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# Correspondence

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## The future of psychiatric care

Sir: Dr Coid concludes his critique of the Clunis enquiry with depressing predictions about the future of psychiatric care (*Psychiatric Bulletin*, August 1994, **18**, 449–452). He thinks the principles of the new guidance (care programme approach (CPA), register etc) are sound but that implementation will fail through lack of resources and lack of knowledge, training, and experience of mental health professionals in caring for the severely mentally ill in the community. Worse, he says that when a disaster does occur the finger of blame will be pointed at the responsible psychiatrist and key worker. He is right to warn. But it need not be like that.

The CPA and register are not just about good standards of care for individuals. Aggregated data from individual CPAs will tell health authorities, trust boards, and their chief executives precisely where there are gaps in service and what levels of risk their front-line staff are carrying. Thus a continuous and constructive dialogue can be fostered between mental health professionals, managers, and authorities, to share risk, give priority to the severely mentally ill, and target new resources.

Local authority social services have managed to create such a climate with child protection. Nowadays, it is the director of social services who faces the music when something goes wrong, rather than a front-line social worker. Not a single chief executive of health authority or trust that I have spoken to in London or elsewhere has disagreed that this is the kind of climate we need to create.

Things will not just remain bad if front-line staff fear scapegoating through the new guidance. Things will get much worse. There will be over-cautious decisions that waste resources. Mental health professionals will implement guidance to the letter, out of self-protection, rather than develop it creatively for their local population. Hence, Ministers and managers will not be encouraged to put in the substantial extra resource that is required because they will see nothing likely to deliver on the investment.

The single most important obstacle to improving the dire situations in some mental health services is the loss of heart by some of their psychiatrists. Health authorities and trusts have no alternative but to develop the relationship with clinicians. They must share the risks, not point the finger of blame. They must give clinicians the freedom to improve central guidance,

not shackle them to rules. They must stimulate interest in successful services elsewhere, and in the question asked by Professor Tom Burns and others: when success is achieved in establishing satisfactory care plans for previously uncooperative chronic and severely mentally ill patients what were the ingredients of the process that distinguished it from failed attempts?

Dr Coid seems to be viewing community care of the severely mentally ill through the keyhole of a locked door. There is much more going on that is effective than he appears to be able to see.

PETER KENNEDY, *Bootham Park Hospital, York YO3 7BY*

## The at risk register

Sir: The at risk register is not law, nor good practice, but it raises important ethical issues.

Physicians hold a position of trust within the community. Patients can turn to them for sympathetic understanding and confidential advice. The psychiatrist often becomes the only friend to those who find themselves alienated in a world perceived as uncaring and persecuting.

The policing role implied within the register is quite unacceptable. The psychiatrist is not a policeman nor a protector of society but a physician who operates within a carefully defined and well established ethical position, standing with the patient and offering support, confidentiality and asylum.

Of course we must recognise the concerns of government which have led to the introduction of the register and we should address these concerns. There are patients who need special provision in the interests of health, safety and for protection of others. This is provided by good psychiatric practice now called the care programme approach. Provision is also made through the Mental Health Act and it is this that should be extended as appropriate. Those detained or regulated have rights; a tribunal can hear their case; they may be represented by a solicitor; the Mental Health Act Commission ensures that they are being given proper care. Sufficient provision for asylum in whatever modern context is thought to be appropriate must be made. For our part, we must not collude with anything which threatens civil liberties, breaches confidentiality and places the responsibility on the physician alone.

For many years at the Annual General Meeting of the College, there was a motion of censure of

psychiatrists in the Soviet Union who submitted to political pressure against the ethical standards of their profession. Now, colleagues throughout this country seem prepared to acquiesce in a similar way with the unchallenged requirements of government. Now is the time for a censure motion to be brought against British psychiatrists, as it was against those of the Soviet Union a decade ago, or at least there should be a cry of 'Shame!'

DAVID GILL, *Mapperty Hospital, Nottingham, NH3 6AA*

### Support registers instead of supervision registers

Sir: I am writing to express concern about the use of the title supervision register and sociolinguistic aspects of informing a recently traumatised person recovering from his illness that his name is going to be placed on a supervision register.

The implications of the word 'supervision' may seem condescending and patronising to some patients with psychiatric disorders, especially when they are going to be on an official register and a computerised databank for that purpose. The idea of 'being on a computer' and 'being supervised' may lead to provision of new material for delusional elaborations in some psychiatric patients. The latter will hardly be likely to come forward and confide their homicidal thoughts and place their trust in their doctor or key worker (Adams, 1994). This also may further reduce the acceptability of psychiatric services to these patients (Caldicott, 1994).

I suggest that the title of supervision register be changed to support register as the use of the latter seems less likely to have an adverse effect on therapeutic relationships. Using the designation support register would also make easier the task of psychiatrists who must formally let their patients know about the decision of placing their names on such a list.

It is also true that the aims of the register are not to facilitate pure policing of psychiatric patients, but to promote such support as to make recurrence less likely, and to render regular monitoring by a key worker more acceptable to these patients. In this perspective, calling the lists support register would give a better message about the other side of the coin, i.e. what patients may perceive as true care.

ADAMS, R.D. (1994) The dangers of the supervision register *Psychiatric Bulletin*, **18**, 429.

CALDICOTT, F. (1994) Supervision registers: The College's response *Psychiatric Bulletin*, **18**, 385-388.

R. HAGHIGHAT, *University College and Middlesex Medical School, London W1N 8AA*

### Towards three tiers?

Sir: A cornerstone of the NHS reforms is the establishment of GP fund-holding practices which are able to purchase services for their patients. However, concern exists about fundholders' willingness to purchase services for the chronic mentally ill who require labour intensive and expensive interventions (Soni *et al.*, 1993). Since more and more GPs will become fund-holding, either alone or in consortia, it is important to look at their involvement in acute psychiatric admissions. I have recently completed a study looking at this.

One hundred consecutive admissions to West London Healthcare Trust from 1 March 1994 of patients between 16 and 65 were considered prospectively. This trust serves the London Borough of Ealing and has 80 beds for acute adult care only. When the patient had a GP, the GP was contacted by letter. When GPs denied the patients were on their lists, or the patients were unsure of their GP, the patients' names were checked with the local health agency to determine if they were unregistered.

Of the 100 patients in the study, eight had no GP. Ninety-two patients had GPs who were sent the questionnaire, 69 (75%) of these replied. Of the 69 patients with a GP, 41 (59%) of the GPs knew the patient was unwell and were involved in his or her referral, 18 (26%) knew the patient was unwell, but were not involved in his or her referral and ten (14%) were not aware of the patient's current mental health problems.

That only 8% of admissions did not have a GP was surprisingly low. The majority of patients were referred by GPs; yet a substantial minority (41%) had been admitted through alternative routes - usually self-referral, referral from family, friends, or social services. With GP fund-holding one could assume that the former admissions would be secure, while the latter admissions, where sanctioning was not clearly from the GP, may not be secure. It is important that safeguards are available to patients without GPs, and those admitted to hospital without direct GP involvement, are not penalised under the health reforms.

SONI, S.D., MAHMOOD, R.F. & SHAH, A. (1993) The future of services for the chronically mentally ill: a priority case? *Psychiatric Bulletin*, **17**, 582-585.

ANDREW J. SMITH, *South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London SW10 9NG*

### Transfers from special hospitals: trial leave

Sir: There appears to be discrimination in how restricted and non-restricted patients are treated