get better to improve your morale. More specifically the splendid issue of *Advances in Psychiatric Treatment* on the health of doctors (September 1997) was a valuable contribution.

Formulation

So, in conclusion, what kind of mental state *are* we in? I think it is like the depressed patient whose relatives are saying she is getting better but who cannot yet perceive the improvement in herself. We are insecure about our effectiveness, made to feel guilty by complaining patients, trying too hard to be perfect, while perceiving our imperfections in the gap between the ideal and the real services we offer. But, as we often say to our depressed patients 'you have been well so you *can* get better'. Perhaps the new Government is already addressing some of these issues. As they say 'things can only get better'.

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Consultant psychiatrists' views on the supervision register

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A questionnaire on attitudes to the supervision register, about one year after its introduction, was sent to all consultant psychiatrists identified as working in the National Health Service South Thames Region. A response rate of 72.3% was obtained. Half of the respondents felt that the supervision register was not likely to reduce the risk of violence to the public by mentally disordered people and a quarter was unsure. Just over half felt confident in predicting violence, and over half felt that they had been reasonably trained to do so. Most had not changed their practice in admitting or discharging patients, or in the use of the Mental Health Act. There were criticisms of the register, for example: lack of resources needed to implement it, increased paperwork, stigmatisation of patients and the lack of a formal appeal mechanism. Fifty per cent felt the register should be abolished, only 25.5% felt it should not be.

Following a series of homicides by mentally ill patients, there has been increasing media attention on a small group of patients – those who are mentally ill and are at increased risk to others. In response to public concern, the NHS Executive produced several proposals including the introduction of a supervision register. The guidelines for this were issued in February 1994 (National Health Service Management Executive, 1994), and required implementation beginning from April 1994.

The aim of the register is to identify patients in contact with psychiatric services who are suffering from a severe mental illness and are at significant risk of harming others, of suicide or severe self-neglect. A care plan should be provided that aims to reduce the risk and to ensure that the patient is reviewed regularly. The register would be a point of reference for relevant staff, and be used to help plan the facilities and resources necessary to meet the needs of this priority group.

Objections were raised by the Royal College of Psychiatrists (Caldicott, 1994) and MIND (Sayce & Gorman, 1993) about a range of issues, including a lack of identified resources, the excessive speed of implementation, the inclusion of personality disorders and serious concerns about the erosion of civil liberties.

Vaughan (1996) concluded that not all consultants have accepted the supervision register, with 32% having no entries as at 31 March 1995.

The study

In mid-1995 questionnaires were sent to 209 consultant psychiatrists working in the NHS within the South Thames Region, as identified from the *Medical Directory* (1994) and by telephone enquiries. The questionnaire sought their views on the effectiveness of the register in reducing violence their confidence in predicting violence, and training issues. They were asked whether the register had changed their clinical practice, whether they had concerns about the ethics of the register and if they had experienced benefits or difficulties since the register had been introduced. Space was left for comments.

Statistical significance was measured using the chi-squared test as a null hypothesis (i.e. that there was no difference between the numbers of consultants who answered either 'yes' or 'no' to the questions).

Findings

One hundred and fifty-three (73.2%) questionnaires were returned. The sub-specialities represented were as follows: 52.3% of the replies were from adult psychiatrists, 18.3% from old age psychiatrists, 10.5% from child, 6.5% from learning disabilities, 5.2% from forensic and 7.2% from other specialists (including academic, substance misuse, neuropsychiatry, psychotherapy and two who did not state their speciality). Table 1 summarises their responses to the questionnaire.

Just over half (52.5%) of respondents felt the supervision register would not reduce the risk of violence by mentally disordered people to the public. Only 23.5% thought it would. Just over half felt either moderately or extremely confident in predicting serious violence; 42.5% either felt not very or not at all confident; 62.7% felt they had been reasonably or excellently trained to predict violence; 36% felt they had not been well trained, poorly trained or had had no training at all; 64.7% felt that further training might

