

Alternative Perceptions of Statutory Community Aftercare: Patient and Responsible Medical Officer Views

*Sharon Riordan**, *Helen Smith*** and *Martin Humphreys****

ABSTRACT

The need for more effective means of caring for mentally disordered individuals in the community has been given a prominent place by the Department of Health. The inclusion of user perspectives in mental health care research, to inform and improve the development of services, has also been given a high priority and the necessity of incorporating patients' and carers' views has been recognised by the Department of Health in the National Service Framework for Mental Health published in 1999. Studies incorporating both the service user and professional viewpoints of statutory community care have been relatively sparse. This study, looking at the process of conditional discharge of restricted hospital order patients sought the views on the benefits, deficits and recommendations for change from those people providing and receiving statutory community aftercare. The findings may assist in any future review of the Mental Health Act, policy development and in the planning and delivery of psychiatric services to other groups of severely mentally ill people.

* *Research Associate, The University of Birmingham*

** *Consultant Forensic Psychiatrist, South Birmingham
Mental Health NHS Trust*

*** *Senior Lecturer and Honorary Consultant Forensic
Psychiatrist, The University of Birmingham and South
Birmingham Mental Health NHS Trust*

INTRODUCTION

The Department of Health and NHS Executive have placed great emphasis on the importance of effective supervision of mentally disordered individuals in the community, in particular, in the context of issuing guidance on the supervision of such individuals in the community¹, the introduction of supervision registers² and the power of supervised discharge under Sections 25A Mental Health Act 1983.

The process of statutory community aftercare for patients conditionally discharged from a restricted hospital order (Section 37/41 MHA 1983) is known to be successful³. Supervision is comprehensive, potentially long lasting and resource intensive in terms of professional time. The purpose of formal supervision is essentially to protect the public from further serious harm by assisting the patients' successful reintegration into the community after what may have been an extended period of hospitalisation in conditions of varying levels of security. It allows close observation of the patients' mental condition and also is beneficial in identifying any perceived change in the risk of danger to the public in order that measures can be taken to support the patient and provide public protection. The conditional discharge process enables professionals involved in the supervision a period of time to assess the patients' progress in the community before any decision is made to abolish the controls affected by the imposition of the restriction order by way of an absolute discharge.

What is not known is why exactly the process of conditional discharge works. It may be that legal constraints force both patients and clinicians to comply with Home Office regulations. But it could be that legal enforcement provides the framework within which individuals have the opportunity to form good relationships with each other, allowing for successful supervision and rehabilitation.

One of the principal objectives of the White Paper, *Caring for People* (1989) was to emphasise the importance of user and carer involvement in the planning and development of services. It anticipated that users would have a greater individual say in how they live their lives and the services needed to help them do so. This subsequently translated into the NHS and Community Care Act (1990) that required local authorities to produce community care plans and to actively involve users and carers in the development of services. To what extent this has been realised is debateable.

A sample of 92 psychiatric service users in the City of Westminster were interviewed regarding their experiences and levels of satisfaction with community care services provided. The findings highlighted the vulnerability of service users, the high regard most had for their helpers, the benefits of day centres and 'drop-in' facilities, which were perceived as lifelines by the majority of those that used them, and the difficulties caused by the loose co-ordination between health and social services. Service users provided a rich source of information on how services might be improved⁴.

1 Department of Health (1994a) *The guidance on the discharge of mentally disordered people and their continuing care in the community*. NHS Executive Health Service Guidelines. HSG(94)27. London; Dept of Health.

2 Department of Health (1994b) *Introduction of supervision registers for mentally ill people from 1st April 1994*. HS Management Executive HSG (94)5 London; Department of Health.

3 Dell, S and Grounds, A. (1995) *The discharge and supervision of restricted patients*. London. Home Office.

4 MacDonald, G and Sheldon, B. (1997) *Community Care Services for the Mentally Ill*. *International Journal Of Social Psychiatry* Vol.43 No 1 35-55.

In another study, 94 psychiatric outpatients were individually interviewed about their views on the characteristics of ideal outpatient treatment. Fifty-seven statements were generated concerning characteristics of ideal outpatient treatment. A second sample of 84 psychiatric outpatients were asked to rate the importance of the 57 statements generated in the first part of the study. Patients put great emphasis on the ability of staff to display empathic qualities in taking patients seriously, being caring and understanding and exhibiting respectful behaviour towards the patient. The next most important theme to patients concerned matters of the quality of information given to them about their mental illness and medication by their care team⁵.

