

Supervision registers

Recent government policy and legislation

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With the possible exception of the proposed supervised discharge, the supervision register is the most controversial current government initiative within the mental health field. This paper presents both the guidance issued by the NHS Executive and the concerns that the psychiatric profession has expressed. Time will tell whether the supervision register turns out to be a visionary policy that successfully allays public concerns over community care or an example of a bureaucratic response to an issue of inadequate resources.

Supervision registers were formally introduced into the NHS from 1 April 1994. Health Service Guidelines issued by the NHS Executive (HSG(94)5) in February 1994 set out the action that health authorities and provider units had to undertake. It was recognised that the timescale for implementation was unrealistically short and HSG(94)5 therefore conceded that full implementation could be delayed until 1 October 1994 at the latest.

Supervision registers for "patients who may be most at risk and need most support" form a component of the Secretary of State's "ten point plan for developing successful and safe community care", which was released to the press in August 1993. The cornerstone of the ten point plan was the introduction of the power of supervised discharge, which requires primary legislation (an amendment to the 1983 Mental Health Act) that is yet to be enacted. The ten point plan also included the formulation of guidance on the discharge of mentally disordered people and their continuing care in the community: this was issued in May 1994 (HSG(94)27). The context for the ten point plan was growing public, professional and political concern over the implementation of community care for the mentally ill, and in particular evidence of occasional dramatic failures of care, of which the most notable recent example has been the case of Christopher Clunis (Ritchie, 1994). The supervision register guidelines must be interpreted within the other current policy developments described in this series of papers, notably the raft of initiatives set out in *Health of the Nation* (Jenkins, 1994) and the care programme approach (CPA) (Kingdon, 1994).

HSG(94)5 has caused considerable concern among the psychiatric profession, as evidenced

by the President of the Royal College of Psychiatrist's correspondence with the Secretary of State (Caldicott, 1994). The Secretary of State's response vigorously rebutted these concerns (Secretary of State for Health, 1994). Communications to health authorities from the NHS Executive by way of the regional outposts make it clear that, despite the fears of psychiatrists, other health care professionals and the user movement, full and effective implementation of supervision registers by local providers is a major priority of the Department of Health.

The facts

According to HSG(94)5:

- All mental health provider units should "set up registers which identify and provide information on patients who are, or are liable to be, at risk of committing serious violence or suicide, or of serious self-neglect . . . as a result of severe and enduring mental illness . . . includ-(ing) people with a diagnosed personality disorder".
- Assessments and reviews of patients under the CPA should consider the question of whether the patient should be registered.
- Provider units should "incorporate the supervision register in the development of mental health information systems to support the full implementation of the CPA".

The document sets out the required contents of supervision registers (Appendix A):

- identification data (name, address, Mental Health Act status etc)
- the nature of the risk (category of risk, warning indicators and evidence of specific episodes of behaviour, including relevant criminal convictions)
- key worker and relevant professionals
- care programme (date of registration and reviews, components of the care programme).

The purpose of the supervision register is to identify on an information system particularly problematical patients with a severe and enduring mental illness (defined according to the

criteria spelt out above) under the care of NHS provider units (HSG(94)5, Annex A). It is expected that inclusion on the register will assist in the task of individual care planning, result in the prioritisation of those most in need of care, provide a point of reference for health and social services staff to enquire whether individuals under the CPA are at particular risk, and contribute to the process of service planning for this group of patients.

Patients are included on the supervision register following discussion within a CPA review meeting if they are found to fit the criteria for inclusion after an assessment of risk using the principles spelt out in HSG(94)27. Patients should, in general, be informed of their inclusion on the register. Withdrawal, which is the decision of the responsible consultant psychiatrist, should be considered routinely at follow-up CPA review meetings or at any specially convened meeting involving "any of the agencies involved in the care programme". In addition the patient or his or her advocate "should have the right to request . . . removal from the register." If the patient is dissatisfied "the normal channels for complaint and the right to a second clinical opinion apply." NHS(94)5 helpfully notes that patients may be withdrawn if they have died and additionally if they no longer fulfil the inclusion criteria or have been transferred to another provider unit (with the written agreement of that unit). Out of contact patients should remain on the register.

The supervision register is technically a health record and access to the patient's entry is "confidential in the same way as any other health records." HSG(94)5 states that the GP "should be informed of . . . inclusion on the register" and that the GP "should inform other members of the primary health care team on a need to know basis". Although it is implied within HSG(94)5 that social worker members of the mental health team will know about registration (as in practice they undoubtedly will) the guidance notes that disclosure to other agencies, including social services authorities, could only occur with the consent of the patient or if "disclosure can be justified in the public interest . . . taking full account of the views of the consultant psychiatrist."

The guidance also addresses management issues. Within mental health provider units a Trust Board executive member, "preferably with a professional background", should take responsibility for the implementation of the register and report regularly to the Trust Board as part of the CPA reporting process. The register should be one component of a comprehensive mental health information system. Guidance on computerised information systems has subsequently been circulated by the Department of Health

(Letter from the Department of Health, 27 April 1994).

It is important to emphasise that, despite superficial similarity, the supervision register guidance is quite distinct from the recommendations of the Clunis Enquiry (Ritchie, 1994).

Implications for individual psychiatric practice

Professional concern about the implementation of the supervision register focuses on a number of issues (Caldicott, 1994). In correspondence with the Secretary of State the President of the College made a number of points.

