



Guidance for social supervisors

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Section 1 – Introduction

1. This guidance should be read in conjunction with the Mental Health Act 2007 Code of Practice, with particular reference to the emphasis on public protection, risk assessment and staff safety. These Notes are for the guidance of mental health professionals. They are about the role of social supervisors of patients who are subject to the special restrictions (restricted patients) set out in section 41 of the Mental Health Act 1983 (the Act) and who have been conditionally discharged from hospital by either the Secretary of State under S.42(2) or by the First tier Tribunal - Mental Health under S.73(2) of the Act. The term 'social supervisor' is used throughout the Notes to mean the mental health professionals who have a responsibility to report to the Secretary of State on the progress in the community of such a patient. 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 cannot be comprehensive and do not represent instructions; much must be left to the discretion of the social supervisor and his or her senior officers. They are intended, however, to cover the broad aspects of the work and to give examples of, and guidance in, procedures and practices which have been found, over the years, to be most effective. It is strongly recommended that any social supervisor who does not have experience of managing restricted patients should attend one of the Mental Health Casework Section's open days which explain the role of the Ministry of Justice in managing restricted patients. These are held approximately every two months. These notes revise the 2007 edition of the "Notes for Guidance of Social Supervisors" (the pink booklet). Any questions arising from the Notes should be sent to Public_enquiry.mhu@justice.gov.uk

Section 2 – The Legal And Statistical Framework

Restriction orders and restriction directions

3. Restricted patients represent only a small percentage of all patients in psychiatric hospitals. Patients may become subject to restriction orders in a number of ways, but for the purpose of this guidance it is assumed that those patients subject to social supervision will be as follows:
 - Under section 37 of the Act, the Court may, where a convicted offender is reported to be suffering from mental disorder for purposes of the Act, by order authorise his admission to, and detention in, a hospital for psychiatric treatment. When such an order, known as a hospital order, is made by the Crown Court or the Court of Appeal, and the Court concludes that it is necessary to protect others from serious harm, it may make a further order known as a restriction order. The principal effect of a restriction order is that the patient may not be allowed leave outside the hospital or be transferred to another hospital without the authority of the Secretary of State, and may not be discharged from hospital except by the Secretary of State or the First tier Tribunal - Mental Health (see paragraphs 5 and 7 below)
 - Following the introduction of the Domestic Violence, Crime and Victims Act 2004, a person charged with an offence before a Crown Court and found unfit to plead to the charge or not guilty of an offence by reason of insanity may be made subject to a hospital order with a restriction order. There are a few of these cases each year.
4. Since 1 October 2007, all restriction orders made by a court are without limit of time, although restriction orders of finite duration made before that date may still be encountered for the foreseeable future.

Discharge and recall

5. Under the Section 42 of the Act, the Secretary of State may by warrant discharge a patient subject to conditions at any time while a restriction order is in force. This is known as a conditional discharge. The Secretary of State may by warrant recall a conditionally discharged patient to hospital and, after recall, a patient once again becomes subject to detention with restrictions. The role of the Ministry of Justice is set out in more detail under Section 3 of this Guidance.

The First tier Tribunal - Mental Health

6. A detained restricted patient may apply to have his case heard by the First tier Tribunal - Mental Health roughly once each year. If he does not apply, his case will be referred to the Tribunal by the Secretary of State every three years, under section 71(2). After a conditionally discharged patient has been recalled, the Secretary of State must, under section 75(1), refer the case to the Tribunal within one month of recall but, in practice, will do this within a few days. Under section 75(2), conditionally discharged patients may apply to the Tribunal once during the second year of their discharge and once in every two year period thereafter.
7. Under section 73 of the Act, the Tribunal has a duty to discharge a restricted patient absolutely or conditionally if it cannot be satisfied that the criteria for detention are met.
8. Where the Tribunal decides to direct the conditional discharge of a patient it may, under section 73(7), defer that direction until it is satisfied that adequate arrangements have been made to implement the conditions it has set. It may impose any conditions on discharge, but these are likely to include a condition of residence and of co-operation with clinical and social supervision. After the Tribunal has directed the conditional discharge of a patient, the Secretary of State may add to or vary those conditions under section 73(4). Under section 75(3), the Tribunal may, on application by a patient conditionally discharged by either the Tribunal or the Secretary of State, vary any condition on discharge, impose fresh conditions or direct an absolute discharge.
9. The Tribunal has no power to direct the recall of a conditionally discharged patient, nor to direct leave from hospital or the transfer to another hospital of a detained restricted patient. This sometimes creates tension where the Tribunal wishes to direct discharge to a hostel, subject to the patient having leave there. The law explicitly reserves the power to agree to leave to the Secretary of State, so that all such decisions may be taken subject to a risk assessment for the protection of the public. The Tribunal has no power to order a discharge which is dependent on the patient making further rehabilitative progress before the discharge is finally effected. Sometimes, however, leave is necessary to enable a hostel to assess the suitability of the patient. The Tribunal must be satisfied that the applicant qualifies for discharge at the time the initial order is made. In these circumstances, there may need to be negotiation so that the leave sought can be safely achieved.
10. Paragraphs 87 to 93 below deal with the ways in which social supervisors may come into contact with the Tribunal and the procedures that apply.

