

---

# Managing the high risk psychiatrist

Nigel Fisher

---

Psychiatrists, politicians and the public continue to be concerned about the care of mentally ill people who are potentially dangerous or vulnerable. In this context the College convened a conference on 'Managing the high risk patient'<sup>1</sup>, which addressed issues of risk assessment, resources and legislation. The issues debated were of relevance beyond 'high risk' patients and underscored the difficulties the College and the Department of Health face in trying to achieve a satisfactory level of psychiatric service and practice across the country.

Variations in psychiatric services have been widely reported by the Audit Commission (1994), and the College's MILMIS project group (1995). These bodies have tended to focus on service provision in terms of funding; availability of beds and implementation of the Care Programme Approach. A more difficult and uncomfortable subject to comment on is the variation in clinical practice between individual psychiatrists, and the extent to which this variation is unacceptable. This variation is evident from the 'Clunis' inquiry (Ritchie *et al.*, 1994). Discussion of variation in clinical standards is often deflected to a debate on resources. There is no doubt that effective clinical practice depends on the availability of adequate resources and services, but it must also be recognised that resources can only be effectively used by capable practitioners. So what role does the College have in identifying and rectifying any problems in this area? The view that this was an area of responsibility in which the college had failed was aired during the debate on the proposed Mental Health (Patients in the Community) Bill.

Dr Eastman, a forensic psychiatrist, barrister and secretary of the Mental Health Law Subcommittee of the College, opened the discussion presenting the College's view on the Bill. He was careful to state that he would attempt not to colour this with his own opinions (Eastman,

1995). The Bill, it was suggested, was substantially politically motivated, a substitute for adequate resources, would be anti-therapeutic, clinically unworkable and was medicolegally flawed. The government could and should do better, especially if it had listened to the experts, including the College.

Dr Reed, Special Advisor to the Department of Health, in an unscheduled rebuttal would have no truck with this. The College had to recognise the history of the Bill and its part in pushing for additional mental health legislation. He criticised the College's changed approach to the Bill which was based very largely on the College's own proposals for a community supervision order (Royal College of Psychiatrists, 1993) adapted to meet the needs of the European Convention on Human Rights. The College had not raised serious concerns about the proposals when replying to the report of the Review of Legal Powers, circulated in August 1993 (Department of Health, 1993). To suddenly change their view and describe the Bill as the "worst of both worlds" in a letter to *The Times* was unhelpful to an attempt to improve the care of patients living in the community. More broadly Dr Reed regretted that the College had not been more active in responding to concerns about the management of violent or vulnerable patients. Notably they had failed to fulfil the recommendation of the Sharon Campbell Inquiry (DHSS, 1991) to publish a consensus statement *agreed with other professional groups* on discharge and aftercare procedures. The lack of response was the cause of the current, almost unique position of the Department, rather than the College, having to draft and implement clinical guidelines. Dr Reed agreed that this position should be a source of embarrassment to the psychiatric profession (Fisher, 1994).

Behind these apparently different stances there was considerable agreement between Dr Eastman and Dr Reed. Both acknowledged the unacceptable inconsistency in using the 1983 Mental Health Act and the role this had in the Clunis and Robinson tragedies. Dr Eastman highlighted the lack of formal training among psychiatrists on the therapeutic uses of legislation. Neither a Section 12 approved doctor, nor a Member of the Royal College of Psychiatrists nor

---

1. Joint conference of sections for social, community & rehabilitation psychiatry and forensic psychiatry held 9th May, 1995, Royal College of Psychiatrists.

indeed a consultant psychiatrist is required to formally demonstrate any expertise in mental health law.

There was also agreement that the time may be approaching for a comprehensive review of the 1983 Act to take into account "community care", despite the intention of the Act to incorporate "the principle that no one should be admitted to hospital if care in the community would be more appropriate" (Jones, 1991). Such a review would take several years and would need to take into account the effects of the initiatives included in the "Ten Point Plan" (Burns, 1994). However, there was pressure, not least from the College, to bring forward some changes immediately. The theoretical and practical difficulties in using legislation to forcibly treat patients in the community and the potential limitations imposed by the European Convention of Human Rights were also recognised by both parties.

Finally, regarding resources; there was even some agreement here - the Department recognises this as an issue but sees prioritisation as the solution. Again Dr Eastman did not entirely disagree with this, expressing the view that the Supervision Register would be more acceptable (to psychiatrists) and useful if it had been called and overtly recognised to be primarily a "priority care register". However, the practical difficulties of prioritising were somewhat glossed over, especially in terms of contracting with fund-holding GPs.

These common areas of concern could not only be identified from the conference but are also present in the Campbell (DHSS, 1988), Ciunis (Ritchie *et al*, 1994) and Robinson (Blom-Cooper *et al*, 1995) reports, the Mental Health Task Force London Project (Department of Health, 1994) and recent articles in psychiatric and medical journals. The recurring issues include: risk management; knowledge of mental health law; and maintaining contact with people with continuing disabilities. The skills required relate to service management and organisation as much as face to face clinical skills such as interview technique, but are equally essential in ensuring good outcomes for patients. Furthermore, they would seem to be non-controversial and cut across the arguments about models of service philosophy and delivery.

