12. Risk assessment and discharge planning

INTRODUCTION

The statutory criteria for detention or guardianship under Part II of the Act and the criteria to be applied when determining whether any patient must be discharged always comprise at least two grounds. The first of these grounds (the "diagnostic question") requires considering whether the patient is suffering from a mental disorder the nature or degree of which makes in-patient treatment appropriate or, as the case may be, warrants his reception into guardianship or detention for assessment. The second ground requires considering whether further treatment or the individual's detention or restraint is "necessary" or "justified" on his own account (specifically for his health, safety or welfare) or that of others (in order to protect them). The criteria which comprise the second ground are therefore directed towards the issue of risk — specifically, the likelihood of undesirable consequences if the individual is allowed a citizen's usual freedom to decide how to act and what medical treatment or social care to accept. The risks involved in restoring a patient's liberty to him may consist of a likelihood of significant deterioration in his health, a risk to his physical safety, or a risk to others. In some cases, others may be at risk from the individual quite independently of whether or not he is mentally disordered at a given moment in time. There may be a general risk of domestic violence and an offender cured of his mental disorder may still be disposed to commit crime. Hence, the need for both statutory grounds and, unless psychopathy is an issue, the duty to release a person who though a threat to others is not mentally disordered or, if he is, the danger does not arise from this fact. Assessing risk in the context of mental disorder therefore also requires forming a judgement about the extent to which any identified risks are a feature or consequence of mental disorder (the first, diagnostic, question). Whether a patient's detention is justified or necessary in a particular case will often partly depend upon what arrangements have been, or can be, made for his treatment outside hospital. In non-restricted cases, the patient's willingness to accept appropriate treatment as an informal in-patient, and his capacity to adhere to an agreed treatment programme and discharge plan, will also be highly relevant.

RISK ASSESSMENT

It can be seen that the assessment of risk is an integral part of any decision to invoke or to rescind compulsory powers and tribunals must assess the likely risk to the patient's health and safety and the risk to others if he is discharged. Strictly speaking, risk is simply the probability that an event will occur but the word is most often used

to signify the probability of an unfavourable outcome.[1] Risk-b[illegible]t analysis involves analysing and comparing the expected positive and negative results of a given action. For example, considering whether to discharge a patient involves balancing the benefits of liberty against the risks arising from allowing the patient his liberty. The key issue in cases involving mental illness is often that of the patient's judgement, the way he is likely to use his liberty if it is restored to him and he is again free to make his own decisions, including to refuse supervision or medical advice. Few people, whether mentally disordered or not, are unconditionally dangerous. Consequently, it is not enough to simply consider whether an individual's present behaviour is aggressive, threatening or self-injurious. Most people are only capable of violence, towards themselves or others, if certain events or phenomena occur either in conjunction or in succession. Large changes in a situation may result from small changes in some critical variable. Just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on his mental state or behaviour. In practice, unless the individual's propensity for violence has an unusually simple and readily understandable trigger, it is impossible to identify all of the relevant situations. Indeed, some of them lie in the future and will not yet have been encountered by the patient during his life. It is therefore essential to define as far as possible the circumstances in which a person has been or may be dangerous. However, because future events can never be predicted, it is equally important to put in place an adequate system for supervising any individual whose own safety may potentially be at risk or who may pose a threat to the safety of others. This maximises the likelihood of obtaining early warning that the person is drifting into a situation known to be risk-laden, or one which may be dangerous albeit that the particular constellation of events was not foreseen or planned for prior to discharge. In essence, the approach is based on the assumption that most attacks do not erupt like thunderstorms from clear skies, so that the individual can be brought inside until the gathering storm has passed. Unfortunately, as with weather systems, only the pattern for the next 24 hours can usually be forecast with some accuracy, and contact with supervisors is much less regular than that.

Explanation and prediction

The difference between explanation and prediction cannot be over-emphasised. Explanation relies on hindsight, prediction on foresight, and the prediction of future risk therefore involves more than an explanation of the past. No person who commits suicide has previously committed suicide and the vast majority of people who commit homicide have not previously done so. While it is quite common for risk assessments to focus only on the circumstances (if any) in which the patient has previously been dangerous, understanding those situations and avoiding their repetition may merely lead to a false sense of security about the future. While life is understood backwards, it must be lived forwards and once the past has changed it is a past guide to future events. Although reading the history is preferable to gazing into a crystal ball, it is nevertheless an unreliable guide. As Russell once put it, the man who has fed the chicken every day throughout its life at last wrings its neck instead.

[1] *A Dictionary of Epidemiology* (ed. J.M. Last, International Epidemiological Association/ Oxford University Press, 3rd ed., 1995), p.148.

THE FOUR STAGES OF RIS[illegible]SESSMENT

At its simplest, risk assessment can be seen as consisting of four steps: (1) identifying the hazard; (2) characterising the risk; (3) assessing the likelihood of exposure to the hazard; (4) estimating the risk. By way of example, the hazard in the case of a restricted patient with previous convictions for sexual assaults on young boys is unsupervised contact with young children. The particular risk is characterised by the fact that the patient has a psychopathic disorder with abnormal sexual drives and interests which he has historically been unable to control. If the patient is discharged he is likely at some stage to be exposed to contact with unsupervised young children. Therefore the risk of further similar offending must be high unless either his exposure to potentially dangerous situations can be avoided (which is difficult to foresee given the number of children in society) or his characteristic sexual interests and behaviour are reformed or controlled by pharmacological means.

ACTUARIAL AND CLINICAL APPROACHES

Predictions are most often founded on retrodiction, not fact,[2] and all violence takes place in the present, not in the past or the future. The current departmental guidelines acknowledge that there "have been a number of cases which demonstrate how difficult it can be in the present state of knowledge to make accurate judgements about future risks." All professional staff can do is "to recognise these difficulties and make an honest and thorough assessment based on best possible practice and taking account of all the known circumstances of each case."[3] There are two main, contrasting, approaches to assessing the risk of violence, whether by the patient to himself or to others: the clinical model and the actuarial (statistical) approach. It should, however, be emphasised that there is no evidence that psychiatrists are better able to predict future offending behaviour than other professionals who spend their time working with offenders. Hence, tribunals and the Aarvold Board comprise professionals from a number of disciplines. Whether a risk is acceptable must be a judicial decision based on the medical and other relevant evidence.

The clinical model

A psychiatrist who uses the clinical model of risk assessment approaches the issue in three distinct steps[4]—

a. determining whether the patient has a demonstrable mental disorder;

b. determining the connection between any disorder and any aggressive, potentially aggressive, or feared behaviour;

c. spelling out how any connection comes about and what aspects of the disorder are behind any violent behaviour.

[2] Predictions of what will occur in the future are based on "retrospective predictions" of what has occurred in the past. In philosophy, this is a form of retrodiction.

[3] Department of Health, *Health Service Guidelines HSG (94)27*, para. 26.

[4] J. Gunn, "Clinical approaches to the assessment of risk" in *Risk-taking in Mental Disorder: Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990), p.15.

If the mental disorder is the decisive factor which defines the individ potential for dangerous behaviour, the management of that disorder is also the management of the potential dangerousness. Understanding that, and spelling it out, are useful pointers for rehabilitation and for a reduction of risk in the future. The choice of procedural safeguards will depend upon the nature of the danger to be guarded against. If the patient is released under supervision then recurrence of the illness can be monitored. This gives some confidence about the release in a planned, supervised, way and provides information about what to do if things start to go wrong. The clinician therefore makes predictive judgments rather than simple predictions. He "is not asking the statistician's simple question: How likely is it that a man like this will cause grave harm? His is the more complex question: In what circumstances would this man now be going to cause grave harm, and what is the strength or persistence of his inclination to do so in such circumstances? And, in order to make a prediction, the clinician must ask the supplementary question: How likely is it that this man will find himself in such circumstances in the foreseeable future."[5]

RISK ASSESSMENT — GUNN'S CLINICAL MODEL

1. Assessment

1. Detailed history
2. Substance abuse or not
3. Sexual interests and attitudes
4. Criminal history
5. Intelligence and personality
6. Mental state
7. Treatment

2. Demography

1. Age
2. Sex
3. Race
4. Previous violence
5. Previous sexual assaults
6. Socio-economic status
7. Substance abuse
8. Intelligence
9. Marital status

3. Environment

1. Family supports
2. Personal relationships
3. Employment
4. Accommodation

4. Interests and attitudes

1. Sexual
2. Violence
3. Cruelty
4. Social domination
5. Racism

5. Context

1. Availability of victims
2. Availability of weapons
3. Availability of drugs and alcohol

6. Declared intentions

1. To potential victims (including self)
2. To potential future victims
3. To caring staff

Source : Clinical approaches to the assessment of risk, John Gunn, in Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies. Ed. by David Carson. S.L.E. Publications Ltd., 1990, pp.15–16.

5 J. Floud, "Dangerousness in social perspective" in *Psychiatry, human rights and the law* (ed. M. Roth and R. Bluglass, Cambridge University Press, 1985), p.90.

Actuarial approaches

In theory, a sound statistical statement can be made concerning the correlation between two events and the relationship expressed as a frequential probability. Advocates of an actuarial approach to risk assessment argue that it is more scientific and objective. Consequently, it produces more consistent decisions than the present system which essentially relies on subjective judgement based on experience. However, statistical statements lack certainty when applied to the individual occasion,

> "A sound statement can be made to the effect that when a coin is tossed 1000 times, it will come down heads approximately 500 times, and the limitation of this approximation can be stated precisely. What statistics cannot do is to tell you whether the coin will come down heads or tails next time it is tossed, and yet this is precisely the type of information usually required. It is in the hope of rectifying this uncertainty that we seek a chain of causation."[6]

The limits of the actuarial approach are largely obvious. Although one can say for a group of persons what the likely figures will be there are too many variables in the individual case. Many events and processes cannot be predicted by conventional mathematical theorems or laws because small, localised perturbations have widespread general consequences. Examples include long-range weather changes, the performance of racehorses, and human behaviour. However, basic actuarial information may have significant implications which can be taken into account alongside the other things. Occasionally, this information may reduce the time and effort needed to reach decisions by confining attention to a relatively small number of key factors. Statistical patterns also direct attention to what may be key areas in a particular case, so helping to ensure that relevant considerations are not ignored. The general view is that the one approach complements the other although the features of the particular case must always be paramount.

AVOIDING TAKING RISKS

Risk cannot be avoided. All decisions to discharge or not to discharge involve the assumption of a risk. In the case of a decision to discharge, the risk is that the individual will use his greater freedom in a way which is injurious to himself or others. The risks involved in not discharging may similarly include an increased likelihood of harm to the patient or others but, more often, consist of the possibility that a citizen is detained who could safely be discharged. In other words, there is a risk of injustice. A tribunal which declines to discharge cannot be faulted insofar as no one will ever know whether its assessment of the patient's case was right or wrong. The person who is not released is thereby prevented from demonstrating that if released he would have resettled safely in the community. However, the converse is not also true. A tribunal which discharges risks catastrophe and, if the patient then either attempts or commits suicide or a serious offence against a third party, public criticism. Yet, however careful the assessment of the nature and extent of the risks involved in discharge, it is inevitable that some patients will later take their own lives or, more rarely, commit a serious offence outside hospital. These events also happen in hospitals, and in respect of patients granted leave or discharged by their consultants. The occurrence of such tragedies does not *per se* demonstrate any error

6 G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, Chichester, 1993), p.41.

of judgement on the part of those who discharged or supervised t[illegible] atient. The public cannot be made entirely safe from the risk of reoffending and, arguably, cannot properly expect any higher measure of protection before offenders committed to hospital are released compared with those sent to prison. It must also be borne in mind that all in-patients are members of the public and themselves at increased risk of being victims of violence for as long as they are detained on a psychiatric ward. Thus, the tribunal system aims to ensure both that members of the public are not unnecessarily detained and also that members of the public are protected from people who must necessarily be detained. Balancing these different considerations is a formidable task.

Freedom to take risks and to make mistakes

While the public must be realistic about the problems involved in assessing risk and deciding what is an acceptable risk, it is equally important that tribunal members do not add to their burden in cases involving non-offenders by balancing risks which are constitutionally matters for the citizen to weigh in his own mind. The purpose of invoking compulsory powers is not to eliminate that element of risk in human life which is simply part of being free to act and to make choices and decisions. Rather, their purpose is to protect the individual and others from a particular and somewhat limited kind of risk — that which arises when a citizen is of unsound mind and his judgement of risk, or his capacity to control behaviour he knows puts himself or others at risk, is in consequence of this markedly impaired. The key issue is the patient's judgement and appreciation of his situation, the way in which he will use his liberty if it is restored to him and he is again free to make decisions for himself. It cannot be over-emphasised that a citizen who has not offended against society is generally entitled to place a high premium on his liberty, even to value it more highly than his health. Within certain limits, he is as entitled as the next person to make what others may regard as errors of judgement and, in particular, to behave in a way which a doctor regards as irrational in the sense that it does not best promote his health. Thus, a person may chain-smoke cigarettes even though the risks involved in this activity, both to the individual and others, are significant and potentially life-threatening. Even though the individual's judgement is partially impaired by his addiction, nevertheless he is able to fully comprehend the medical advice and so, in this sense, is able to rationally assess the risks involved, when exercising his freedom to follow or ignore that advice. Likewise, a patient who has been receiving treatment for mental disorder is not to be compelled to follow medical advice simply because he disagrees with all or part of that advice, provided the choices he proposes making if set at liberty are not manifestly irrational. Accordingly, if the medical opinion is that a patient needs to continue taking medication and this should be given in depot form, it is not irrational *per se* for the patient to prefer to take prophylactic medication orally simply because from a medical viewpoint this is the treatment of second choice. If the patient can rationally explain that for him the slightly increased risk of relapse is outweighed by the disadvantages for him of injections, and other persons are not at risk, such a way forward represents a reasoned balance of the risks involved.

