Community care for dangerous patients in UK

Clinicians working with the mentally ill must be capable of eliciting a history of violent behaviour and of assessing the risk of future dangerous actions. Thus said Dr Donald Dick, one of the three persons who had carried out the inquiry into the care and treatment of Christopher Clunis. Clunis, a paranoid schizophrenic, was convicted of the manslaughter of Jonathan Zito on June 28, 1993, and has since been detained in Rampton Hospital.

In the report[1] of the inquiry, the group said, "Despite the fact that an accurate history is widely recognised to be invaluable in assessing a patient's dangerousness, we found that time and again either violent incidents were minimised or omitted from [Clunis'] records or referred to in the most general of terms in discharge summaries. Often histories were unavailable to those who came to care for the patient afterwards. We noted throughout our inquiry that serious violent incidents were often only recorded in the nursing notes and not picked up by the clinicians or social workers".

The overall conclusion drawn by the inquiry group was that Clunis' care and treatment up until the attack on Zito had been "a catalogue of failure and missed opportunity". Lack of adequate resources also played a part. The recommendations for future services delivery include the setting up of a national register of patients who have been compulsorily detained in hospital. In addition, the team want to see special care for mentally ill patients who require very close supervision and fulfil two of the following four criteria: having been detained more than once, having a history of violence or persistent offending, not responding to treatment from general psychiatric services, or being homeless. The need to identify this group, which is estimated to be no more than 3000–4000 people, was stimulated in part by the group hearing of serious and violent acts by a small number of other patients with severe mental illness during the Clunis inquiry. The group note, however, that existing mental health budgets could not provide for the specialist service providers required, so new funds would be needed.

The above are only some of a long list of recommendations. The inquiry group emphasises that "the whole package" in improvements is necessary for both the public and patients living in the community to be protected.

Sarah Ramsay

1 The report of the inquiry into the care and treatment of Christopher Clunis. London: HM Stationery Office. 1994. Pp 146. £9.50. ISBN 0-11-701798-1.

Australian NHMRC review

The Minister for Health, Senator Graham Richardson, has told parliament that funding will be increased dramatically within four to five years, following a critical external review of the National Health and Medical Research Council (NHMRC). The review, by Dr John Bienenstock, dean of health sciences at McMaster University, Ontario, found the NHMRC to be an organisation vital to the nation's interests.

Yet, it said, medical research was underfunded. It also said that the NHMRC was underfunded and lacked administrative support, had no clear mechanism for determining priorities or for distributing information publicly, had allowed infrastructure support of research to fall behind, and was incapable of monitoring its own activities. The NHMRC had also failed to address adequately Aboriginal health, a matter of great importance. In effect, the review says the NHMRC's agenda is based on the "old public health" of chemicals, air and water quality, poisons, foodstuffs, and waste management. It does not address the "new public health" of inequality, housing, access, and environmental issues. Despite these flaws, the review found that NHMRC distributed its Aus$110 million budget among researchers fairly and reasonably well.

Although the review is critical, it makes few suggestions for change. Two principal committees should merge and another be formed. But it does not suggest how to improve the NHMRC's lack of interaction with the public, the inadequate use of NHMRC's expertise, its cumbersome committee structure, or the feeling that the Council, in the words of one member, "only meets twice a year to watch the principal committees report to the media".

Before the March, 1993, election the Deputy Prime Minister and former Minister for Health, Brian Howe, promised that funding for medical research would be increased from 1·25% to 2% of the health budget—the minimum standard seen as acceptable by the World Health Organization. After the election Senator Richardson repeated that pledge, while making it clear that he expected private enterprise to improve a commitment to research. But the government's commitment to assisting private enterprise has come under question. Several years ago it established Factor F, a scheme under which pharmaceutical companies would receive substantial tax concessions for exporting drugs. The aim was to establish a viable national pharmaceutical industry, rather than one which relies largely on imports. Just before Christmas the government announced that only 2 of 10 applicants for Factor F concessions had been successful. The companies were surprised. They had assumed that if they fitted the criteria, they would be granted Factor F concessions. They were not.

Mark Ragg

Asset-stripping New Zealand's elderly people

"Asset stripping—march to Parliament, 3 March, 1994. All Ex-Service Personnel are requested to show their concern for their fellow men and women by rallying to the Flag once again and joining the Anti-Income an Asset Testing March to Parliament. Medals will be worn". With advertisements like these in daily papers, Greypower has been recruiting vocal superannuitants to confront the government over its policy that elderly people requiring long-term hospital stay have to liquidate their assets to pay for their care before the government will pick up the bill. The new system was introduced in July last year, but did not become an issue until the Greypower president, Neville McLindon, recently made it the subject of a public address. Those needing permanent hospital stay have to declare their assets and to sell or rent these if necessary. People may retain only $NZ6500 if single or widowed, $13 000 if both husband and wife are in care, and $20 000 and the home and car if a spouse is still living at home. Working wives with elderly husbands in geriatric care will be allowed to retain an income of $28 927, resulting in what one health official coyly described as "a diminished lifestyle".

The beleaguered National government Minister of Health Mrs Jenny Shipley says that the scheme simply brings public hospital patients into line with those in the private sector, who are similarly means and asset tested before government subsidies are paid. But critics say that the policy means that long-term geriatric patients are being treated differently from younger people needing similar care and that asset-testing violates the principles of a public health system. Greypower has lodged a complaint with the Human Rights Commission, and elderly people complain that they will be humiliated by having nothing to leave their children. The protests have the support of the New Zealand Medical Association.

The elderly have been staunch National supporters since 1976, when their superannuation provisions were greatly increased. Later governments have been reluctant to tackle the recurring costs of this move. Labour earned implacable hostility when it introduced a surtax on other earnings in the mid-1980s. Asset-testing may well prove a similar liability for National.

Sandra Coney