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# Supervision registers and the care programme approach: a practical solution

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Although the principles behind the care programme approach have generally been welcomed, its implementation has at best been patchy and at worst a complete failure. The principles behind supervision registers have not been welcomed by most psychiatrists. This paper presents a practical solution to the major problems associated with the implementation of the care programme approach and supervision registers by defining pragmatic criteria for inclusion on these registers and the services which should be provided to registered patients. This solution was agreed between purchasers and providers following a series of consultative meetings and this is a process which must be recommended.

Although the principles behind the introduction of the care programme approach (CPA) have generally been welcomed, in practice its implementation has at best been patchy, and at worst an almost complete failure. Many of the factors behind the difficulty in implementing the CPA have been highlighted (Social and Community Planning Research, 1993). Most psychiatrists have considered the criteria for inclusion to be too broad and their services too under-resourced to cope with the added work-load involved. The Guidance on the Introduction of Supervision Registers (HSG(94)5), has met with expressions of similar concern and some dismay from many sources including the Royal College of Psychiatrists (Caldicott, 1994). In its submission to the Secretary of State, the President's letter included 12 key points which it stated must be addressed, the first two points being that the criteria for inclusion were too broad and that new resources would be required for its implementation. Identical problems have undermined the implementation of the CPA.

The implementation of the CPA in South East London has been patchy. We face the typical problems that inner London and inner city services have to contend with. These include inadequate resources to meet an ever increasing number of seriously disturbed patients, increasing levels of violence, increasing diversion of patients from the courts and prison services putting greater pressure on our already overstretched community, in-patient, intensive care, and forensic services, increasing use of distant private sector beds where aftercare planning is unsatisfactory, increasing numbers of referrals from primary care and other sources for non-psychotic conditions, and a major shortage of suitable aftercare accommodation into which our most needy patients can safely be discharged.

It was therefore clear to us that we did not and could not apply a comprehensive care programme approach as required, i.e. to all patients accepted by specialist psychiatric services. Although it would be possible to *appear* to apply it, this would merely be a paper exercise and would be so time-consuming that patient care would actually suffer rather than be enhanced. It was also clear that the Guidance on the Introduction of Supervision Registers, if accepted, would also be impossible to implement. It would become a mere administrative task which, while significantly adding to the burden of work for psychiatric services, would actually decrease the amount of time and resources that would be available for patient care and contact.

As a result of these problems Lewisham and Guy's Mental Health Trust, West Lambeth Community Care Trust, the Maudsley and Bethlem Trust, and Lambeth Southwark and Lewisham Health Commission agreed to

develop a joint approach to the problem of how to implement these two registers. We accepted that it would be impossible to implement them fully as described in the guidelines. However, as we all supported the underlying principles, we agreed to develop an innovative and pragmatic approach to the registers taking into account the fact that no new resources were available. This paper describes the result of this work.

### **Criteria for inclusion on the care programme approach and supervision registers**

Following a series of meetings between Lambeth Southwark and Lewisham Health Commission (LSLHC), Lewisham and Guy's Mental Health Trust, West Lambeth Community Care Trust and the Bethlem and Maudsley NHS Trust, it was agreed that LSLHC wished to continue to purchase a comprehensive mental health service. LSLHC has accepted that if the care programme approach (CPA) and supervision register were to be implemented literally as directed the providers would be able to provide a 'psychosis only' service. LSLHC have therefore accepted that with resources so stretched and pressures so great in this area, the CPA must be implemented in a modified and stratified form. They also accepted that local providers must introduce and adopt supervision registers, but this too must be in a pragmatic way, taking account of the same pressures and resource implications. The following guidelines for inclusion of patients on these registers have been accepted by LSLHC and the three providers.

### **The care programme approach**

We agree that all patients accepted by specialist psychiatric services are subject to the CPA. However a clear differentiation has now been agreed between a simple statement of good clinical practice and an agreed care plan, called the CPA, and a CPA register which will only apply to those patients who experience a major degree of disability as a result of their mental illness and who fulfil certain other criteria. For the majority of patients the usual arrangement of a statement of a plan of clinical action will be sufficient, they will not be on any register, they will not require a multidisciplinary

assessment, and nor will they have a registered key-worker.

