NHS Management Executive

Health Service Guideline HSG(94)5

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INTRODUCTION OF SUPERVISION REGISTERS FOR MENTALLY ILL PEOPLE FROM 1 APRIL 1994

Executive summary

The Secretary of State for Health announced in December 1993 a requirement on all health authorities to ensure that mental health service providers establish and maintain supervision registers which identify those people with a severe mental illness who may be a significant risk to themselves or to others. This requirement builds upon guidance set out in HC(90)23/LASSI(90)11 on the introduction of the Care Programme Approach and focuses on the first stage of the development of comprehensive mental health information systems as set out in the *Health of the Nation*, which required all mental health provider units to have effective information systems in place by 1995. It aims to ensure that people with a severe mental illness receive appropriate and effective care in the community.

The annex to this guidance sets out the administrative arrangements required to identify those people significantly at risk and to maintain the register.

Action

Health Authorities are required to have in place by 1 April 1994 contracts which ensure that:

- All provider units providing mental health care set up registers which identify and provide information on patients who are, or are liable to be, at risk of committing serious violence or suicide, or of serious self neglect, whether existing patients or newly accepted by the secondary psychiatric services;
- All initial assessments and follow up reviews of patients under the Care Programme Approach consider the question of whether the patient should be registered;
- All provider units incorporate the supervision register in the development of mental health information systems to support the full implementation of the Care Programme Approach.

It is envisaged that existing systems set up in connection with the Care Programme Approach will require only simple modifications to comply. The Supervision Register need and should not be separate from such systems as long as the information described below is recorded and the procedures outlined are in place.

It is recognised that:

- It will not be possible to create comprehensive registers by 1 April as this will require a review of the status of existing patients. This should be completed by 1 October;
- In many cases full integration with comprehensive mental health information systems envisaged in The Health of the Nation will need to take place in the longer term.

ADMINISTRATIVE ARRANGEMENTS REQUIRED FOR SUPERVISION REGISTERS

Background

1. This guidance takes forward the policy of ensuring those patients subject to the Care Programme Approach who pose most risk to themselves or others receive adequate care, support and supervision in the community to assist in preventing them from falling through the care network. The establishment and maintenance of these records (referred to in this guidance as supervision registers) develops existing policy in the area of mental health information systems. The supervision register should form part of the wider information systems being developed by Health Authorities/provider units under the initiatives detailed below:

The Care Programme Approach

a. The White Paper *Caring for People* proposed the development of a *Care Programme Approach* and suggested the maintenance of registers as a component (para 7.7). This was subsequently set out in a Health Circular ("Caring for People": The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services, HC(90)23/LASSL (90) 11). The Care Programme Approach should have been introduced by all Health Authorities, in co-operation with Social Services Departments, in April 1991. It involves the development of personalised care packages for all patients accepted by the specialist psychiatric services to ensure that they receive the care they need. A key worker is appointed to keep in close contact with the patient. The present guidance does not alter the general principles of the Care Programme Approach, nor does it affect arrangements for aftercare under the Mental Health Act, 1983, section 117, or local authorities' duties in relation to care management.

The Health of the Nation *White Paper*

b. The *Health of the Nation* White Paper further stressed the requirement to develop information systems designed to ensure that patients at risk of relapse did not get lost to follow up. The *Mental Illness Key Area Handbook* proposed that, within the context of comprehensive information systems for all patients referred to specialist mental health services, an alert status should be used to designate individuals at particular risk to

themselves or to others. The supervision register is a logical extension of this proposal and now supersedes it.

The Ten Point Plan

c. The Ten Point Plan, announced by the Secretary of State in August 1993 to improve community care for mentally ill people contained a commitment to introduce special supervision registers of patients who are most at risk and need most support, as part of the development of mental health information systems generally.

Purpose of the supervision registers

2. Identifying all individuals who are under the care of an NHS Provider Unit known to be at significant risk or potentially at significant risk of committing serious violence or suicide or of serious self neglect as a result of severe and enduring mental illness is a key element in:

a. providing a care plan that aims to reduce the risk and ensuring that the patient's care needs are reviewed regularly and that contact by a key worker is maintained;

b. providing a point of reference for relevant and authorised health and social services staff to enquire whether individuals under the Care Programme Approach are at risk;

c. planning for the facilities and resources necessary to meet the needs of this group of patients; and,

d. identifying those patients who should receive the highest priority for care and active follow up.

Mental illness in this context includes people with a diagnosed personality disorder including psychopathic disorders who are receiving treatment from specialist psychiatric services. The register is not intended for young people under 16 years of age. Complementary guidance on the discharge of mentally disordered patients has been issued for consultation and will be published in definitive form as soon as this is complete.

Mechanisms for patient inclusion on the supervision register

3. All patients who fall within the scope of the supervision registers should be patients of the specialist psychiatric services. Consideration for inclusion on the supervision register should take place as a normal part of the discussion of the Care Programme before they leave hospital and at Care Programme reviews following discharge, or for new patients at initial assessments. The decision as to whether a patient is included in the register rests with the consultant psychiatrist responsible for the

patient's care. This should be made in consultation with the other members of the mental health team (includes the social worker) involved in that patient's care.

