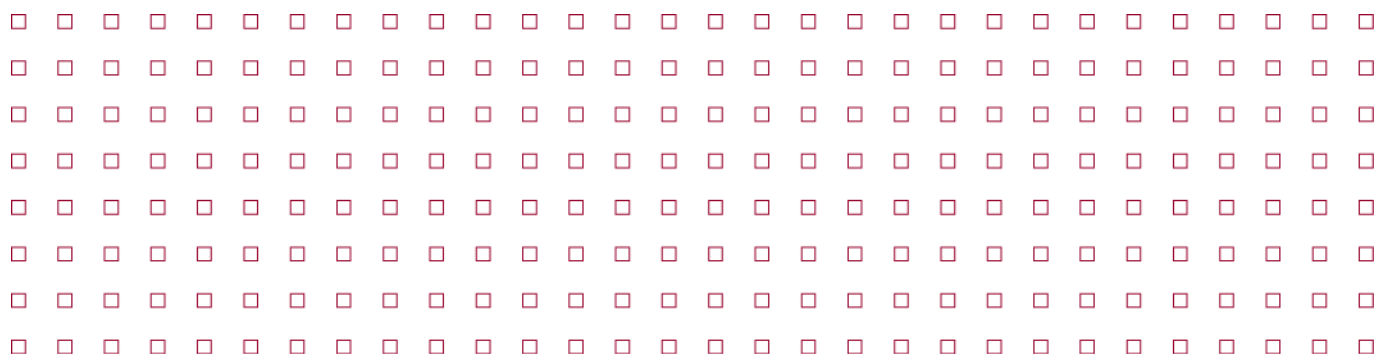


Guidance for clinical supervisors

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Section 1 – Introduction

This Guidance should be read in conjunction with the 2007 Mental Health Act Code of Practice with particular reference to the emphasis on public protection, risk assessment and staff safety.

1. These Notes are for the guidance of clinicians who take on the role of clinical supervisors for a restricted patient subject to a conditional discharge. That is a person who, having been made subject to the special restrictions set out in section 41 of the Mental Health Act 1983 (the Act) , is conditionally discharged from hospital either with the agreement of the Secretary of State or by the First tier Tribunal - Mental Health under section 42(2) or 73(2) respectively of the Act. The Notes may also assist clinical staff who become involved with the clinical supervision of such patients in support of the clinical supervisor. The Notes cover the procedures which should take place before the patient leaves hospital, the responsibilities of those involved with the patient after discharge from hospital and the action to be taken in some of the circumstances which may arise while the patient is in the community. The Notes are not intended to limit the clinical freedom of the responsible clinician to treat the patient as he or she sees fit. They are intended to cover those aspects of the work which differ from purely clinical practice by virtue of the restriction order, which affords certain priorities to the need for public safety. The Notes refer throughout to the “clinical supervisor”. It is not for the Secretary of State to determine the grade at which medical professionals should be responsible for restricted patients, but he strongly recommends that the supervision of restricted patients in the community should be undertaken by professionals who are of consultant grade or equivalent and who have experience of the care and treatment of forensic patients. This guidance sets out the role and responsibilities of the clinical supervisor. It is strongly recommended that any clinician who does not have experience of managing restricted patients attends a Mental Health Casework Section open day which explains the restricted patient system and the role of the Ministry of Justice. These are held approximately every two months.
2. The Notes were first issued in 1987 following a review of procedure and practice relating to the supervision of conditionally discharged restricted patients carried out by the Home Office in association with the then Department of Health and Social Security (DHSS). They have been repeatedly revised following the recommendations of non-statutory public inquiries following failures in supervision which contributed to homicides being committed by conditionally discharged patients. The present edition emphasises the need to adhere to practice which, when followed, has proved effective. Any questions arising from the Notes, or suggestions for their improvement, should be sent to Mental Health Casework Section, Ministry of Justice Ground Floor, Grenadier House, 99-105 Horseferry Road, London SW1P 2DD.

Section 2 – The restricted patient population

3. Restricted patients represent only a small percentage of all patients in mental hospitals. There are about 3900 restricted patients detained in hospital. Over 50% have been convicted of offences of violence against the person, with a further 12% convicted of sexual offences and 12% of arson. About 600 are detained in the high secure hospitals. Only patients who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities are admitted to the high secure hospitals (section 4, National Health Service Act 1977). The remaining detained restricted patients are in medium and low secure units, or other National Health Service or independent sector hospitals.
4. The number of conditionally discharged patients under active supervision in the community is currently around 1600.

Section 3 – The role of the Ministry of Justice

5. The Mental Health Casework Section of the Ministry of Justice employs nearly 60 officers whose sole concern is to carry out the Secretary of State's responsibilities under the Mental Health Act 1983 and related legislation. Among their duties, they authorise the admission to hospital of patients transferred from prison. They consider recommendations from responsible clinicians for the leave, transfer or discharge of restricted patients from hospital, seeking the personal authority of a Ministry of Justice Minister in some instances. They prepare the Secretary of State's statement to tribunal panels hearing restricted patient cases, as required under the First tier Tribunal – Mental Health Rules 2008. After the conditional discharge of a patient by authority of either the Secretary of State or the tribunal, they monitor the patient's progress and give consideration to the variation of conditions, recall to hospital, or absolute discharge as circumstances require.
6. Staff in Mental Health Casework Section are ready and willing to discuss the case of any restricted patient with a clinical supervisor. The letter to the clinical supervisor which notes the discharge of a restricted patient should contain a name and telephone number for use in that case. If it does not, or if in any doubt, a clinician wishing to make telephone contact should telephone the Ministry of Justice on 020 3334 3555 and ask to speak to an officer in Mental Health Casework Section dealing with the patient, whose name he should give. Arrangements for making urgent telephone contact out of office hours are given in paragraph 54 below.