### **The care programme approach register**

The criteria for inclusion on this register are:

- (a) a diagnosis of a severe and persistent major illness, and any of the following:
  - (1) a history of repeated relapse of their illness due to a breakdown in their medical or social care in the community
  - (2) individuals with severe social disability or major housing difficulties as a consequence of their illness
  - (3) individuals who require multi-agency involvement and coordination
  - (4) a history of serious suicidal risk or self harm, severe self neglect, or of violence or dangerousness to others as a consequence of their illness, which the clinicians judge to be relevant in view of the patients' current or likely future mental health, taking account of their past history
- (b) all patients who fulfil the criteria for section 117 aftercare should be included on the CPA register.

All patients admitted as in-patients should be systematically assessed for inclusion on the CPA register. Patients who have not been admitted in the recent past but who are also suffering from severe and persistent major mental illness and fulfil the same criteria should be registered. Of course, there may be some patients who do not fulfil these criteria but whom clinicians judge would benefit from inclusion on the register. These patients should be registered.

Inclusion on the CPA register will imply that:

- (a) the patient has received a systematic assessment by the multidisciplinary team of their health and social care needs
- (b) a care plan has been agreed between the team, the user and their carer(s), where possible
- (c) a key-worker has been allocated with clear responsibilities and tasks agreed in the care plan
- (d) regular post discharge reviews will occur for as long as this is deemed appropriate.

The CPA register must include details of the patients' care plans, their key-workers, all professionals involved in their aftercare, and review dates that will allow for a systematic audit of this register. The level of services that should be provided for patients on the register must depend on the level of need identified in the systematic assessment. Shortfalls in service provision or providers' ability to make appropriate assessments should be systematically recorded and fed back to purchasers. Patients with the highest level of need and who fulfil the criteria listed in (c) below will in addition be registered on the supervision register.

### Supervision register

HSG(94)5, 'Introduction of supervision registers for mentally ill people from 1 April 1994', proposed that all individuals who are under the care of an NHS provider unit known to be at significant risk of committing serious violence or suicide or of serious self neglect as a result of severe and enduring mental illness (including personality disorder), should be on a supervision register. If the broad criteria listed in this guidance are applied, the patients on this register would in the vast majority of cases be the same patients who are also on the CPA register. The numbers that would then be included would make it impossible for providers to fulfil the requirements of this guidance.

The three provider units and LSLHC have agreed that the criteria for inclusion of a patient on to the supervision register will be all of the following:

- (a) a diagnosis of a major mental illness and
- (b) either incomplete symptomatic response or a documented history of relapse following non compliance and
- (c) history of serious violence or serious dangerousness to others consequent on psychotic symptomatology. Due to (b), there is a significant risk of future violence or dangerousness and
- (d) history of having been detained in hospital under the Mental Health Act.

**Note:** all patients conditionally discharged from hospital under section 37/41 of the Mental Health Act should be included on the register.

This will, therefore, be a register of patients with relevant histories of violence or dangerousness. Clinical teams will have to judge both the seriousness of the history of violence and the risk of future violence. Guidance on how to make this assessment is included in the footnotes.

### Services to be provided to patients on the supervision register

- (a) A key-worker who is an experienced community mental health professional.
- (b) An allocated social worker.
- (c) A general practitioner.
- (d) A multidisciplinary assessment of health and social care needs.
- (e) A care plan that adequately addresses the assessed risk and needs of the patient. This care plan must be agreed by a consultant psychiatrist, the allocated social worker, and the key-worker and other relevant members of the multidisciplinary team. If possible, the care plan should be agreed with the patient and their carers.
- (f) Regular multidisciplinary review meetings should occur at least every six months.
- (g) An assessment by the forensic psychiatric team within six months of the patient's name being entered on the register. Each supervision register patient will represent at a minimum one fifteenth of a key-worker's clinical activity.

Inclusion on the register will imply that all the other requirements for patients on the CPA register are also fulfilled and that shortfalls in service provision should be recorded in the same way. These patients will also be placed on the CPA register which has many common points of reference.

These criteria will be implemented by the three provider trusts. The criteria and their implementation will be reviewed by the trusts and LSLHC after six months. Further work that will, hopefully, lead to agreements on other aspects of the registers including documentation, information, confidentiality and civil liberties, liaison with social services and probation services, and the role of key-workers will be undertaken by the trusts and LSLHC.

**Footnotes**

(a) The separation of CPA registers from the CPA, as a generally agreed approach to good clinical practice, is explicit, as is the agreement that the CPA register will only apply to a minority of all the patients referred by primary care to specialist psychiatric services.

