

The supervision register: one year on

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A postal survey was conducted within four regional Health Authorities to ascertain how widely the supervision register had been applied in its first year of operation in adult mental health. A 72% response rate was achieved. The results showed that the register has been absorbed organisationally but is less accepted professionally. One hundred and nineteen of the 367 consultants in the sample (32%) had no entries on the register at 31st March 1995. The provision of training on its use had a significant effect on compliance, although London-based services had marginally less registrations per consultant than their colleagues elsewhere. Very few outside agencies had required access to the register.

Health Service Guidelines issued on 10th February, 1994 required all mental health provider units to establish supervision registers by 1st April, 1994 and to have them fully implemented by 1st October, 1994 (NHS Management Executive, 1994). The aim of the register is to identify those people with a severe mental illness who may be at significant risk to themselves or others and ensure that they receive appropriate and effective care in the community. However, there has been much controversy over the introduction of the register. Considerable doubts have been expressed by the Royal College of Psychiatrists about its feasibility and effectiveness (Caldicott, 1994), and by MIND about its lawfulness (MIND, 1994).

Accordingly, the establishment of such registers nationwide appears to have been undertaken without much enthusiasm by mental health professionals and is likely to be reflected in a variable pattern of relevant activity. In order to test this hypothesis a study was undertaken to measure the use of the supervision register in the first twelve months of its implementation.

The study

As a precursor to a more detailed investigation a simple questionnaire was devised to gather quantitative data on the register's introduction and use. The questionnaire focused on the practicalities and results of applying the register to the adult mentally ill (16–65) during the period

1st April 1994 to 31st March 1995. Information was requested on operational policies, patient information leaflets, training, number on the register as at 31st March 1995, access to the register by other agencies and use of the Care Programme Approach (CPA).

The questionnaire was sent to the Chief Executives of 90 NHS Trusts with mental health provider units within the four Regional Health Authorities covering the Southern half of England.

Findings

Sixty-five questionnaires were returned representing a response rate of 72%.

Organisational issues

All but seven (11%) of the respondents had implemented the supervision register by the deadline set for full implementation of 1st October 1994. The remainder had complied at a later date. Sixty (92%) had developed an operational policy and 43 (66%) had produced an information leaflet for patients. Rather less, 39 (60%) had provided training for their staff which varied from 1.5–7 hours and which was often incorporated into more general training on the use of the Care Programme Approach (CPA).

The use of the CPA for vulnerable patients being discharged from hospital on an 'often' or 'always' basis was reported by 63 (97%) respondents. The rate for vulnerable patients newly accepted by community mental health services was 52 (80%).

Registrations

Of the 367 consultants included in the study, 119 (32%) had no patients registered as at 31st March 1995. The remaining 248 had 1151 registered patients between them with a mean of 4.6 per consultant with a range of 1–30 entries.

A comparison was made between provider units serving London and the rest of the sample by isolating data from the 12 Trusts with a telephone code of 0171 (4) or 0181 (8). Thirty-eight per cent of the London consultants had no registrations as

opposed to 31% with no registrations in the rest of the sample and those that did register scored slightly lower than their colleagues in terms of mean entries per consultant (4.5 entries per consultant as opposed to 4.7 entries per consultant). However, there was no significant difference between the two sets of data ($\chi^2=1.415$, d.f.=1, $0.5>P>0.1$).

Seven hundred and nine (62%) entries were categorised. These were divided into risk of suicide (38%), risk of violence (32%) and risk of self-neglect (30%). One hundred and eighty-six were listed separately as having more than one category although in many instances these entries had also been listed in the single categories and were listed twice.

Requests by other agencies for access to the register were very low with only 10 respondents (16%) being effected and totalling only 35 enquiries. Most enquiries 18 (51%) came from other mental health agencies. The remainder were from Probation 10 (29%), Police 4 (11%), Social Services 1 (3%) and others 2 (6%).

Comment

Despite its rather rushed introduction and the expressed opposition from professional bodies such as the Royal College of Psychiatrists, most services had implemented the supervision register by the deadline for full implementation of 1st October 1994. Indeed, by the end of March 1995 most had produced their own local policies and over two-thirds had produced an information leaflet for patients. Organisationally, therefore, the supervision register appears to have been integrated into the normal procedures of mental health services.

It is gratifying to note that CPAs for vulnerable patients are the norm for both hospital discharge and new referrals to mental health services. As supervision register candidates are by definition vulnerable it is reasonable to assume that the decision to include them on the register is being taken within the CPA process.

However, although the supervision register appears to have been absorbed organisationally, the variation in the number of patients on consultants' lists may indicate that for many it has yet to be absorbed professionally. Almost one-third of consultants had no registered patients although it seems unlikely that all of them had no suitable candidates for registration, particularly when their colleagues within the same local service had many. Additionally, some mental health units appear to have a culture of non-registration. For example, in five units with a total of 32 consultants, 27 had no registrations, and five units with 29 consultants had no entries at all. It is possible that the availability of training

on the use and application of the supervision register had some effect on the willingness of consultants to use it. It is significant that in Trusts offering no training 59 out of 133 consultants (44%) had no entries on the register whereas in Trusts where training had been given only 60 out of 234 consultants (26%) had no entries ($\chi^2=13.563$, d.f.=1, $P<0.001$). It may be that the provision of training reflects a commitment by the organisation to endorse the use of the register, support staff and achieve some consensus in its application. Staff left to their own devices may feel less inclined to comply.

Surprisingly, there were slightly less pro-rata registrations for London consultants than consultants elsewhere and more (38%) had nil registrations than their colleagues (31%). In view of the often stated higher incidence of psychiatric morbidity in London with associated problems of deprivation and shortage of services, one would have expected the reverse to be true. One explanation could be that the number of vulnerable psychiatric patients in London simply overwhelms the system so that the services find the additional bureaucracy of implementing the supervision register an administrative task too far. Indeed, several London Trusts have acknowledged that they could not cope with the full implementation of the supervision register due to the numbers involved. Their solution has been to adopt a pragmatic approach to the situation by registering only those who meet fairly strict criteria of serious risk of violence to others (McCarthy *et al.*, 1995). It may be that others are adopting a similar pragmatic approach as a way of surviving.

Concerns about widespread access to the register by other agencies was not substantiated. Very few instances were given of agencies using this facility. It is possible that it is too early in the development of the supervision register for the right to request access in relevant circumstances to have been absorbed into the consciousness of other organisations.

Conclusions

All mental health provider units in the sample have implemented the supervision register and those patients put onto the register appear to have been listed in the context of the CPA. However, there are indications that not all consultants have accepted the supervision register, with 32% having no entries as at 31st March 1995. In view of the possible impact of training in facilitating its use, more time spent by organisations in this direction may produce a more active and consistent use of the register.

The lower number of registrations in London may be due to services being overwhelmed by the administrative burden imposed by large numbers

of vulnerable people who are potentially registerable. If this is the case, then the whole purpose of introducing such a measure to areas of highest need will have been defeated.

Furthermore, if the objective of enabling other agencies involved in patients' care to request relevant information is to be achieved, more energy needs to be expended into educating other services about the purpose and use of the supervision register.

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