausea which, he says, is preventing him from getting a job. On the other hand, Kumar is now able to live independently in the community rather than in hospital.

ACTUALITY ON PSYCHIATRIC WARD

ZIGMOND: This is my ward, it's the psychiatric intensive care unit.

O'REILLY: And this is a locked ward?

ZIGMOND: It is a locked ward, it's a twelve-bedded ward. We take patients mainly from Leeds, but we will take them from all over Yorkshire. You need to have a second door opened before you can go on the ward.

O'REILLY: Dr Tony Zigmond is a Consultant Psychiatrist at the Newsam Centre at Seacroft Hospital in Leeds.

ZIGMOND: We will take anybody that can't be managed safely on an open ward - that's the main criteria, usually due to the degree of aggression, sometimes that they just keep running away, sometimes because of self harming.

O'REILLY: Can the patients here mix with each other?

ZIGMOND: They do, as you can see, they are all walking around.

O'REILLY: Hello.

PATIENT: Hello, my name's Anjam, nice to meet you. Best doctor in the world, Dr Zigmond is.

ZIGMOND: You'd better keep that in! [Laughter]

O'REILLY: How long have you been in the hospital?

PATIENT: About four weeks, five weeks now, but I'll be going home soon if Dr Zigmond lets me go.

O'REILLY: You're on the mend?

PATIENT: I'm on the mend, yeah, yeah.

O'REILLY: Community Treatment Orders enable patients like these to recover at home instead of hospital. Once released, they won't get the intensive monitoring they receive as an in-patient, so an amendment to the Mental Health Act in 2007 required that psychiatrists overseeing the orders have to get a second opinion doctor to sign off the treatment.

ZIGMOND: One of the safeguards that Parliament built into the Act was that an opinion from another psychiatrist, completely independent of the hospital and not chosen by the hospital, would confirm whether or not the medication could and should be given to the patient. There have been some difficulties with the second opinion service. There have been a lot of delays. This is partly because of the very large number of CTOs that have been put in place, far greater than the Government predicted.

O'REILLY: When the Government introduced CTOs, it estimated that about three hundred patients would be placed on them in the first year, but after only ten months File on 4 has discovered the actual number of orders so far is ten times that estimate - close to four thousand - and steadily rising. This miscalculation is putting enormous pressure on the system.

ZIGMOND: It's proven very difficult to see the patient. Patients who are in the community don't want to keep coming back to hospital. But one of the problems has been the recruitment of second opinion doctors, there just aren't enough of them. Quite a number of us have been very concerned at that. These safeguards were put in place to ensure that patients weren't treated inappropriately, and if the safeguard is deemed not to be necessary, then one is keeping the powers without the safeguards, which is an

ZIGMOND cont: imbalance. The purpose of the Mental Health Act was to have a balance between powers and safeguards, and this changes that.

O'REILLY: File on 4 has discovered the sheer number of patients being released on CTOs is forcing psychiatrists to bend or even break the law to make them work. The key requirement of the CTO procedure is that the second opinion doctor has to be brought in on the 28th day, but we've found many doctors are having to by-pass that vital element of the new law. A way round this shortage has been suggested by the Care Quality Commission, the independent regulator of health and social care in Britain. They're advising doctors to invoke a clause of the Mental Health Act which allows them to continue medicating without a second opinion. The legislation states that this get-out clause should only apply if it's an emergency and treatment is 'immediately necessary'. It goes on to define that as being:

READER IN STUDIO: necessary to save the patient's life, prevent serious deterioration of their condition, alleviate serious suffering, or to prevent the patient from behaving violently towards themselves or others.

O'REILLY: According to Dr. Zigmond, these circumstances simply don't apply to the day to day administration of treatment under a CTO. As a result it's putting psychiatrists in an impossible position.

ZIGMOND: The Mental Health Act code of practice which we are obliged to follow says that these tests for emergency treatment, let me quote, it says, 'These are strict tests. It is not enough for there to be an urgent need for treatment or for the clinicians involved to believe the treatment is necessary or beneficial.' I'm not a lawyer and whether the guidance is lawful I can't say. It would seem to me to be stretching the position. But what's the alternative? The alternative is that patients go untreated.

O'REILLY: If the patients go untreated though, they may not just personally suffer as a result of that, but if there are patients who have had a history of violence, then surely they could put the community at risk if they are not medicated?

ZIGMOND: That's very rare, but it certainly happens, and some of the patients on CTOs will need them for that very reason, for the protection of other people. That's why it's such an unsatisfactory position, that either one puts the patient and perhaps others at risk by not giving treatment, or one gives treatment and is perhaps breaking the law.

O'REILLY: But many would argue that it's better to have patients medicated, even if it is, as you say, stretching the law a bit, than leaving them without medication and them posing a danger to people walking the streets.

ZIGMOND: The majority of clinicians agree with you.

O'REILLY: So they are continuing to medicate?

ZIGMOND: The vast majority are continuing to medicate, even if that is bending or breaking the law.

O'REILLY: Dr Zigmond has never been in the situation where he has had to bend or break the law, but we've heard concerns about the impact of this new policy on an already over-burdened service from numerous psychiatrists. One who didn't want to be identified said:

PSYCHIATRIST: The sheer number of Community Treatment Orders in place have overwhelmed the service. The Department of Health made a serious miscalculation. Some of my patients have not been seen by a second opinion doctor, even after three months of being on a CTO.

O'REILLY: So how did the Government make such a big miscalculation? Tom Burns is a consultant psychiatrist and Professor of Social Psychiatry at Oxford University.

BURNS: People are always pointing out that psychiatrists get it wrong. Well plenty of politicians and lawyers get it wrong. They didn't listen enough, in my opinion, and they were too ambitious and over technical.

O'REILLY: Should the Government not have had a pilot?

BURNS: That's exactly what they should have done. It's difficult to do, because it's legislation, and legislation is national, but having said that, this is a perfect example where some preliminary legislation might have made it possible to introduce in one part of the country a pilot to run for three or four years which would have got rid of some of these complications, so that when the final legislation was introduced we would have been able to tailor it to what was feasible and what was effective. But that's not a thing which, of course, politicians find easy to do.

O'REILLY: The Department of Health denies there's a shortage of psychiatrists. It does admit, however, that more second opinion doctors are being encouraged to come forward. Care Services Minister Phil Hope admits it's not an ideal situation.

HOPE: I would share a concern that delays in providing second opinions is unsatisfactory and I think it's important that the Care Quality Commission works further to put those matters right.

O'REILLY: How could the Government get it so badly wrong?

HOPE: Well, I'm pleased to say that the Community Treatment Order has been so successful rolled out …

O'REILLY: But it's putting extra stress on an already fragile service. There are more people now in the community and there aren't enough front line staff to support them.

HOPE: It is a legal criteria that putting people onto a Community Treatment Order is only the case if they have got appropriate treatment available to them. Community Treatment Orders do offer, I think, an important new legal framework to help professionals ensure that patients keep getting the treatment that they need. They don't create new patients or needs, the services would have to address those needs anyway. The question is whether there is a legal framework for both the professionals and the patients to get the treatment that they need, and I think that's an important new development that's making a real different to people's lives.

O'REILLY: The Care Quality Commission – the independent regulator of health and social care in Britain – said in a statement that the lack of second opinion doctors was an extremely important issue and it was working hard to address the problem, but said it would take time. Meanwhile we've been told a legal challenge has been mounted to test the legality of CTOs. A measure aimed at improving mental health has, in reality, added an extra burden to an already fragile system.

SIGNATURE TUNE