- (1) Criteria for inclusion are broad and non-specific.
- (2) Implementation may have significant cost implications.
- (3) Clinicians (and key workers) may be at increased risk of litigation as a result of acts carried out by patients on the register.
- (4) The measurement of risk is, at best, an imprecise art.
- (5) It may be difficult to identify key workers who will, in the words of the Secretary of State, be "responsible" for the acts of their clients or patients.
- (6) The inclusion of people with personality disorders may lead to an inappropriate diversion of clinical activity away from people with a major mental illness.
- (7) There are ethical concerns over the implications for the patient of being included on the register without any obvious benefit accruing to the individual in terms of an improved level of service.
- (8) The placing of a patient on the register may impair the therapeutic relationship between mental health professionals and the patient.
- (9) Confidentiality may be difficult to ensure.
- (10) Patients on a supervision register may find difficulty in obtaining primary medical care.

In addition forensic psychiatrists have expressed serious concern over the "violence" criterion for inclusion, noting the very complex relationship between violence and diagnosed mental illness and the difficulty psychiatrists face in predicting dangerousness. It is feared that the supervision register will reinforce perceptions of psychiatrists and mental health professionals as agents of social control whose major role is protecting the public from dangerous or deviant behaviour.

The Secretary of State provided a point by point rebuttal of the concerns expressed by the profession which has been published (Secretary

of State, 1994). In particular, the Secretary of State denied that registration criteria were over-inclusive, noted that there should be no additional costs where the CPA had been introduced (itself supposedly a cost-free exercise) and stated that entry on the register would neither add to nor subtract from the legal responsibilities of clinicians. The concerns of key workers, who have a role analogous to that of the child care social worker with all that this implies for personal responsibility if disaster should strike, were not addressed.

It has subsequently become clear in correspondence with the Department of Health that the supervision register is intended to include only a small minority of those in contact with psychiatric services, in the region of 15 per 100,000 total population for a catchment area of average morbidity. Inclusion criteria should be restrictive, representing those patients who cannot adequately be managed by well developed care plans within the CPA. Such patients would have unremitting psychoses or have a dual diagnosis or have committed crimes but have been unable to access forensic services (Letter to Dr Harris, Mapperly Hospital, Nottingham from Dr Jenkins, Principal Medical Officer, Department of Health, 14 June 1994).

Guidance is likely to be forthcoming clarifying the relationship between the CPA (intended to be a broad approach to meeting the needs of all patients in contact with specialist psychiatric services), patients on the CPA register (a subset of "vulnerable" patients, including those to whom the aftercare responsibilities set out in section 117 of the Mental Health Act apply) and patients on the supervision register, who would represent a further particularly vulnerable (or dangerous) subset of the total population in contact with psychiatric services. Ideally the CPA register and the supervision will represent flagged subsets of the computerised local mental health information system.

Implications for users of mental health services

A relatively small number of psychiatric patients will be included on the register. It is unclear how inclusion will affect them in practice. Concerns have been expressed that inclusion will be stigmatising and enhance the negative responses "difficult" or "hard to treat" patients already experience within psychiatric services. Alternatively the supervision register may be used by local purchasers and providers as an exciting opportunity to target particularly needy patients with additional high quality services that adopt an "assertive outreach" case management approach. Intuitively providing the most "difficult"

patients living in the community with additional support should benefit both them and society as a whole. The evidence from the existing case management literature is equivocal, although patients do appear to prefer more innovative person-centred services (Holloway *et al.*, in press). It is unlikely that substantial resources can flow towards patients on the supervision register within highly stressed inner urban catchment areas, particularly where the CPA is already being used effectively to target those most in need.

Implications for working arrangements with purchasers and providers

The responsibility for the implementation of HSG(94)5 lies with the health authorities, working with provider units within the contracting framework. Local purchasers and providers must together interpret the guidelines, develop clearer operationally defined criteria for inclusion on the CPA register and the supervision register and some vision of the services that should be offered to those patients who are included on the registers. The introduction of supervision registers may catalyse closer working relationships between purchasers and providers over the broader field of implementing the CPA, targeting resources to patients with major mental illnesses and identifying patients who are most in need.

International perspective

To my knowledge, the supervision register represents a unique initiative to identify particularly problematical psychiatric patients in the community within the context of a comprehensive mental health information system. Along with the CPA the supervision register represents a bold attempt to ensure that vulnerable patients do not "fall through the net" and that services are targeted at those most in need. In many countries with advanced mental health services the prevailing civil rights climate (which has, for example, curtailed the operation of a number of psychiatric case registers) would render the initiative difficult if not impossible. Demonstrable success of the CPA and supervision register may encourage the more general adoption of this approach.

Concluding remarks

At the time of writing, discussions are under way between the Department of Health and the Royal College of Psychiatrists over the details of the

implementation of supervision registers. Currently most professionals are either indifferent to or hostile towards the proposals. It remains to be seen whether guidelines for inclusion on the register and a vision of what inclusion might mean in terms of practical services to highly disabled or disturbed patients can be agreed between the Department of Health and mental health professionals. In the absence of such agreement the onus is on local purchasers and providers to develop practically applicable policies and procedures that will ensure that appropriate patients are targeted and that key workers receive adequate experience, training and support to carry out what may be a very difficult and unrewarding role.

It is possible to argue that supervision registers will turn out to be a bold policy initiative which will be of practical benefit to patients and offer essential reassurance to a public opinion that has become nervous of community care. It is equally possible to assert that the register is a mistaken policy that yet again proposes a

bureaucratic solution to what is essentially a problem of inadequate resources. Time will tell.

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