The aim of the present study was to address the paucity of research evaluating statutory community aftercare from the dual perspectives of service users and responsible medical officers, and to provide a basis for future comparison with other groups of patients with severe mental illness under other statutory community supervisions, as well as those managed in the community with no statutory framework or requirements.

METHOD

A semi-structured questionnaire was administered to 14 Responsible Medical Officers involved in the care of 38 conditionally discharged restricted hospital order patients in the West Midlands. Of those 38 patients, 24 agreed to participate in the study. Each participant was asked about:

- The quality of the relationship between the responsible medical officer and the patient.
- The good things about supervision from each individual's point of view.
- The bad things about supervision from each individual's point of view.
- Any recommendations for change from each individual's point of view.

Responses were analysed using a qualitative approach.

RESULTS

Patient Perceptions

Sixteen patients (67%) said there were good and bad things about statutory supervision. Seven (29%) said there were only good things, and in one case a patient said there were only bad things. Overall the perception of the quality of the relationship between the patient and their clinical team was positive. Thirteen patients (54%) said they got on well with their RMO; their RMO agreed on 12 occasions, and in the remaining case the RMO said the relationship was okay. Eight patients (33%) said the relationship was okay; however the RMO thought the quality of the relationship was good in six cases and okay in the remaining two. Three patients (13%) said the relationship was bad, in contrast to the RMO who thought they got on well with their patient in one case and okay for the remaining two.

5 Bjorkman, T; Hansson, L; Svensson, B and Berglund, I. (1996) *What is Important in Psychiatric Outpatient Care? Quality of Care from the Patient's Perspective.*

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Good things about supervision

Relationships/support

The best thing about supervision from the patients' perspective was the general support given in all aspects of their lives. In the main they felt confident enough to approach their clinical teams if they needed help with anything. Patients confirmed that they received help with practical issues such as money matters and housing. They felt that they could trust their supervisors and in many instances described them as 'friends'.

'The community aftercare is supportive. I respect my nurse and social supervisor, they're there to sort things out. My social supervisor is more like a friend than a social worker.'

The theme of loneliness felt by patients emerged on a number of occasions. Clinical teams were acknowledged for their willingness to listen, discuss and provide help.

'If I need someone to talk to they are good at listening and I can take or leave their advice. I can talk to them about anything that bothers me. A lot of people like me have their bad days and the first people I think of is the team.'

Patients on the whole made positive comments about their consultant psychiatrists and medical supervision overall. There was recognition that the clinical team would, wherever possible, keep the patient out of hospital.

'The clinic is the only place that has really understood me and looks after me on a one to one basis... the best aftercare anyone could wish for.'

It was also clear that relationships between patients and their clinical teams took time to develop.

'When I first went into the community I wouldn't be inclined to tell the team first if I was unwell or relapsing I would now as I've got to know the team well...The more my Social Supervisor knows about me the less chance there is that things will go wrong...consistency is important.'

Outside agency involvement

Patients often mentioned the help of other outside agencies involved in their care. The extra assistance from them added to the sense of security and confidence patients felt.

'I'm given lots of different support and this lets you know you're not on your own. I get support from a MIND support worker.'

Some patients had the offer of support from outside agencies seven days a week. A number did, however, acknowledge that not all people would necessarily welcome this sort of input and that it was an issue of personal preference and choice.

'Some people would be dubious about having a support worker, they might be seen as interfering in people's lives ...I have an outreach worker who is very helpful and understands me. It improves my life, I know people will do what they can as soon as they can.'

Legal framework

The legal framework of the conditional discharge process was considered beneficial by a third of all those interviewed. Patients emphasised their own vulnerability once out in the community after a long period of hospitalisation and said they felt a sense of extra security knowing that a hospital bed was available should they need it. Patients also felt that being subject to a restricted hospital

order gave them a choice of going into hospital as a voluntary patient rather than being admitted compulsorily. As a consequence they felt that this meant they could get out of hospital more rapidly once recovered. Patients recognised that without statutory aftercare they could face difficulties in all areas of their lives.

'If I get stressed its good to know that there's a bed always there for me...Before, I've had to commit silly crimes to get attention for my illness. As I see it, it's the only way forward. Without the supervision a lot of conditionally discharged people would get into problems...'

Bad things about supervision

Legal framework–control/coercion

The most common thing patients thought was bad about statutory supervision was the feeling that the supervision disempowered them in terms of personal autonomy and privacy. Patients particularly mentioned the frustration of having to ask permission from the Home Office to go on holiday.

'I don't really like the restrictions on my travel. ...I did get a bit annoyed when the Home Office refused me a holiday abroad fairly soon after conditional discharge, but I do realise why they did now.'