THE [illegible]SK OF SUICIDE

Mental illness accounted for 18,286 recorded deaths in 1991. Suicide is phenomenologically related to homicide and the two may occur together. However, in statistical terms, the risk that a mentally ill person will kill himself is substantially higher than the risk that he will kill another person.[7] Suicide accounts for approximately one per cent. of all deaths annually. Of the people who commit suicide, 90 per cent. have some form of mental disorder, 33 per cent. have expressed clear suicidal intent, and 25 per cent. are psychiatric out-patients. People who have attempted suicide in the past are at increased risk, the risk being approximately one hundred times greater in the year after an attempt.[8] In the case of short-term in-patients, there is evidence of a significant clustering of suicides soon after discharge from psychiatric care.[9]

GOVERNMENT STRATEGY

In *The Health of the Nation White Paper* published in July 1992, the Government set targets of reducing the overall suicide rate by at least 15 per cent. by the year 2000 (from 11.0 per 100,000 population in 1990 to no more than 9.4) and the suicide rate of severely mentally ill people by at least 33 per cent. by then (from a life-time estimate of 15 per cent. in 1990 to no more than 10 per cent.). The Department of Health also established a Confidential Inquiry into Homicides and Suicides by Mentally Ill People, with the twin purposes of eliciting avoidable causes of death and determining best practice by a detailed examination of the circumstances surrounding such events. The inquiry has been led by the Royal College of Psychiatrists and its first report was published in 1996.[10] According to that report, whereas:

> "some mentally ill or mentally disordered people can make unimpaired judgements, ... the broadly held assumption is that their ability to make unemotional and objective judgements is likely to be impaired. It is therefore not appropriate to take a relaxed attitude to suicide within this group or to take the view that death by suicide is inevitable. The safety of people who are mentally ill or mentally disordered must remain a central issue for the psychiatric services."[11]

THE CONFIDENTIAL INQUIRY

The Confidential Inquiry's terms of reference include enquiring into the circumstances leading up to and surrounding the suicides of people discharged by the specialist psychiatric services. The first report was based on a detailed examination of 240 suicides, involving 154 out-patients (64 per cent.), 53 in-patients (22 per

[7] See *e.g.* W. Böker and H. Häfner, *Crimes of violence by mentally disordered offenders* (Cambridge University Press, 1982). The incidence of homicidal violence for persons suffering from schizophrenia was five per 10,000, with the risk of suicide one hundred times greater than that of homicide. Amongst those suffering from an affective disorder, the rate of homicidal violence was six per 100,000, with a risk of suicide one thousand greater than that of homicide.

[8] *Health of the Nation* (Department of Health, 1992), Appendix 1.3.

[9] M. Goldacre, *et al.*, *Lancet* (1993) 342, 283–286.

[10] *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People* (Royal College of Psychiatrists, 1996).

[11] *Ibid.*, p.84. Although it is clearly erroneous to associate being objective or rational with being unemotional, the basic point remains. To deliberately allow a person who is seriously mentally ill to commit suicide when there is a realistic prospect that he may later feel differently is to deprive him of the rewarding future which he may still have.

cent.), and 33 patients discharged from specialist care during the preceding death (14 per cent.). The most common life event during the period of care preceding suicide was the breakdown of a marriage or partnership. Two-thirds of those individuals whose marital status was known were living alone. Social and employment problems were relatively common and barely a quarter of all the patients were employed, self-employed or in full-time education. Other life events often mentioned as relevant included the patient's reaction to the involvement of psychiatric services; bereavement; physical illness; and financial problems. The most common diagnoses were schizophrenia (men 31 per cent., women 17 per cent.), affective illness (men 29 per cent., women 47 per cent.) and personality disorder (men 18 per cent., women 7 per cent.). Previous self-harm was reported in around half the total cases and some degree of aggressive behaviour in 32 per cent. Slightly more than half of the out-patients had previously been in-patients and 22 per cent. of them had been admitted on five or more occasions. Two-fifths had been in-patients earlier in the episode of illness leading up to the suicide but only 30 per cent. of them had been detained at some stage during that illness. Three-quarters of the in-patients committing suicide were in wards designated as acute and one-quarter were detained at the time of death. All of the 19 per cent. of in-patients who died in their home were on leave at the time. A further 47 per cent. died somewhere else outside hospital and just over one-quarter committed suicide in hospital. It was evident that in many cases the suicide had come as a surprise to the clinical team. Although 52 per cent. of all patients had given clear intention of suicidal intent at some stage during the final episode of illness, staff felt that the danger had receded in most cases. Less than 25 per cent. of raters said that they "often" or "nearly always" thought during the period of care that the patient might try to commit suicide. In many reviews it was concluded that nothing could have reduced the likelihood of death, either because there had been no sign of likely danger or because all practical measures of supervision were in place. In only 24 per cent. of all cases were difficulties recorded in maintaining contact with the patient during the follow-up and in only 27 per cent. of cases were lapses in taking medication reported — neither problem was reported in 60 per cent. of the cases. As to those in contact, many were reported as showing poor co-operation, being seen as solitary, isolated, sometimes rigid and inflexible, and unable to build up a relationship with staff. 95 per cent. of raters were of the opinion that the treatment being offered was still relevant. Despite the general feeling that all practical supervisory measures were in place, only 40 per cent. of the out-patients who had previously been in-patients had a care plan and less than one-fifths of all out-patients had an operational care plan. Furthermore, only 38 per cent. of all patients had been provided with specialist social work contact at some stage prior to suicide. It is clearly too early to draw any conclusions but the report makes for depressing reading. While the act of suicide may sometimes have been impulsive, the background circumstances of marital breakdown, social isolation, bereavement, lack of employment, relatively low social work input and poor care planning all suggest an underlying mental deterioration or hopelessness about the future against a perception of relevant treatment and supervision and consequential surprise at the final act. From a tribunal point of view, the lesson is to pay more heed to the patient's view about whether his treatment is relevant to his situation and to be cautious about the ability of medication to resolve suicidal feelings which occur in the setting of unalleviated personal and social isolation.

EPIDEMIOLOGY

Strahan pointed out over a century ago the logical impossibility of ever knowing the mental state of the suicide just before his act. Consequently, he felt that reliable statistics were necessarily unobtainable and those that were obtained were meaningless.[12] While some knowledge of those groups of people statistically at greater risk of suicide is useful, because it directs attention to cases which might otherwise be missed, a psychiatrist cannot make an elderly white single man at lower risk on these factors with any known intervention.[13] Moreover, the vast majority of people in those groups do not commit suicide.

Gender

Rates of suicide are twice as high in men as in women and the difference is increasing. Although motherhood does not protect against depression, mothers of young children are less likely to commit suicide. However, as the following table shows, rates of suicide are higher amongst females in some cultural groups.

Suicide and Undetermined Injury by Gender and Country of Birth. England and Wales 1970-78, Persons aged 20-69 years

Gender and Country of Birth	*Proportional Mortality Ratio*
Indian sub-continent : males	87
Indian sub-continent : females	120
Caribbean commonwealth : males	80
Caribbean commonwealth : females	47
African commonwealth : males	110
African commonwealth : females	120

Source: OPCS Immigration Mortality

Mental disorder

Serious mental disorder has a marked effect on lifetime suicide rates. They are estimated at schizophrenia 10 per cent., affective disorder 15 per cent., personality disorder 15 per cent.

Age

Suicide has risen by 75 per cent. in young men aged 15–24 since 1982 and it is the second most common cause of death in 15-34 year old males. Suicide rates for men under the age of 45 are now higher than those of older men, apart from men aged 75 and over. In contrast, rates for women remain lower in women aged 45 and under.

12 S.A.K. Strahan, *Suicide & Insanity* (Sawn & Sonnenschein & Co., republ. 1983). See *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People* (Royal College of Psychiatrists, 1996), p.85. A point also made by Jack London in his novel *Martin Eden*, whose eponymous hero's suicide foretold the author's own: "and with that thought he ceased to think."

13 W.J. Fremouw, *Suicide Risk: Assessment and Response Guidelines* (Pergamon Press, 1990), p.87.

Social Class and employment status

Suicide rates are higher amongst the unemployed, although the relationship is complex, and also highest in social class V (unskilled workers).

Suicide and Undetermined Injury by Social Class
England & Wales. 1979-80, 1982-83, Persons aged 20-69 years

Social Class	*Standardised Mortality Rate*
I	77
II	65
IIIN	86
IIIM	75
IV	115
V	220

Source: OPCS Occupational Mortality

Family status

The ending of marriages or partnerships — whether by divorce or death — has a direct impact on suicide rates. It may also have a delayed effect on children whose parents separate, leading to mental illness or suicide in later life.

Season

Suicide rates are highest in the spring and early summer, notably April, May and June.

Alcohol abuse

Alcohol abuse has a marked effect on the lifetime suicide rates. 15 per cent. of persons dependant on alcohol are estimated to commit suicide. The presence of psychiatric illness and alcoholism increases the risk of completed suicide.[14]

Access to means

The availability of easy and relatively painless methods of suicide is an important factor in influencing suicide rates. Self-poisoning has declined with reduced prescriptions for barbiturates but still accounts for 66 per cent. of suicides amongst women, paracetamol being commonly used. The inhalation of car exhaust fumes causes 33 per cent. of male suicides.

Health and social services support

Cramer estimated that suicides amongst hospital in-patients account for only 5 per cent. of the overall number of suicides.[15] However, recent research has highlighted

[14] J.H.J. Bancroft and P. Marsack, *British Journal of Psychiatry* (1977) 131, 394.
[15] J.L. Cramer, "The Special Characteristics of Suicide in Hospital In-Patients" *British Journal of Psychiatry* (1984) 145, 460–463.

the hitherto unrecognised freq y of suicide in traditional services.[16] Each mental health sector team can expect between 6 and 12 suicides per annum for a catchment area population of 50,000 to 100,000, of whom 2–5 persons will have been patients of the team. Each health authority responsible for a population of 500,000 persons can expect 50-60 such deaths per annum. The statistics demonstrate the importance of proper after-care arrangements since, although 10–15 per cent. of patients with a major mental disorder can be expected to take their own lives, the vast majority will do so in the community and, in the case of detained patients, following discharge.

SUICIDE — SOME RESEARCH FINDINGS

B. Barraclough, et al., British J. of Psych. (1974) 125, 355–373.	Between one-third and half of those persons who commit suicide were found to have a history of previous attempts. See also Kreitman , *infra.*
J.H.J. Bancroft and P. Marsack, Brit. J. of Psych. (1977) 131, 394.	The presence of psychiatric illness and alcoholism increases the risk of completed suicide.
A.R. Beisser and J.E. Blanchette, Diseases of the Nervous System (1961) XXII, 7, 365–369.	Repeated suicide attempts are most common during the three month period following an attempt.
S. Ganzler, et al., Life-threatening behaviour (1971) 1, 184–202.	There is a marked association between attempted suicide rates and living in an area of relative social deprivation.
K. Hawton and J. Catalan, Psychiatric management of attempted suicide patients. Brit. J. of Hosp. Med.	Approximately 90% of suicide attempts involve deliberate self-poisoning, the rest being self-injuries or a combination of both. Approximately half of male attempters have serious employment problems.
K. Hawton, et al., Journal of Neurology, Neurosurgery and Psychiatry (1980) 43, 168.	High rates of attempted suicide are found in many patients with epilepsy. See also Mackay, *infra.*
N. Kreitman, Parasuicide (John Wiley, 1980).	1–2% of persons who attempt suicide kill themselves within the following year.
H.G. Morgan, et al., Brit J. of Psych. (1975) 127, 564.	Non-opiate analgesics (for example salicylates) are used in a quarter of attempted suicides and in considerably more of the attempts of young persons.
A. Mackay, Brit. J. of Psych. (1979) 134, 277.	High rates of attempted suicide are found in many patients with epilepsy. See also Hawton, *et al.*, 1980.
I.M.K. Ovenstone, Brit. J. of Preventive and Soc. Medicine (1973) 27, 27.	There is a considerable overlap between those who commit suicide and those who attempt it but do not die.
E.S. Paykel, et al., Arch. of Gen. Psych. (1975) 32, 327.	The majority of suicide attempters have recently experienced threatening or undesirable life events, usually in the nature of inter-personal problems.
J. Roberts and K. Hawton, Brit. J. of Psych. (1980) 137, 319.	An association has been demonstrated between child abuse and attempted suicide.
P. Sainsbury, Brit. J. of Hosp. Medicine (1978) 19, 156.	Characteristics disproportionately common to persons who commit suicide include being male, of older age, living alone, and being recently bereaved.
P. Urwin and J.L. Gibbons Psychol. Medic. (1979) 9, 501.	Formal psychiatric disorders requiring treatment are found in a minority of attempted suicide patients.

[16] *Health of the Nation* (Department of Health, 1992), para. 6.16.

ASSESSING THE RISK OF SUICIDE

To predict which individual out of one hundred people who has attempted suicide will die during the next year is necessarily extremely difficult. Even if those persons could be identified with 80 per cent. accuracy, two attempters per thousand will die during that time and many more be identified incorrectly as likely suicides. There is, of course, no evidence that the population can be discriminated with anything near 80 per cent. accuracy; and it would generally not be considered appropriate to continue to detain someone not thought to be in any immediate danger because events in ten months' time may take a decisive turn for the worst.[17]

Assessment following a suicide attempt

Hawton and Catalan developed a semi-structured interview schedule which includes obtaining a detailed account of events in the 48 hours preceding the attempt (degree of planning, isolation, suicide note, motives, actions after attempt, whether alcohol was taken, previous attempts) and clarifying the nature of the patient's problems and their duration. In assessing psychiatric disorders, particular attention should be paid to symptoms suggestive of depression and alcoholism.[18] Assessment following self-poisoning or self injury should include evaluation of risk of suicide; evaluation of risk of repetition; identification of psychiatric disorder; clarification of current problems faced by the patient; obtaining information from other sources, including the general practitioner, family and friends; and making arrangements for appropriate help following discharge from hospital. According to Hawton and Catalan, in-patient treatment is generally indicated for people with serious psychiatric disorders, those at risk of suicide, and those who require a short period of respite.[19] Compulsory admission is often necessary for patients who refuse help but are clearly suffering from serious depression with loss of insight and those judged to be at risk of suicide who cannot give satisfactory assurances about their intentions.

Scales for assessing the risk

Bluglass and Horton developed a six-item scale for predicting the risk of a further attempt, the scales being problems in the use of alcohol; a diagnosis of sociopathy; previous in-patient psychiatric treatment; previous out-patient psychiatric treatment; a previous attempt leading to hospital admission; and not living with relatives. A patient is given one point for each item applicable to him. The higher the score, the greater the risk of repetition. They found that a patient scoring nought had a probability of repetition within one year of five per cent while a patient with a score of five or six had a repetition probability of 48 per cent.[20] Further attempts by some individuals may be characterised by an increase in suicidal intent. The Beck Suicidal Intent Scale is often used to evaluate this.

17 An American study of 4,800 war veteran patients over 4–6 years managed to identify one-half of the actual suicides while misidentifying 1,206 false positives. Of the total group identified as being those who would commit suicide, only 2.8 per cent. were identified correctly. See A.D. Pokorny, "Prediction of suicide in psychiatric patients" *Archives of General Psychiatry* (1983) 40, 249–257.

18 For example, severe mood disturbance, forgetfulness, impaired concentration, feelings of hopelessness and guilt, loss of interest, and impaired libido.

19 K. Hawton and J. Catalan, *Attempted suicide: a practical guide to its nature and management* (Oxford University Press, 2nd ed., 1987).

20 D. Bluglass and J. Horton, "A scale for predicting subsequent suicidal behaviour" *British Journal of Psychiatry* (1974) 124, 573–578.

ASSESSMENT OF PATIENTS

General questions following deliberate self-poisoning or self-injury

What is the explanation for the attempt in terms of likely reasons and goals?

