Supervision registers: the College's response

The membership may be interested to see the College's response to the recent guidelines issued by the Department of Health on the introduction of supervision registers.

27 April 1994
Mrs V. Bottomley, JP MP
Secretary of State for Health

Dear Virginia

re: Guidance on the Introduction of supervision registers

I am writing to you further to my earlier letters of 26 January and 18 February concerning the proposals for the introduction of supervision registers. I should also like to thank you for your subsequent letter received on 5 March. Although I welcomed the inclusion of some of our comments on the draft guidance, I had also pointed out that the timescale for consultation mitigated against a considered and comprehensive response.

Following the issue of the substantive guidance document, I have received many letters of concern from Members and Fellows of the College across the country in relation to the proposals. In addition, strong concerns were voiced at the recent meeting of the College's Council.

The College supports the principle of ensuring that the most seriously mentally ill patients receive the care that they need, and we welcome the attention that the Department is paying to this group of patients. While we support the introduction of a mechanism to document a smaller group of patients who require close supervision and care, there is a very strong view that the current proposals are unlikely to succeed in achieving this end. The following is a summary of the various points which have been raised by members and fellows of the College.

1. The criteria for inclusion on the register remain too broad, and the numbers of patients it will involve are likely to be considerably higher than intended. The guidance document implies that anybody with a severe mental illness, as well as severe personality disorder and psychopathic disorder, who has either aggressive tendencies, or a risk of suicide or of self neglect, should be included. This is likely to involve a considerable proportion of all patients undergoing psychiatric care (estimated in the Nottingham District, which covers a population of 630,000, to involve as many as 2,000 people).
2. We have estimated that the cost of setting up and servicing the supervision registers throughout the country according to the given criteria would be in the region of £77 million. This estimation is based upon the following model.

Average of 2.25 two-hourly case reviews per patient per year, attended by consultant psychiatrist, keyworker, social worker or psychologist (as well as general practitioner, patient, advocate, and next of kin) = 4.5 hours per patient per year.

Number of patients included on the register in the Nottingham District (630,000 people) = 2,000.

Total number of hours devoted to case reviews each year = 9,000 or 173 hours per week.

Average number of hours worked by one Consultant (other than time devoted to administrative and on-call duties) taking into account annual leave, study leave and public holidays = 25.4 hours per week.

Minimum number of consultants required to undertake this work = 6.8.

Estimated cost for the Nottingham District, including clerical time and appropriate computer software = £1 million.

Total population of England = 48,378,000*; proportion of the population in Nottingham representing 1/77 of the total population = total cost £77 million.

**Population Trends*, no 75, HMSO

(This is a broad estimate, which assumes the morbidity rate in Nottingham to be representative of that throughout the country.)

Under the broad terms of the guidance, many severely disturbed adolescents should be included on the register, particularly where there is debate about their discharge from an adolescent in-patient unit. It is unclear whether this has been envisaged at all, or how it might further increase the numbers involved.

3. Strong concerns have been expressed with regard to the legal position facing clinicians, Units or Trusts in the event of serious assault, serious neglect or suicide by a patient who was not included on the register.
4. As I pointed out in my earlier letter responding to the draft proposals, the measurement of risk of suicide or self harm cannot always be precise. While the minimisation of risk has always been a guiding principle of clinical practice, risk cannot be eliminated.
5. Arrangements for withdrawal of a patient from the register are unclear: it is likely to prove difficult to remove patients from the register, as all the relevant risk factors continue to have an effect in the long term.
6. We believe there is now a strong disincentive to become keyworker or consultant psychiatrist for patients included on a list, in relation to professional risk should anything go wrong, and in terms of personal risk.
7. The inclusion of patients with personality disorders is likely to divert resources from the seriously mentally ill further, placing an unacceptable burden on keyworkers to support such individuals.
8. Anxieties in relation to civil liberties and the registers remain. Concerns have been expressed about the possible implications for the patient of having his or her name included on such a register, and it is considered that a major benefit to the patient would have to be demonstrated in order to justify inclusion.
9. However, there is a danger that the registers will simply comprise a list which would be unlikely to be used by psychiatric teams on a day to day basis, as they would have little utility in clinical care. As such, they would easily become inaccurate and out of date. Furthermore, the act of registration might lead to complacency by creating the impression that something had been done.
10. The process of formally placing patients' names on a register is likely have an adverse effect upon therapeutic relationships. Furthermore, the existence of the registers may reduce the acceptability of psychiatric services to patients. Many teams currently maintain informal lists of high risk patients, which allows care to be 'targeted', without the drawbacks of registration.
11. Despite the assurances regarding confidentiality, registration would be known to the patient's GP, which might cause difficulties for those registered due to their risk of violence in obtaining general medical services. Breaches of confidentiality would be bound to occur.
12. The procedures of registration and the extensive rights of appeal are seen as being very time consuming, and are likely to remove clinicians from face to face clinical care, thus having a substantially adverse effect upon treatment delivery.

The College wishes to draw attention to the recommendations set out in the recently published Report of the Inquiry into the Care and Treatment of Christopher Clunis, which we consider would make a significant contribution towards improving the care of the seriously mentally ill. In particular, we support the proposals for special supervision and funding. These proposals are less complex and lack some of the drawbacks outlined above.

If your policy on supervision registers is to be implemented with the commitment of our members, these points must be addressed.

I await with anticipation the publication of further guidance on implementation.

Yours sincerely

Dr F. Caldicott
President

Copies to:
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