There were a number of comments about the protracted length of supervision and the perceived lack of negotiation and communication between the clinical team and the patient.

'Sometimes I feel like a dog on a leash. The authorities will have to release me sometime - why not now?...I don't think there's a need for coercion, you should negotiate with the patient.'

Clinical team meetings

The practice of calling patients to clinical team meetings at the hospital where they had previously been detained was particularly unnerving for many. These places were seen as the focus of bad memories.

'I don't like to go up to the clinic for CPA meetings and out patients appointments because it brings back bad memories...I get nervous and my thoughts race.'

Many patients wanted the venue for clinical meetings to be changed to a neutral location because the hospital setting unnerved them. Two (8%) patients felt they had been treated discourteously in team meetings.

'Perhaps they don't think we deserve respect and courtesy... It's my life, I don't like to be stared at and people asking me about my past.'

Medication issues

Nine (38%) patients said that having to have depot injections was one of the worst things about statutory care. Some expressed their distress about the side effects. Those people who experienced tremors as a side effect of medication said they felt that this made them stand out as different. This affected their social confidence and in their view increased the likelihood of stigmatisation of the individual by others. In the main patients said that having to have medication by injection was painful.

Eight patients (33%) said they would like to change from having injected depot medication to oral antipsychotics. In four cases (17%) the request for change was directly related to the pain of the injections.

Some patients equated the use of injected depot medication by their consultant psychiatrist with punishment.

Recommendations for change

Most patients were generally happy with supervision and recognised the value of support given to them. Some said they would like to be absolutely discharged but stay under the care of their clinical team. One commented.

'I'd rather look after myself but I might need a bit of help though.'

Accommodation

Eight patients (33%) said they would change their accommodation if they could. In two cases (8%) patients said they would like to move so that they were not so lonely.

Responsible Medical Officer Perceptions

Patients were in the main seen by their consultant in out patients or in a minority of cases were seen by the consultant in the patient's own home. Where data were available, evidence suggested that most RMOs saw their patients on a monthly basis. The frequency of contact between the RMO and patient depended upon how long the patient had been conditionally discharged, whether there had been any recent cause for concern about the patient's mental health, behaviour, or non-compliance with treatment or supervision. Where the consultant saw the patient at home this was to gain a clearer view of the patient's mental state and social circumstances in the context of the patient's daily environment.

Responsible medical officers said they got on well with 26 (68%) of their patients and okay with 12 (32%). The data showed that of the 14 patients that declined to take part in the study, in nine cases the RMO said they got on well with their patient and in the remaining five cases said they got on okay. Comments were made, however, to support the contention that sometimes the relationship between the RMO and the patient was only superficially good because of the legal framework surrounding the relationship.

In some cases the RMO perceived the quality of the relationship to be based on enforced tolerance of the supervision process on the part of the patient.

'I get on well with my patient due to the compulsory nature of the relationship. Superficially we get on very well, he's welcoming etc. But it's a tolerance on his part'

In 20 cases (53%) the RMO said there were both good and bad things about supervision and in 18 cases (47%) the RMOs said there were only good aspects of supervision for those specific patients.

Good things about supervision

The benefits of supervision from the perspective of the RMOs are discussed in the order of the frequency in which they were reported.

Legal framework

The benefit of the legal framework towards the development and continuity of a successful community aftercare package for the patient was clearly expressed by RMOs.

Compliance

The conditional discharge arrangement was seen as particularly useful in cases where there was evidence of previous aftercare breakdown and consequent disengagement with services. Many patients were described as having a previous history of non-compliance and therefore the legal framework served to ensure continued treatment and follow-up.

'We offer him support that he finds useful...he hasn't been compliant in the past.'

Statutory supervision was used on some occasions as a lever with which to maintain compliance.

'The order provides a structure that means he takes medication and lives in appropriate accommodation.'

'He doesn't have enough insight to take medication without it.'

Risk

Comments about the benefit of supervision from the point of view of risk reduction figured commonly in the RMO responses. The degree of control over where the patient lived, the intensive multi-disciplinary supervision and the use of compulsory drug screening was seen as helpful.

'His offence was drug related in part and after conditional discharge he started to smoke cannabis.'

'The restriction order assisted us in giving him regular urine screening. It helps minimize the risk'

Repeated interagency collaboration between the psychiatric services, the police and social services was considered a benefit of statutory supervision and an important aspect in reducing potential risk of harm to others.

