# Correspondence

## Guidance on the introduction of supervision registers

Sir: Following the issuing by the NHS Management Executive of the substantive guidance document on the introduction of supervision registers, I have received several 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.

I have therefore written to the Secretary of State for Health, stating that while the College supports the introduction of a mechanism to document a small 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.

Concerns highlighted in my letter covered the broad nature of the criteria for inclusion on the register, the resource implications, the medico-legal implications associated with a decision not to include a patient, the legal position facing clinicians in the event of a violent act or suicide committed by a patient who was not included on the register, potential effects on the doctor/patient relationship, and anxieties in relation to civil liberties and confidentiality.

This letter will be published in the July issue of the *Bulletin*. In the meantime, copies are available on request from the College Secretary.

F. CALDICOTT, *President, Royal College of Psychiatrists*

## The NHS and Community Care Act, 1990

Sir: The article by Graham Thornicroft concerning 'recent Government policy and legislation' (*Psychiatric Bulletin*, January 1994, **18**, 13–17) is a useful outline of the arrangements and problems that have developed. However, the author has not perhaps appreciated the full extent of the difficulties that many of us face in implementing aspects of this Act.

For example, he did not stress enough the problems of high dependency hostels in the inner city. Not only are there extensive needs, needs that will be left further unresourced by the move of funds away from some districts, but the qualifications of the staff required to deal with these needs remain poorly analysed. Thus views as to the nature of 'mental illness', which is often termed 'mental distress' by non-health workers, vary significantly. Some social workers operating in hostels see behaviour differently from trained nurses, and may find it intolerable even though it derives from significant psychotic illness. The acknowledged overlap of social and health care, as Dr Thornicroft has outlined, extends further into a confusion of different philosophies that hinder communication. Perversely, the more hostel places there are, the more acute beds are required as respite care, not least because of the terms of the Mental Health Act.

Furthermore, the Act creates no incentive for discharge. Patients on an acute ward, whose essential needs are appropriate housing and supportive care, are much less of a burden to social services when they stay in hospital. When they leave hospital they have to be looked after and paid for. Delays accrue around obtaining community grants, providing reports and going through assessments, creating frustration for patients and distrust between agencies.

Perhaps the most important factor is the sheer bureaucracy involved in the various terminologies used by Dr Thornicroft. Terms such as 'joint planning', 'brokerage', 'monitoring', 'evaluation', and 'care/case management', all involve lots of people, numerous meetings, and a growing army of administrators. This can lead to easy evasion of direct responsibility, which is the major problem of implementing community care. This is symptomatic of new NHS structures.

Although some of us directly begged Griffiths to unify services, I suspect that the current fragmentation of responsibility nicely shields the Department of Health from the appropriate criticisms of under-resourcing. The unified management of the asylums, without their walled isolation, is still the key requirement.

T.H. TURNER, *St Bartholomew's & Hackney Hospitals, London*

## Shortage of beds

Sir: While there has been a continuous shortage of beds in every hospital I have worked in since starting my career in psychiatry in 1991, in the past six months the situation seems to have become markedly worse. This sudden deterioration has been precipitated by increased reluctance to discharge patients from psychiatric beds. In the wake of more stringent government

guidelines for community services to be in place before discharge and recent well publicised failures in community care, consultants are understandably taking fewer risks and are delaying discharge. Unfortunately this has had a 'knock on effect' for junior doctors assessing patients in accident and emergency departments. Often one is aware that there are no vacant beds on the psychiatry wards and admission could only be effected by using 'leave beds' or trying to use beds in other hospitals. Faced with this situation, the threshold for admission rises and increasing risks are taken. Thus the responsibility for taking risky decisions has been shifted from a consultant psychiatrist on the ward to a junior doctor in casualty.

Surely this trend is not the way forward.

FRANCES FOSTER, *Fazakerley Hospital, Lower Lane, Liverpool*

## Job-sharing a consultant post

Sir: As a consultant psychiatrist imminently expecting the arrival of a fourth baby, I found the article by Black & Callender on job-sharing a consultant post (*Psychiatric Bulletin*, January 1994, **18,** 47–48) very helpful and encouraging.

In 1991 the Department of Health became the first government department to join Opportunity 2000 in an effort to increase women's participation in the NHS. One of the stated goals was to increase the percentage of women consultants to 20 by the end of this year. Sadly there seems to be no prospect of achieving this and I believe that the prospects will remain bleak while colleagues continue to view new ways of working such as job-sharing with a high index of suspicion.

The Royal College of Psychiatrists under the presidency of Dr Fiona Caldicott has been extremely encouraging in this area, and I understand that a College Adviser on flexible training and flexible working is shortly to be appointed. However unless the College exerts strong leadership and continues to send out regular signals on this topic, it is my impression that there will continue to be subtle opposition to job-sharing and fair part-time work with all the resultant wastage of skills and resources that this implies.

ANNE CREMONA, *Wexham Park Hospital, Slough, Berkshire*

## The dangers of the 'internal market'

Sir: In parallel with the development of the NHS purchaser/provider split, an alternative 'internal market' has emerged in many hospitals – the phenomenon of the hospital lobby market stall – usually selling such health-care necessities as cut-glassware, handbags, compact discs, jewellery and training shoes. Informal questioning reveals that these stalls 'generate income' for the hospital in the form of site fees paid by the stallholder.

Recently, a stall was set up in the main lobby of this hospital, selling 'discount cutlery'. Closer inspection revealed an assortment of carving knives and breadknives openly laid out for inspection. Three wards, accommodating up to 75 acutely ill psychiatric patients, are situated in the same building. On that day, as is usually the case, the wards contained a number of patients at risk of self-harm and several with a history of dangerousness to others and risk of further dangerousness.

Alan Lillywhite (*Psychiatric Bulletin*, February 1994, **18,** 113) recently highlighted the assault potential of sharp metal letter-openers offered by drug company representatives. This example focuses attention on the dangers of giving planning responsibility for such income generation schemes to staff who have neither the clinical training, experience nor common sense to make decisions which ultimately affect the safety of staff, visitors and patients. The risks of bypassing clinical input are clear when designing such ventures.

ROBIN IRELAND, *Newtown Branch, Worcester Royal Infirmary, Worcester*

## Health care in Kerala

Sir: We read with interest the foreign report by R. and L. Hackett (*Psychiatric Bulletin*, 1993, **17,** 752–754) which regrettably fails to give a comprehensive picture and is riddled with dangerous generalisations and distortion of facts.

Kerala is one of the most densely populated, culturally mixed and politically unusual states in the world. About the size of Switzerland, it has a population of 30 million people, 60% are Hindus, 20% each Muslims and Christians. Midway along the spice route between Rome and China, Kerala thrived as an international meeting place from the 1st century AD so becoming the first destination in India for Christians, Jews and Muslims, whose descendants have added a cosmopolitan flavour to this enlightened Hindu state.

However, Kerala is now known for different reasons. In 1957 it voted a Communist government to power, the first in history. More recently, its success has received wide attention, "it is a poor state in a poor country which manages to keep its people alive longer and educates them better than any of the world's lower income countries" Baird (1993). Radical land reforms, female literacy and voluntary family planning enabled Kerala's people to achieve a quality of life