Section 4 – The purpose of conditional discharge

7. The Secretary of State will usually make a restricted patient's discharge from hospital subject to certain conditions. The conditions usually imposed by the Secretary of State are those of residence at a stated address, supervision by a social worker and clinical supervision. The tribunal is also likely to make discharge directions conditional, and to impose similar conditions. If it does not, the Ministry of Justice, using powers under section 73(4) of the 1983 Act, will usually add conditions of social and clinical supervision. Supervisors must understand that conditions are designed to operate for the protection of the discharged patient and others and to enable the patient's safe management in the community. They are not measures for social control, nor even for crime prevention. Breach of conditions does not, in itself, justify recall to hospital, but it should act as a trigger for considering what action is necessary in response.
8. The purpose of supervision under conditional discharge arrangements is to protect the public from further serious harm. There are two aspects to this. The first is by assisting the patient's successful reintegration into the community after what may have been a long period of detention in hospital under conditions of security. The second is that the Secretary of State's ability to exercise his statutory powers to protect the public is dependent on the reports he receives from the supervisors about the patient's condition and behaviour in the community. Close monitoring of the patient's mental health and any perceived increase in the risk to the public enables steps to be taken to assist the patient and protect the public. Conditional discharge also allows a period of assessment of the patient in the community before a final decision is taken to remove the control imposed by the restriction order; by means of an absolute discharge.

Pre-discharge procedures

Section 5 – Preparation of supervision and after-care arrangements by the discharging hospital

9. On admission of a restricted patient to hospital, the responsible clinician will, together with rest of the multi-disciplinary clinical team, seek not only to treat the patient's mental disorder but to understand the relationship, if any, between the disorder and the patient's behaviour. The aim will be to understand what led to the dangerous behaviour which resulted in the patient's detention and, as the mental disorder is treated in hospital, to assess the extent to which that treatment has reduced the risk of the patient behaving again in a dangerous manner if returned to the community. This period of assessment and treatment may take several years. The clinical team should only consider recommending the patient's conditional discharge when they are satisfied that the level of continuing risk arising from the patient's condition can safely be managed by resources which can be provided under a care plan in the community.
10. Staff in the detaining hospital will begin preparations for a patient's conditional discharge before authority for discharge is sought. They will also need to consider before a tribunal hearing whether arrangements may be necessary to implement a discharge order made by the tribunal. These arrangements should include the patient's personal preparation for life outside the hospital and the consideration and choice of suitable accommodation, employment or other day-time occupation, a social supervisor, and a clinical supervisor
11. Separate guidance has been issued to hospitals about the importance of careful preparation of the arrangements for the supervision and after-care of a patient. A check-list of the main points of that guidance is at Annex A to these Notes. As soon as the prospective social supervisor and the prospective clinical supervisor are known, they should discuss the patient's after-care and supervision arrangements. These discussions are important both as a means of combining hospital and community expertise in the setting up of practical arrangements most suited to the patient and also in enabling the prospective supervisors to familiarise themselves with the patient before discharge.
12. The clinical supervisor should visit the hospital and take part in at least one multi-disciplinary case conference before the patient's discharge. By doing so, he will be able to discuss the case with the responsible clinician and the staff of all disciplines who know the patient. On this visit he ought also to meet the social supervisor. If it should happen that the clinical supervisor is not invited by the discharging hospital to take part in pre-

discharge discussions and preparations he should ask for suitable contact with the hospital clinical team. In the unlikely event of an inadequate response, the Mental Health Casework Section should be approached for help.

Victims

13. It is important that wherever practicable and possible, conditionally discharged patients are supervised in such a way as to sustain public confidence in the arrangements as a whole, and so as to respect the feelings and possible fears of victims and others who may have been affected by the offences. The Criminal Justice and Courts Services Act (2000) placed a statutory duty on the National Probation Service to contact victims of crime where the offender is sentenced to 12 months imprisonment or more, for a sexual or violent offence. Victims are given an opportunity to be kept informed about key developments in the offender's sentence, and to make representations about an offender's licence conditions on release from custody.
14. From July 2005, this duty was extended to victims of mentally disordered offenders who are subject to one of the following disposals:
 - a) those charged with a sexual or violent offence, who are then made subject to a hospital order with a restriction order (Section 37/41);
 - b) those found unfit to plead and to have done the act charged, or not guilty by reason of insanity, under the Criminal Procedure (Insanity) Act 1964 (as amended) in respect of a sexual or violent offence, and then admitted to hospital with restrictions;
 - c) those convicted of a sexual or violent offence, who are then made subject to a hospital direction and limitation direction (Section 45A);
 - d) those sentenced to 12 months' imprisonment or more, for a sexual or violent offence, and transferred from prison to hospital, under a transfer direction and restriction direction (Section 47/49).

15. This means that, where an offender has committed a qualifying violent or sexual offence (as set out in Schedule 15 of the Criminal Justice Act 2003), and is subject to one of these disposals, the victim will be offered contact with the probation Victim Liaison Officer (VLO) within eight weeks of sentence, and will have a statutory right to make representations to the First tier Tribunal - Mental Health, or the Secretary of State, as to the conditions placed on the offender's discharge. Victims will also receive information, via the VLO, about the conditional or absolute discharge of the offender, including any subsequent recall to hospital, transfer to another hospital, remission to prison and if a patient who has been found unfit to plead is remitted for trial. In certain circumstances, consideration will be given to informing the VLO about a patient absconding and/or leave requests. This will require close liaison between the VLO and the offender's care team, both in hospital and in the community.