The restricted patient population

11. There are about 4000 restricted patients detained in hospital. Over 50% have been convicted of offences of violence against the person, 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 private sector hospitals.
12. The number of conditionally discharged patients under active supervision in the community is around 1500.

Section 3 – The role of the Ministry of Justice

13. 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 Act and related legislation. Among their duties, they authorise the admission to hospital of patients transferred from prison; they consider recommendations from responsible clinicians in hospitals for the leave, transfer or discharge of restricted patients, seeking the personal authority of a Ministry of Justice Minister in some instances. They prepare the Secretary of State's statement to the Tribunal when it hears applications from restricted patients, as required under the First tier Tribunal (Health, Education and Social Chamber) 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.
14. Staff in the Mental Health Casework Section are not specifically trained in law or in medicine but the Section has wide experience of restricted patient cases and detailed records and knowledge of the relevant legislation. Staff are ready and willing to discuss the case of any restricted patient with a social supervisor or with his or her senior officer. Such discussions may be useful for the exchange of information or simply the sharing of experiences or problems.
15. In the Mental Health Casework Section officers of different grades form teams, each of which deals with work relating to a proportion of the restricted patient population. The population is divided alphabetically, according to the patient's surname initial. Written communications should be addressed, where possible, to a named officer. The letter to the social supervisor which accompanies these Notes in an individual case should contain a name and a telephone number for use in that case. If it does not, or if in any doubt, a supervising officer wishing to make telephone contact during office hours should telephone the Ministry of Justice. Contact details can be found here: <https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list>

Section 4 – The purpose of conditional discharge

16. When considering an application for a restricted patient's discharge from hospital, the Secretary of State will usually wish to discharge subject to certain conditions. The conditions usually imposed by the Secretary of State are those of residence at a stated address, social and clinical

supervision. The Tribunal is also likely to make discharge orders conditional, and to impose similar conditions. If it does not, the Ministry of Justice, adding conditions under section 73(4) of the Act, will usually require 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, or 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.

17. The purpose of the formal supervision resulting from conditional discharge 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 of any perceived increase in the risk of danger to the public enables timely 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 whether 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

18. On admission of a restricted patient to hospital, the responsible clinician (the clinician in charge of the case) will, together with the rest of the multidisciplinary 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 is likely to reduce the risk of the patient behaving in a dangerous manner if returned to the community. In some cases this period of assessment and treatment may take several years. The clinical team should only consider recommending the patient's conditional discharge when the patient's condition has so improved that the level of

risk to the public is reduced to the extent that detention in hospital is no longer considered to be necessary.

19. 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 preparations 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.
20. 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 B](#) to these Notes. In some cases contact may have been maintained between the patient and his social worker during the patient's stay in hospital (and this is to be encouraged). In other cases hospital staff are advised that as soon as the prospective social supervisor and the prospective clinical supervisor are known, they should be involved in discussion of 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. It is good practice to establish a plan before discharge for the patient's re-admission to hospital in the event that recall proves necessary. If there is no such plan,

the Secretary of State will probably need to direct recall to the hospital from which the patient was discharged. He does not in law require the agreement of the hospital to direct recall there, and does not always have the luxury of time to negotiate where the safety of the public is at risk. So a pre-arranged plan is in the interest of all parties.
21. Wherever possible, pre-discharge contact should include at least two visits to the hospital by the social supervisor to meet the patient and participation in at least one multi-disciplinary case conference at which the prospective social supervisor can discuss the case and the plans for discharge with the responsible clinician, and the staff of all disciplines who know the patient. He or she should also meet the prospective clinical supervisor. If a social supervisor is asked to take on the case of a restricted patient shortly to be conditionally discharged and is not invited by the hospital to participate in pre-discharge discussions in this way, he or she should request contact with the hospital clinical team through the responsible clinician, the hospital social worker or the liaison probation officer where one exists.

Victims

22. 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.
23. From July 2005, this duty was extended to victims of mentally disordered offenders who are subject to one of the following disposals:
- those charged with a sexual or violent offence, who are then made subject to a hospital order with a restriction order; or
 - 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;
 - those convicted of a sexual or violent offence, who are then made subject to a hospital direction and limitation direction;
 - 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.
24. 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 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 probation Victim Liaison Officer and the offender's care team, both in hospital and in the community.

Section 6 – Provision of written information by the discharging hospital

25. In addition to the pre-discharge contact recommended in [paragraph 21](#) above, it is essential that the social supervisor should receive, as early as possible before discharge, detailed written information about the patient which can be retained for reference in the files of the supervising agency. All supervisors should possess full and relevant background information about the patient and his offending history. Thus, when a social supervisor moves on, the incoming supervisor has access to full written information about the case, as do senior officers in the agency at any time.
26. Discharging hospitals are advised that the full information provided to the social supervisor for retention should cover the following aspects of the case:
- A pen-picture of the patient including his diagnosis and current mental state;
 - Admission, social, offending and medical history;
 - 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;
 - Present medication and reported effects and any side-effects;
 - Any warning signs which might indicate a relapse of the patient's mental state or a repetition of offending behaviour together with the time lapse in which this could occur, including information about any groups or individuals who may be at risk;
 - A report on present home circumstances; and
 - Supervision and after-care arrangements which the hospital considers appropriate and inappropriate in the particular case.

