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Supervision registers for mentally ill people

Medicolegal issues seem likely to dominate decisions by clinicians

See also news story on p 559 and letter on p 611

The Department of Health and the Royal College of Psychiatrists do not see eye to eye over the introduction of supervision registers for patients in the community who are judged to be at risk. In a recent exchange of correspondence the college expressed "strong concerns" about guidelines issued by the department for the introduction of the register on 1 October.[1-3] Further discussions are planned, but the differences will not easily be resolved.

The issue is much more than a little local difficulty between psychiatrists and the Department of Health; its resolution will be important for all mental health professionals and for purchasers of psychiatric services. The college is concerned that the criteria for including patients on supervision registers are too broad and about the substantial costs of setting up and servicing the registers. It is also worried about the unclear arrangements for withdrawing patients from a register once they have been placed on it and the implications for patients' civil liberties—and about the legal position facing clinicians and trusts in the event of a serious assault or suicide of a patient.

The Department of Health disagrees that concern is justified. The secretary of state denies that the criteria for inclusion are too broad, refuses to accept that the introduction of the registers implies the need for any new services requiring additional expenditure, and asserts that the proposed conditions for removing patients from the register are perfectly clear. She has avoided any detailed discussion of the college's concern about civil liberties and on the legal position has asserted that the introduction of supervision registers "does not add to (or subtract from) the existing legal and ethical responsibilities placed on clinicians." All of these points warrant full and frank discussion, but we shall concentrate on the medicolegal implications for mental health professionals and for purchasers and providers.

The guidelines state that independent inquiries will be required for each case of homicide and may be necessary for other serious incidents of violence. Consideration is to be given to appointing a lawyer to chair these inquiries—suggesting an increasingly legal focus on the gathering of evidence, due process, and procedure. A psychiatrist's decision to include someone on a register could be subject to judicial scrutiny, as is the case with child abuse registers (which were created under precisely similar administrative provisions). Such proceedings will not expose doctors to personal liability, but they are time consuming and expensive. Judicial review in relation to child abuse registers is increasing, and supervision registers seem likely to follow their example.

The introduction of supervision registers will be an invitation to litigation. Nowhere is this clearer than in the case of a failure to include a person on the register, when in the event of a subsequent untoward incident this decision may in retrospect create an impression of negligence, whatever the reality. The prediction of dangerousness is far from an exact science, and a court might recognise that—but only at trial, after the defendants have undergone considerable frustration, professional soul searching, and expense. Violent incidents and tragic suicides provoke enormous public concern, evident recently in media responses to the confidential inquiry into homicides and suicides by mentally ill people (p 559).[4,5] In such cases there is pressure to identify responsible people and to uncover defects in the system. These risks are highly visible to mental health professionals and will be guarded against most carefully by doctors anxious to avoid litigation.

Ambiguous criteria

Yet the criteria for including patients on the registers remain unclear. At first glance the guidelines seem to restrict potential candidates to those "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." But they go on to include "people with a diagnosed personality disorder" and those liable to be at significant risk in "some foreseeable circumstances which it is felt might well arise in this particular case (e.g., ceasing to take medication, loss of a supportive relationship or loss of accommodation)." The ambiguities in these criteria—personality disorder, severe and enduring mental illness, foreseeable circumstances—will be the meat for litigation.

The introduction of registers may extend the legal duty of care of psychiatric professionals. At present a patient leaving hospital can make a clean break: he or she can terminate the patient-doctor relationship and so end the psychiatrist's legal duty of care. That may not be a desirable option, but it is both practical and an important civil right—after all, the patient is no longer detained under the Mental Health Act. The introduction of supervision

registers potentially places the psychiatrist and the key worker in an untenable position subject to a duty of care over a "patient" who probably does not want to see them and who may actively evade them. It may or may not be reasonably possible to know whether the patient is actually dangerous or at risk of suicide, but the duty of care may extend as long as the patient is on the register. As the guidelines cogently argue, the best predictor of the future is the past; but since many of the risk factors cited in the guidelines will remain in the patient's history, a decision to remove him or her from the register may be delayed notwithstanding a favourable change in circumstances.