What was the degree of suicidal intent?

Is the patient at risk of suicide now, or is there an immediate risk of further overdose or self-injury?

What problems, both acute and chronic, confront the patient? Did a particular event precipitate the attempt?

Is the patient psychiatrically ill, and if so what is the diagnosis and how is this relevant to the attempt?

What kind of help would be appropriate, and is the patient willing to accept such help?

Issues concerning the degree of suicidal intent

Whether the attempt was impulsive or planned; if the latter, the duration of the plans.

Whether the patient was alone, or whether someone was present or within easy access.

Whether the patient was likely to be found soon after the attempt.

The nature of any precautions taken to prevent or ensure discovery.

The drugs taken, including the quantity, and whether other drugs were available but not taken; this includes the consumption of alcohol during or preceding the attempt.

The patient's expectation regarding the effect of the drugs or injury.

The presence of a suicide note or message, including tape-recorded statements.

The patient's efforts to obtain help after the attempt, and events leading to admission to hospital.

Assessment of current problems

Relationship with partner or spouse

Relationship with other family members, particularly young children

Employment or studies; Financial matters; housing

Legal, including pending court proceedings

Social isolation, relationship with friends

Psychiatric and physical health

Use of alcohol and drugs

Sexual adjustment

Bereavement and impending loss

Source: Adapted from K Hawton and J Catalan, Attempted suicide: a practical guide to its nature and management (Oxford University Press, 2nd ed., 1987).

Factors associated with subsequent suicide

Factors found to be associated with subsequent suicide include an age of 45 or over; male sex; being unemployed or retired; being separated, divorced, or widowed; living alone; poor physical health; having received medical treatment within six months; psychiatric disorder, including alcoholism; having used violent methods such as hanging, shooting, jumping, or drowning; the presence of a suicide note; and a history of previous attempts. As to these eleven factors, Tuckman and Youngman found that the risk of actual suicide increased in proportion to the number of predictors present. Attempters with two to five factors had a suicide rate of 6.98 per 1000 while those with ten or eleven had a suicide rate of 60 per 1000.[21] It can be seen that one weakness of some scales is that they concentrate only on things which tend towards hopelessness, despair, and thoughts of death. In concentrating on what the person does not have, his problems, they do not count how many things he still has left which predispose him to want to live — persons dear to him, opportunities for the future, and so forth.

SHORT-TERM CLINICAL SUICIDE RISK FACTORS

		Low	*Moderate*	*High*
1	**Recent losses**	None	Within last month	Within days of loss
2	**Depression-Anxiety**	Mild	Moderate	Severe
3	**Isolation-Withdrawal**	Regular social contacts	Some social contact	Socially isolated
4	**Hostility**	Mild	Moderate	Severe
5	**Hopelessness**	Mild	Moderate	Severe
6	**Disorientationdisorganisation**	None	Moderate	Severe
7	**Alcohol/drug abuse**	None to little	Frequent to excess	Chronic abuse
8	**Change in clinical features**	None		Unexplained improvements
9	***Suicide plan***			
9.1	**Method**	Undecided	Decided	Decided
9.2	**Availability**	No	Yes	Yes
9.3	**Time-place**	Not specific	Not specific	Yes
9.4	**Lethality**	Low None	Moderate	High
10	**Final arrangements**	None	Some planning	Written note, wills, possessions given away

Source: W.J. Fremouw, Suicide Risk: Assessment and Response Guidelines (Pergamon Press, 1990), p.38.

21 J. Tuckman and W.F. Youngman, "A scale for assessing suicide risk of attempted suicides" *Journal of Clinical Psychology* (1968) 24, 17–19. See K. Hawton and J. Catalan, *Attempted suicide: a practical guide to its nature and management* (Oxford University Press, 2nd ed., 1987), p.66.

The short-term risk

Motto studied a sample of 3000 hospitalised patients who were severely depressed or in a suicidal state, 38 of whom committed suicide within 60 days of the assessment.[22] The following nine factors were identified as indicators of short-term risk among this already high risk group of hospitalised patients: (1) prior psychiatric hospitalisation; (2) contemplation of suicide by hanging or jumping; (3) severe, moderate, or questionable suicidal impulses; (4) divorced marital status; (5) threat of financial loss; (6) sense of being a burden to others; (7) the interviewer having a mixed or negative reaction to the patient; (8) severe crying or inability to cry; (9) severe or moderate ideas of persecution or ideas of reference. The presence of any of the first four factors increased the risk of suicide three times within the next sixty days while the remaining factors increased the risk at least twofold. Motto reported that when four or more factors were present, 71 per cent. of the suicides were correctly identified while correctly excluding 81 per cent. of the non-suicides.

Levels of supportive observation

As a final note on the subject, it is worth referring to the different levels of observation in hospital. The following levels of observation are described by Morgan and Owen and it will be found in most cases that a similar three-tier structure is practised.[23]

OBSERVATION LEVELS

• Level 3	*Known place observation*	Patient not actively suicidal and judged free from immediate significant suicidal risk.
• Level 2	*15 minute observation*	Close relationship has been established with the patient who is judged not to be actively suicidal, but is considered to be at significantly increased suicidal risk compared with the average psychiatric inpatient.
• Level 1	*Constant observation*	Patient is expressing active suicidal intent, particularly if no close relationship has been established with him. Unpredictable psychotic states or recent deliberate self-harm with apparent serious suicidal intent may indicate this level of supportive observation.

FURTHER READING

There is an extensive literature on the subject of suicide, the following articles being but a small sample of those available: L. Appleby, "Suicide in psychiatric patients: risk and prevention" *British Journal of Psychiatry* (1992) 161, 749–75; C.V.R. Blacker, *et al.*, "Assessment of deliberate self harm on medical wards" *Psychiatric*

22 J.A. Motto, "Nine short-term predictors of suicide identified" *Clinical Psychiatry Newsletter*, June 1988. See W.J. Fremouw, *Suicide Risk: Assessment and Response Guidelines* (Pergamon Press, 1990), p.88.

23 H.G. Morgan And J.H. Owen, *Persons at risk of suicide: Guidelines on good clinical practice* (Boots, 1990).

Bulletin (1992) 16, 262–263; K. Hawton, "Assessment of suicide risk" [illegible]*ish Journal of Psychiatry* (1987) 150, 145–153; H.G. Morgan, "Suicide prevention. Hazards on the fast lane to community care" *British Journal of Psychiatry* (1992) 160, 149–153; H.G. Morgan and J.H. Owen, *Persons at risk of suicide. Guidelines on good clinical practice* (Boots, 1990); H.G. Morgan and P. Priest, "Suicide and other unexpected deaths among psychiatric in-patients. The Bristol confidential inquiry" *British Journal of Psychiatry* (1991) 158, 368–374; J.C. Rossiter, "Suicidal patients – effect on staff" *Psychiatric Bulletin* (1989) 13, 495–6; J.C. Rossiter, "Suicide" *Psychiatric Bulletin* (1991) 15, 674–5; P.M. Marzuk, *et al.*, "The effect of access to lethal methods of injury on suicidal rates" *Archives of General Psychiatry* (1992) 49, 451–8; N. Kreitman, "The coal gas story: UK suicide rates 1960–71" *British Journal of Preventative & Social Medicine* (1976) 30, 86–93; N.L. Farberow, *et al.*, "Case history and hospitalisation factors in suicides of neuropsychiatric hospital patients" Journal of Nervous and Mental Diseases (1966) 142, 32–44; C. Perris, *et al.*, "Some remarks on the incidence of successful suicide in psychiatric care" *Social Psychiatry* (1980) 15, 161–166; A. Prasad and G.G. Lloyd, "Attempted suicide by jumping" *Acta Psychiatrica Scandinavica* (1983) 68, 394–396; Warlingham Park Hospital (1974/75), Report of the Committee of Inquiry, Croydon Health Authority; C.P. Seager and R.A. Flood, "Suicide in Bristol" *British Journal of Psychiatry* (1965) 111, 919–932; A. Sims and K. O'Brien, "Autokabelesis: an account of mentally ill people who jump from buildings" *Medicine Science and the Law* (1979) 19, 195–198; I.W. Sletten, *et al.*, "Suicide in mental hospital patients" *Diseases of the Nervous System* (1972) 33, 328–334; E. Robins, *et al.*, "Some clinical considerations in the prevention of suicide, based on 134 successful suicides" *American Journal of Psychiatry* (1959) 49, 888–898; B. Rorsman, "Suicide in psychiatric patients: a comparative study" *Social Psychiatry* (1973) 8, 55–66; D.R. Chambers, "The Coroner, the Inquest and the Verdict of Suicide" *Medicine, Science and the Law* (1989) 29(3).

RISK TO SAFETY OF OTHERS

Although research findings tend to demonstrate a positive relationship between mental illness and offending, including violence, this must be seen against the general level of prevailing violence in homes and public houses and on the roads.[24] Mentally ill people contribute proportionately very little to the general problem of dangerous behaviour and the preventive confinement of dangerous offenders is of only marginal value as a protective device. Measured against the full range of modern social hazards, its contribution to public safety is tiny, as also is the likely impact on the rates at which serious offences are committed.[25]

24 E. Fottrell, "Violent behaviour by psychiatric patients" in *Contemporary Psychiatry* (ed. S. Crown, Butterworths, 1984), pp.19–20.

25 See J. Floud and W. Young, *Dangerousness and Criminal Justice* (Heinemann, 1981). A point endorsed by Sir Leon Radzinowicz in "Dangerousness and Criminal Justice: a few Reflections" (1981) *Criminal Law Review* 756. In 1976, the Howard League set up a committee under Floud's chairmanship to inquire into the protective sentencing of dangerous offenders in England and Wales other than those provided for under the Mental Health Act 1959.

RISK AND DANGER

A risk can in theory be measured and is the basis of actuarial prediction — in theory because in practice all of the critical variables never are known. While the risk depends on the situation, all of the situations in which the patient may find himself in the future can only be speculated upon. Danger is sometimes said to incorporate the weighting that people put on different kinds of risk. A situation is often viewed as dangerous when there is an unknown risk or a small known risk of a catastrophic outcome, such as suicide or homicide, or a significant risk of an adverse outcome involving significant physical harm. Thus, Floud has written that risks are perceived as dangers when fear is present.[26] It is the fear that the behaviour of people when mentally ill is unpredictable and not situation specific which mainly gives them such a high dangerousness rating, not danger as assessed by some objective criterion.[27] While people tend to ignore the risk of driving on a motorway or being killed by their spouse, they are fearful of the actuarially much smaller risks of flying or being injured by a dangerous offender. Although the actual risk posed by a person is static at any given time, the sense of danger is heightened if the situations in which that risk arises are not understood. No human event is ever truly random and terms such as "random violence" simply describe the predictable outcome of an unpredictable sequence of events, some of which take place in the person's mind. What level of uncertainty is tolerable is ultimately for the courts, including tribunals, to decide.

THE CONFIDENTIAL INQUIRY

The first report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People was published in 1996.[28] The terms of reference include enquiring into the circumstances leading up to and surrounding homicides committed by people discharged by the specialist psychiatric services. The first report was based on detailed consideration of 39 cases of homicide. 19 of the patients had previously been in-patients and five of them had been detained at some stage during the episode of illness leading up to the homicide. Three of these patients had been detained during the previous six months. The primary diagnoses of the patients were schizophrenia (males 55 per cent., females 8 per cent.); affective disorder (males 19 per cent., females 75 per cent.); personality disorder (males 26 per cent., females 17 per cent.). A secondary diagnosis of personality disorder was made in the cases of five men suffering from schizophrenia or paranoid psychosis. Two-thirds of the victims were family members. Nine of the 12 women killed their own children, eight of the nine being diagnosed as having a depressive disorder. Two-thirds of the offenders had been involved in earlier episodes of violent or aggressive behaviour and 26 per cent. had criminal convictions for violence. However, no aggression had

26 J. Floud, "Dangerousness in social perspective" in *Psychiatry, human rights and the law* (ed. M. Roth & R. Bluglass, Cambridge University Press, 1985), p.82.

27 J. Gunn, "Clinical approaches to the assessment of risk" in *Risk-taking in Mental Disorder: Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990); M. Roth and R. Bluglass, "A postscript on the discussions at the Cambridge Conference on Society, Psychiatry and the Law" in *Psychiatry, human rights and the law, supra*, p. 232. This is one reason why the view that "if a person frightens you, he is probably dangerous" is so dangerous. As one of the Commissioners, Jeremy Walker, has pointed out, the important thing is that each mental health professional understands whether he is naturally over-anxious or under-anxious, a risk-avoider or a risk-taker, and then makes allowance for that.

28 *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People* (Royal College of Psychiatrists, 1996).

been reported in 41 per cent. of cases during the period of care lea_, up to the death. Violent behaviour in other family members was noted in 11 cases. Only 16 per cent. of the out-patients had a care plan and in half the cases it was reported that no care plan had been implemented. There were problems with the administration of medicines in 41 per cent. of cases. Staff often said that the homicide had been totally unpredictable and that there had been no indicators of possible violence. Certain information about when patients were last seen by a doctor prior to the homicide appears to have been omitted from the published report.

PREDICTING VIOLENCE TOWARDS OTHERS

Having reviewed the literature, Steadman concluded that nowhere was there any documentation that clinicians can predict dangerous behaviour beyond the level of chance.[29] However, he has suggested five factors that may be risk markers for violence: the characteristics of social support available to the patient; impulsiveness; reactions to provocation; ability to empathise; and the nature of any hallucinations and delusions.[30] However, Crichton's recent review of the literature demonstrates that neither statistical models nor clinical skills are reliable predictors of future violence[31] and Monahan drew the following conclusions about assessments of dangerousness in the context of mental disorder[32]—

- The upper bound of accuracy that even the best system of risk assessment system could achieve was in the order of .33 so that for each mentally disordered person predicted to be violent two would not be.
- The best demographic predictors of violence among the mentally disordered were the same for the non-mentally disordered, *i.e.* age, gender, social class and history of offending.
- The poorest predicting factors among the mentally disordered were diagnosis, severity of disorder and personality traits.

The patient's mental state

The poorest predictors of violence include diagnosis and the severity of the disorder. In illnesses with a paranoid component, it is important to consider how a rational person would respond to the events which the patient believes are real if they were real, and to establish how he is likely to deal with these perceived threats. Most people who are sexually interfered with, or whose spouses are unfaithful, or whose

29 See *e.g.* H.J. Steadman, "Predicting Dangerousness" in Rage, Hate, Assault and Other Forms of Violence (ed. D.J. Madden & J.R. Lion, Spectrum, 1976).

30 H.J. Steadman, *et al.*, "From Dangerousness to Risk Assessment: Implications for Appropriate Research Strategies" in *Mental Disorder and Crime* (ed. S. Hodgins, SAGE Publications, 1993).