If a social supervisor has not received the information detailed before the patient is discharged, it should be requested from the discharging hospital. If there are difficulties in complying with such a request, the supervisor should seek help from the Mental Health Casework Section.

27. In addition, the discharging hospital may provide details of the circumstances of the offence that led to the patient's admission to hospital and of the legal authority for that admission. If this information is not received the Ministry of Justice Mental Health Casework Section should be notified.

28. A Care Programme Approach (CPA) document should be prepared on handover at every stage of the patient's care pathway, which should contain 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.

Post-discharge procedures

Section 7 – Manner and frequency of supervision

29. 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. He recognises that this places great reliance on the personal skills and dedication of individual social supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the social supervisor adopts a continuing proactive approach to the patient and maintains a consistent pattern of contacts.
30. The specific requirements of supervision will vary from case to case and an individual patient's needs will vary over time. It is impossible, therefore, to draw up a blueprint for successful supervision. However, there are some elements in the role of a social supervisor which are important if supervision is to be effective in achieving its purpose.
31. A social supervisor will have many difficult decisions to make when working with a conditionally discharged patient. Social supervisors should explain to patients at an early stage what their purpose and role is, the expectations they have of the patients, and what the patients may expect in return. The patient should consult the supervisor when considering any significant change in circumstances, for example a new job, a new home, financial matters or a holiday. Careful consideration of risk should precede any such proposal and the supervisor should advise the patient against taking any step which, in the supervisor's view, would involve an unacceptable degree of risk. Some proposals will involve the social supervisor making a special report to the Ministry of Justice (see references to change of address and holidays in [paragraphs 60 to 65](#) below).
32. A sound knowledge of the case is essential if the social supervisor is to be able to spot warning signs before dangerous behaviour occurs. [Section 5](#) above recommends that the supervising officer should have an opportunity before discharge to discuss the patient with those in hospital who know him best. [Section 6](#) covers the provision of written information by the hospital to the supervising officer including, specifically, any known warning signs. Social supervisors should seek to build on this initial background to the case by establishing an effective rapport with the

patient, ideally well before the patient is discharged. In a close relationship, changes in the patient's mental state, behaviour or circumstances are likely to be reported to, or noticed by, the supervisor. If the patient is in close contact with, or living with, friends or relatives the social supervisor should see them regularly also.

33. The protection of the public from serious harm is best assured, in the long run, by the successful reintegration into the community of the patient. Supervisors should therefore have a positive and constructive approach towards the patient's social rehabilitation rather than simply monitoring progress. Focusing on some positive future achievable goal, rather than measuring success by an absence of failure, is more likely to succeed.
34. Close supervision is important, but this cannot be assured by any set prescription for the nature or frequency of meetings with the patient. Every effort should be made to build a working relationship with the patient. The supervisor should anticipate that the patient may resent the continuing control over his life imposed by a conditional discharge and fear the "policing" role of the supervisor.
35. There is a certain level of supervision that should be maintained if possible changes in a patient's mental state or behaviour are quickly to be spotted. It is recommended that meetings should take place at least once each week for at least the first month after discharge reducing to once each fortnight and then once each month as the social supervisor judges appropriate. These are considered to be minimum periods. Sometimes the Ministry of Justice will request more frequent meetings to take place. Generally, individual supervisors will consider more frequent meetings appropriate, particularly for the initial period of the first year during which the patient settles down to life in the community. Meetings should usually take place on the patient's home territory but some meetings away from the home, perhaps in the supervisor's office, may also prove valuable.
36. When a social supervisor is absent from his or her post even for a short period, for example when on leave, it is important that responsibility for the case should be transferred to a colleague and that both the patient and the clinical supervisor should know whom to contact as social supervisor. If absences are to be for longer than two months, the Ministry of Justice should also be informed. Paragraph 62 below deals with permanent changes of social supervisor.
37. When changes in social supervisors occur, it is important that the outgoing supervisor passes to his successor full information about the case and supplements this with oral briefing. This should include details of when the next report to the Ministry of Justice is due. A change of supervisor may be upsetting for a patient and care should be taken to ease the transition.
38. As well as the importance of a close and informed relationship between the supervising officer and the patient, and the framework of an aftercare

plan based on a multi-disciplinary consultation, the most valuable element in successful supervision is liaison with other professionals involved in the case. This aspect is discussed separately in paragraphs 41–55 below.