Section 6 – Provision of written information by the discharging hospital

16. In addition to the pre-discharge contact recommended in paragraph 12 above, it is essential that the clinical supervisor should receive, as early as possible before discharge, detailed written information about the patient which can be retained for reference in the records of the responsible hospital management. All supervisors should possess comprehensive background information about the patient and his offending history. It is crucial that these records are available to successive supervisors and to officers of the responsible primary care trust.
17. Discharging hospitals are advised that the full package of information provided to the clinical supervisor for retention should cover the following aspects of the case:
 - a) A pen-picture of the patient including his diagnosis and current mental state;
 - b) Admission, social, offending and medical history;
 - c) Summary of progress in hospital including insight into disorder, state of compliance and extent to which tendency to offend has been addressed by the care programme;
 - d) Present medication and reported effects and any side-effects (see paragraph 29);
 - e) Any warning signs which might indicate a relapse of his mental state or a repetition of offending behaviour together with the time lapse in which this could occur, and details of any individuals or groups who may be at particular risk;
 - f) A report on present home circumstances; and
 - g) Supervision and after-care arrangements which the hospital considers appropriate or inappropriate in the particular case.
 - h) If the clinical supervisor has not received this information before the patient is discharged to his care, he should ask the discharging hospital for it. If there are difficulties in complying with such a request, the supervisor should seek assistance from Mental Health Casework Section.

18. In addition, the discharging hospital should provide details of the circumstances of the offence which led to the patient's admission to hospital and of the legal authority for that admission. If this information is not received, Mental Health Casework Section should be notified.
19. The social supervisor will also receive the information about the patient and the offence described in paragraphs 17 and 18 above.
20. A Care Programme Approach (CPA) document should be prepared on handover at every stage of the patient's care pathway, which contains the information set out below. This document should remain on the patient's file, and copied to the Ministry of Justice. Every CPA or risk management plan should include a contingency plan to deal with any relapse. This should be regularly reviewed and updated and copies sent to the Ministry of Justice. In certain circumstances, the minutes of CPA meetings may be accepted by MHCS in lieu of a quarterly report.

Post-discharge procedures

Section 7 – The role of the clinical supervisor

21. It is the Secretary of State's hope that, by means of conditional discharge of a restricted patient, a situation of danger to the patient or to others can be averted by effective supervision, by appropriate support in the community or by recall to hospital if need be. The Secretary of State's ability to act effectively is reliant on the quality of information he receives from individual supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the supervisor provides constant and reliable support to the patient and regular and honest reports to the Ministry of Justice. Experience shows that mere crisis intervention does not suffice.
22. The clinical supervisor is responsible for all matters relating to the mental health of the patient, including regular assessment of the patient's condition, monitoring any necessary medication and its effects and consideration of action in the event of deterioration in the patient's mental state.
23. A Ministry of Justice warrant for the conditional discharge of a restricted patient usually specifies that the patient "shall comply with treatment as directed by the clinical supervisor". This form of words allows the supervisor, in any particular case, to determine the appropriate manner and frequency of clinical supervision and treatment. The minimum frequency of contact is determined by the interval at which the Secretary of State requests reports on the patient's progress, but there will of course be many cases in which the clinical supervisor considers more frequent contact appropriate. Reports to the Ministry of Justice are dealt with separately in section 10 (paragraphs 45–54) below.
24. The clinical supervisor should be directly involved in the treatment and rehabilitation of the patient and should offer support for the patient's progress in the community, rather than simply checking that the patient is free from symptoms. The clinical supervisor should be prepared to work with other professionals involved in the patient's care, including the social supervisor and possibly the general practitioner, community psychiatric nurse and hostel staff. If he is not himself a forensic psychiatrist the clinical supervisor should seek advice or information as required from specialists in this field.

25. The Secretary of State recognises that many clinical supervisors have had infrequent experience of restricted patients and the associated legislation and procedures. The Mental Health Casework Section can provide information about an individual patient's history or advice on any non medical aspect of supervision, including the legal framework.
26. A number of responsible clinicians, particularly in NHS hospitals, continue to supervise their own restricted patients after conditional discharge. This is an obvious course if the patient is to be discharged near the detaining hospital. In other cases a clinical supervisor should be chosen who is within easy travelling distance of the patient and can easily keep in touch with the other professionals involved in the case, particularly the social supervisor. It may be appropriate, in some cases, for the responsible clinician to supervise the patient for an initial period of several months and then to make arrangements for a local consultant psychiatrist to take over as clinical supervisor. Identification of the hospital to which the patient may be recalled should always form part of the discharge plan. Where it does not, the Secretary of State will normally recall to the hospital from which the patient was discharged. Prior identification is in the interests of all parties, since the circumstances of recall seldom leave scope for negotiation. Clinical supervisors should be clear that normal arguments about admission criteria or funding responsibility may not be persuasive.
27. The two most important elements in effective supervision are the development of a close relationship with the patient and the maintenance of good liaison with the social supervisor.
28. The clinical supervisor should see the patient as frequently as required to establish rapport and build trust, and to learn enough about the patient to be able to detect a deterioration in their mental health. The Ministry of Justice expects, as a minimum, the clinical supervisor to see the patient before each report is due and a report should not be sent without him/her having first seen the patient. However often the supervisor decides he needs to see the patient, he should see him in a situation in which he can detect deterioration in the patient's mental health or behaviour at an early stage. This should include visiting the patient at home from time to time. The therapeutic relationship may be made more difficult by the fear of resentment of a conditionally discharged patient that he is being "policed" by his supervisors. However, such concern must never lead to the patient setting the agenda for meetings which would enable him to conceal problems from the supervisor. Liaison with the social supervisor is dealt with separately in section 9 (paragraphs 33-39) below.