Relationships

Many comments were made about the benefits of the legal framework in assisting the development of good relationships between the clinical team, the patient and the patients' family. The assistance and support of the family were perceived as key factors of successful supervision.

'His parents are also very supportive and that has been key. They have been able to keep me informed about his mental health.'

Bad things about supervision

Legal Framework

Although the RMOs saw the legal framework as being a major factor of successful statutory supervision, paradoxically the legal framework was mentioned most commonly as a bad feature of supervision. The restriction order was seen as too inflexible and long lasting in some cases.

'The potential downside of statutory supervision is that patients become frustrated with the length of time they are on conditional discharge, especially if they have been stable for a long time.'

Recommendations for change

In more than half (53%) of the cases of patients currently under supervision the RMOs said that they were happy with the supervision and could not make any recommendations for change. In a number of cases the consultants said that they would support an application for absolute discharge for their patient and were convinced that the patients would keep in contact with psychiatric services after absolute discharge.

Accommodation

There were a large number of comments referring to the lack of appropriate housing for these patients. Consultants said that they would like access to more supported housing particularly for the more vulnerable patients who were subject to exploitation from various sectors of society. There was also recognition that some individuals were suffering from the negative effects of the stigmatisation of being an offender-patient in the community.

'We would like to accommodate him in another area because he's attracted a lot of vigilante type attention.'

Staffing issues

Due to the high numbers of black people in secure psychiatric provision there was recognition by the consultants for the need for more black staff on clinical teams. In some cases it was also suggested that it would be preferable to have some more male CPNs, particularly for those patients with a history of violence towards women.

The problems caused by intensive statutory follow-up in terms of the financial cost and professional time involved led to some consultants suggesting that the amount of professional input time be reduced for some patients. In some cases the reduction in staff input was linked to the consultant wanting to facilitate the rehabilitation process and improve patient autonomy.

'Reduce the amount of time he gets from others so that he can deal with his own problems and increase his independence.'

Drug misuse

Psychiatrists indicated a need for more effective means of drug misuse prevention. Some said they would welcome the imposition of more stringent conditions that could be enforced to stop patients using illicit drugs. They highlighted the difficulties caused by patients abusing drugs.

'He was no management problem before he started using He may have been vulnerable and targeted.'

DISCUSSION

The benefit of a restricted hospital order has long been recognised⁶, not because of the constraint it involves on movements through the hospital and rehabilitation process, but because of the intensive community aftercare that is required.⁷

The National Service Framework published by the government in 1999 sets out new standards that health and social services will be obliged to meet in the delivery of mental health and social care to people experiencing mental health problems. It requires that mental health services must be planned and put into practice in partnership with local communities and involve service users and carers. There have been a number of reasons suggested for the inclusion of service user perspectives. One is that any evaluation without service user participation is unsatisfactory and will be biased towards the providers.⁸ In addition, psychiatric patients, particularly offenders, are a particularly socially marginalized and disadvantaged group with little or no bargaining power and no alternative to public health service programmes⁹. Without service user evaluation the sufficiency and quality of care is left solely to service providers. It might be argued that where legal requirements are involved in addition to clinical considerations, user opinion and involvement is even more important, hence the value of the work presented here.

The uptake rate by patients was 63%. It could be argued that patients who agreed to take part in this study were more likely to be content with their supervision and therefore represent a biased sample. Nevertheless they did, in most cases, identify areas of supervision that they were not happy about and were prepared to make recommendations for change in respect of supervision.

Those that declined to take part in the study included all of the women in the sample. Refusal did not appear to be linked to unsuccessful community aftercare for this group as they were all maintaining good mental health and were viewed by their clinical team as progressing well in the community. In addition none had a history of poor compliance with treatment or supervision. The reasons why these women did not wish to participate are therefore unclear. The men that declined to take part did have a background of non-compliance and previous recall to hospital and therefore may not have been so happy with their statutory community aftercare arrangements. This is obviously a potential limiting factor in interpreting the results of the present study.

As might have been anticipated, the benefits and deficits of statutory community aftercare from the perspectives of patients and Responsible Medical Officers differed in their focus. Patients valued the practical support it gave and the human relationships it fostered. Doctors emphasised the strength of the legal framework in keeping the patient well through compliance with treatment and supervision.

6 Walker, N and McCabe, S. (1973) *Crime and Insanity in England* Vol 2. Edinburgh. Edinburgh University Press.

7 Humphreys, M, Kenney-Herbert, J and Gray, C. (1998) *Restricted hospital orders: a survey of forensic psychiatrists' practice and attitudes to their use. The Journal of Forensic Psychiatry*. Vol 9 No 1 May 1998 173-180.