Section 8 – Disclosure of information

39. Both the social supervisor and the supervising clinician will have detailed information about the patient's case. However, many other people may become involved with the patient in the community and the supervisors will need to consider whether certain information about the patient should be disclosed to such people. Except where medical information is concerned, it will usually be the social supervisor who has to make such decisions.
40. Decisions about disclosure of information should be taken by social supervisors in the light of their knowledge of the case and their professional judgement and in cases of doubt they will almost certainly find consultation with their line managers helpful. In general, information about the patient should be disclosed only with the full knowledge and agreement of the patient and information should only be given against the patient's wishes when there are strong overriding reasons for doing so. Such reasons may include the patient's known propensity for offending in circumstances which arise from the accommodation, workplace or some types of job. For example, the supervisor of a patient with a history of offending against a child should be particularly conscious of that fact in discussions with those providing accommodation which does or may also contain children or those providing employment or voluntary work which may bring the patient into contact with children.

Section 9 – Liaison with others involved in the patient's care

The clinical supervisor

41. The clinician who acts as the clinical supervisor to a conditionally discharged patient is responsible for all matters relating to the mental health of the patient. The manner in which that responsibility is carried out in a particular case will depend on the needs of the patient. However, the clinician is asked to report to the Ministry of Justice on the patient's condition one month after discharge and every three months thereafter. The practice is that the social supervisor also adopts the same pattern

and timing in reporting. (A brief summary of the guidance issued to clinical supervisors is at [Annex A](#).)

42. Where the patient requires medication for the treatment of mental disorder after leaving hospital, the clinical supervisor will be responsible for ensuring that arrangements are in place for the administration of any necessary medication and for monitoring its effects, by a doctor if he is not one himself. (See also the reference in [paragraph 48](#) below to general practitioners.)
43. Should the patient's mental health deteriorate, the clinical supervisor will consider whether steps are necessary to arrange for the patient to receive additional out-patient treatment or to be admitted to hospital for treatment, whether voluntarily or by recall (see also [paragraphs 71–76](#) below). Any decision to admit the patient for short-term treatment on a voluntary basis will generally be taken with the knowledge of, and often in consultation with, the social supervisor, and in all cases he should be advised when the patient is admitted or discharged in these circumstances. The Ministry of Justice must also be notified as early as possible.
44. Close liaison with the clinical supervisor is essential if supervision is to be effective. Both supervisors should be involved in the pre-discharge discussions about the patient's after-care and it is expected that they will meet at least once at this stage ([Section 5](#) 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.
45. If the patient will be taking medication, the clinical supervisor should inform the general practitioner and the social supervisor of the nature of the medication, its effects on the patient's condition and behaviour and any possible side effects. If he is not a doctor, he will need to ensure that such information is available, probably via the responsible clinician. The clinical supervisor 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. With this information

the social supervisor, while not primarily concerned with the patient's medical health, may identify aspects of the patient's state of mind during his or her regular contact with the patient which might be helpful to the clinician.
46. The social supervisor should send a copy of all reports to the Ministry of Justice to the clinical supervisor. Similarly, the clinical supervisor is advised to send a copy to the social supervisor of his reports to the Ministry of Justice. If these exchanges do not take place, the Ministry of Justice Mental Health Casework Section should be notified.

47. On receipt of the clinical supervisor's reports and at any other time during supervision, the social supervisor should be ready to contact him or her to discuss the patient's case and review progress. In addition, the supervisors should have a meeting together with the patient on a periodic basis and at least once a year.

Liaison with other professionals

48. All conditionally discharged patients should be registered with a general medical practitioner and arrangements for this should be made by the discharging hospital. The supervisors should always bear in mind the need to keep the general practitioner informed of any significant developments in the case.
49. Other clinical staff involved other than the principal supervisors may include a community psychiatric nurse or a psychiatric nurse based at the supervising clinician's hospital whose responsibilities would include visiting the patient to administer or monitor his medication.
50. The social supervisor will usually be the key worker in liaison between those involved in the patient's care and support. Before discharge all those practitioners involved with the future care and support of the patient should be invited to a multi-disciplinary meeting at which a comprehensive plan of care and strategy for intervention will be agreed. Subsequently, the social supervisor will need to arrange regular meetings to review the aftercare arrangements.

MAPPA

51. Social supervisors should be aware of the local Multi Agency Public Protection Arrangements which apply to certain sexual and violent offenders, and other offenders who pose a risk of serious harm to others. Full details, including national guidance, local reports and contact details can be found at <http://www.probation.homeoffice.gov.uk/output/page30.asp>. Local Authority Social Services are subject to a duty to co-operate with the Responsible Authority (i.e. probation, police and prisons) in relation to these arrangements and the local authority may well have drawn up a Memorandum of Understanding which sets out in some detail local agreements on co-operation, including the identification of MAPPA qualifying offenders and the referral of cases for consideration at MAPPA meetings.
52. All cases of offenders who would potentially qualify for MAPPA management (principally sex offenders subject to registration and those subject to hospital orders in relation to serious sexual and violent offences) should be identified by Trusts and notified to the MAPPA

responsible authority prior to discharge from hospital. Although all cases should be notified, it is considered unlikely that referral of a patient for active MAPPAs management will be required in the majority of cases. Arrangements agreed under the Care Programme Approach will generally provide the most effective management plan, although in cases of doubt it is best to refer. In addition, risk is dynamic and referral for MAPPAs management might become appropriate depending upon the demands of the risk management plan.