31 See *e.g.* Crichton; P.D. Scott, "Assessing dangerousness in criminals" *British Journal of Psychiatry* (1977) 313, 127–142; T.R. Litwick, *et al.*, "The assessment of dangerousness and predictions of violence: recent research and future prospects" *Psychiatric Quarterly* (1993) 64, 245–273. See also J.J. Cocozza and H. J. Steadman, "Prediction in Psychiatry: an example of misplaced confidence in experts" *Social Problems* (1978) 25(3), 245–276; S. Winter, "Psychiatry in the Witness Box" *Social Work Today* (1981) 12,14.

32 J. Monahan, "Risk assessment of violence among the mentally disordered: generating useful knowledge" *International Journal of Law and Psychiatry* (1988) 11, 249–257.

property is being stolen, or who: ›od is being poisoned, do not idly let this happen. Some people resort to litigation, others report the matter to the police, others move house or leave their job, or become reclusive, or make their home more secure, or confront their persecutors and angrily take the law into their own hands. In this respect, people who subjectively believe that these events are happening to them show a similar range of responses. Likewise, the person who thinks people are talking about him is as likely as anyone else to feel hurt about this and to respond meekly or violently. Similarly, some people who are dying take their lives, as do some people who only believe they are dying. If violence has not previously been a feature, predicting future violence depends on assessing the likelihood of the subjective events recurring and the ways in which the patient is likely to protect himself, as determined by his personality. According to Taylor, the range of risks have to be assessed in terms of their seriousness, immanence and likelihood. Relevant historical data, current dispositions (*e.g.* empathy and anger), symptomatology (*e.g.* delusions) and environmental stressors (including alcohol) all need to be considered.[33]

The importance of the personality

The underlying personality may be the determining factor in deciding whether the end result of an aggressive thought or fantasy is a violent act.[34] Megargee distinguished between "under-controlled" and "over-controlled" aggressors. He hypothesised that extreme assaultors are typically weak, mild-mannered people, with excessively high levels of inhibition about acting violently.[35] Psychometric measures of impulsivity have been shown to have a positive correlation with assaultativeness and with a tendency to "fail" subsequent to discharge from a special hospital. Blackburn concluded that in schizophrenia the patient's premorbid personality was more important in determining hostile behaviour than the illness.[36] Fottrell's view is that Brill and Malzburg's opinion that "an attack of mental illness with hospitalisation does not tend to leave an inclination towards criminal activity greater than that which existed prior to the illness" remains valid today.[37] Indeed, Sir Denis Hill considered that there were strong counterforces within the personalities of persons suffering from schizophrenia that prevented the expression of aggressive drives and this led to withdrawal and preoccupation with delusional ideas.[38]

Personality traits

Although it is commonsense that an individual's personality lays as large a part in determining how he responds to a subjectively threatening situation as it would if that event was actually taking place, it is nevertheless not possible to devise a list of personality traits which account for such variability of behaviour:

33 P. Taylor, Rehabilitation of Mentally Disordered Offenders conference, Oxford, 20 January 1993.

34 E. Fottrell, "Violent behaviour by psychiatric patients" in *Contemporary Psychiatry* (ed. S. Crown, Butterworths, 1984), p.20.

35 E.I. Megargee, "Uncontrolled and overcontrolled personality type in extreme antisocial aggression" *Psychological Monographs* (1966) 80, No. 3.

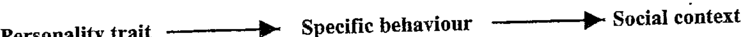
36 R. Blackburn, "Personality in relation to extreme aggression in psychiatric offenders" *British Journal of Psychiatry* (1968) 114, 821.

37 H. Brill and B. Malzburg, *Statistical Report on the Arrest Record of Male Ex-patients. aged 16 and over, Released from New York State Mental Hospitals during the period 1946–1948* (New York State Department of Mental Hygiene, 1954); E. Fottrell, "Violent behaviour by psychiatric patients," *supra*, p.21.

38 D. Hill in *The Natural History of Aggression* (ed. J.D. Corth & F.J. Ebbing, Academic Press, 1964).

"research has failed to show as much personality consistency as theoris ,uld lead us to believe ... Studies which have looked at general traits such as anxiety or hostility have found that individual differences in the strength of a trait account for little of the variability of behaviour. What appears to matter most is the interaction of the differences in individuals with the differences in situations. In other words, it is not very useful to talk about general traits such as anxiety or hostility without considering the situation in which they may be exhibited. The importance of this in helping people with personality disorders is that one's efforts may be much more fruitfully directed towards finding situations in which the individual behaves less deviantly than in trying to change personality with psychotherapy."[39]

That being so, Powell has emphasised the importance of considering the underlying traits, then stating clearly the specific behaviour causing concern, and then describing the social context in which the personality problems exhibit themselves.[40]



The internalisation of acceptable behaviour

In personality disorder cases, some psychiatrists consider that the internalisation of acceptable behaviour is essential and reliance on external control is insufficient. This reflects the fact that people with a persistent impulse to act or react in a certain way are by definition prone to acting without much thought for the consequences. Indeed, the impulse to behave in that way may be triggered by finding themselves in a uncontrolled setting where there seems to be little prospect of detection.

The importance of the situation

Together with the individual's personality, the other factor which is always important is the particular situation. As to this, the Butler Report observed that dangerous behaviour depends in the majority of cases not only on the personality of the person concerned but also on the circumstances in which he finds himself:

> "The practice of referring to some individuals as 'dangerous' without qualification creates the impression that the word refers to a more or less constantly exhibited disposition, like left-handedness or restlessness. It is true that there are people in whom anger, jealousy, fear or sexual desire is more easily aroused and whose reactions are more extreme than in most people, prompting them to do extremely harmful things. But these emotions are aroused and lead to harmful behaviour only in certain situations. A persistent housebreaker may go right through his criminal career without physically harming anyone; but if one day he is surprised, he may have it in him to commit an offence of violence. For some people drugs, alcohol or the excitement of a crowd may be a precipitating factor. The situation and circumstances which are potentially dangerous can often be defined, and sometimes foreseen and avoided or prevented. The individual who spontaneously 'looks for a fight' or feels a need to inflict pain or who searches for an unknown sexual victim is fortunately rare, although such people undoubtedly exist. Only this last group can justifiably be called 'unconditionally dangerous."[41]

39 C.P.L. Freeman, "Personality disorders" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.591.

40 G.E. Powell, "Personality" in *Scientific principles of psychopathology* (ed. P. McGuffin, *et al.*, Academic Press, 1984).

41 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 4.5.

The importance of supervision

It is crucial to assess the range of ...uations which might trigger the patient to behave violently given his personality and the likelihood of exposure to them. As to this, the Butler Report commented that those who discharged restricted patients had a responsibility to ensure that they "were subject to reassessment and control appropriate to their needs, that is to say having regard to the particular situations in which they may find themselves, and their possible reactions to them."[42]

Alcohol and drug-taking

A high percentage of murderers and their victims are intoxicated at the time of the crime. Lewis concluded that whilst the use of particular drugs in drug-dependent individuals may be associated with violent crime it is likely that a particular type of personality is necessary to produce violence.[43]

Arson

Persons suffering from schizophrenia may set fire to their home in response to auditory hallucinations and other patients may set fire to their property when manic or depressed. In a study of arsonists in a special hospital, McKerracher and Dacre found that as a group they had a higher psychotic morbidity level and a more marked history of attempted suicide than the other patients in the hospital.[44]

Past behaviour

Not surprisingly, there is evidence that the more violent offences a person has committed, the more chance there is that he will commit another. Although repeated offending is likely to be further repeated, the majority of offenders convicted of a single violent offence are not again convicted of violence.[45] Thus, while it is sometimes said that nothing predicts behaviour like behaviour, the approach has strict limitations (**724**).

CHARACTERISTICS OF VIOLENT IN-PATIENTS

Crichton has comprehensively reviewed the literature, drawing together the findings of various studies concerning the characteristics of violent in-patients.[46] A common feature of the studies was that a small number of patients were responsible for a significant proportion of the violent incidents reported. The highest rates of violence were in locked wards and intensive care units. In one special hospital, there was more than one life threatening incident per week.[47] The Health Services Advisory

42 *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), *para. 4.6.*

43 A.J. Lewis, *Cannabis — A Review of the International Clinical Literature* (Home Office Advisory Committee on Drug Dependence), p.40.

44 D.W. McKerracher and A.J. Dacre, *British Journal of Psychiatry* (1966) 112,1151; See E. Fottrell, "Violent behaviour by psychiatric patients" in *Contemporary Psychiatry* (ed. S. Crown, Butterworths, 1984), p.23.

45 All that distinguishes a violent offender who does not reoffend from a non-violent person may be that a particular combination or sequence of events which causes both of them to react violently has actually taken place in the case of one of them but not the other. Hence, attempts to differentiate them from "normal" people have generally been unsuccessful.

46 J.M.H. Crichton, *Violence caused by psychiatric in-patients and its prediction: An introductory paper prepared for the Robinson Inquiry Seminar Day* (1994).

47 E. Larkin, *et al.*, "A preliminary study of violent incidents in a Special Hospital (Rampton)" *British Journal of Psychiatry* (1988) 153, 226–231.

Committee survey found that about one-tenth of psychiatric i[illegible]ients commit violent assaults against staff and NHS staff are three times more likely to suffer injury than industrial workers, mainly because of assault.[48] There is some evidence that recorded rates of in-patient violence are increasing.[49]

Diagnosis, gender and race

Although active psychotic symptoms are associated with an increased risk of violence,[50] the studies did not collectively establish a higher rate of violence among persons with a diagnosis of schizophrenia.[51] They tended to show either an equal rate of violence between the sexes or a greater rate of violence in female patients.[52] This was particularly so in secure settings such as special hospitals and prisons.[53] There was no consensus concerning the relationship between in-patient violence and race.

Structural factors

Violence appears to be more common where there is little structured activity.[54] Factors reported as being significant include poor staffing levels, the use of temporary staff, unpredictable ward programmes, and patients being under-occupied.

Antecedents of violence

Powell found that violence was commonly preceded by a high state of arousal (31 per cent. of cases), restrictions placed on patients (21 per cent.), and provocation by others (19 per cent.).[55]

48 *Violence to staff—Report of D.H.S.S. Advisory Committee on violence to staff* (D.H.S.S., 1988).

49 J.H.M. Crichton, Violence caused by psychiatric in-patients and its prediction (1994); R.M. Haller and R.H. Deluty, Assaults on staff by psychiatric in-patients *British Journal of Psychiatry* (1988) 152, 174–179; A.K. Shah, *et al.*, "Violence among psychiatric in-patients" *Acta Psychiatrica Scandinavica* (1991) 84, 305–309; D.V. James, *et al.*, "An increase in violence on an acute psychiatric ward: A study of associated factors" *British Journal of Psychiatry* (1990) 156, 846–852; P. Noble and S. Roger, "Violence by psychiatric in-patients" *British Journal of Psychiatry* (1989) 155, 384–390; Z. Walker and R. Seifert, "Violent incidents in a psychiatric intensive care unit" *British Journal of Psychiatry* (1994) 164, 826–828.

50 See J.M.H. Crichton, *Violence caused by psychiatric in-patients and its prediction, supra;* J. Monahan, "Risk assessment of violence among the mentally disordered: generating useful knowledge" *International Journal of Law and Psychiatry* (1988) 11, 249–257.

51 Various early studies conducted between 1965 and 1986 had failed to take into account the higher proportion of patients with schizophrenia found in hospital compared with other diagnoses.

52 See *e.g.* P. Noble and S. Roger, "Violence by psychiatric in-patients" *British Journal of Psychiatry* (1989) 155, 384–390; L. Binder and E. McNeil, "The relationship of gender to violent behaviour in acutely disturbed psychiatric patients" *Journal of Clinical Psychiatry* (1990) 51, 110–114; E. Fottrell, "A study of violent behaviour among patients in psychiatric hospitals" *British Journal of Psychiatry* 136 (1980) 216–221; E. Larkin, *et al.*, "A preliminary study of violent incidents in a Special Hospital (Rampton)," *supra.*

53 See *e.g.* E. Larkin, *et al.*, "A preliminary study of violent incidents in a Special Hospital (Rampton)," *supra*; T. Maden, "Women as violent offenders and violent patients" in *Violence in Society* (ed. P.J. Taylor, Royal College of Physicians, 1993); R.P. Dobash, *et al.*, *The Imprisonment of Women, Penal Regimes* (Blackwell Publications, 1986).

54 See *e.g.* M. Pearson, *et al.*, "A Study of violent behaviour among in-patients in a psychiatric hospital" *British Journal of Psychiatry* (1988) 149, 232–235; E. Fottrell, "A study of violent behaviour among patients in psychiatric hospitals," *supra.* Crichton also draws attention to the Torpy and Hall's study, which found virtually no violence in areas designated for occupation or therapy: D. Torpy and M. Hall, "Violent incidents in a secure unit" *Journal of Forensic Psychiatry* (1993) 4, 517–544.

55 G. Powell, *et al.*, "What Events Precede Violent Incidents in Psychiatric Hospitals?" *British Journal of Psychiatry* (1994) 165, 107–112;; G.J.M. Aiken, "Assaults on staff in a locked ward: prediction and consequences" *Medicine Science and the Law* (1984) 24, 199–207.

DISCHARGE A[illegible] AFTER-CARE PLANNING

The existence of separate health and social services authorities, and concern about the premature discharge of patients, has resulted in a plethora of enactments, directions, guidelines and codes concerning the discharge of patients and their after-care. The most important of them, and the way in which they inter-relate, are briefly summarised below before being considered in greater detail. For the sake of clarity, it is important to distinguish between statutory and non-statutory provisions and also between those which require only an assessment of a person's need for after-care; those which impose a duty to provide after-care; and those which are simply systems for carrying out assessments and delivering care.

MENTAL HEALTH ACT 1983, S.117 (413)

Health and social services authorities have a duty under section 117 of the 1983 Act to provide after-care for patients who have been detained in hospital for treatment. What constitutes after-care and the exact nature of that duty is not defined and no regulations have been made which prescribe how the duties are to be performed. The ambit of section 117 has already been considered (**418**).

DISCHARGE OF PATIENTS FROM HOSPITAL, HC(89)5 (750)

The Health Circular, "*Discharge of Patients from Hospital,*" was issued in 1989 in response to criticism by a Select Committee of the lack of up to date guidance on discharge arrangements. It emphasises the need to provide families with information about after-care and to inform relevant community-based professionals of the patient's potential needs in time for them to be met. Planning should begin at an early stage. In non-emergency cases, where it is known that support will be required on discharge, discharge planning should start before admission. In emergency cases, it should be commenced as soon as possible after admission. No patient should be discharged without the authority of the doctor responsible for him, nor until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the necessary care in the community.