(b) Clearly, the criteria that we have agreed for the supervision register depart from the guidelines laid down in HSG (94) 5, in two specific ways. First, we are excluding patients whose major risk is one of self harm or self neglect from the supervision register in focusing on those with a forensic history only. Secondly we are excluding those who do not have a major illness, i.e. personality disordered patients. This is in line with the Reed report (Department of Health, 1992) which recognised the different and often contentious issues concerning the care of this group of people. The most recent report from the working group set up to study this issue has concluded that further research is required because of our ignorance in this area. Our approach may clearly be altered in the future in the light of any new research findings. LSLHC has explicitly accepted that the risk involved in accepting these exclusions will be shared by the purchaser and provider units, and not by the individual clinicians.

(c) It was agreed that clinicians across the three trusts should have some guidance with regards to the assessment of dangerousness as a condition for inclusion on the supervision register. It is recognised that the assessment of dangerousness is always a difficult task and that it is impossible to always predict when it is likely to occur. We hope that by targeting the supervision register on a small group of patients we may improve clinical outcomes but we are aware that there is no evidence that placing a patient on the register will have any impact on the likelihood of the patient committing further offences.

(d) Minor forms of violence or dangerous behaviour are common in our wards and in our catchment areas in South East London. The history of violence must be documented and serious before a patient should be placed on the supervision register, and the violence must be consequent on psychotic symptomatology. Clear examples would include a conviction for GBH, arson, or rape consequent on a psychotic disorder, or a history of a series of assaults involving use of a weapon when psychotic. In addition there

will be cases where minor violence is escalating in a way which necessitates intervention and inclusion on the register.

It was agreed that the best predictor of dangerousness is a past history of dangerousness but that this in itself is only one element and needs to be assessed in context. Clinicians when assessing this risk should also take into account that the following factors are associated with dangerousness.

**(1) Current episode of violence**

Lack of provocation  
Bizarre violence  
Lack of remorse  
Continuing denial

**(2) Mental state**

Persecutory delusions  
Depressive delusions with idea of killing others  
Morbid jealousy  
Deceptiveness  
Threats to repeat violence  
Unwillingness to be treated  
Sadistic fantasies

**(3) Circumstances**

Persistence of known provoking events  
Alcohol and drug abuse  
Social difficulties and lack of support

**(4) History**

Previous episodes of violence  
Repeated impulsive behaviour  
Inability to cope with stress  
Low ability to tolerate frustration  
Low ability for self restraint  
Sadistic or paranoid personality traits.

This list is not exhaustive and serves only as a guidance to clinicians.

(e) It is anticipated that the approach being taken here may not be supported in full by the Department of Health. However we believe that local solutions have to be found in situations where national guidance is unworkable and, if accepted fully, would actually lead to a deterioration in patient care. The innovative and pragmatic approach adopted here which brings purchasers and providers together in an attempt to address the needs of patients rather than individually embarking on yet another form filling exercise is one that we believe is to be recommended.

### References and further reading

- CALDICOTT, F. (1994) Supervision registers: the College's response. *Psychiatric Bulletin*, 18, 385-386.
- DEPARTMENT OF HEALTH (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: HMSO.
- (1994) *Report of the Department of Health and Home Office Working Group on Psychopathic Disorders*. London: HMSO.
- RITCHIE, J. H., DICK, D. & LINGHAM, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- SOCIAL AND COMMUNITY PLANNING RESEARCH (1993) *Factors Influencing the Implementation of the Care Programme Approach*. London: HMSO.

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## To be or not to be discharged: an ethical dilemma

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**We describe the problems encountered in dealing with a 'discharge refuser' in the context of recent government guidelines on good practice in the discharge of mentally disordered people.**

A recent Department of Health document on good practice in the discharge of mentally disordered people gives the following guidelines:

- that psychiatric patients are discharged only when and if they are ready to leave hospital;
- that any risk to the public or to patients themselves is minimal and is managed effectively;
- that when patients are discharged they get the support and supervision they need from the responsible agents." (Department of Health, 1994).

These guidelines written in the wake of the Clunis enquiry and the Silcott affair make sense for dealing with the majority of patients with severe mental illness, in particular those who are reluctant to stay in touch with services and who all too easily slip through the net. These guidelines, however, are not at all helpful in dealing with 'discharge refusers' or 'professional patients'. Azuonye (1989) pointed out that patients have many reasons for refusing discharge including delusional beliefs about their 'rightful' place of residence, reluctance to have yet another move, satisfaction with the 'hotel aspects' of the hospital or the belief that they are 'too ill' to cope in the community. Discharge can be refused through a number of ingenious ways including acting-out or expressing psychotic-like symptoms. Provider units have been