53. Referral to MAPPAs will be a decision to be reached in discussion with the clinical supervisor and should be conveyed to the local MAPPAs Coordination Manager, who will decide whether to accept the referral. Any referral must be based upon the information available which indicates that the offender poses a high or very high risk of serious harm to others and the delivery of an effective risk management plan cannot be achieved under the CPA arrangements but requires the active collaboration of a number of MAPPAs agencies. In exceptional circumstances offenders posing a lower risk of harm may be appropriately referred to MAPPAs risk meetings if there are aspects of the case that require multi-agency collaboration (e.g. local notoriety/threats to the offender/difficult victim issues). Social supervisors should propose referral in any case where the patient is being considered for absolute discharge but where serious concerns about risk remain.
54. In submitting a referral, social supervisors should attach all relevant information regarding the likelihood of re-offending, the risk of serious harm (when and to whom) and any indication of imminence, together with the summary of any formal risk assessment undertaken. They should also identify the factors known to contribute to the risk of serious harm and that require management through MAPPAs as opposed to the CPA process, and identify any core agency central to the delivery of an effective risk management plan and any other known agency currently involved in the management of care of the offender.
55. In any case where social supervisors are considering referral to MAPPAs, they should ensure that the Mental Health Casework Section is aware of this.

Section 10 – Reports to the Ministry of Justice

56. 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. Reports are submitted to the Ministry of Justice 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. The Mental Health Casework Section will be assiduous in pursuing any that are not, and will write to the Clinical Director and/or the Chief Executive of the relevant NHS Trust or the Director of Social Services if reports are not received.

57. Reports to the Ministry of Justice should be made on the form available on the website <https://www.gov.uk/government/publications/conditionally-discharged-restricted-patient-report>. Officials in the Mental Health Casework Section will read the report with a view to deciding whether:

- there is a need to discuss the patient's management with the supervisors
- there is a need to amend the conditions attached to discharge, or
- there is a case for recall to hospital.

The report itself should convey sufficient information to enable the Ministry of Justice to consider whether the patient may remain in the community or whether, in the patient's own interests or for the protection of the public, steps should be taken to return him/her to hospital. As indicated on the pro-forma, the report should include a detailed account of the patient's current circumstances including accommodation, employment, training, major relationships and other interests and spare time activities, any changes since the previous report and the reasons for those changes. 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 social 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. Home visits should be the norm, as they give the clearest indication of how well the patient is coping with life outside hospital.

58. 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 that showed clients in an unfavourable light. It is absolutely crucial to the effectiveness of your 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 the social supervisor's plans for the patient's continued rehabilitation, which will have been

agreed with the clinical supervisor in consultation with all staff, irrespective of their profession, who may be involved.

59. All reports to the Ministry of Justice should be copied to the clinical supervisor and discussed with him or her as necessary. For one year following discharge, two copies of each report should also be sent, for information, to the former responsible clinician in the hospital which discharged the patient if the clinical supervisor was not the responsible clinician (see [Section 11](#) below). In the event of the social supervisor being absent from his/her post for any reason, he/she should provide both a verbal and written handover report to the person who is to cover his/her work.

Changes in address

60. The warrant or direction for the patient's conditional discharge, of which the social supervisor should have a copy, usually specifies a named address at which the patient must reside. If the patient wishes to change his address or to be away from that address for more than a short absence, and the social supervisor agrees that the new accommodation proposed is suitable, then the supervisor should write to the Ministry of Justice Mental Health Casework Section, to seek agreement to a change in the conditions attaching to discharge (although in an emergency the social supervisor may have to agree to a change of address without prior reference to the Ministry of Justice, in which case he should contact the Mental Health Casework Section as soon as possible afterwards). Agreement to routine changes of address may be sought at any time before the proposed change and need not await the next quarterly report. It would be helpful if details were given of the new accommodation proposed and the reasons for the change. In agreeing to a change the Ministry of Justice may need to issue a formal amendment to the warrant of discharge, depending on the conditions imposed. The clinical supervisor should also be informed.
61. Although the names of supervisors are not usually entered on a warrant of discharge, the Ministry of Justice should be notified as soon as there is a permanent change of social supervisor ([paragraph 36](#) above deals with temporary absences from work of the social supervisor, for example during leave). The clinical supervisor should be informed of any impending change of social supervisor. The new social supervisor should be told of the date that the next report to the Mental Health Casework Section is due.

Transfer to another care team/change of clinician

62. 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 to the new care team. 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.

63. The Mental Health Casework Section should be informed as soon as possible about a change of clinical supervisor, and certainly before the date of handover. MHU must be provided with full contact details, including address, telephone number and e-mail address.