CARE PROGRAMME APPROACH, HC(90)23 (752)

The care programme approach, set out in *Health Circular* (90)23, applies to all mentally ill patients who require psychiatric treatment or care, including persons residing in the community.[56] The purpose of the circular is to ensure the development of "systematic arrangements" and "effective systems" for assessing, reviewing, and meeting the health and social care needs of patients who can potentially be treated in the community. The circular emphasises that it is for professional staff to decide whether available resources enable acceptable arrangements to be made for treating a specific patient in the community and, where that is not the case, in-patient treatment should be provided or continued. The circular recommends that individual care programmes be co-ordinated and monitored by key-workers, who may come

56 As drafted, the care programme approach circular only applies to persons suffering from mental illness but many authorities also apply the same approach to persons who suffer from mental impairment or psychopathic disorder, *e.g.* the Special Hospitals Services Authority.

from any discipline. In essence, the care programme approach as its name suggests, a non-statutory system for assessing and delivering communitybased health and social care. Because section 117 imposes a duty to provide after-care but no system for delivering it, the care programme approach has generally been used as the framework for providing after-care to such patients.[57]

CARE MANAGEMENT AND ASSESSMENT, NHS&CCA 1990 (156)

The 1990 Act requires local authorities to conduct community care assessments in certain circumstances. Section 47(1) states that, where it appears to a local authority that a person may be in need of "community care services", the authority is required to carry out an assessment of his need for those services and, having regard to that assessment, to decide whether his needs call for the provision by them of any such services. Although section 117 after-care is a "community care service," it should be emphasised that its provision to patients coming within the section is mandatory. There can be no question of unmet need with regard to such patients. "Care management" involves carrying out an assessment under section 47(1) and, where indicated, designing and implementing a "care package" agreed with the patient, his carers, and contributing agencies. "Care managers" undertake all or most of the "core tasks" of care management and act as brokers for services across the statutory and independent sectors; in theory, they are not involved in providing services.

Care management and the care programme approach

Departmental guidance stresses the need to ensure that social services care management systems are effectively integrated with the care programme approach, the development of which is primarily the responsibility of Health Authorities.[58] The Department of Health's present view is that multi-disciplinary assessment under the care programme approach will, if properly implemented, fulfil the statutory duties of social services departments to assess patients' needs for community care services under section 47.[59] To this extent, the care programme approach may be seen as a specialist variant of care management for people with mental health problems. Authorities should be aiming for a situation in which the appointed key worker carries out the overlapping care management functions of co-ordinating, monitoring and reviewing an agreed care plan.[60] Where the key-worker (provider) and care manager (purchaser) functions are vested in a single person, that person is expected to separate out his service provider and service purchasing roles as far as possible. However, if the two roles are combined, the care programme approach principle that the key worker not only co-ordinates care programmes but also provides services is not ultimately reconcilable with the care management principle that a care manager

57 Section 117 planning is sometimes said to have been "subsumed" within the care programme approach, with the provision of after-care to all in-patients being assessed under the latter system. Because resources are finite, after-care services may then be allocated to an informal patient or a section 2 patient in preference to a patient who has a statutory entitlement to them. It is difficult to see how the provision of after-care under s.117 can ever be "subsumed" within the care programme approach, since the first is a statutory duty and the second a mechanism for providing it. Insofar as the two overlap at all, to contend that the greater can be subsumed within the lesser is both contrary to logic and the meaning of the verb.

58 *Department of Health Executive Letter EL(93)119*, para. A8.

59 *NHS Management Executive Guidelines HSG(94)27*, para. 16.

60 *The Health of the Nation Key Area Handbook: Mental Illness* (Department of Health, 2nd ed., 1994), paras. 9.14–9.23.

is not involved in providing care [illegible] duties of local authorities under the 1990 Act have already been considered (154). The important thing to remember here is that, in practice, the social services assessment of an in-patient's need for community care services is conducted as part of the overall care programme approach process.

SUPERVISION REGISTERS, HSG(94)5 (755)

Health Service Guidelines HSG(94)5,[61] issued on 1 February 1994 and in force from 1 April 1994, "requires" all Health Authorities to ensure through their contracts for mental health services that providers draw up, maintain and use supervision registers. The register is intended first and foremost for patients being cared for outside hospital. Supervision registers represent an extension of the care programme approach and are now an integral part of it. The purpose of the registers is to enable NHS trusts (and other NHS "provider units") to identify all individuals known "to be at significant risk of committing serious violence or suicide or of serious self-neglect as a result of severe and enduring mental illness," and who should therefore receive the highest priority for care and active follow-up.[62] For the purpose of the guidelines, "mental illness" includes people with a diagnosed personality disorder (psychopathic disorder).[63]

GUIDANCE ON DISCHARGE, HSG(94)27 (758)

On 10 May 1994, the NHS Executive issued further health service guidelines on the discharge of mentally disordered people and their continuing care in the community. The guidance in HSG(94)27[64] was part of the Secretary of State's ten point plan announced in August 1993. The other elements included the introduction of supervision registers and the proposed new power of supervised discharge, now known as after-care under supervision. The guidance set out in this circular includes advice on risk assessments and a recommended after-care form in the format of a check-list.

INTRODUCTION OF AFTER-CARE FORM (760)

In February 1995, the Department of Health circulated to health and local authorities, and other relevant organisations, an after-care form designed to be used for all patients discharged from psychiatric in-patient treatment, including those subject to section 117 of the Mental Health Act 1983. This should appear in the case notes.

AFTER-CARE UNDER SUPERVISION (422)

It has been noted that section 117 of the Mental Health Act 1983 imposes a statutory duty on Health Authorities and local social services authorities to provide after-care to patients who leave hospital having been detained there for treatment. The Mental Health (Patients in the Community) Act 1995 introduced a new power of supervised discharge. This allows an application to be made under Part II for an unrestricted

61 *NHS Management Executive Health Service Guidelines HSG(94)5.*

62 *Ibid.*, Annex A, para. 2.

63 *Ibid.*

64 "Guidance on the discharge of mentally disordered people and their continuing care in the community," *NHS Management Executive Health Service Guidelines HSG*(94)27.

patient who is liable to be detained for treatment, and therefore [illegible] to after-care under section 117, to be subject to "after-care under supervision" when he leaves hospital. The supplement to the Code of Practice states that the new power is primarily intended for patients whose care needs to be specially supervised in the community because of risk to themselves or others. This applies particularly to revolving door patients who have shown a pattern of relapse following discharge. The Act also amended the law concerning patients who are lawfully or unlawfully absent from hospital or place where they are required to reside. Thus, the Act provides for each of the three situations in which an unrestricted patient who has been detained for treatment may be in the community — he may have leave to be absent from hospital, or he may be absent from there without leave, he may have been discharged and no longer liable to detention. The new after-care under supervision provisions have already been considered. The important point to remember is that if an unrestricted patient is entitled to statutory after-care under section 117, he is now liable to receive it under statutory supervision. If he is not entitled to statutory after-care then nor is he liable to statutory supervision.

SUMMARY

Given the number of circulars issued since 1989, add to this the new legislation in 1995, and it is not surprising that most practitioners are confused about the precise inter-relationship between the different provisions and guidelines. The following table indicates which of them applies to each kind of detained patient. Because of public concern about incidents following the discharge of some patients, the Department of Health "requires" that supervision registers include where necessary persons suffering from a personality disorder. To this extent, the care programme approach has by implication also been extended to such persons.

DISCHARGE AND AFTER-CARE PROVISIONS

Authority for detention	Form of disorder	s.117	H.C. (89)5	C.P.A	Assess NHS&CCA	Register	1995 Act
Sections 3, 37, 47, 48	Mental illness	•	•	•	•	•	•
	Psychopathic disorder	•	•	?	•	•	•
	Mental impairment	•	•		•		•
Section 2	Mental illness		•	•		•	
	"Personality disorder"		•	?		•	
	Mental impairment		•				

The various enactments and guidelines do not ultimately form an entirely coherent framework. However, the guidelines require that all adults suffering from mental

illness must have the benefit of [illegible] discharge planning under the care programme approach. Beyond this, if confusion is to be avoided, it is important—

- to distinguish between statutory provisions, which have the force of law, and non-statutory guidelines issued by the Department of Health, which do not.
- to appreciate that the care programme approach confers no right to after-care and is simply a practical framework for assessing, delivering and co-ordinating medical treatment and social care in the community.
- to realise that, although section 117 after-care is a community care service for the purposes of the 1990 Act, the local authority cannot assess the patient as not requiring it and, furthermore, such assessments are in practice conducted as part of the overall care programme approach process.
- to note that the after-care under supervision legislation is an addendum to the duty to provide after-care under section 117 (the two statutory provisions in the 1983 Act form part of one framework) while supervision registers are an addendum to the care programme approach, and together form part of one non-statutory framework.

Bearing these points in mind, it can be seen that the following different situations can be identified.

Patients detained for assessment

Patients detained for assessment have no statutory entitlement to after-care under the 1983 Act but, equally therefore, they are not liable to after-care under supervision. The need for after-care services of patients considered to be mentally ill or to have a personality disorder should be assessed and, as necessary, delivered using the non-statutory care programme approach framework. Such patients should also be considered for placement on the supervision register where indicated. Although, as drafted, the care programme approach does not apply to patients whose only problem is mental handicap, it is almost invariably the case that hospitals apply the same care programme approach principles.

Unrestricted patients detained for treatment

Patients detained for treatment have a statutory entitlement to after-care under the Mental Health Act 1983 but, consequently, they may also be required to receive those services under statutory supervision. What the 1983 Act lacks is any framework for assessing the after-care services such patients need and for co-ordinating and delivering those services. The non-statutory care programme approach, which it is the primary responsibility of Health Authorities to implement, provides that practical framework. As long as the local social services authority which also has the duty to provide the patient with after-care is fully involved in that process, its involvement will also satisfy its obligation to assess the patient's need for after-care under the 1990 Act — after-care being a community care service. In the

process of applying the care programme approach framework, the He_ Authority will also determine whether a patient who is mentally ill or has a psychopathic disorder should be placed on the supervision register. Because of the way the statutory criteria for after-under under supervision are drafted, the Government's expectation is that if a supervision application is accepted in respect of a patient then he will normally also be placed on the supervision register. While the purpose of supervised discharge is to provide some statutory control over a patient in the community, the main purpose of the register is to record warning signs and other practical information about the identified risks in the particular case.

Restricted patients detained for treatment

The important point to remember in this case is that the after-care under supervision legislation does not extend to restricted patients. The pre-existing statutory framework, which provides for conditional discharge and recall, makes it unnecessary.

DISCHARGE PLANNING, HC(89)5

Health Circular (89)5 was issued in response to criticism of the Select Committee on the Parliamentary Commissioner for Administration. The Select Committee drew attention to the lack of up-to-date guidance on discharge arrangements and emphasised the need to provide families with information about care following discharge; to check the patient's mental state on the day of his planned departure from hospital; and to inform the patient's general practitioner and other relevant professionals of the patient's potential needs in time for them to be met. The circular emphasises the importance of ensuring that, before patients are discharged, proper arrangements are made for their return home and for any continuing care which may be necessary. The aim should be to encourage and restore independence in the home wherever possible or to facilitate the smooth transfer of the patient to alternative care in the community where this has been agreed.[65] The circular's particular importance in the context of tribunal proceedings lies in the emphasis which it places on the need to begin discharge planning at an early stage, involving where appropriate the primary health care team, local authority social services and others. In non-emergency cases, where it is known that support will be required on discharge, planning should start before admission.[66] In emergency cases, it should start as soon as possible after admission.[67] To ensure that all arrangements have been completed, responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given in one member of the staff caring for that patient.[68] No patient may be discharged without the authority of the doctor with responsibility for him[69] nor should any patient be discharged until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the care which the patient will need in the community.[70] Relevant paragraphs of the circular are reproduced on the following page.

65 Department of Health Circular HC(89)5, para. 3.
66 *Ibid.*, para. 2.
67 *Ibid.*, para. 2.
68 *Ibid.*, para. 6.
69 *Ibid.*, para. 4.
70 *Ibid.*, para. 5.

HEALTH CIRCULAR (89) 5

February 1989

DISCHARGE OF PATIENTS FROM HOSPITAL

Background

2 ... Planning should begin at an early stage and involve, where appropriate, the primary health care team, local authority social services and others. For non-emergency cases where it is known that support will be required on discharge, planning should start before admission. For emergency cases it should start as soon as possible after admission. Lack of early and effective planning for services required after discharge can lead to "blocked beds" and unplanned readmission to hospital.

Discharge arrangements

5. Patients should not be discharged until the doctors concerned have agreed and management is satisfied that everything reasonably practicable has been done to organise the care the patient will need in the community. This includes making arrangements for any follow-up treatment, travel to, and any necessary support in, the home or other place in the community to which they are being discharged. They or their relatives must also be fully informed, and important points confirmed in writing, about such things as medication, lifestyle, diet, symptoms to watch for and where to get help if it is needed. Their ability to cope and access to emergency services and out-of-hours advice must be taken into account.

6. A number of staff (medical, nursing, therapy, social work, etc) may be involved in the preparations for discharge. To ensure that all arrangements have been completed, responsibility for checking that the necessary action has been taken before a patient leaves the hospital should be given in one member of the staff caring for that patient. The member of staff should have a check-list of what should have been done. If the completed check-list is filed in the patient's notes it will provide a permanent record of action taken before discharge. In many cases the patient, family or friends, will be capable of making all the arrangements for the return home. All that will be required of the nominated member of the hospital staff will be to ensure that they and the general practitioner have been given all the information they need. In other cases much more will be required, a range of services will have to be organised in advance and several agencies involved.

Local authorities and discharge planning

Local Authority Circular LAC(89)7 draws the attention of local authorities to *Health Circular* (89)5 and asks them to review their existing procedures, to ensure that people do not leave hospital without adequate arrangements being made for their support in the community. Local authorities are asked to co-operate with Health

Authorities in planning jointly for the discharge of patients from _ spital and to ensure that relevant local authority staff have a clear understanding of their respective roles and responsibilities. The circular states that local authorities have a key role to play in ensuring that a range of services are available for patients who will need care and support on a continuing basis which cannot be provided by family and carers alone. Social services departments are responsible for a range of services which may be needed on discharge, including domiciliary help and care, day care services and the provision of disability equipment and adaptations. The services of local authority occupational therapists and rehabilitation officers may be required in some cases. In such cases, social services staff should be involved in assessing the patient's social care needs and home circumstances at an early stage before discharge. Social workers can advise on the particular package of services available from both statutory and non-statutory suppliers which will best meet the patients needs and preferences. They therefore have an important role to play in determining readiness for discharge and providing information, advice and counselling. Suitable accommodation is essential if people are to be able to resume independent living in the community. Social services departments should make sure that local authority housing departments are involved at an early stage in the planning process if the patient is not able to return to his or her former home or if it requires major adaptations. Any adaptations immediately necessary should have been made, or at least a firm timetable agreed, before the patient leaves hospital. Some patients may require a higher level of support which can best be provided through residential or nursing home care. Social services staff should be fully involved in assessing the need for residential care. If residential care is judged to be appropriate and is acceptable to the patient (and his or her family or corer if appropriate), close liaison with the staff of the residential care home, whether in the public, private or voluntary sector, should be established at an early stage in order to plan ahead for admission.