8 Bjorkman, T; Hansson, L; Svensson, B and Berglund, I. (1996) *What is Important in Psychiatric Outpatient Care? Quality of Care from the Patient's Perspective. International Journal for Quality in Health Care*. Vol. 7.No.4. pp355-362.

9 *Ibid*

Comparisons between our study and an earlier review¹⁰ showed that overall, interpersonal aspects of psychiatric care are rated consistently as more important by patients than impersonal dimensions. One service user study found that individuals felt left on their own after discharge from hospital. In addition, negative attitudes of the public towards mentally disordered people translated into damaging experiences for users.¹¹ However, although the issue of isolation was mentioned by some in the present study, overall, patients felt less isolated under statutory provision than they had in the past under non-statutory care. This may be explained at least partially, by the intensive nature of the care required by restricted patients who may have had a long period of hospitalisation and the added Home Office requirement for more regular supervision than those people in the community who are not subject to any legal control.

Both patients and responsible medical officers made some mention of the problems of stigmatisation and vulnerabilities of the mentally ill within the community. The public may not always be sympathetic or understanding of the mentally ill, a problem exacerbated by a criminal background. Some restricted patients are likely to have committed the sort of offence that makes their acceptance back into the community particularly problematic.

Both parties did, to varying degrees, acknowledge the benefit of the legal framework in assisting the development of good relationships between all those involved in the process. However, both groups agreed that in certain cases statutory supervision was continued for too long, paradoxically causing damage to the therapeutic relationship.

Both the patients and responsible medical officers recognised the value of multi disciplinary clinical team and family support in the conditional discharge process. Patients felt their teams and families gave them extra security whilst doctors recognised that families could be a vital source of support and information regarding patients' mental health. This is very much in keeping with the guidelines for supervising psychiatrists which state that '...the two most important elements in effective supervision are the development of a close working relationship with the patient and the maintenance of a good liaison with the social supervisor'.¹² Teamwork and close communication have previously been highlighted as key factors in any work with offender patients.¹³

In line with other research¹⁴, the patients in the present study agreed that using the facilities of outside agencies and befrienders was beneficial. Staff allied to these services were seen as knowledgeable about the specific problems encountered by individuals and were able to provide a cushion between the individual and the pressures of everyday life in the community.

10 Ruggeri, M. *Patients and relatives' satisfaction with psychiatric services: the state of art of its measurements.* *Soc Psychiatry Psychiatr Epidemiol* 29:212, 1994.

11 Rose, D. (1996) *Living in the Community.* London, The Sainsbury Centre for Mental Health.

12 *Mental Health Act 1983 Supervision and After-Care of Conditionally Discharged Restricted Patients – Notes For The Guidance of Supervising Psychiatrists.* Home Office and Department of Health and Social Security 1987.

13 Prins, H (1983) *The care of the psychiatric prisoner-discharge into the community and its implications.* *Medicine, Science and the Law*, Vol. 23, No.2, 79–86.

14 MacDonal, G and Sheldon, B (1997) *Community Care Services for the Mentally Ill: Consumers' Views* *International Journal of Social Psychiatry* (1997) Vol.43 No1 35–55.

A key factor in community care policy is that patients should have a greater say in determining the services they receive and have the opportunity to influence their quality. Almost half of the respondents in an earlier study¹⁵ felt they had no choice at all in the services they used. In our study participating patients and responsible medical officers generally felt that needs were met by the services offered. This was particularly true where services were tailored to the individual concerned. There were, however, recommendations for change put forward from both groups. These were mainly to do with specific needs on the part of patients and more general changes to do with staffing and lack of appropriate accommodation from the responsible medical officers.

Restricted hospital order patients have in the past been asked for their opinions of statutory supervision¹⁶ but have not explicitly been asked to make recommendations for change. This research indicates that by and large conditionally discharged patients were content to be supported in the community within the confines of statutory provision and responsible medical officers were satisfied with its value and effectiveness. The Mental Health Act 1983 introduced aftercare planning for certain categories of detained patients. The more recent introduction of Section 25A Supervised Discharge provides a way of formalising aftercare within a legal framework for those patients who meet specified criteria. On the basis of the results described here the long established process of conditional discharge might, in some ways, be viewed as a template for a model of psychiatric community aftercare that is, for a substantial group of patients and their supervising psychiatrists, successful from two seemingly contrasting perspectives.

15 *Ibid*

16 Dell, S and Grounds, A. (1995) *The discharge and supervision of restricted patients*. London. Home Office.