Patients' holidays

64. A conditionally discharged patient is not precluded by his status from having holidays away from home. The patient should always discuss plans for such holidays with the social supervisor so that the suitability of the arrangements can be considered. During the first six months after discharge, absences from home of more than a few days are not usually advisable. If the patient is to be away for two weeks or more the social supervisor should notify the social services department or probation service (as appropriate) in the holiday area and should inform the patient whom to contact there in case of any problems arising. Holidays abroad do not allow any form of supervision to continue and should be considered very carefully. 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 supervisor has 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 unmanageable risk. It may be appropriate to seek arrangements in the country of travel for the patient to receive medication or care in an emergency. Where a proposal does not appear safe, the Ministry of Justice may consider the risk sufficient to consider recall to hospital for the protection of the patient or others. Recall would be a last resort, and only undertaken on advice from the supervisor and evidence that the patient's mental state justified it.
65. The clinical supervisor should be informed of any of the above proposals. In the case of proposed absences from the patient's home, consideration of special medication arrangements to cover the absence may be necessary.

Section 11 – Post discharge contact with the discharging hospital

66. The practice of copying supervisors' reports to the discharging hospital for a period of about one year after discharge is intended to produce a number of benefits. For supervisors the sharing of community experience of the patient with the discharging hospital can prepare the way for potentially valuable contact with staff there. A social supervisor who needs further background information about a patient or to discuss the patient's behaviour should make direct contact with the hospital social work department. All hospitals should expect and welcome such approaches.

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

67. If a social supervisor is concerned about a conditionally discharged patient’s mental state or behaviour, the concern should be discussed, if possible, with the other professionals involved in the case, particularly the clinical supervisor. An early telephone call must be made to alert the Mental Health Unit and to the MAPPAs co-ordinator, if the case has already been referred to MAPPAs. This contact need not be limited to those professionals performing the roles of supervisor. If any professional who is responsible for a restricted patient, such as a community psychiatric nurse or a hostel manager, becomes concerned about a patient then he/she should inform one of the patient’s supervisors and the Ministry of Justice immediately.
68. If the social supervisor has reason to fear for the safety of the patient or of others, he should contact the clinical supervisor immediately. He or she may decide to initiate local action to admit the patient to hospital without delay with the patient’s consent or using the civil powers such as those under sections 2, 3 or 4 of the Act. Whether or not such action is taken, and even if the clinical supervisor does not share the social supervisor’s concern, the social supervisor should report to the Ministry of Justice at once so that consideration may be given to the patient’s recall to hospital. Social supervisors should subsequently inform their line managers of the situation as soon as possible.
69. Telephone discussion in such circumstances is welcomed by staff in the Mental Health Casework Section. In normal office hours, the caseworker should be contacted at the Ministry of Justice, Public_enquiry.mhu@justice.gov.uk. Outside office hours the Ministry of Justice should be contacted on 0300 303 2079. A telephone report should be followed up by a written report as soon as practicable.
70. A common reason for concern is that the patient has a history of abusing illegal substances and is refusing to co-operate with testing. 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 cooperation with testing. Refusal to co-operate with testing cannot in itself justify recall as a breach of conditions. But where the supervisors are 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

71. 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 powers under section 42(3) of the Mental Health Act and 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. There will always be an MHCS officer available to discuss the case, and with the authority to instigate recall. MHCS staff will not over-react to any concerns expressed, but the lesson of a number of homicides committed by restricted patients is that failure to report concerns in timely fashion proved fatal. A report to the Ministry of Justice should always be made in a case in which:

- there appears to be an actual or potential risk to the public;
- contact with the patient is lost or the patient is unwilling to co-operate with supervision;
- the patient is admitted to hospital for any reason;
- the patient's behaviour or condition suggests a need for further inpatient treatment in hospital and/or;
- the patient is accused of, charged with or convicted of a serious offence, or an offence similar to the Index Offence: and/or;
- 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.

72. 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. The Mental Health Casework Section 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 cooperative 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 voluntarily in hospital for more than a short time. 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.

73. Whether the Secretary of State decides to recall a patient depends partially on the advice of a clinician that the patient's mental condition justifies detention for 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 of co-operation 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 clinical 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 not wish 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 antisocial 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 clinicians concerned and with the social supervisor. However, the decision will always give precedence to public safety considerations.
74. There has been some 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 medical evidence that the patient is mentally disordered. This does not mean that the patient's condition has to have deteriorated; or 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 make it necessary. In emergency, he will recall for assessment in the absence of fresh medical evidence of disorder. In such circumstances, immediate discharge would follow if the clinical assessment found no mental disorder and the responsible clinician requested discharge.
75. 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 the clinical supervisor or members of the supervisory team locally should seek assistance from the police and provide them with a copy of the warrant. Recall may sometimes be authorised out of office hours by the MHCS Duty Officer. In those circumstances, no paper warrant will immediately be available. The police will be invited to accept the same verbal authority as the supervisors, until a warrant can be produced. There is a general duty to inform the patient as soon as possible after his admission, and in any event within 72 hours, of the reasons for his recall. Where a social supervisor is involved in returning the patient to hospital, this duty should be borne in mind. Mental Health Casework Section should be informed as soon as a recalled patient is back in hospital, and/or in case of any difficulty.