CARE PROGRAMME APPROACH, HC(90)23

The requirement to implement a care programme approach derives from the joint *Health/Social Services Circular* HC(90) 23/LASSL(90)11.[71] The care programme approach applies to all patients who require psychiatric treatment or care, including persons residing in the community. It requires health and social services authorities to develop care programmes based on proper "systematic arrangements" for treating patients in the community rather than by way of admission to hospital.[72] As its name suggests, it is a general scheme and does not give rise to a statutory duty towards any individual patient.

Aims of the Care Programme Approach

The care programme approach was developed with two purposes in mind. Firstly, to seek to ensure that patients treated in the community receive the health and social care they need, by introducing more systematic arrangements for deciding whether patients referred to the specialist psychiatric services can, given available resources, realistically be treated in the community. Secondly, to ensure that proper

[71] "The Care Programme Approach for People with a Mental Illness referred to the Specialist Psychiatric Services" *Department of Health Circular HC(90)23/LASSL(90)11.*

[72] *Ibid.*, Annex, para. 6.

arrangements are made for tl ontinuing health and social care of those patients who can be treated in the community. The underlying purpose is therefore to ensure the support of mentally ill people in the community, thereby minimising the risk of them losing contact with services and maximising the effect of any therapeutic intervention.

Key elements of the care programme approach

Although the exact form which the care programme approach takes locally is largely a matter for individual Health Authorities, in discussion with social services authorities, all care programmes should include the following key elements—

- systematic arrangements for assessing the health care needs of patients who can potentially be treated in the community and for regularly reviewing the health care needs of those being treated in the community.
- systematic arrangements, agreed with social services authorities, for assessing and regularly reviewing the social care such patients need, in order to give them the opportunity of benefiting from treatment in the community.
- effective systems for ensuring that agreed health and social care services are provided to those patients who can be treated in the community.

It is essential to obtain the agreement of all professional staff and carers who are expected to contribute to a patient's care programme that they are able to participate as planned.

Resources

Proper arrangements should be in place for determining whether any services assessed as being necessary can be provided within available resources. It is for health and social services staff to decide whether the resources available enable acceptable arrangements to be made for treating specific patients in the community. If a patient's minimum needs for treatment in the community — both in terms of continuing health care and any necessary social care — cannot be met, in-patient treatment should be offered or continued. Health authorities should ensure that any reduction in the number of hospital beds does not outpace the development of alternative community services.

Key workers

Once an assessment has been made of the continuing health and social care needs of a patient who can be treated in the community, and all those expected to contribute have agreed that it is realistic, it is necessary to have effective arrangements for monitoring that the agreed services are provided and for maintaining contact with the patient. In the Department of Health's view, the most effective means of undertaking this work is through named individuals, called key-workers. Where this can be agreed between the relevant health and social services authorities, the ideal is for

one named person to be appointed as the patient's key worker. His r[illegible]vill be to
keep in close touch with the patient and monitor that the agreed health and social
care is given. The key worker can come from any discipline but should be suffic-
iently experienced to command the confidence of colleagues from other disciplines.
A particular responsibility of the key worker is to maintain sufficient contact with
the patient to advise professional colleagues of changes in circumstances which
might require review and modification of the care programme. When the key worker
is unavailable, proper arrangements should be made for an alternative point of
contact for the patient and any carer(s).

Maintaining contact with patients

Every reasonable effort should be made to maintain contact with the patient and,
where appropriate, his carers, to find out what is happening, to seek to sustain the
therapeutic relationship and, if this is not possible, to try to ensure that the patient
and carer knows how to make contact with his key worker or the other professional
staff involved. It is particularly important that the patient's general practitioner is
kept fully informed of a patient's situation, and especially of his withdrawal from a
care programme, and that day care, residential and domiciliary staff are given
sufficient information to enable them to fulfil their responsibilities to the patient.
The general practitioner will continue to have responsibility for the patient's general
medical care if he withdraws from the care programme. Where a patient wishes to
withdraw from part of a care programme only, the programme should be sufficiently
flexible to accept such a partial withdrawal.

Supplementary guidelines

The "essential elements" of an effective care plan are systematic assessment, a care
plan, the allocation of a key worker, and regular review. Supplementary depart-
mental guidelines stress that the professionals responsible for making discharge
decisions must be satisfied that these conditions are fulfilled before any patient is
discharged.[73] The patient and others involved (including, as necessary, the carer,
health and social services staff, and the patient's General Practitioner) should be
aware of the contents of the care plan and should have a common understanding of
— its first review date; information relating to any past violence or assessed risk of
violence on the part of the patient; the name of the key worker; how the key worker
or other service providers can be contacted if problems arise; what to do if the
patient fails to attend for treatment or to meet other requirements or commitments.[74]

Mental Health Review Tribunals

Where a patient has applied for a tribunal, it is important that the "essential
elements" of the care programme approach have been considered and can be put into
operation if the patient is discharged, and that the key worker is made immediately
aware of any conditions imposed.[75]

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73 "Guidance on the discharge of mentally disordered people and their continuing care in the community," *NHS Management Executive Health Service Guidelines HSG*(94)27, para. 10.

74 *Ibid.*, para. 11.

75 *Ibid.*, para. 19.

SUPERVISION REGISTERS, H[illegible]4)5

Health Service Guidelines HSG(94)5[76] "requires" all Health Authorities to ensure through their contracts for mental health services that providers draw up, maintain and use supervision registers. The register is intended first and foremost for patients being cared for outside hospital. Supervision registers represent an extension of the care programme approach and are now an integral part of it.

Purpose of the supervision registers

The purpose of the registers is to enable NHS trusts (and other NHS "Provider Units") to identify all individuals known "to be at significant risk of committing serious violence or suicide or of serious self-neglect as a result of severe and enduring mental illness," and who should therefore receive the highest priority for care and active follow-up.[77] For the purpose of the guidelines, "mental illness" includes people with a diagnosed personality disorder (psychopathic disorder).

Administrative arrangements

Consideration for inclusion on the supervision register should take place as a "normal part" of discussing a patient's care programme before he leaves hospital and at care programme reviews following discharge. The decision as to whether a patient is included in the register rests with the consultant psychiatrist responsible for the patient's care. The decision should be taken in consultation with other members of the mental health team, including the social worker.

Criteria for inclusion

Patients should be included if they are suffering from a "severe" mental illness or a personality disorder and "are, or are liable to be at significant risk of committing serious violence or suicide or of serious self-neglect in some foreseeable circumstances which it is felt might well arise in this particular case (e.g. ceasing to take medication, loss of a supportive relationship or loss of accommodation)."[78] Judgements about risk should be based on detailed evidence, that evidence recorded in written form and available to relevant professionals.

Criteria for deregistration

The criteria for deregistration are that there is no longer considered to be a significant risk. The Health of the Nation Key Area Handbook includes guidelines about the possible need for registration of patients based upon their need for support.[79]

Categorisation

Patients entered on the register should be assigned to one or more of the three risk categories (significant risk of suicide, significant risk of serious violence to others, significant risk of severe self-neglect).

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76 *NHS Management Executive Guidelines HSG(94)5.*

77 *Ibid.*, Annex A, para. 2.

78 *Ibid.*, Annex A, para. 3.

79 The Health of the Nation Key Area Handbook: Mental Illness (Department of Health, 2nd ed., 1994), p.100.

THE NEED FOR SUPPORT OR REGISTRATION

Group	Patient characteristics	Register
High support group	Individuals with severe social dysfunction (*e.g.* social isolation and/or difficulty with skills of daily living) as a consequence of severe or persistent mental illness or disorder. In particular individuals with the following difficulties will be identified for high levels of support— • current or recent serious risk to self or to others or of self-neglect • severe behavioural difficulties • high risk of relapse • history of poor engagement with mental health services • little contact with other providers of care • precarious housing (*e.g.* bed and breakfast) • require staff : patient ratio of about 1:15	√ ?
Medium support group	Individuals with a moderate degree of social disability arising from mental illness or disorder, *e.g.* those able to work at least part-time and/or to maintain at least one enduring relationship. This group will also include the following individuals: • those likely to recognise and to seek help when early in relapse • those receiving appropriate services from other agencies	x
Low support group	Individuals who, following assessment, have been found to have specific and limited mental health-related needs which do not require extensive, multi-disciplinary input. In general, such individuals are likely to respond to brief or low-intensity intervention. For example: • patients with psychosis in remission • moderately severe personality disorder	x

Content of the registers

The Annex to *Health Service Guidelines* HSG(94)5 sets out the required contents of supervision registers, which are set out on the following page.

Challenging registration

In *ex p. M.*,[80] Waite J. granted certiorari quashing the entries on a council's child abuse register purporting to identify M. as the known or suspected abuser of a child K His Lordship stated that he was satisfied that it is not the law that local authorities are free to exercise arbitrary control over the entry of names of alleged abusers on a child abuse register with total immunity from supervision by the courts. Any such

[80] *R. v. Norfolk County Council, ex p. M.* [1989] 2 All E.R. 359, *per* Waite J.

immunity would seriously erod_e rights of the citizen. If similar principles to those propounded in *ex p. M.* are applied to supervision registers, an NHS provider unit has a legal duty to act fairly towards a patient whom it is considering registering. An entry on the register will be reviewable in the courts if that duty is breached, the entry was made in bad faith, or the decision to register was unreasonable within the limited sense of that term approved in *Associated Provincial Picture Houses Ltd. v. Wednesbury Corp.* 1 K.B. 223. Health service professionals will, however, enjoy a sensible latitude when deciding how the requirements of fairness are best to be satisfied in each case. Provided the registration procedure adopted represents a genuine attempt which is reasonable in the circumstances to reconcile the different interests, the courts will not substitute their judgement for that of health service professionals on the question of whether a significant risk exists.[81]

REQUIRED CONTENTS OF REGISTERS

Part 1. Identification

i. Patient's full name, including known aliases, home address including postcode (or "no fixed address"), sex, and date of birth

ii. Patient's current legal status in respect of the Mental Health Act (*i.e.* whether on leave, under guardianship or subject to supervised discharge when available).

Part 2. Nature of risk

i. Category of risk and specific warning indicators.

ii. Evidence of specific episodes of violent or self-destructive behaviour (including relevant criminal convictions) or severe self-neglect.

Part 3. Key worker and relevant professionals

i. Name and contact details for patient's key worker.

ii. Name and contact details of other professionals involved in the care of the patient including the consultant responsible for his care.

Part 4. Care Programme

i. Date of registration.

ii. Date of last review.

iii. Date of next programmed review.

iv. Components of care programme.

[81] As to art. 17 of the European Convention on Human Rights, see *A. v. Norway* (unreported, January 1996), which involved the issues of whether a mental health register should be destroyed because it lacked the necessary basis in law and whether a registration provision contravened the Convention.

GUIDANCE ON DISCHARGE AND RISK ASSESSMENT, HSG(94)27

On 10 May 1994, the NHS Executive issued further health service guidelines on the discharge of mentally disordered people and their continuing care in the community. The guidance in HSG(94)27[82] was part of the Secretary of State's ten point plan announced in August 1993. The other elements included the introduction of supervision registers (755) and the proposed new power of supervised discharge (422). The guidance seeks to ensure that psychiatric patients are discharged only when and if they are ready to leave hospital; that any risk to the public or to patients themselves is minimal; and that when patients are discharged they get the support and supervision they need from the responsible agencies.

Discharge from hospital

The guidelines note that risk is a prime consideration in discharge decisions[83] and that, "generally speaking, mentally disordered people are much more likely to harm themselves or to harm others."[84] It is thus fundamental that full account is taken of the following three issues when deciding whether a person should be discharged from in-patient care: (1) whether, with adequate medication, care, and community supervision, he could still present any serious risk to himself or to others; (2) whether his need for therapy, supervision, sanctuary, or security requires continuing in-patient treatment; and (3) whether he can be cared for effectively and safely in the community, if necessary in staffed or supported accommodation.[85] Where discharge is indicated, it is essential that arrangements for discharge and continuing care are agreed and understood by the patient and everyone else involved, including private carers.[86] In particular, they should have a common understanding of the community care plan's first review date; information relating to any past violence or assessed risk of violence; the name of the key worker (prominently identified in clinical notes, computer records and the care plan); how the key worker or other service providers can be contacted if problems arise; and what to do if the patient fails to attend for treatment or to meet other requirements or commitments.[87]

Mental Health Review Tribunals

The guidelines state that where a patient has applied for a tribunal, it is "important" that the "essential elements" of care programme approach have been considered and can be put into operation if the patient is discharged, and that the key worker is immediately aware of any conditions imposed.[88]

Advice on risk assessment

The guidelines emphasise that patients "with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking

82 "Guidance on the discharge of mentally disordered people and their continuing care in the community," *NHS Management Executive Health Service Guidelines HSG*(94)27.
83 *Ibid.*, para. 3.
84 *Ibid.*, para. 2.
85 *Ibid.*, para. 1.
86 *Ibid.*, para. 4.
87 *Ibid.*, para. 11.
88 *Ibid.*, para. 19.

behaviour need special consideration both at the time of discharge and during follow-up in the community. No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions have been taken after full and proper consideration of any evidence about risk."[89] There must be a full risk assessment prior to discharge.[90] Although the progress of many people after discharge can be monitored adequately by attendance at an out-patient clinic to see a psychiatrist, and/or by visits by a community mental health nurse, "this is unlikely to be sufficient for those patients presenting a complex range of needs. They are likely to need regular and, at times, possibly urgent multi-disciplinary re-assessments by the community based team ... Where an urgent problem arises, one responsible person (preferably the key worker or another professional in consultation with the key worker) should take the necessary immediate action followed by a wider consultation as soon as possible."[91]

Risk assessment

The guidelines include very brief notes on four stages in the assessment of risk: (1) ensuring that relevant information is available; (2) conducting a full assessment of risk; (3) seeking expert help; and (4) assessing the risk of suicide.

Making sure relevant information is available

A proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour. It is essential to take account of all relevant information, whatever its source. Too often, it has proved that information indicating an increased risk existed but had not been communicated and acted upon.[92]

INFORMATION ABOUT RISK — THE KIRKMAN INQUIRY

- the past history of the patient
- self reporting by the patient at interview
- observation of the behaviour and mental state of the patient
- discrepancies between what is reported and what is observed
- psychological and, if appropriate, physiological tests
- statistics derived from studies of related cases
- prediction indicators derived from research

Source: Report of the Panel of Inquiry Appointed to Investigate the Case of Kim Kirkman; West Midlands Regional Health Authority, 1991; Health Service Guidelines (94)27, para. 28.