Section 8 – Medication

29. For many conditionally discharged patients continuation of medication is crucial to avoid a relapse and the attendant possibility of a reversion to potentially dangerous behaviour. It is important, therefore, that the clinical supervisor is fully informed, before discharge, of the patient's medical history including details of current medication and what is known of its effects, side-effects and the effect on the patient's condition and behaviour if medication is stopped. The supervision of medication after a patient's discharge is the responsibility of the clinical supervisor but the social supervisor, the patient's general practitioner and, where appropriate, the community psychiatric nurse and hostel staff will also need to have basic information about medication.
30. Medication should be one of the subjects covered in periodic discussions about a patient between the supervisors. Immediately after discharge and again when any change or cessation of medication has been made, the clinical supervisor must inform other members of the multi-disciplinary team and Mental Health Casework Section of the arrangements made, including when, where and by whom medication is to be given. Unless this information is clearly understood by all concerned, there is a grave danger of confusion with potentially dire consequences for the patient and for others.
31. The consent to treatment provisions in Part IV of the Mental Health Act 1983 do not apply to conditionally discharged patients. The clinical supervisor has no specific legal authority to require a conditionally discharged patient to take medication without his consent. However, where medication is prescribed to relieve mental disorder which, if untreated, would be likely to lead to the patient becoming a danger to himself or others, the patient's co-operation with such medication is likely to be fundamental to his remaining in the community. If, therefore, the patient refuses medication against the clinical supervisor's advice, he may need to be recalled to hospital as a detained patient. It is crucial that any withdrawal of co-operation with medication should be reported at once to the Mental Health Casework Section. Sometimes the Secretary of State will make cooperation with medication at the direction of the clinical supervisor a condition specified on the warrant of discharge. Generally this is unnecessary since it adds nothing to the powers of the supervisor or the Secretary of State, but there can be circumstances in which it is helpful in the management of a particular patient.

Section 9 – Liaison between the clinical supervisor and other professionals involved, and their role

The social supervisor

32. The social supervisor will usually have more frequent contact with the patient than the clinical supervisor and will provide practical support to the patient in his everyday life, especially in matters relating to accommodation, relationships and employment.
33. The social supervisor is likely to be the key worker in the necessary liaison between all those involved with a patient in the community, having contact with those providing accommodation, employers or day care staff, relations, general medical practitioners and the clinical supervisor.
34. It is recommended that the social supervisor sees the patient at his discharge address at least once each week for the first month after discharge reducing to once each month as the supervisor judges appropriate. The social supervisor may consider more frequent contact to be necessary, particularly while the patient settles down after discharge from hospital.
35. Close liaison between the supervisors is essential if supervision is to be effective. Both supervisors should be involved in the pre-discharge discussions about the patient's community care and they should meet at that stage (section 5 (paragraphs 9 to 12) above refers). They should agree a common overall approach to the patient's treatment, after-care and reintegration into the community and discuss how they can liaise effectively after discharge.
36. As section 8 of these Notes (paragraphs 29-31 above) records, the clinical supervisor should inform the social supervisor of the nature of any medication, its effects on the patient's condition and behaviour and any possible side-effects. The clinician should also inform the social supervisor of the arrangements to be made for the medication to be given, including when, where and by whom, and of any changes in those arrangements. This will equip the social supervisor with basic information during regular contacts with the patient, to identify indicators of a relapse in mental state (and, possibly, indicators of other problems arising) which should be brought to the psychiatrist's attention.
37. The clinical supervisor should send a copy of all reports to the Ministry of Justice and to the social supervisor, who should reciprocate. (See also paragraph 47 below.)
38. On receipt of the social supervisor's quarterly reports and at any other time during supervision, the clinical supervisor should be ready to contact him or her to discuss the patient's case and review progress. In addition, the

supervising clinical supervisor should have a meeting with the social supervisor together with the patient on a periodic basis and at least once a year.

Liaison with other professionals

39. All conditionally discharged patients should be registered with a general medical practitioner and arrangements for this should be made before discharge by the discharging hospital. The discharging hospital should inform the general practitioner of the names and addresses of the patient's supervisors. The clinical supervisor should contact the general practitioner to give brief details of the patient's background and current status as a conditionally discharged patient, to explain his or her role as clinical supervisor and to provide the general practitioner with a point of contact in the event of any concern about the patient's mental condition.
40. The work of other clinical personnel involved with the patient, such as psychiatric nurses or psychologists, should be under the general direction of the clinical supervisor who should consult with them periodically about the patient's progress.
41. The availability of a well-developed community psychiatric nursing service should be of considerable assistance to successful rehabilitation. The clinical supervisor who is not a CPN, may wish, perhaps through the general practitioner, to bring all available nursing services to help the patient.
42. Supervisors should consider as part of the discharge package whether the assistance of the local Multi Agency Public Protection Panel should be sought. This will always be appropriate where the risk of further serious offending is thought to be high, whether the risk is directly related to mental disorder or not. The following list indicates cases which would most benefit from reference, although it is in no way exhaustive:
 - Where there is a history of repeated serious offending or violent behaviour
 - Where substance or alcohol abuse is involved
 - Where there is little or no positive family support
 - Where the case has a high profile and discharge may lead to public hostility
 - Where there are difficult victim issues
 - Where non co-operation with supervision is anticipated.
43. Reference to the MAPPP will be a decision to be reached in discussion with the social supervisor, who will also take the lead in liaison with other, non clinical professionals involved, such as social workers, hostel staff and day care staff.