76. After recall a patient is once again detained as a restricted patient in pursuance of the legal authority which was operating immediately before the conditional discharge. In some cases, the patient may need to return to hospital for only a short while but, in others, the lessons learned in the community may indicate a longer stay in hospital. The Secretary of State is aware of fears that recall will inevitably mean the patient's detention in hospital for months until a tribunal hearing can be convened. Such fears are harmful to the patient and to public safety if they lead to reluctance to report potentially dangerous deterioration in mental state or behaviour. The Mental Health Casework Section will look sympathetically, and as a priority, at proposals to discharge swiftly patients who have been recalled and whose health or behaviour has responded favourably to hospital treatment. The Secretary of State will always refer the case of a recalled patient to the Tribunal within days of readmission to hospital. Where the patient has not been discharged by the Secretary of State before his tribunal hearing, the supervisors will usually become involved in those tribunal proceedings. Paragraphs 87 to 93 give guidance in such circumstances.

Patients absent without permission

77. 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 absence to the Ministry of Justice immediately and then make every reasonable effort to locate the patient, contacting his colleagues in other areas if he has reason to believe that the patient may have gone to a particular place in a different locality. The Secretary of State will usually issue a warrant for the recall of the patient, thus providing the police with the powers to bring the patient into custody.
78. 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 with a view to detaining the patient on re-entry to the country or, if advised in time, preventing the patient from leaving.

Further offending

79. If a conditionally discharged patient has committed an offence and legal proceedings are pending, the Secretary of State will usually consider it advisable, if the patient is in safe custody and presents no danger to others, to 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 if that reflects 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 the patient will be returned at once to hospital).
80. If a conditionally discharged patient is convicted of a further offence and the court imposes a non-custodial sentence, the terms of the previous conditional discharge will continue and the supervisors should resume their roles.
81. If a conditionally discharged patient is convicted of a further offence and the court imposes a sentence of imprisonment, the Secretary of State will usually reserve judgement on the patient's status under the Act until he nears the end of his prison sentence, when he will seek fresh medical evidence. At that stage, the Secretary of State will decide whether to:
- allow his continued conditional discharge under conditions of residence and supervision,
 - direct his recall to hospital on release from prison, or
 - authorise the patient's absolute discharge from liability under the Act.

Section 13 – Length of supervision and absolute discharge

82. Where a conditionally discharged patient is subject to a restriction order of specified duration, then on the date of expiration of the order he is automatically absolutely discharged from liability to conditions or to be recalled.
83. Where, as in most cases, (and in all cases since 1 October 2007) the restriction order is of indefinite duration, there is no tariff.
84. 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 not to 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 present a risk to others if not well supervised in the future, and where future supervision is not guaranteed.

85. 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.
86. 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 will notify the patient and the Ministry of Justice and interested parties including the supervisor of the decision but, in addition, the Ministry of Justice will also write to both supervisors informing them of the decision.

Section 14 – The First Tier Tribunal - Mental Health

87. There are two circumstances in which a social supervisor may become involved with the First tier Tribunal - Mental Health:
 - when a conditionally discharged patient applies to the tribunal to have his case heard under section 75(3) of the Mental Health Act 1983, i.e. for variation of conditions or absolute discharge.
 - when the case of a conditionally discharged patient who has been recalled to hospital is referred to the tribunal under section 75(1) of that Act.

This section of the Notes deals with the procedures likely to affect social supervisors in those circumstances.

88. The First tier Tribunal - Mental Health 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 application to the Tribunal to the appropriate office.

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First tier Tribunal - Mental Health (for England) PO Box 8793 5 Floor
Leicester LE1 8BN

First tier Tribunal - Mental Health (for Wales) 4th Floor Crown Buildings
Cathays Park Cardiff CF1 3NQ

Conditionally discharged patients' Tribunals

89. When a conditionally discharged patient applies for a hearing, the Tribunal will ask the Ministry of Justice to provide a statement containing the information specified in the First tier Tribunal - Mental Health Rules 2008. This information includes a report from a 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.
90. On receipt of the Tribunal's request, the Ministry of Justice will write to the social supervisor asking for a report, including details of the patient's home circumstances, response to supervision and general progress, and the supervisor's views on the value of continuing social supervision. The 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 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, is withheld from the patient. The social 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 on a separate sheet of paper, and the reasons for its non-disclosure explained.
91. The supervisors will be informed by the Tribunal secretariat of the date of the hearing and invited to appear at the hearing.
92. The Tribunal's decision in the case of a conditionally discharged patient is notified to the patient, the Ministry of Justice, other interested parties and the supervisors.

Recalled patients' Tribunals

93. 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 give an account of the circumstances which led to the recall and his views on whether the patient should again be discharged. In referring to the decision to recall, the Secretary of State is likely to draw on reports received from supervisors. In some cases the Tribunal may decide to ask the

supervisors 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 that is necessary to inform a decision under Section 73.