89 "Guidance on the discharge of mentally disordered people and their continuing care in the community," *NHS Management Executive Health Service Guidelines HSG*(94)27, para. 23.
90 *Ibid.*, para. 24.
91 *Ibid.*, para. 25.
92 *Ibid.*, para. 28.

Conducting a full assessment of risk

According to the Kirkman Inquiry, "the decision on risk is made when all these strands come together in what is known as clinical judgement; a balanced summary of prediction derived from knowledge of the individual, the present circumstances and what is known about the disorder from which he suffers."[93]

Defining situations and circumstances known to present increased risk

Research has established that there are particular situations and circumstances which may indicate an increased level of risk, examples being when drug or alcohol misuse co-exist with a major mental disorder or when a patient has multiple psychiatric diagnoses.[94] Based on past experience, it is often possible to identify circumstances under which it is likely that an individual will present an increased risk; to indicate what must change to reduce this risk; to propose how these changes might be brought about; and to comment on the likelihood of interventions successfully reducing risk. Some examples are when a patient stops medication; when a person who has previously offended under the influence of alcohol or drugs starts drinking again or enters an environment where drugs are commonly available; when a person whose aggression has been apparent in one particular situation, *e.g.* in the context of a close relationship, enters another similar relationship.[95]

Seeking expert help

Expert forensic help should always be accessible to local psychiatric teams and should be used in difficult or doubtful cases.

Assessing the risk of suicide

The guidelines note that two-thirds of people committing suicide previously mentioned their suicidal ideas and a third had expressed clear suicidal intent. Most people who kill themselves have had recent contact with health care professionals. Among adolescents the most significant predictor in males is attempted suicide (possibly with a mood disorder or substance misuse) and, in females, a mood disorder. The period around discharge from hospital is a time of particularly high risk of suicide, which emphasises the need for proper assessment prior to discharge and effective follow-up afterwards."[96]

INTRODUCTION OF AFTER-CARE FORM

In February 1995, the Department of Health circulated to health and local authorities, and other relevant organisations, an after-care form designed to be used for all patients discharged from psychiatric in-patient treatment, including those subject to section 117. The use of the form, though not mandatory, was strongly recommended as constituting good practice and was devised in response to a recommendation of the *Inquiry into the Care and Treatment of Christopher Clunis*.[97]

93 *Report of the Panel of Inquiry Appointed to Investigate the Case of Kim Kirkman* (West Midlands Regional Health Authority, 1991); "Guidance on the discharge of mentally disordered people and their continuing care in the community," *NHSME Health Service Guidelines HSG(94)27*, para. 28.

94 *NHS Management Executive Health Service Guidelines (94)27*, para. 28; J. Swanson, *et al.*, Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys" *Hospital and Community Psychiatry* (1990) 41, 761–770.

95 *NHS Management Executive Health Service Guidelines (94)27*, para. 28.

96 *Ibid.*, para. 31.

97 *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (H.M.S.O., 1994).

Those parts of the form particularly relevant to tribunal decision-making are presented below. In many cases, it will be appropriate to require the responsible authority to furnish the tribunal with the form, as a convenient summary of where the discharge process has reached. The following parts of the form are not reproduced: 1 About the patient; 2 Patient's nominated contact; 3 Key worker's details; 7 Review; 8 Transfer of responsibility for patient's after-care; 9 Discharge from after-care.

CHECKLIST FOR THE AFTER-CARE OF PSYCHIATRIC PATIENTS

4 After-care plan

(a) an after-care plan was agreed with the patient on	*give date*
(b) patient agrees with the after-care plan	*yes / no*
(c) the patient is subject to section 117 of MHA 1983	*yes /no*

5 Information to be included in the after-care plan

If any of the following apply to the patient, details must be recorded in the after-care plan

(a) in receipt of local authority care management	*yes / no*
(b) on supervision register	*yes / no*
(c) subject to conditional discharge	*yes / no*
(d) subject to statutory supervision by probation service	*yes / no*
(e) subject to statutory supervision by probation service	*yes / no*
(f) subject to guardianship	*yes / no*
(g) subject to CPIA 1991	*yes / no*
(h) subject to supervised discharge	*yes / no*

6 Availability of information

Where any of the following information is not available a full explanation must be recorded in the patient's after-care plan

(a) full contact list of those involved in the patient's care	*yes / no*
(b) patient's health and social needs identified	*yes / no*
(c) patient's health and social needs addressed in the after-care plan	*yes / no*
(d) risk assessment carried out	*yes / no*

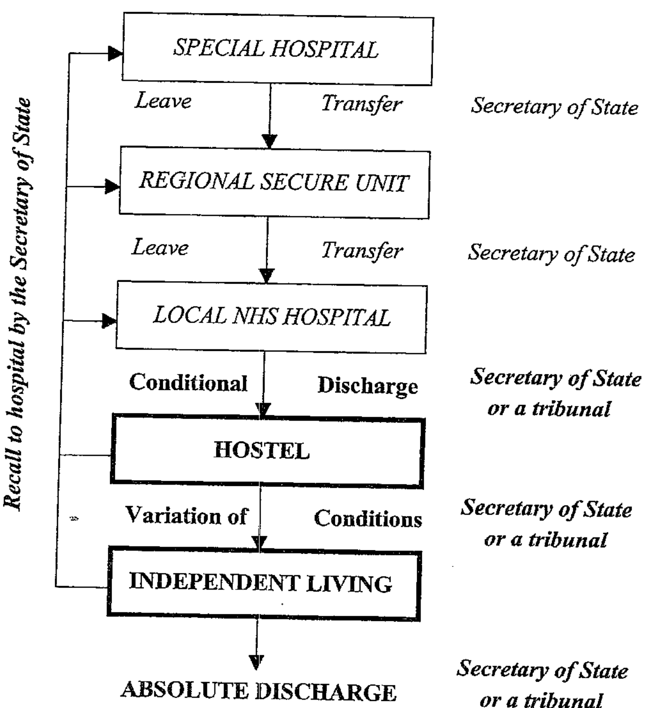
Patient's after-care plan contains

(e) details of signs and symptoms suggesting likely relapse	*yes / no*
(f) steps to be followed in the event of relapse	*yes / no*
(g) steps to be followed if the patient fails to attend for treatment or meet other commitments	*yes / no*
(h) action to be taken if the patient's relative or carer can no longer provide assistance and support	*yes / no*

The assessment of risk in a restricted case is often, but not exclusively, concerned with the probable repetition of the conduct comprising the index offence, since a person is likely to be labelled as dangerous only if such behaviour is expected to continue.[98] In deciding whether detention is no longer necessary for the protection of other persons, tribunals will inevitably have particular regard to the likelihood of future serious offending. The impossibility of certain prediction is the central problem. Much of the research has concentrated on the actuarial use of information about people's past behaviour, ages, circumstances, psychological and social characteristics, as well as assessments of them by other people with relevant training or experience. Prediction of this kind assigns individuals to probability groups with differing rates of offending but it is impossible to predict with certainty that a given individual will or will not offend in future. A patient who is a model of conformity and good behaviour and exhibits no symptoms of mental disorder in hospital over a period of years may behave differently after release, given the greater opportunities to do harm which freedom in the community brings. Because assessments of risk are unreliable, most restricted patients will be granted leave of absence before being discharged from hospital subject to conditions, including supervision by a psychiatrist and social supervisor. Patients detained in special hospitals are usually rehabilitated into the community via regional secure units or local hospitals. Very few are conditionally discharged from a special hospital to independent or supervised accommodation. Responsibility for arranging transfer to conditions of lesser security rests with the hospital managers and the patient's doctor.

THE USUAL DISCHARGE PROCESS

While each case must necessarily be considered on its own merits, the general pattern of progression from detention in conditions of maximum security to absolute discharge is most often as follows. After progressing through the special hospital system to a pre-discharge ward, the patient will spend a period of leave of absence at a regional secure unit. If this is successful, and it is likely that he can be discharged from there within eighteen months to two years, he will be formally transferred to the hospital. Prior to being discharged, the patient may spend a period of time on an open ward in the local hospital, gradually being granted increasing periods of leave in the community. Leave is usually granted subject to an escort in the first instance. Discharge from hospital is initially subject to conditions and recall. In most cases, serious consideration will be given to a conditionally discharged patient's absolute discharge if he remains well and there are no other problems for a period of between two and five years. Prior to then, the conditions may be gradually relaxed but the patient remains liable to be recalled to hospital for a further period of in-patient treatment. Before a special hospital patient can realistically expect to be discharged, it is therefore often necessary for him to first be transferred to a less secure hospital and to have trial periods of leave in the community. However, a tribunal has no power to direct that a patient be transferred or granted leave with a view to facilitating his discharge on a later date. Similarly, it does not possess any statutory power to recommend that such a step be taken and to reconsider the patient's case in the event that its recommendation is not complied with. In practice, this means that, if the Secretary of State considers that a patient should remain in a special hospital, or does not consent to a patient having trial leave in the community, it will often be difficult for a tribunal to be satisfied that he meets the criteria for being discharged from hospital. In short, the Home Secretary has sole control over the steps preparatory to discharge and sole control over the patient's recall to hospital once discharged.



HOME OFFICE POLICY AND PROCEDURES (162, 334)

The Home Office's policies and procedures in relation to proposals for transfer, leave and discharge have been summarised by Pickersgill.[99]

[98] *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 4.9. It should be emphasised that it was not a condition of imposing a restriction order under the 1959 Act that restrictions were necessary to protect the public from serious harm. Furthermore, prior to 1991, a restriction order was mandatory if a person's case was disposed of under the Criminal Procedure & Insanity Act 1964. Under the present provisions, it is similarly the case that a restriction direction is mandatory if a person remanded in custody in criminal proceedings is removed to hospital under section 48. In all these cases, therefore, there is no "serious harm" requirement.

[99] A. Pickersgill, "Balancing the public and private interests" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990).

Proposals for transfer or leave to reside at another hospital

The Home Secretary will only agree to a patient being moved to another hospital if he is satisfied that this will not give rise to any unacceptable risk. In reaching his decision, he takes account of information provided by the police and psychiatrists at the time of the index offence and information on the patient's condition and progress contained in subsequent reports from the responsible medical officer, including the periodic reports which the latter must submit at yearly intervals. He does not operate a "tariff" system on the length of time for which individual patients, or types of offender, should be detained. Nor does he try to second guess medical opinions, because he is not qualified to do so. The Home Office does, nevertheless, scrutinise transfer proposals closely, in order to verify that account has been taken of all the relevant factors; that there is an adequate understanding of how the patient came to commit his index offence; and that there is sufficient evidence to suggest that he has changed in hospital and is unlikely to abscond or reoffend if treated in less secure conditions. If the Home Office is not persuaded by the responsible medical officer's arguments in favour of transfer, or there appear to be serious gaps in his knowledge, it normally writes to him and invite his further comments before reaching a final decision. While recognising that assessing a person's mental condition and potential risk to the outside world is extremely difficult, the Home Office's concern is always to satisfy itself that the apparent risk to the public is low enough to be acceptable, and that everything possible will be done to minimise that risk if the patient moves to less secure conditions or into the community. It is these considerations which may lead to a proposal for transfer being refused if the responsible medical officer is unable to allay the initial doubts about its validity.[100]

Consideration of proposals for leave to be absent from hospital

Following transfer to a less secure hospital, the Home Office monitors the patient's progress closely to see how he settles into the new environment. Once it is satisfied that he has settled, consent is usually given to any reasonable leave arrangements which the responsible medical officer may propose.[101] These vary depending on the type of hospital and the individual's response to further treatment. While his escorted leave and group outings take place from special hospital, unescorted leave is extremely rare. However, patients at regional secure units are normally given gradually increasing freedom, working through escorted leave and short periods of unescorted leave to longer periods of unescorted leave, involving overnight or weekend absences, or regular absences to attend a training course or to take a job.

Proposals for conditional discharge

Proposals for a restricted patient's conditional discharge are considered with a similar or even greater degree of caution than transfer proposals. However, the Home Office recognises that no decision can be completely without risk and it has never sought to detain any patient until such an unlikely state is reached.[102] In particularly difficult cases, the Secretary of State seeks the views of the Advisory Board on Restricted Patients (**165**). Consideration of a patient's suitability for

100 A. Pickersgill, "Balancing the public and private interests" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990).

101 *Ibid.*

102 *Ibid.*

conditional discharge invol\ a complete reappraisal of the case, including scrutinising all the reports on the patient from the time of his arrest, and assessing the likely effectiveness of the proposed placement and supervision arrangements in terms of reducing the risk of relapse or reoffending. As with transfers, the key factors are that the Home Office wishes to be satisfied that the circumstances and motivation for the index offence are fully understood and that there is strong evidence to suppose that the patient is no longer the person he was when the offence occurred. Consideration is always given to the type and location of the proposed placement and the degree of supervision which will be provided. The supervising psychiatrist and social worker are given as much information as possible about his background and the offence and sent copies of the relevant Home Office guidance.

The form of disorder from which the patient suffers

The type of disorder from which the patient suffers often has a bearing on how difficult it is to assess his suitability for discharge. According to Pickersgill—

- A number of people with schizophrenia who attack other people because of delusions they suffer when unwell respond to medication. Consideration of proposals for the discharge of such patients therefore tends to be relatively straightforward as long as the Home Office is satisfied that the offences stemmed solely from the mental illness and will not be repeated as long as the patient takes his medication. A more cautious approach has to be exercised where such patients have little insight into their illness and the need for medication unless they receive depot injections and will be closely supervised in independent accommodation or a hostel setting.

- The suitability for discharge of patients suffering from mental impairment, severe mental impairment or psychopathic disorder, on the other hand, can be extremely difficult to assess, since the motive for the index offence in such cases is not always readily understood. This is especially so if a patient's mental handicap means that he cannot readily explain his thoughts and feelings at the relevant time. It is also extremely difficult to assess the degree of response to treatment. A number of these patients will require hospital care for the rest of their lives, in their own interests as well as the interests of others. Where possible, they can be discharged to sheltered housing if they have clearly become less explosive, less impulsive and better behaved with prolonged training.

- The word of patients suffering from psychopathic disorder cannot always be relied on, which poses similar problems in trying to gauge their motives and the extent to which psychotherapy and other treatment has successfully addressed their personality problems. The factors which the Home Office looks for include signs of a greater maturity, more stable behaviour, a greater tolerance of frustration and stress, together with evidence that the patient has some insight into his condition, a realistic conception of his life in the community, and a willingness to co-operate with his supervisors. Evidence of an ability to abstain from drugs, and to reduce or stop his intake of alcohol, can also be an important precondition to discharging a patient where these substances clearly contributed to the index offence.