Section 10 – Reports to the Ministry of Justice

44. The Ministry of Justice usually asks for reports on the patient's progress from both supervisors one month after conditional discharge and every three months thereafter. In addition, the Ministry of Justice expects there to be an annual review of a conditionally discharged patient, undertaken by both supervisors. This is irrespective of whether the patient was discharged by authority of the Secretary of State or by direction of the tribunal. In some cases, the Ministry of Justice may ask for more frequent reports. It is crucial to the safe management of restricted patients in the community that supervisors' reports are delivered regularly and in good time. MHCS will be assiduous in pursuing any that are not and will write to the Clinical/Medical Director and/ or the Chief Executive of the relevant NHS Trust if reports are not received.
45. Reports to the Ministry of Justice should be completed in the manner shown on the conditional discharge report pro-forma (found on our website www.justice.gov.uk). Officials in Mental Health Casework Section will read the report with a view to deciding whether:
- i) there is a need to discuss the patient's management with the supervisors,
 - ii) there is a need to amend the conditions attached to discharge, or
 - iii) there is a case for recall to hospital.

The report itself should convey sufficient information to inform the questions immediately above. As indicated on the pro-forma, reports should include a detailed account of the patient's current mental condition, including any changes since the last report and the apparent reasons for those changes. The report should cover the subject of medication, if it is being given. Reference should be made to any notable improvements or achievements by the patient. The effectiveness of monitoring is enhanced when there are several available sources of information from other people about how the patient is progressing. If the clinical supervisor has identified any signs of deterioration in the patient's mental health or behaviour, these should be described in detail, together with any steps already taken to improve the situation and any further proposals for doing so. The reader should be left in no doubt about when the supervisor last saw the patient, and where.

46. A repeated theme in reports into homicides committed by discharged restricted patients is the reluctance of supervisors to send reports to the Ministry of Justice which showed clients in an unfavourable light. It is absolutely crucial to the effectiveness of the Ministry of Justice's supervisory role that reports should be comprehensive and honest.

Reports should never overlook or minimise problems for fear of jeopardising the patient's progress. This is not in the patient's interest and can lead to the most serious consequences. Finally the report should include plans for the patient's continued rehabilitation which will have been agreed by both supervisors in consultation with all staff, irrespective of their profession, who may be involved.

47. As indicated at paragraph 37 above, all reports to the Ministry of Justice should be copied to the social supervisor, and they should be discussed with him or her as necessary. In addition, copies of each report should be sent for information to the patient's former responsible clinician at the hospital from which the patient was discharged (if the responsible clinician is not also the clinical supervisor). In the event of the clinical supervisor being unavailable for any reason, he/she should provide both a verbal and a written handover report to the person who is to cover their work.

Changes in address

48. If the patient wishes to change his address which is specified on the warrant of his conditional discharge, the social supervisor should write to the Ministry of Justice to seek agreement to a change in the conditions attaching to discharge.

Transfer to another care team/change of clinician

49. It is sometimes the case that the care and supervision of a patient needs to be transferred between care teams. In such cases all the information relating to the patient as set out in Section 6 above, together with any relevant CPA documentation, risk assessments and reports to the Ministry of Justice should be passed over to the new team.
50. It is also highly recommended that the new care team attend a professionals meeting and/or CPA to discuss every aspect of the patient's background, care plan and risks before the full handover of responsibility.
51. The Mental Health Casework Section should be informed as soon as possible about a change of responsible clinician, or of supervisor, if different, and certainly before the actual date of handover. We must be provided with full contact details including address telephone number and e-mail address.
52. The social supervisor should be informed of any impending change of clinical supervisor.

Patients' holidays

53. A conditionally discharged patient is not precluded by his status from having holidays away from his approved address. However, the patient should always discuss plans for such holidays with both supervisors. If a period of absence is agreed, the Mental Health Casework Section will expect the clinical supervisor to consider whether any special arrangements will be necessary to ensure continuity of medical treatment. Any proposals for the patient to leave the United Kingdom should be put to the Ministry of Justice for consideration. The Secretary of State has no power to prevent a conditionally discharged patient from travelling abroad, but he expects that any such proposal will have received the most careful risk assessment on the clear understanding that neither he nor the supervisors have any authority over the patient once out of the country. Patients must be discouraged from making plans and bookings to travel until their supervisor, in consultation with the Ministry of Justice, is satisfied that the proposal does not present an unmanageable risk. Where a proposal does not appear safe, or the patient travels abroad without the consent of the Mental Health Casework Section, the Ministry of Justice may consider the risk sufficient to consider recall to hospital for the protection of the patient or others. Recall would only be a last resort, and only undertaken after discussion with the supervisors.

Section 11 – Post-discharge contact with the discharging hospital

54. The practice of copying supervisors' reports to the discharging hospital after discharge can have benefits for both the hospital and the supervisors. It is clearly helpful for the hospital staff to know how their former patient is progressing in the community, and their knowledge and experience of the patient while detained may enable them to make helpful suggestions about the patient's management during the early stages of his discharge. A clinical supervisor needing further background information about a patient or to discuss the patient's behaviour should make direct contact with the responsible clinician in hospital. All hospitals should expect and welcome such approaches.