See you in court

The key worker will find himself or herself under the spotlight alongside the consultant psychiatrist, and general practitioners also have their responsibilities for communication and effective action within the agreed care plan. The department may be right to claim that the introduction of supervision registers and detailed guidelines regarding their operation may not technically impose new legal or ethical responsibilities on these professionals, but they set comprehensive standards, such as the obligation to convene urgent multidisciplinary reassessments of the patient's status. Failure to meet the standards of care spelt out in the guidelines may well be cited in evidence in court.

New obligations are also placed on purchasers and providers of mental health care. For example, the guidelines specify that all staff "must be adequately trained in the care programme approach and in risk management and assessment." Having guidelines that require the provision of urgent multidisciplinary assessments is pointless if there are too few staff to implement them. The courts have held that a health authority providing a service is obliged to meet a reasonable standard of care in the provision of that service.[6] Shortage of money will not be accepted as a defence by a health authority for failure to measure up to the required standard. How a court would decide these matters when considering the complex issues surrounding duty of care toward vulnerable patients in the community is uncertain, but the registers (and the detailed guidance accompanying them) offer an invitation for aggrieved patients and relatives to find out.

The guidelines may still be modified after further discussions between the college and the Department of Health, but, whatever the final outcome, effective operational systems will be needed for the care of vulnerable people in the community. Pugh *et al* calculate that substantial numbers of psychiatric patients will need to be placed on registers according to the proposed criteria (p 611).[7] These guidelines, together with those for the care programme approach, thus represent a substantial shift of resources within the mental health budget, and purchasers and providers will have to make the changes quickly and effectively. In some cases radical changes in working practices will be required to deliver the required standards of supervision, communication, and documentation. Harsh decisions may be required on priorities. Speed will be essential: civil litigation may soon ensure that any laggards catch up.

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3 NHS Management Executive. *Guidance on the discharge of mentally disordered people and their continuing care in the community*. Leeds: NHSME, 1994. (HSG(94)27.)
4 Steering Committee of the Confidential Enquiry into Homicides and Suicides by Mentally Ill People. *A preliminary report on homicide*. London: SCCIHSMIP, 1994.
5 Kingman S. Psychiatric patients who kill have often refused treatment. *BMJ* 1994;309: 559.
6 Wilsher *v* Essex Area Health Authority [1986] 3 ALL ER 801 (CA).
7 Pugh R, Gardner J, Allen R. Implications of supervision registers in psychiatry. *BMJ* 1994;309:611.

Tiaprofenic acid and cystitis

Grounds for withdrawal?

See articles on pp 574 and 599

Non-steroidal anti-inflammatory drugs are widely used and most of their adverse reactions are well known. The sites mainly affected by toxicity are the gut, the skin, and the kidney. Unusual toxic reactions, such as hepatotoxicity in the case of benoxaprofen or haematological toxicity in the case of phenylbutazone, have led to the drugs being withdrawn or their use severely restricted.[1,2]

Clinical use of non-steroidal anti-inflammatory drugs should be based on their known adverse reactions, particularly their toxic effect on the gut. On this basis it is possible to construct a league table of risk: low dose ibuprofen is the safest drug, naproxen and diclofenac have intermediate risk, and piroxicam and azapropazone are the most toxic.[3] Other adverse effects, such as the high rate of skin reactions with fenbufen, may also need to come into the equation.[4]

In 1991 Ahmed and Davison reported a case of cystitis in association with the non-steroidal anti-inflammatory drug tiaprofenic acid.[5] Cystitis has occasionally been reported through the Committee on Safety of Medicines' yellow card scheme with other non-steroidal anti-inflammatory drugs, but recent evidence from Australia has highlighted the risk with tiaprofenic acid.[6] In three years' postmarketing surveillance in Australia 47 reports of cystitis associated with tiaprofenic acid were received out of a total of 71 urinary tract reactions to this drug. In contrast, only three reports of cystitis out of 74 urinary tract reactions to other non-steroidal anti-inflammatory drugs were received by the Australian adverse drug reaction scheme in its 25 year existence.

Similar evidence now comes from Britain in this week's *BMJ* in the form of two series of patients with cystitis induced by tiaprofenic acid—one from Manchester (eight patients), and one from Newcastle (three patients).[7,8] Some of these patients had cystectomies, and, worryingly, two of the patients in the Manchester series had symptoms that