The Home Office Checklist

The Secretary of State sends a checklist of relevant considerations to the responsible medical officer each year when a report is due on a restricted patient's progress. The questions comprised within it are an excellent aide-mémoire for tribunals and advocates when it comes to dealing with considerations of public safety.

THE HOME OFFICE CHECKLIST

1. Has any information come to light since the last report which increases understanding of the circumstances surrounding the index offence?
2. Is the motivation for behaviour that has put others at risk understood?
3. Is there any evidence that the patient has a persistent preoccupation with a particular type of victim or a particular type of violent/sexual/ arsonist activity?
4. What are the chances of circumstances similar to those surrounding the offence arising again and similar offences occurring?
5. In cases of mental illness, what effects have any prescribed drugs had? Do any symptoms remain? How important is the medication for continued stability? Has stability been maintained in differing circumstances? Does the patient have insight into the need for medication?
6. In cases of mental impairment, has the patient benefited from training? Is the patient's behaviour more socially acceptable? Is the patient explosive or impulsive?
7. In cases of personality disorder, is the patient now more mature, predictable and concerned about others? Is he more tolerant of frustration and stress? Does he now take into account the consequences of his actions? Does he learn from experience?
8. Does the patient now have greater insight into his condition? Is he more realistic and reliable?
9. Have alcohol or drugs affected the patient in the past? Did either contribute towards his offences?
10. Has the patient responded to stressful situations in the hospital in the past and how does he respond now — with physical aggression or verbal aggression?
11. If the patient is a sex offender, has he shown in the hospital an undesirable interest in the type of person he has previously been known to favour as his victim? What form has any sexual activity taken? What have been the results of any psychological tests?
12. What views do members of the clinical team have about the patient's continuing dangerousness?
13. Is it considered that the patient should/should not continue to be detained? For what reasons?
14. If so, is it considered that detention in conditions of special security is necessary?

PATIENT'S MENTAL STATE AND INDEX OFFENCE

When determining whether a patient meets the criteria for discharge, and the conditions of discharge, a tribunal will have particular regard to the circumstances of the index offence, the patient's mental state, his personality, the circumstances in which the public might be at risk, and (having regard to all of these matters) the management and supervision of the patient if discharged.

Prins' approach

Prins has suggested nine questions which may help in deciding whether to relax control and supervision of a mentally disordered offender who has a proven history of past violence.[103]

PRINS' NINE QUESTIONS

1. Have past precipitants and stresses in the patient's background been removed or sufficiently alleviated?
2. What is the patient's current capacity for dealing with provocation?
3. Have the clues to the patient's self image been explored at sufficient depth?
4. How vulnerable and fragile does the patient seem to be? Were the circumstances of the original offence the last straw in a series of stressful events, or does the individual see everybody else as hostile?
5. Was the behaviour person-specific or aimed at society in general?
6. Has the patient come to terms, in part if not in toto, with their offending act?
7. Have the details about the original offence been examined?
8. Has the health care institution monitored the patient's reaction to stress and temptation?
9. Has it been borne in mind that the patient's denial of the original offence may reflect the truth?

Other issues to be addressed

In various other publications, Prins has recommended that the following questions also be asked where consideration is being given to the release of a restricted patient—

[103] H. Prins, "Social factors affecting the assessment of risk; with special reference to offender patients" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990).

- How well has the patient used the various therapeutic opportunities in hospital? Is there a reasonable degree of consensus about progress? If not, what conclusions can be drawn from this fact?

- If mental illness contributed to the commission of the index offence, is it now under control? If there is a clear need for medication after discharge, how reliable are estimates of the individual's capacity to co-operate with those responsible for its administration upon discharge?

- Have the circumstances that contributed to the original offence changed substantially? If not, how much oversight may be needed to combat the resurgence of stressful events?

- Is it possible to gauge the degree of empathy the patient has for others? This question is particularly important in relation to patients suffering from a psychopathic disorder and those who have committed serious sexual offences, particularly against children.

- If alcohol or illicit drugs played a key role in the commission of the index offence, what is his likely response to them following release? A graded or phased return to the community in which opportunities for controlled and observed ingestion may be indicated.

THE MANAGEMENT OF DANGEROUS BEHAVIOUR

Because it is impossible to accurately predict the circumstances in which a person who has previously behaved dangerously might again behave dangerously, a cautious approach is taken to discharge. Consequently, many people are not discharged who could safely be discharged because there is no compelling evidence that they are now safe. More particularly, it is usually difficult to determine whether the improved behaviour of a previously violent patient in a secure hospital is attributable to natural remission or maturation, successful treatment or skilful management. That being so, there is generally a presumption that the person may still be dangerous in certain circumstances and this possibility is explored by gradually reintroducing him into the community, and monitoring his behaviour in different situations.

The three Ss

Professor John Gunn has emphasised the three "Ss" involved in the management of risk: security, supervision and support.[104]

Security

Security involves considering the necessity for detention in locked accommodation, the need for specialist services, and the level of nursing support. Decisions about the degree of security required will be affected by the seriousness of previous aggression; the seriousness of the disorder; and the nature of the disorder. The aim should be for the minimum level of security which is compatible with good management.

[104] J. Gunn, "Clinical approaches to the assessment of risk" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990), pp.16–17.

Supervision

It is usually a condition of any discharge that the patient is supervised by a social worker or a probation officer. Supervision is the continuous assessment of risk with a readiness to intervene if the risk increases in some way. It requires resources, good relationships between supervisors and the other persons in contact with the patient, and an in-depth knowledge of the individual and his environment. The majority of restricted patients require considerable supervision following discharge and each person involved in the process needs to be fully informed about his background and present situation.[105] The assessment of the likely effectiveness of subsequent control must be a major consideration when the decision whether or not to release is taken.[106] Supervision "cannot provide, and is not intended to provide, physical surveillance hour by hour and day by day, and it is evident that control over the personal relationships of a person who is subject to supervision entails particular difficulty."[107] However, the "supervising officer is sometimes in a position to recognise that the discharged patient may be moving into a similar situation to that which originally precipitated an offence of violence; or to perceive other signs indicating the likelihood of a repetition of dangerous behaviour. Where this is so he can take steps to warn the patient and if necessary arrange for him to be recalled to hospital."[108] If a patient is recalled as soon as a difficulty or risk arises, he is not helped to deal with the situation, suffers a positive set-back and a fresh interruption of his life, and his attitude towards his supervising officer is likely to be seriously undermined. However, the consequences of failure to recall in a deteriorating situation may be serious. The Butler Committee had "no doubt that in general the presumption on the part of the hospital should be in favour of supporting the supervising officer by readily agreeing to accept a patient on recall, even if only for a brief period of observation."[109]

Support

Support entails a strong commitment to an individual, mutual trust, and an acceptance of him without acceptance of his behaviour. It means being available at inconvenient hours and making special arrangements for him, such as having an emergency admission policy.

Sex offenders

Sexual behaviour is very difficult to alter but sometimes very potent in creating aggressive or risky behaviour.[110] It is unwise to discharge a child-sex offender to unsupervised accommodation in close proximity to a park or school, with no pre-arranged activities to occupy him during those hours when children will be in the vicinity.

[105] *Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients subject to Special Restrictions* (Cmnd. 5191, 1973), para. 43.

[106] *Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 6244 (1975), para. 4.7. In the Iliffe case, in which it was known that if the patient remarried there might then be a specific risk to his wife. In the event, he remarried without the knowledge of the supervising officer.

[107] *Ibid.*, para. 4.30.

[108] *Ibid.*

[109] *Ibid.*, para. 4.31.

[110] J. Gunn, "Clinical approaches to the assessment of risk" in *Risk-taking in Mental Disorder; Analyses, Policies and Practical Strategies* (ed. D. Carson, S.L.E. Publications, 1990), p.15.

PREPARING FOR DISCHARGE

The Home Office and Department of Health guidelines for staff of the discharging hospital are set out below.[111] The guidelines are particularly useful when it comes to considering whether any conditional discharge should be deferred.

Notes for the guidance of hospitals preparing for conditional discharge

Summary of recommendations 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. 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 work 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, 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.

THE EXERCISE OF THE POWER OF DISCHARGE

Only the Home Secretary could discharge a restricted patient under the 1959 Act. During each year of the period from 1976 until 1983, about 6 per cent. of detained restricted patients were first conditionally discharged by the Home Secretary. During the first two years the new provisions were in force, the percentage of patients first conditionally discharged rose to approximately 8 per cent., presumably because some of them had never posed a risk of serious harm to the public. Subsequently, the

111 *Supervision and after-care of conditionally discharged restricted patients: Notes for the guidance of hospitals preparing for the conditional discharge of restricted patients* (Home Office/Department of Health and Social Security, 1987), Annex A.

overall rate has dropped to around 5 per cent. The general position is therefore that tribunals and the Secretary of State together release proportionately fewer patients than the Secretary of State did when acting alone. Absolute discharge is rare and it has historically been the case that more restricted patients die each year than are absolutely discharged.[112] Although the statistical bulletins provide no evidence that patients have benefited from an independent review, it remains possible that this is so. The introduction of a serious harm requirement means that more restricted patients these days have committed serious offences, so it is possible that the Home Secretary acting alone would today discharge fewer patients still. It is also possible that patients are being discharged sooner than was previously the case, although the bulletins no longer provide that information.

NUMBER OF PATIENTS CONDITIONALLY DISCHARGED : 1981-1990

Year	Detained population	*Number of persons first discharged* By Home Secretary	By MHRT	Total
1981	1864	127 (6.81%)	—	127 (6.81%)
1982	1812	112 (6.18%)	—	112 (6.18%)
1983	1816	97 (5.34%)	—	97 (5.34%)
1984	1780	55 (3.09%)	93 (5.22%)	148 (8.31%)
1985	1705	52 (3.05%)	82 (4.81%)	134 (7.86%)
1986	1691	31 (1.83%)	62 (3.67%)	93 (5.50%)
1987	1758	38 (2.16%)	49 (2.79%)	87 (4.95%)
1988	1828	46 (2.52%)	48 (2.63%)	94 (5.15%)
1989	1879	58 (3.09%)	76 (4.04%)	134 (7.13%)
1990	1909	37 (1.94%)	59 (3.09%)	96 (5.03%)
1991	1996	24 (1.20%)	60 (3.01%)	84 (4.21%)

Notes: The percentage of patients first conditionally discharged by the Home Secretary during the period 1976-80 was virtually identical to that in 1981. The percentage of patients discharged has been calculated by reference to the number of detained restricted patients as at 31 December the previous year. Source: Home Office Statistical Bulletins.

RECONVICTION FOLLOWING DISCHARGE

Reconviction following discharge is relatively rare. However, the emphasis on diversion in recent years has led to some discrepancy between levels of reoffending and rates of reconviction.[113] The term "grave offence" covers mainly offences of homicide, serious wounding, rape, buggery, robbery, aggravated burglary, and arson. Standard list offences include these offences and also matters such as theft and drug offences, and some summary offences.

Reconviction rates for tribunals and the Home Secretary

The table below indicates that patients discharged by a tribunal are more likely to be reconvicted during the following two years than those discharged by the Secretary of State. However, if the statistics concerning patients discharged by tribunals since 1984 are compared with those concerning patients discharged by the Secretary of State before then, the reason for this appears to be that the Secretary of State now leaves it to tribunals to discharge patients whom he would previously have discharged himself. When only the Home Secretary could discharge a restricted patient, he could not avoid decisions about the need to rehabilitate those for whom he had sole responsibility. With the introduction of an independent review, he has been freer to focus his attention on the issue of public safety, leaving it to tribunals to decide whether a patient should be discharged if the competing considerations are more finely balanced. As a result, "consultants are likely to be highly selective in choosing cases to recommend to the Home Secretary, and from these the Home Office can pick the best cases for release."[114]

Number of conditionally discharged patients recalled and/or convicted

Period	No. discharged		% recalled within 2 years		% convicted within 2 years of: A grave offence		Any standard list offence	
	MHRT	*SofS*	*MHRT*	*SofS*	*MHRT*	*SofS*	*MHRT*	*SofS*
1975–77	—	402	—	10.0%	—	1.7%	—	14.9%
1978–80	—	373	—	8.0%	—	2.1%	—	17.7%
1981–83	—	336	—	3.9%	—	2.7%	—	13.4%
1984–86	237	138	18.6%	13.0%	2.1%	1.5%	14.4%	8.0%
1987–89	173	142	12.1%	12.7%	1.2%	0%	5.8%	0.7%

Source: Home Office Statistical Bulletin, Issue 18/94, Home Office, London, July 1994.

Reconviction and the form of mental disorder

As can be seen from the table below, patients classified as suffering from mental illness or severe mental impairment are much less likely to be reconvicted than those suffering from psychopathic disorder or mental impairment. It is noteworthy that no patient classified as being mentally ill who was conditionally discharged by a tribunal between 1984 and 1989 was convicted of a grave offence during the following two years.

112 Because death previously constituted an absolute discharge for statistical purposes, it used to be said that a "St. Peter's discharge" was a detained patient's best hope of being unconditionally released. The cynics refused to believe this, claiming that the Secretary of State would find some ground for recalling the patient.

113 The number of (unproven) offences reported to the Home Office may be twice as high as the number of reconvictions. See S. Dell and A. Grounds, *The discharge and supervision of restricted patients* (Institute of Criminology, 1996), p.85.

114 S. Dell and A. Grounds, *The discharge and supervision of restricted patients* (Institute of Criminology, 1996), p.84.

Patients reconvicted after conditional discharge by a tribunal

Discharged during period 1984-1989

Form of mental disorder	% convicted of a grave offence		% convicted of any standard list offence	
	within 2 yrs	*within 5 yrs*	*within 2 yrs*	*within 5 yrs*
Mental illness	0%	3%	4%	11%
Mental impairment	2%	5%	15%	29%
Psychopathic disorder	5%	7%	22%	41%

Notes: Mental impairment includes severe mental impairment but none of the 19 severely mentally impaired patients discharged during the period 1977-86 were reconvicted within five years of a grave offence and only one of them of a standard list offence. Source: Home Office Statistical Bulletin, Issue 18/94, Home Office, London, July 1994.

Reconviction rates for ordinary prisoners

The information concerning the number of patients who reoffend upon being returned to the community has to be seen in the context of the reconviction rates for other kinds of offender. In general terms, the public has relatively little to fear from the mentally ill offender compared with violent young men considered not to have mental health problem.

Reconviction rates for prisoners and restricted patients

Percentage of persons reconvicted of a standard list offence within *two years of release*

Category of offender	% reconvicted
Adult males released from prison in 1987	50%
Adult males released from prison following a sentence of imprisonment imposed for a violent offence in 1987	45%
Patients classified as suffering from psychopathic disorder conditionally discharged between 1984-89	20%
Patients classified as suffering from mental illness conditionally discharged between 1984-89	4%

Source: Home Office Statistical Bulletin, Issue 18/94, Home Office, London, July 1994

FURTHER READING

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