Inquiries: who needs them?

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In recent years the public's perception of psychiatry and community care has been influenced by a series of media headlines. Public concerns are reflected, and perhaps incited by critical media coverage of tragic and high-profile incidents involving patients who are receiving, or who have received psychiatric care, ranging from the standard ('The fools who let out the madman', *Evening Standard*, 20 February 1996; 'Cared to death: five innocents butchered by nutters freed too soon', *Daily Star*, 26 September 1995) to the more balanced ('Another killing blamed on care failures', *Daily Telegraph*, 26 September 1995).

These incidents lead invariably to court appearances and inquiries. Those involved in the process can be dazzled by all the attention such inquiries attract, which may explain the impression that inquiries now seem to play to an even larger national audience than those who commissioned the report. Add to this the many 'experts', including some psychiatrists, who seem quite prepared to rub salt in the wound in return for a media slot, and the spiral of inquiries can be explained.

During the 1960s and 1970s a series of inquiries questioned the standard of care in the old institutions, ironically (in light of the views that prevail now) raising demands for their closure. These inquiries are associated with names such as Ely (1969), Napsbury (1973), Warlingham Park (1976), Rampton (1980) and more recently Stanley Royd (1985). Some were massive in scale. The Rampton inquiry implicated more than 100 nurses in the alleged abuse of over 800 patients. Most of these patients were held under the relevant Section of the NHS Act which permits the Secretary of State to hold an inquiry into a matter of public concern and grants considerable powers to the inquiry team. The lessons learned were predictable to anyone familiar with Goffman's work (1961), but action based on recommendations was haphazard. The media were indignant about conditions when they were brought to light, such as in the BBC documentary *The Secret Hospital*, which exposed brutality at Rampton, but publicity was generally low-key as compared to present media interest, and rarely was the ability of mental health care as a whole questioned.

Change was heralded by the Spokes inquiry (1988) into the killing of social worker Isobel Schwarz by her client Sharon Campbell, which precipitated the introduction of the Care Programme Approach. The introduction of the community care policy meant that the goalposts moved as far as inquiries were concerned. Previous inquiries had addressed poor care in large institutions affecting anonymous residents, but community care had created victims everyone could identify with. It is probably no exaggeration to say that nothing symbolises the public perception of community care better than the distraught face of Jayne Zito, frequently seen by millions of TV viewers. The implicitly perceived message was that 'it could have been me who was stabbed in the tube station!' Pressure changed rapidly from demands to improve quality of care for institutionalised victims of the system to demands for safety for the public as potential victims. The Government's response was increased guidance, regulation and legislation, which led to directives such as the CPA, supervision registers, discharge guidance and supervised discharge, increasing the pressure on an already over-stretched system. Even the guidance on inquiries (Department of Health, 1994, 1995), stipulating an external inquiry following every case of homicide committed by a person under psychiatric care, was part of the Government's response to public concern.

The subsequent barrage of inquiry reports – there are about 30 inquiries in progress – has served few people well. Inquiries are time-consuming and costly. Psychiatry is identified with neglect and poor judgement. All staff are at risk of intense scrutiny and presumed guilt if unpredictable events occur. The public is fed misleading impressions of the danger presented by people with mental illness, and victims and their relatives, constantly reminded of the tragedy that has befallen them, find it hard to get on with their lives.

On the other hand, inquiries provide accountability of a key public service and, if successful, lead to improvements in the system of care and, if necessary, action to be taken against the negligent.

Inquiries are addressing incidents at three levels: they address relatives' concerns, the implications for local management and they also encompass a wider political agenda. There is a strong suggestion that this balance has shifted

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over time. Initially, inquiries concentrated on recommendations relevant to local circumstances, but later on the national agenda took on greater importance. For example, a recent inquiry into the case of Jason Mitchell (Blom-Cooper *et al*, 1996) offers recommendations categorised under A: 'directed to purchasers and providers of health and social services in Suffolk', and B: 'of general application in the field of mental health'. Interestingly, there follow nine category A recommendations and 35 category B recommendations. Obviously this was not an inquiry with parochial ambitions.

Individual care failures are increasingly perceived as indicators of a general failure in the system. This deduction is undermined by the problem of retrospective justification. The limits of the methodology of inquiries were very well analysed in a review of an earlier inquiry (Maden, 1995). These limitations are unavoidable, and lead to the inescapable conclusion that inquiries have become redundant as a general response to major incidents.

Every inquiry emerges with the conclusions that responsibility across as well as within agencies were unclear, communications appalling, risk assessment unsatisfactory and resources inadequate. Almost invariably they also conclude that the incident could not have been attributed to failings of individual managers or clinicians.

The current system is as damaging to everyone involved as it is costly, and adds little that is new to our knowledge of what can and does go wrong in mental health services. Under such circumstances, a rigid continuation of the present system cannot be supported. This is not an argument against accountability, but an argument in favour of a system where failures are properly investigated on indication, rather than one where mental health services are presumed to be responsible for every incident.

Several options for change can be suggested, all based on the idea of an authoritative individual or body to sift through incident reports and decide what level of audit or inquiry is necessary in each case. Independent scrutiny of each case would be retained, but panel inquiries would be ordered only in exceptional cases, where due to their novelty or public concern such an inquiry seems desirable.

Such an agency must be perceived as independent by the public, while having access to ministers. A body which is perceived as being independent of both the public and government, while retaining the respect of both, would be hard to find, but several existing and some new ones could be considered. These include the Confidential Inquiry, the Health Advisory Service, The Social Services Inspectorate and The Mental Health Act Commission. However, the role of the Confidential Inquiry would become confused, and it is presently too academic in nature. The Health Advisory Service could take this role on as a new departure, although it might sit uncomfortably with its inspection status. The Mental Health Act Commission seems a logical contender, and a new agency such as a mental health ombudsman could be set up.

Any of these solutions would improve the status quo, although the difficulties of introducing such a system without various parties screaming 'Cover-up!' cannot be underestimated. It requires political and professional leadership and courage, coupled with strong support from managers and clinicians from the statutory and independent sectors alike, as well as user and carer groups. Maybe then, we can rebuild the reputation of mental health care and concentrate on what matters, caring positively for vulnerable people.

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