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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 health 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.

BAYNEY, R. & IKKOS, G. (2003) Managing criminal acts on the psychiatric ward: understanding the police view. *Advances in Psychiatric Treatment*, **9**, 359–367.

EASTMAN, N. & MULLINS, M. (1999) Prosecuting the mentally disordered. *Journal of Forensic Psychiatry*, **10**, 497–501.

HOME OFFICE (1990) *Provision for Mentally Disordered Offenders* (Circular 66/90). London: HMSO.

NATIONAL AUDIT OFFICE (2003) *A Safer Place to Work: Improving the Management of Health and Safety Risks to Staff in NHS Trusts*. http://www.nao.org.uk/publications/nao_reports/02-03/0203623.pdf

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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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impact upon their trust in us? Is our current practice of prescribing this formulation to this population not analogous to offering them a roast beef dinner?

ROBINSON, D., WOERNER, M. G., ALVIR, J. M. *et al* (1999) Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry*, **56**, 241–247.

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Reply

It is correct to state that Zyprexa Velotab (olanzapine orodispersible tablets) contains gelatin as an excipient of the formulation. This information is listed in the Summary of Product characteristics section 6.1. The gelatin is of bovine origin and this information is available from the Lilly Medical Information Department on request. If a patient is prescribed Zyprexa Velotab and is concerned about the bovine gelatin in the preparation because they are vegetarian or for religious reasons, Lilly advise them to discuss their treatment with their doctor who should consider an alternative formulation such as Zyprexa tablets.

If readers are interested in the wider issue of the presence of bovine gelatin in prescription medicines it should be pointed out that the alternative licensed orodispersible atypical antipsychotic Risperdal Quicklet also contains this excipient. Furthermore, bovine gelatin is used as a major structural excipient in the majority of encapsulated medications. This is because it has properties of flexibility combined with rapid solubility, allowing predictable dispersal of the drug. The pharmaceutical industry is investigating alternatives to bovine gelatin, but it should be noted that any change to the formulation of a medicine requires resubmission to the regulatory authorities with the demonstration that the new formulation is bioequivalent to the existing formulation.

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Patient-centred psychiatry

We welcome the article 'Patient-centred psychiatry' (Bhugra & Holsgrave, *Psychiatric Bulletin*, February 2005, **29**, 49–52) providing information and stimulating debate on the likely future of postgraduate psychiatric training.

Currently most trainees spend substantially longer than the proposed 5 years training. It seems that future trainees will have to learn less, learn more intensively or do less service work. The impact on patients and trainers, and resources necessary to implement changes, must be examined in advance. There may be further deterioration in continuity of care, particularly if all posts are for 6 months. Psychotherapy higher specialist training currently takes 5 years; how would this be incorporated into the proposed model? Will sub-specialist ('super-specialist') training exist as we know it now? Will special interest and research sessions remain unchanged? Information is also needed on what form assessments might take. It is crucial that factual knowledge remains important within any new competency-based assessment.

What flexibility will exist within the new system; for example: if a trainee wants further experience in a sub-specialty; if a trainee does not achieve necessary competencies within the 5-year period; or achieves them well before this? Consideration should be given to transitional arrangements, for example, for trainees taking time away from psychiatry and returning to a new system.

The College runs training programmes and examinations in jurisdictions not affected by Modernising Medical Careers or the Postgraduate Medical Education and Training Board; trainees in such areas wonder how the proposed new system might affect them.

The authors suggest using the MRCPsych Part I as a 'suitable screen for entry into the specialty'. We would welcome clarification of this. We worry that the College wishes to control entry to training by deeming people suitable or unsuitable for psychiatry. Currently even repeatedly failing the MRCPsych examination does not prevent one from working in psychiatry, but under the new system would this remain the case? Should it?

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False-positive drug tests

A forensic patient tested positive for amphetamine on eight occasions over an 8-week period using a Dade Behring amphetamine/methamphetamine assay. Low concentrations of urinary creatinine in two samples suggested specimen dilution.

Telephone advice from the laboratory emphasised that a positive result from a dilute sample was highly significant. The same advice stated that according to the literature from Dade Behring, chlorpro-

mazine and other medication that the patient was on could not account for the test result. This led us to conclude that amphetamine consumption was recent.

An extensive search for the source of amphetamine proved negative. Subsequent testing of the original samples at an alternative laboratory was negative using both the Cedia kit for an Olympus analyser and the gold standard method of gas chromatography/mass spectrometry (GC/MS).

Closer reading of the literature from Dade Behring revealed a footnote confirming that false-positive results for amphetamine may occur with patients taking chlorpromazine. The advice is that all positive results require confirmation with an alternative method, preferably GC/MS.

The conclusion of Acosta-Armas (2003) that a positive result on LSD (lysergic acid diethylamide) immunoassay should be confirmed by at least one alternative method can be generalised to amphetamine immunoassays.

National guidelines for testing employees (Steering Group, 2004, section 4.9.3) extend this conclusion to all positive drug tests:

'Only drugs which have been confirmed by a recognised confirmation test can be reported as positive.'

The consequences of a positive test for certain patient groups makes following these guidelines of paramount importance.

ACOSTA-ARMAS, A. J. (2003) Problems encountered when testing for LSD in a regional medium secure unit. *Psychiatric Bulletin*, **27**, 17–19.

STEERING GROUP (2004) *United Kingdom Laboratory Guidelines for Legally Defensible Workplace Drug Testing*. <http://ramindy.sghms.ac.uk/~ltg/wdtge.pdf>

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The new consultant contract in Scotland

In Scotland, in April 2003 the new consultant contract added impetus to job planning. Following some reported problems, the Scottish child and adolescent psychiatry section executive undertook a postal survey of consultants in Scotland in July 2004. Responses were received from 35 (57%).

All respondents had opted to transfer to the new contract, and most had 'definitely' or 'probably' agreed job plans. Six respondents had not – two were in locum posts and for the remaining four there was some dispute. Total sessions ranged from 6 to 12 (36%). Agreed job