These skills should be as much a part of the ordinary psychiatrist's repertoire as the ability to make a diagnosis or initiate a treatment plan. Yet they seem to be sadly neglected and in part responsible for major tragedies. This is not to suggest some sort of panacea. If all psychiatrists were empathic clinical experts, delivering proactive and targeted services, tragedies involving psychiatric patients would still occur. Psychiatrists are obliged to manage mental health problems that carry a very high individual and

social morbidity and mortality with interventions that are limited in their efficacy. In improving clinical practice the limits of this practice and so the limits of psychiatry need to be recognised. The current inconsistency in standards of practice prevents this boundary of responsibility being delineated and defended. The College's difficulty in bringing its influence to bear in this area, perhaps even to recognise the problem, is undoubtedly the cause of so much frustration within the Department of Health. As Tyrer & Kennedy (1995) recently stated, clinicians not civil service mandarins should be the ones improving and being seen to improve psychiatric practice.

How might this be done? A precedent is perhaps the College's role in improving clinical practice in the use of electroconvulsive therapy. The role of poor practice by psychiatrists, especially consultants, was identified as the major cause of low standards in a national audit. The College has since organised a series of workshops around the country, aimed at consultants, addressing the issues raised by the audit. The continuing professional development programme would perhaps offer the ideal vehicle to address the problems of service management and organisation. Yet the first three continuing professional development workshops have been on: staff supervision; ethics and psychiatry; and rationality and culture, interesting enough, but are these really the most pressing subjects for psychiatrists in the 1990s?

There is one final spanner in the works. That is the shortage of trained psychiatrists. If there is one thing worse than a poor psychiatrist it is no psychiatrist at all. Draft figures from the College's 1994 manpower census indicate that there were 285 consultant vacancies across all psychiatric specialities. In general psychiatry there were 88 posts filled by locums and a further 36 unfilled posts. Provider units are desperate to recruit to these posts, to the extent at times of ignoring College advice on who may be a qualified candidate. Secondly, consultants who are in post must cover these vacancies and have an increased workload with corresponding difficulties in maintaining standards.

In the same way that mental health services need to be proactive and assertive in identifying, engaging and treating at risk patients so the College needs to be proactive and assertive in identifying and tackling poor quality services. The management of the high risk patient is also the management of the high risk psychiatrist.

### Acknowledgements

I am grateful to Drs Eastman and Reed for their helpful comments on an earlier draft of this paper.

## References

- AUDIT COMMISSION (1994) *Finding a place: a review of mental health services for adults*. London: HMSO.
- BLOM-COOPER, L., HALLY, H. & MURPHY, E. (1995) *The falling shadow*. London: Duckworth.
- BURNS, T. (1994) Mrs Bottomley's Ten Point Plan. *Psychiatric Bulletin* **18**, 129-130.
- DEPARTMENT OF HEALTH (1993) *Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review*. London: Department of Health.
- DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1988) *Report of the Committee of Inquiry into the Care and After-Care of Miss Sharon Campbell*. London: HMSO.
- EASTMAN, N. (1995) Anti-therapeutic community mental health law. *British Medical Journal*, **310**, 1081-1082.
- FISHER, N. (1994) The discharge of mentally disordered people and their continuing care in the community. *Psychiatric Bulletin*, **18**, 453-456.
- JONES, R. M. (1991) *Mental Health Act Manual*. London: Sweet & Maxwell.
- MENTAL HEALTH TASK FORCE PROJECT (1994) *Priorities for Action*. London: HMSO.
- MILMIS PROJECT GROUP (1995) Monitoring inner London mental illness services. *Psychiatric Bulletin*, **19**, 276-280.
- RITCHIE, J., DICK, D. & LINGHAM, R. (1994). *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Community supervision orders (CR 18)*. London: RCPsych.
- TYRER, P. & KENNEDY, P. (1995) Supervision registers: a necessary component of good psychiatric practice. *Psychiatric Bulletin*, **19**, 193-194.
- Nigel Fisher, *Consultant in General and Rehabilitation Psychiatry, Pathfinder NHS Trust, Wimbledon CMHT, U Corridor, Nelson Hospital, Kingston Road, SW20 8DB*

# Caring for a Community

The Community Care Policy of the Royal College of Psychiatrists

by Dinesh Bhugra, Keith Bridges and Chris Thompson

This report presents some examples of philosophy, approaches, good practices, and service aspirations found in the UK. Some of these services have resulted from Government policy and research into specific psychiatric disorders while others have drawn upon developments abroad. Many services, however, have developed based on clinical experiences, pragmatism, a sensitivity to local needs, collaborative approaches involving a variety of local organisations, and the desire of practitioners to have available to the public an effective range of services. The report describes actual and potential community services providing for the mental health needs of the severely mentally ill.

● £10.00 ● 90pp. ● 1995 ● ISBN 0 902241 77 X

Available from bookshops and from the Publications  
Department, Royal College of Psychiatrists, 17 Belgrave Square,  
London SW1X 8PG (Tel. 0171-235 2351 extension 146)