Section 12 – Action in the event of concern about the patient’s condition

55. If a clinical supervisor is concerned about a conditionally discharged patient’s mental state or behaviour, the concern should first be discussed with the other professionals involved in the case, particularly the social supervisor. In addition, an early telephone call must be made to alert the Mental Health Casework Section. The contact need not be limited to the clinical supervisor. If any professional who is responsible for a restricted patient, such as the social supervisor, community psychiatric nurse or even a hostel manager for example, becomes concerned about a patient then he/she should inform the patient’s responsible clinician and the Ministry of Justice immediately.
56. If the clinical supervisor has reason to fear for the safety of the patient or of others, he may decide to take immediate local action to admit the patient to hospital for a short period either with the patient’s consent or using civil powers such as those under sections 2, 3 or 4 of the Mental Health Act 1983. Whether or not such action is taken, and even if the social supervisor does not share the clinical supervisor’s concern, the clinical supervisor should report to the Ministry of Justice at once so that consideration can be given to the patient’s recall to hospital.
57. Telephone discussion in such circumstances is welcomed by staff in Mental Health Casework Section. In normal office hours an officer in the Section should be contacted at the Ministry of Justice, Ground Floor, Grenadier House, 99-105 Horseferry Road, London SW1P 2DD depending on the surname initial of the patient. Full details of Casework Managers and their telephone numbers can be found on our website, www.justice.gov.uk (or ask the switchboard on 020 3334 3555 for an officer in Mental Health Casework Section, or email us on public_enquiry.mhu@noms.gsi.gov.uk). Outside office hours the duty officer at the Home Office switchboard should be contacted, on 020 7035 4848, who will in turn contact a member of Mental Health Casework Section staff at home. The clinical supervisor should follow up his telephone report with a written report without delay.
58. A common reason for concern is that the patient has a history of abusing illegal substances and is refusing to co-operate with testing to establish whether he is abstaining. Where substance abuse has played a part in the patient’s dangerous behaviour, it will be appropriate to make co-operation with testing a condition of discharge. It will never be acceptable to ignore a withdrawal of co-operation with testing. Refusal to co-operate with testing cannot in itself justify recall as a breach of conditions. But where the clinical supervisor is of the opinion that refusal is indicative of behaviour likely to lead to relapse in the patient’s mental condition, and consequent dangerous behaviour, recall for assessment is likely to be appropriate.

Recall to Hospital

59. The community team should have agreed and recorded a threshold for recall of the patient to hospital. However there must be sufficient flexibility in the process to respond to unexpected or unforeseen grounds for concern. As stated above supervisors should discuss any concerns with the Ministry of Justice immediately, and recognise that the Ministry of Justice may take a different view about the threshold for recall. It is not possible to specify all the circumstances in which the Secretary of State may decide to exercise his power under section 42(3) of the Mental Health Act to recall to hospital a conditionally discharged patient, but in considering the recall of a patient he will always have regard to the safety of the public. An immediate report to the Ministry of Justice must always be made in a case in which:

- i) there appears to be an actual or potential risk to the public;
- ii) contact with the patient is lost or the patient is unwilling to co-operate with supervision;
- iii) the patient is admitted to hospital for any reason;
- iv) the patient's behaviour or condition suggest a need for further in-patient treatment in hospital;
- v) the patient is accused of, charged with, or convicted of a serious offence or an offence similar to the index offence; and/or
- vi) the patient's relatives or carers have expressed concern about the patient's behaviour or condition.

Where the supervisor considers it necessary he or she should not hesitate to contact the Mental Health Casework Section's out of hours duty officer to discuss the case.

60. Consideration of a case for recall will take into account any steps taken locally to remove the patient from the situation in which he presents a danger. MHCS must be notified at once of the need to readmit a conditionally discharged patient to hospital. The Secretary of State welcomes prompt admission to hospital, either voluntarily or under civil powers, for a short period of observation or treatment. Where admission is voluntary and the patient remains co-operative with treatment in hospital, the Ministry of Justice will not normally recall if medical advice is that only a brief period of in patient treatment is necessary for observation or stabilisation. The patient will again be subject to the formal conditions of his earlier discharge when he leaves hospital. However, it is generally inappropriate for a conditionally discharged patient to remain in hospital for more than a few weeks time voluntarily. If the use of civil powers is necessary to detain a patient or enable compulsory treatment to be given, immediate recall will almost invariably be appropriate to regularise the restricted patient's status under the Act.

61. In cases where it seems that admission is necessary to protect the public from possible harm the supervising clinician may recommend that the patient be recalled to a hospital. The Secretary of State would normally be prepared to act on such a recommendation.
62. Whether the Secretary of State decides to recall a patient depends partially on the advice of an approved clinician that the patient's mental condition requires treatment in hospital. Such opinion is not final, however. Where the patient has in the past shown himself capable of serious violence, comparatively minor irregularities in behaviour or failure to co-operate with supervisors would be sufficient to raise the question of recall. The Secretary of State does not require evidence of deterioration in the patient's condition but, except in an emergency, he will seek medical evidence that the patient is currently mentally disordered. If the patient's history does not suggest that he is likely to present a serious risk, the Secretary of State may be slower to take the initiative unless there are indications of danger to other persons. There are cases in which recall to hospital for a period of observation can be seen as a necessary step in continuing psychiatric treatment. There are other cases in which anti-social behaviour may be unconnected with mental disorder, so that recall to hospital is not an appropriate sanction and there may be no alternative to leaving the conditionally discharged patient to be dealt with as necessary by the normal processes under the criminal law. Each case is assessed on its merits in the Ministry of Justice and a decision is reached after consultation with the doctor(s) concerned and with the social supervisor. However, the decision will always give precedence to public safety considerations.
63. There has been confusion over the effects of Human Rights law on the use of the recall power. In sum, the position is that a patient may not be recalled to hospital, except in an emergency, in the absence of current objective medical evidence that the patient is mentally disordered. This does not mean that the patient's condition has to have deteriorated; nor that he has to be suffering from disorder to a degree which would justify fresh compulsory admission to hospital. The Secretary of State will consider the recall of a restricted patient where it appears to him that it is necessary for the protection of others from serious harm because the combination of the patient's mental disorder and his behaviour makes it necessary. In an emergency he will recall for assessment in the absence of fresh medical evidence of disorder. In such circumstances immediate discharge would follow if the medical assessment found no mental disorder and the responsible clinician requested discharge.
64. Where recall is considered by the Secretary of State to be necessary and a warrant is signed to that effect, the patient may be returned in the most appropriate manner to the hospital specified on the warrant. If the patient will not return to hospital willingly, on being told of his recall, then assistance may be requested from the police, to whom a copy of the warrant will have been sent. There is no statutory duty on the police to assist, but they have authority under section 137 of the 1983 Act, if their assistance is requested by a supervisor, and will normally be ready to

assist in the interests of preserving public order and preventing crime. There is a general duty to inform a patient, within 72 hours of his recall to hospital, of the reasons for that recall. Mental Health Casework Section should be informed as soon as a recalled patient is back in hospital or in case of any difficulty.

