the columns

correspondence

Prosecution of violent patients

A poster campaign was launched on 28 January 2005 by the National Health Service (NHS) Security Management Service (SMS), which operates within the NHS in England. The campaign heralded the introduction of a new profession – the local security management specialist 'dedicated to improving security in the NHS and investigating incidents of violence' (http://www.cfsms.nhs.uk/). Three assaults on staff in our intensive psychiatric care unit (IPCU) in recent months have focused our minds on the issue of potentially criminal acts by patients, and the related issues of reporting, police investigation and prosecution of patients.

Only one of the three cases above was reported to the police. In this case the patient's mental illness was felt to be well controlled and the assault was considered to be unrelated to his illness. The patient considered himself innocent of any crime and blamed NHS staff in general for his behaviour at the time of the assault. The patient had a history of threatening behaviour towards mental health staff. He had been charged for one such incident immediately prior to his admission but this charge had been dropped by the procurator fiscal while the subject was an in-patient in the IPCU.

The process of police investigation and referral to the procurator fiscal in this case could be important in reducing the risk of future violence by this patient, by communicating to him that he would not avoid the usual legal processes simply because of his status as a psychiatric patient. Following the assault we wrote to the procurator fiscal's office to urge that the charge be considered carefully, but included our belief that the patient should be held accountable for his actions.

In the other two cases, the victims did not report the assaults to police. The patients involved were considered to be mentally ill, one psychotic and the other hypomanic, at the time of the assaults, and their behaviour was felt to be largely due to their abnormal mental state. One of these attacks was a 'near miss' which might have resulted in the victim's death if no other staff had been nearby to restrain the patient.

Referral to the criminal justice system has additional complexities where psychiatric patients are involved (Bayney & Ikkos, 2003), particularly where patients are deemed to lack responsibility for their actions (Eastman & Mullins, 1999). This probably accounts for greater under-reporting of assaults on mental heath staff than in other specialties (National Audit Office, 2003). In the case of more serious assaults or 'near miss' incidents, we suggest there should be a procedure to allow the issues to be considered independently from those directly involved in the care and/or treatment of the patient, although consulting closely with the relevant staff. Presumably the new security management specialists would fill such a role, backed up by the 'NHS SMS Legal Protection Unit – who work with the police and Criminal Prosecution Service to increase the number of criminal prosecutions against those who assault NHS staff' (http://www.cfsms.nhs.uk/).

Many psychiatrists may be unaware that Home Office guidance (Home Office, 1990) on mentally disordered offenders states explicitly:

> 'the existence of a mental disorder is only one of the factors to be taken into account when deciding whether the public interest requires a prosecution. The fact that a person is detained under the MHA does not prevent a prosecution.'

Also, detention under the Mental Health Act 1983 does not prevent the patient from being taken into custody. The guidance continues:

> 'It may be appropriate to consider the views of the patient's psychiatrist as an apparently minor offence may form part of a disturbing pattern of behaviour that may point in favour of prosecution. A prosecution may also be appropriate in order for a patient to accept responsibility for his or her actions . . . The views of the victim should also be sought and taken into account in the decision making process.'

We think that more work is needed to establish 'best practice' and wish to hear the views of our colleagues on this complex area.

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Zyprexa Velotab (olanzapine): suitable for vegetarians?

Zyprexa Velotab (olanzapine) is one of the most commonly used antipsychotics in the UK, but how many of us are aware that the gelatin used to make the orodispersible tablets is of bovine origin?

This would obviously impact widely upon the vegetarian, Muslim, Jewish and Hindu communities, to name but a few. There are over four million vegetarians in the UK but this number is likely to be vastly expanded by the other religious faiths described above.

We think that it is important that not only do the manufacturers of this medication publicise this constituent in their summary of product characteristics but we as healthcare professionals are knowledgeable of and culturally sensitive to our patients' beliefs and wishes.

We are all aware that the major reason for relapse of any mental illness is poor compliance with treatment (Robinson *et al*, 1999). How many of those mentioned above would continue with their Zyprexa Velotab upon discovering the formulation of their medication and how would this

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