4. Patients should be included if a Care Programme review meeting concludes that they are suffering from a severe mental illness and are, or are liable to be, at significant risk of committing serious violence or suicide or of severe self neglect in some foreseeable circumstances which it is felt might well arise in this particular case (eg. ceasing to take medication, loss of a supportive relationship or loss of accommodation). Risk assessment should be of the type described in the discharge guidance circular (circulated in draft to all authorities on 12 January and to be issued substantively following consultation). Patients subject to supervised discharge, when the legislation has been enacted, will be among those included on the register.

Patients, and where they wish an advocate, relative, friend or carer, must have an opportunity to state their views and have these taken into account, for example, through attendance at the review meeting or in discussion with the responsible clinician and key worker. Wherever possible the patient's GP should be involved in the decision.

5. Judgements of the risk of serious violence, suicide or severe self neglect should always be based on detailed evidence about the patient's psychiatric and social history and current condition (including the available evidence from any criminal justice agencies with which the patient has been involved). The evidence on which the judgement was made should be recorded in written form and should be available to the relevant professionals for the review meeting.

6. Supra-district services, such as special hospitals and medium secure units, will need to ensure that all relevant information is available on patients discharged from those services into the care of local Provider units, so that they can make an appropriate assessment as part of the Care Programme Approach as to whether they should be included on the supervision register.

7. If a patient on a supervision register is transferred to a different Provider unit a copy of their record should as a matter of urgency be transferred to them. The system manager should be personally accountable for ensuring that the transfer is rapid, accurate and secure. The patient's inclusion on the unit's supervision register should be reviewed as part of the Care Programme drawn up at the new Provider unit. The receiving Provider unit will be responsible for liaison with the new Social Services Department and GP.

8. The register is intended first and foremost for patients being cared for outside hospital. Where a patient on the register is admitted to hospital this may reduce risk sufficiently for the registration to be inappropriate. However they should not be removed if significant risk persists.

Categories of inclusion

9. At the time of inclusion on the register and at each subsequent review at which the patient is left on the register, patients should be assigned to one or more of the following three categories. Assignment to more than one single category should be for specific reasons.

a. Significant risk of suicide

b. Significant risk of serious violence to others

c. Significant risk of severe self neglect.

10. Where the risk of committing serious violence, suicide or severe self neglect is considered to be contingent on specific events (eg. ceasing to take medication, or loss of a supportive relationship or home), the identified warning signs should be recorded in line with current best practice.

11. Further guidance on information that should be kept on the supervision record is at Appendix A.

Informing the patient of inclusion on the Register

12. Patients should be informed orally and in writing when they are put on a supervision register and broadly told why they have been placed on it, how the information on the register will be used, to whom it may be disclosed, and the mechanisms for review. The only exception to this may be for clinical reasons—for example, when informing the patient would probably cause serious harm to his or her physical or mental health. This is very unlikely to arise in a patient suitable for care outside hospital. If it does, the patient should be informed as soon as there is no longer any risk of harm. A decision not to inform the patient immediately should not be taken lightly, and should be agreed by the mental health team including the consultant psychiatrist responsible.

Criteria for withdrawal

13. A patient's continued inclusion on the supervision register should be considered at every review. Care Programme Approach reviews of patients on the supervision register should occur at least every 6 months and specific consideration must be given to whether registration should continue. The patient, and if he or she wishes an advocate, relative, friend or carer, must have a suitable opportunity to state his or her views and have them fully considered.

14. Any of the agencies or professionals involved in the care programme may request that a special review meeting be held to consider withdrawal of the at risk status of the patient.

15. There may be occasions when a patient requests a review to consider their withdrawal from the supervision register. The supervision register is a health service record. The inclusion of a patient is a matter for the judgement of health care professionals in consultation with social work colleagues. The decision to withdraw a patient from the register is ultimately a matter for the consultant psychiatrist responsible for the patient's care, taking into account the views of other professionals involved in the patient's care and of the patient.

16. The patient, or his or her chosen advocate, should have the right to request, verbally or in writing, his or her removal from the register. It will be for the consultant psychiatrist, in conjunction with professional colleagues, to consider these representations and inform the patient of the outcome and the reasons for the decision. If the patient remains dissatisfied the normal channels for complaint and the right to a clinical second opinion will apply.

17. Withdrawal of a patient from a supervision register will be appropriate if:

a. The patient is no longer considered to be at significant risk of serious violence, suicide or severe self neglect. This decision may only be taken at a review meeting.

b. The patient's care and records have been transferred to another Provider Unit. Withdrawal by transfer may only occur on the basis of written agreement with the receiving provider unit.

c. The patient has died.

18. Provider Units which have lost contact with the patient should not change the at risk status on the patient's personal record, but should designate the patient as out of contact with the unit. Providers should make every reasonable effort to re-establish contact. The patient's GP, social worker and other members of the care team should be urgently notified and asked to advise and a review meeting should be convened to which they should be invited.