65. After recall a patient is once again detained as a restricted patient in pursuance of the order of the Court which made the restricted hospital order. In some cases the responsible clinician may be able to recommend the patient's further discharge after only a short while. The Secretary of State understands this, and will be willing to consider discharge of a recalled patient as soon as the responsible clinician thinks appropriate. Under no circumstances should a supervisor hesitate to inform the Ministry of Justice of concerns about a patient in the community, for fear of a long period of further detention. In many cases, long detention will not be necessary. In other cases what has been learned about the patient in the community may point to a need for a longer period of assessment and treatment in hospital. The Secretary of State will always refer the case of a recalled patient to the Tribunal within days of recall. If he has not agreed to discharge before the tribunal hearing occurs, the supervisors may become involved in the tribunal proceedings. Section 14 of these Notes (paragraphs 76 to 82) gives guidance in such circumstances.

Patients absent without permission

66. A conditionally discharged patient may leave the approved address and break off contact with both supervisors. In such cases the social supervisor should report the fact to the Ministry of Justice immediately and then make every effort to locate the patient. The Ministry of Justice will usually issue a warrant for the recall of the patient, thus providing the police with the powers to bring the patient into custody as soon as he is located.
67. If a conditionally discharged patient is suspected of having left his approved address to go abroad, the Secretary of State may decide to issue a recall warrant and alert the immigration authorities.

Further offending

68. If a patient has committed an offence and a prosecution is pending, and if he is in safe custody and presenting no danger to himself, the Secretary of State will usually let the law take its course so that the Court may reach a fresh decision on the need for medical treatment or other measures. By preference, he will not recall the patient to hospital. The patient may, however, be recalled in accordance with the Court's wishes and if the doctor concerned agrees (for example if the Court decides, on conviction, to take no action or to impose a nominal penalty in the knowledge that he patient will be returned at once to hospital).

69. If a conditionally discharged patient is convicted of a further offence, the Court imposes a non-custodial sentence, and recall to hospital is not considered appropriate, the terms of the conditional discharge will continue and the supervisors should resume their roles. MHCS should be informed at once.
70. If a conditionally discharged patient is convicted of a further offence and the Court imposes a sentence of imprisonment, the Secretary of State will often reserve judgement on the patient's status under the Mental Health Act 1983 until he nears the end of his prison sentence, when he will seek fresh medical evidence. On the basis of that evidence, he may decide:
- i) to allow his discharge to resume under conditions of residence, social and clinical supervision,
 - ii) to direct his immediate recall to hospital on release from prison, or
 - iii) to authorise the patient's absolute discharge, so ending his liability to detention under the Mental Health Act.

Section 13 – Length of supervision and absolute discharge

71. Where a conditionally discharged patient is subject to a restriction order of specified duration, made before 1 October 2007, then on the date of expiration of the order he is no longer subject to conditions, and cannot be recalled to hospital.
72. Where, as in most cases (and in all cases since October 2007), the restriction order is of indefinite duration, there is no tariff. The decision on absolute discharge will turn on the extent to which the maintenance of conditions and supervision is seen to be contributing to public safety. Where a patient's offence is assessed as directly linked to his disorder, and he is entirely compliant with treatment which controls that disorder, restrictions may not need to persist for long even where the offence was serious. However where the link is less apparent, or the patient's co-operation with treatment less reliable, it may be necessary to retain conditions for a much longer period.
73. The Mental Health Casework Section is responsible, on behalf of the Secretary of State, for ensuring that restricted patients are managed in such a way as to minimise the risk to the public. MHCS's policy is that we will not grant absolute discharge unless it is clear that the restrictions are no longer required to ensure the patient's safe management. This means that the Secretary of State will not grant absolute discharge where the patient still has a mental disorder, and has the potential to be a risk to others if not well supervised in the future, and where future supervision is not guaranteed. In forming this view we are conscious that the First tier Tribunal – Mental Health is available to safeguard patients' rights,
74. If the Secretary of State does agree to the absolute discharge of a conditionally discharged patient, a warrant will be issued and copied to both the patient and the supervisors. Such a decision does not, of course, preclude continuing contact between the patient and the supervisors on a non-statutory basis.
75. The First tier Tribunal - Mental Health has the power to hear the case of a conditionally discharged patient and either to direct a variation in the conditions attaching to discharge or to direct absolute discharge. In either case the Tribunal itself will notify the patient and the Ministry of Justice, who, in turn, will then write to both supervisors informing them of the Tribunal's decision.

Section 14 – First Tier Tribunal - Mental Health

76. The circumstances in which a supervising clinician may become involved with the First tier Tribunal - Mental Health are:

- i) when a conditionally discharged patient applies to a Tribunal to have his case heard under section 75(3) of the 1983 Act for variation of conditions or absolute discharge or,
- ii) when the case of a conditionally discharged patient who has been recalled to hospital is referred to a Tribunal under section 75(1) of the Act.

This section deals with the procedures likely to affect supervising clinicians in those circumstances, although the tribunal is entirely independent of the Secretary of State, and this is for guidance only.