Annex A: Summary of guidance issued by the Ministry of Justice to clinical supervisors

1. Staff in the Mental Health Casework Section of the Ministry of Justice are ready to discuss the case of any conditionally discharged patient with a supervising clinician.
2. Prior to the conditional discharge of a patient the clinical supervisor should have an opportunity to get to know the patient and participate in at least one multi-disciplinary case conference at the discharging hospital.
3. As early as possible prior to conditional discharge, a clinical supervisor should receive from the discharging hospital full written information about the patient's case (including the same information itemised in paragraph 25 of the Notes for the guidance of social supervisors).
4. A clinical supervisor is responsible for all matters relating to the mental health of the patient, including the regular assessment of the patient's condition, the monitoring of any necessary medication and the consideration of action in the event of deterioration in the patient's mental state.
5. The frequency and manner of psychiatric supervision and treatment appropriate in any case may be determined by the clinical supervisor.
6. The clinical supervisor should be prepared to be directly involved in the treatment and rehabilitation of the patient and to offer constructive support to the patient's progress in the community.
7. If a patient requires medication after discharge, then immediately after discharge, and again when any change or cessation of medication has been made, the clinical supervisor should inform the social supervisor and other members of the multi-disciplinary team of the arrangements made, including when, where and by whom medication is to be given. Medication should also be one of the subjects covered in periodic discussions between supervisors.
8. Close liaison between the supervisors is essential if supervision is to be effective and this should take the form of regular discussions. Any clinical

personnel involved with the patient should be under the general direction of the clinical supervisor.

9. The clinical supervisor should have a meeting with the social supervisor together with the patient on a periodic basis, and at least once a year. This annual meeting should be followed by a report to the Ministry of Justice.
10. Supervisors should consider as part of the discharge package whether a referral to the local Multi-Agency Public Protection Arrangements should be sought.
11. The Ministry of Justice will usually ask a clinical supervisor for reports on the patient's progress one month after conditional discharge and every three months thereafter. The periodic report should include a detailed account of the patient's current mental condition, including any changes since the previous report and the apparent reasons for these changes. The report should always cover the subject of medication, where appropriate. Any signs of deterioration in the patient's mental health or behaviour should be described in detail, together with proposals for improving the situation. Finally, the report should include the clinical supervisor's plans for the patient's continued rehabilitation.
12. All reports to the Ministry of Justice should be copied to the social supervisor. For about one year after discharge two copies of each report should also be sent to the hospital which discharged the patient.
13. Where a patient wishes to spend a holiday away from home and both supervisors agree to such a holiday, the clinical supervisor will wish to consider whether any special medication arrangements should be necessary.
14. Where a clinical supervisor is concerned about a conditionally discharged patient's mental state or behaviour the concern should first be discussed, if possible, with the social supervisor. Where that concern amounts to a fear for the safety of the patient or of others, the clinical supervisor may decide to take immediate local action to admit the patient to hospital. Whether or not such action is taken, the clinical supervisor should report to the Ministry of Justice at once. Under no circumstances should a supervisor hesitate to inform the Ministry of Justice of concerns about a patient in the community, for fear of long period of further detention.
15. If a clinical supervisor considers that a patient no longer requires active psychiatric supervision, the matter should be discussed with the social supervisor and then an appropriate recommendation put forward to the Ministry of Justice. Where the Ministry of Justice agrees to allow formal clinical supervision to lapse, it will usually wish social supervision to continue until he has seen evidence of a prolonged period of stability in the community.

16. A clinical supervisor is required, by the Tribunal Rules, to submit a report to the First tier Tribunal - Mental Health which is considering the case of a conditionally discharged patient. The report, submitted via the Ministry of Justice, should include details of the patient's medical history, current mental state, response to psychiatric supervision and to any medication, and observations on the need for continuing psychiatric supervision.

Annex B: Summary of recommendations for good practice for staff of 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 multi-disciplinary 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. The responsible clinician, after consultation with the other members of the multi-disciplinary team, is responsible for arranging psychiatric supervision by a local consultant psychiatrist.
8. Responsibility for arranging suitable accommodation should be allocated by the multi-disciplinary team to a named social worker or probation officer.
9. 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.

10. It is important to identify suitable accommodation and to specify which types of accommodation would not be appropriate for individual patients.
11. 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.
12. A member of staff of a proposed hostel should meet the patient and discuss the patient's needs with hospital staff.
13. The patient should visit and possibly spend a period of leave in a hostel or other accommodation before the decision is taken to accept an available place.
14. There are a number of important factors to be considered in the selection of a hostel or other accommodation for a particular patient.
15. The manager 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 work department of the discharging hospital, for further information or advice.
16. Written information about the patient taken on admission as set out in paragraph 25 should be sent by the hospital social work department to supervising and after-care agencies as soon as discharge is in view and when nomination of a social supervisor is requested.
17. 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.
18. Copies of supervisors' reports to the Ministry of Justice should be sent to the discharging hospital for a period of one year after discharge, for information.
19. After the conditional discharge of a patient, supervisors may sometimes seek information, guidance or support from those who know the patient well. Discharging hospitals should respond helpfully to such requests.