19. Withdrawal from the supervision register on the grounds of diminished potential risk must not automatically entail a withdrawal of any services provided for the patient. *All of the responsibilities set out in the Care Programme Approach will continue to apply to such patients as long as they remain under the care of the specialist psychiatric services.*

Access to the Supervision Register

20. The patient's entry on the register should be considered confidential in the same way as any other health records. Information from the register should be rapidly accessible to mental health professionals with a need to know in order to plan or provide care. The methods of access, with appropriate confidentiality safeguards, should be estab-

lished in each Provider Unit. All members of the mental health team involved in the care of the patient, including any social worker directly involved, will normally need to know whether a patient is on the register. In addition, the patient's GP should be informed of his or her inclusion on the register and should have a copy of the care plan. The GP should inform other members of the primary health care team on a need to know basis.

21. Disclosures from the register to other agencies (including social services authorities, independent sectors providers involved and, in respect of mentally disordered offenders, probation or other criminal justice agencies) may be made either if the patient consents or without the consent of the patient if disclosure can be justified in the public interest. The Provider Unit must be able to justify such disclosure taking full account of the views of the consultant psychiatrist responsible for the care of the patient.

22. The patient has a legal right of access to the relevant part of the register, subject to essential safeguards, by virtue of the Access to Health Records Act 1990 or the Orders made under Section 29 of the Data Protection Act 1984.

Management of the Supervision Register

23. A system should be established and maintained by each Provider Unit undertaking mental health care work for the National Health Service.

24. Responsibility for this will lie with the Board of an NHS Trust, or in the case of a Directly Managed Unit, with the Health Authority. In either case, one executive member, preferably with a professional background, should be identified to oversee the process. Where the Health Authority places a primary contract for mental health care with an independent sector provider, similar arrangements will be required.

25. The responsible executive member should report not less than annually to the Trust Board or, in the case of directly managed units, to the Health Authority on the performance of the Register. These reports should include anonymized statistics of numbers of patients documented on the supervision register, classified by risk category, and numbers joining and leaving, classified by reason. Copies should be furnished to visiting members of the Mental Health Act Commission who should also be given access to that part of the register which relates to the detention or treatment of any person who has been detained under the Mental Health Act. It would be good practice if these reports were produced as part of a more extensive report covering all patients within the Care Programme Approach.

26. The supervision register will form one component of the information system which providers are required to have in place by 1995

(Health of the Nation, para c16) to support the Care Programme Approach.

27. Initially the supervision register may be maintained in manual form or on a computer. A computerised format offers greater potential for clinicians to be automatically alerted to patients who are in danger of falling through the network of care. Practical aspects of access and updating may also be eased. Providers will wish to ensure that wherever a computerised system is introduced:

a. this is undertaken over an appropriate time scale;

b. the system will be capable *in due course* of meeting wider information requirements in relation to the Care Programme Approach, *Health of the Nation* targets, and the provisions of the Mental Health Act, 1983, section 117, and

c. is in line with the IMGME Information Management and Technology Strategy.

28. Provider Units which have implemented clinically based, patient oriented, information systems will be able to satisfy the technical requirements of the supervision register with comparatively little modification.

29. If the records are held in computerised form, they will be subject to the requirements of the Data Protection Act. Register Managers should take advice from their local information manager on this issue. It should be noted that supervision registers prepared using a word processor will still require registration under the Data Protection Act. Where they are held on computer of whatever type, management of the register should include steps to ensure compliance with the Data Protection Principles, in particular the Fifth Principle relating to accuracy and the Eighth Principle dealing with security. There should be a procedure which sets out clearly who, in what circumstances, can access, add alter, disclose or remove personal data. The computer system should include a record on who has added or altered personal data and when this has been done. Additionally there should be a record retained of who has gained access to the data and when, particularly whenever such access is by someone from outside the mental health team directly involved in the care of the patient.

Further Guidance

30. The Department will be preparing a further detailed guide to the practicalities of operating supervision registers, which will be distributed later this year, and will be devising a programme of evaluation of the registers.

REQUIRED CONTENTS OF SUPERVISION REGISTERS

Part 1. Identification

i. Patient's full name, including known aliases, home address including postcode (or "no fixed address"), sex, and date of birth.

ii. Patient's current legal status in respect of the Mental Health Act (i.e. whether on leave, under Guardianship or subject to supervised discharge when available).

Part 2. Nature of risk

i. Category of risk and nature of specific warning indicators.

ii. Evidence of specific episodes of violent or self destructive-behaviour (including **relevant** criminal convictions) or severe self-neglect.

Part 3. Key worker and relevant professionals

i. Name and contact details for patient's key worker.

ii. Name and contact details of other professionals involved in the care of the patient including the consultant responsible for the care of the patient.

Part 4. Care Programme

i. Date of registration.

ii. Date of last review.

iii. Date of next programmed review.

iv. Components of care programme.