77. Tribunal hearings are held in informal conditions. For restricted patients they are always chaired by a senior lawyer, often a judge, and also comprise a psychiatrist and a lay member. All administrative tribunal business is handled by the tribunal secretariat and supervisors should address any general queries about a patient's tribunal hearing to the appropriate office.

First tier Tribunal – Mental Health PO Box 8793 5 Floor Leicester LE1 8BN

First tier Tribunal – Mental Health 4th Floor Crown Buildings Cathays Park Cardiff CF1 3NQ

Conditionally discharged patients' tribunal hearings

78. When a conditionally discharged patient applies to the tribunal, the tribunal will ask the Ministry of Justice to provide a statement containing the information specified in the First tier Tribunal (Health, Education and Social Chamber) Rules 2008. This information includes a report from the clinical supervisor on the patient's medical history and present mental condition and a report from the social supervisor on the patient's progress in the community since discharge from hospital.

79. On receipt of the tribunal's request, the Ministry of Justice will write to the clinical supervisor asking for a medical report, including details of the patient's medical history, current mental state, response to clinical supervision and to any medication, and observations on the need for continuing supervision. The clinical supervisor will be asked to reply to the Ministry of Justice within three weeks and it is important that this deadline is met. The Tribunal Rules provide that the Ministry of Justice statement,

including the supervisors' reports, will be disclosed to the patient in full unless the Secretary of State recommends, and the tribunal agrees, that part of it, submitted separately, should be withheld from the patient. The clinical supervisor should consider whether his or her report to the Ministry of Justice can be fully disclosed to the patient. If not, the part not suitable for disclosure should be recorded separately, and the reasons for its non-disclosure explained.

80. The supervisors are usually informed of the date of the tribunal hearing and often invited to appear at the hearing. In some cases the patient may ask a supervisor to speak on his behalf, and in others the tribunal may call a supervisor to appear.
81. The tribunal's decision in the case of a conditionally discharged patient is notified to the Ministry of Justice, who will inform the supervisors of the nature of the decision.

Recalled patients' tribunal hearings

82. . When a recalled patient's case is referred to the tribunal or such a patient applies in his own right, statements will be prepared for the tribunal both by the hospital to which the patient is recalled and by the Secretary of State. The Secretary of State's statement will set out his reason for believing that the patient is currently appropriately detained in hospital. The Secretary of State's statement is likely to draw on reports received from supervisors, and in some cases the tribunal may decide to ask a supervisor to appear at the hearing. In these circumstances, the tribunal's powers are those at section 73 of the 1983 Act to determine whether the patient is appropriately detained in hospital. It is no part of the tribunal's function to review the circumstances of the recall, except insofar as necessary to inform a decision under section 73.

Annex A: Summary of guidance issued by the Home Office and DHSS in 1987 for the multi-disciplinary team at the discharging hospital

1. Preparation for discharge should begin as soon as such an outcome seems likely.
2. The multi-disciplinary clinical team should instigate an individual programme of treatment and rehabilitation and reach a common view about the patient's expected approximate length of stay.
3. The hospital social work department should maintain links with outside individuals and agencies who may be able to offer support to the patient after discharge.
4. The multi-disciplinary team should have a clear idea of the arrangements in the community which will best suit the patient.
5. The potential supervisors should be involved as early as practicable in the multidisciplinary team's preparations for the patient's discharge: with an opportunity to attend a case conference and meet the patient.
6. After the identification of supervision and after-care arrangements best suited to the patient's needs, nominated members of the multi-disciplinary team should be responsible for arranging the various elements to be provided.
7. Where the choice of supervision between the probation service or the social services department is clear cut, a request for the nomination of an individual social supervisor, accompanied by information about the patient should be made to the Chief Probation Officer or Director of Social Services as appropriate.
8. Where the choice of supervising agency is not clear cut or cannot be resolved quickly, information about the patient should be sent to both the Chief Probation Officer and the Director of Social Services with an invitation to send representatives to a case conference for discussion of the issue.
9. The responsible medical officer, after consultation with the other members of the multi-disciplinary team, is responsible for arranging psychiatric supervision by a local consultant psychiatrist.
10. Responsibility for arranging suitable accommodation should be allocated by the multi-disciplinary team to a named social worker or probation officer.

11. The views of the multi-disciplinary team should be taken into account and the question of accommodation discussed in a pre-discharge case conference, attended by both supervisors.
12. It is important to identify suitable accommodation and to specify which types of accommodation would not be appropriate for individual patients.
13. There should be no question of a patient going automatically to unsuitable accommodation simply because a place is available and equal care is necessary whether the proposal for accommodation is to live with family or friends, or in lodgings or a hostel.
14. A member of staff of a proposed hostel should meet the patient and discuss the patient's needs with hospital staff.
15. The patient should visit and possibly spend a period of leave in a hostel before the decision is taken to accept an available place.
16. There are a number of important factors to be considered in the selection of a hostel for a particular patient.
17. The warden of the hostel should be given detailed information about the patient, including information which he may need about medication. He should be encouraged to contact the two supervisors and, if necessary, the social department of the discharging hospital, for further information or advice.
18. Certain written information about the patient should be sent by the hospital social work department to supervising and after-care agencies on admission, as soon as discharge is in view and when nomination of a social supervisor is requested.
19. Supervisors should receive comprehensive, accurate and up-to-date information about a patient before he is discharged to their supervision. A standard package of information should be provided to both social and psychiatric supervisors as soon as they have been nominated.
20. Copies of supervisors' reports to the Home Office should be sent to the discharging hospital for a period of one year after discharge, generally for information.
21. After the conditional discharge of a patient, supervisors may sometimes seek information, guidance or support from those who know the patient well. It is hoped that discharging hospitals will be able to respond helpfully to such requests.