Table 1. Consultant psychiatrists' views of the supervision register

Question	Yes (%)	No (%)	Don't know (%)	Not stated (%)	*P* values (yes/no) (%)
Do you think the supervision register is likely to reduce the risk of violence by mentally disordered people to the public?	36 (23.5)	80 (52.3)	33 (21.6)	4 (2.6)	<0.01
Has the supervision register changed your practice with regard to:					
(i) admitting patients?	13 (8.5)	128 (83.7)		12 (7.8)	<0.001
(ii) discharging patients?	35 (22.9)	106 (69.3)		12 (7.8)	<0.001
(iii) follow-up?	39 (25.5)	102 (66.7)		12 (7.8)	<0.001
(iv) use of the Mental Health Act?	9 (5.9)	131 (85.6)		13 (8.5)	<0.001
Do you think the supervision register:					
(i) is likely to lead to increased resources for the mentally ill?	29 (19.0)	85 (55.6)	36 (23.5)	3 (2.0)	<0.001
(ii) increasingly jeopardises patient confidentiality	101 (66.0)	29 (19.0)	19 (12.4)	4 (2.6)	<0.001
(iii) stigmatises the mentally ill?	102 (66.7)	33 (21.6)	14 (9.2)	4 (2.6)	<0.001
(iv) unnecessarily takes away a patient's rights?	48 (31.4)	67 (43.8)	33 (21.6)	5 (3.3)	NS
(v) is a justified response to public concern?	46 (30.1)	83 (54.2)	18 (11.8)	6 (3.9)	<0.05
(vi) should have a formal appeal mechanism with legal representation?	91 (59.5)	33 (21.6)	23 (15.0)	6 (3.9)	<0.001
Would you like to see the supervision register amended?	73 (47.7)	29 (19.0)	44 (28.8)	7 (4.6)	<0.01
Would you like the supervision register to be abolished?	76 (49.7)	36 (23.5)	38 (24.8)	3 (2.0)	<0.01

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possibly or would definitely improve their ability to assess risk; 30.7% thought this was at the least unlikely. Most psychiatrists felt the supervision register had not changed their practice in admitting, discharging, following up patients or in using the Mental Health Act. They also felt that the supervision register would not lead to increased resources for the severely mentally ill, but would stigmatise them, and jeopardise patient confidentiality. They also felt there should be a formal appeal mechanism with legal representation. Around half felt the supervision register should be amended or abolished (47.7 and 49.7%, respectively), compared with 19.0 and 23.5% who did not.

Comment

The response rate to this survey was higher than expected and may have reflected the strong feelings within the profession towards the supervision register. These were generally negative. Consultants complained of the additional policing role imposed upon them, that they had become responsible for all the actions of their patients without any means of discharging that responsibility, and that with the Government's other reforms they had become bureaucrats for a failing system, and scapegoats for the lack of community resources.

There were numerous ethical concerns about the register, in particular that it was not statutory, that people could be on the register without the fact being disclosed to them and that inclusion on the register adversely affected the response of other agencies to them. For instance, a general practitioner removed a patient from his list on hearing that a patient was on the register. There were also concerns that it jeopardised the doctor–patient relationship and encouraged the public in the false belief that violence was predictable and preventable.

Difficulties with implementation included finding keyworkers prepared to take on the role, endless paperwork reducing patient contact, the hostility of clinicians, no additional resources, vagueness of criteria and pressure from managers and social services to place people with personality disorders on the register. On suggestions for amendment, a common response was to abolish it on the grounds that the Care Programme Approach was sufficient. Other suggestions were a change of name, incorporation into the Mental Health Act, that personality disorders should be excluded and that there should be a formal appeal mechanism.

Favourable comments were in the minority. Consultants felt that it formalised what they did anyway. There were improvements in documentation, multi-disciplinary input to the severely mentally ill, better risk assessment, coordination of care and more attention to defaulting. Because of this it was easier to recommend less restrictive care plans, as patients were less likely to be lost to follow-up.

There is a need for a repeat of this survey as many of the views expressed would have been based on anticipatory concerns, not from a wide experience with the supervision register. The continuing publicity about mentally ill people offending in the community may also have changed views. It would also be of interest to see whether the recently produced *aide-mémoire* on risk assessment has been helpful (Royal College of Psychiatrists, 1996). Despite these reservations, it appears from the results of the survey that Governmental enthusiasm for the supervision register is not shared by the majority of consultant psychiatrists who remain suspicious of recent reforms; a view summarised by one of the comments: "The gradual change from doctor to public servant continues".

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