NHS Executive

Health Services Guidelines HSG(94)27

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GUIDANCE ON THE DISCHARGE OF MENTALLY DISORDERED PEOPLE AND THEIR CONTINUING CARE IN THE COMMUNITY

Executive summary

The Secretary of State for Health attaches great importance to the responsible consideration of the discharge of psychiatric patients from hospital and to the effectiveness of the care and supervision provided in the community when they leave. This guidance is part of the Secretary of State's ten point plan announced in August 1993. The plan's other elements, of which the present document takes account, include the introduction of supervision registers (under HSG(94)5) and the proposed new power of supervised discharge.

The guidance sets out good practice which should be followed for all patients who are discharged following referral to the specialist mental health services. It is based on application of the Care Programme

Approach, with particular emphasis on the need for risk assessment prior to discharge. The text takes account of the many comments the Department received on the draft which was circulated for consultation on 12 January 1994.

Action

NHS professionals and provider unit managers should:

- ensure in cooperation with their personal social services counterparts that the guidance is put into immediate practice;
- establish local guidelines, agreed with purchasers, to ensure that the necessary priority is given to meeting the needs of the most seriously ill patients;
- establish audit and monitoring systems to support implementation;
- discuss any problems with purchasing authorities.

NHS purchasers, including GP fundholders, should in cooperation with health service providers, social services, criminal justice agencies, voluntary organisations and other relevant groups:

- secure, through contracting, not later than 1995/96, the necessary service provision to support the aims of this guidance:
- set up arrangements to monitor and evaluate the implementation of the guidance.

FHSAs are asked to bring the guidance to the attention of GP fundholding practices and GP practices preparing for fundholding status in 1995. They should also send copies, for information, to Secretaries of Local Medical Committees.

Progress will be followed up centrally through the corporate contract process and the Department's monitoring of the Care Programme Approach.

DEPARTMENT OF HEALTH

GUIDANCE ON THE DISCHARGE OF MENTALLY DISORDERED PEOPLE[1] AND THEIR CONTINUING CARE IN THE COMMUNITY

This guidance seeks to ensure:

- that psychiatric patients are discharged only when and if they are ready to leave hospital;

[1] This covers people with mental illness and other mental disorders as defined in the Mental Health Act 1983. Where different considerations apply to different forms of disorder, this is stated.

- that any risk to the public or to patients themselves is minimal and is managed effectively;
- that when patients are discharged they get the support and supervision they need from the responsible agencies.

It is part of the ten point plan announced by the Secretary of State for Health on 12 August 1993 to ensure the safe and successful care of mentally ill people in the community. It brings together the elements of existing guidance and reinforces it with specific advice on assessing the risks which patients may present to themselves or to other people. This guidance draws on practical experience of cases in which the arrangements have not worked as they should have. The guidance should be read with that issued by the Department (*Health Service Guidelines (94)5*) requiring the introduction of supervision registers for those patients most at risk.

Relevant existing guidance is listed at *Annex A*. *Paragraphs 17–18* refer to the implications of the Secretary of State's proposals for introducing a new power of supervised discharge[1] which are also part of the ten point plan.

DISCHARGE FROM HOSPITAL

1. It is fundamental in considering whether a person should be discharged from in-patient hospital care that full account is taken of his or her assessed needs and capabilities, including:

- whether, with adequate medication, care, and supervision in the community, the patient could still present any serious risk to him or herself or to others;
- whether his or her needs for therapy, supervision, sanctuary, or security require continuing in-patient treatment; and
- whether he or she could be cared for effectively and safely in the community, if necessary in staffed or supported accommodation.

2. Generally speaking, mentally disordered people are much more likely to harm themselves than to harm others. Either eventuality can be devastating for any of those affected. ***Those taking individual decisions about discharge have a fundamental duty to consider both the safety of the patient and the protection of other people. No patient should be discharged from hospital unless and until those taking the decision are satisfied that he or she can live safely in the community, and that proper treatment, supervision, support and care are available***. Detailed advice on ***risk assessment*** is set out in *paragraphs 23–32* below.

3. Risk is a prime consideration in discharge decisions. But it is important to remember that patients do *not* have to present a risk to themselves or to other people in order to be detained in hospital. Under

the ***Mental Health Act 1983***, a patient may be admitted compulsorily to hospital where this is necessary:

- in the interests of his or her own health, *or*
- in the interests of his or her own safety, *or*
- for the protection of other people.

Only one of the above grounds needs to be satisfied (see Mental Health Act *Code of Practice*, paragraph 2.6).

4. Where after full consideration of all relevant factors, the conclusion is that it is safe to discharge the patient, and that to do so is in his or her best interests, it is essential that arrangements for discharge and continuing community care are, subject to *paragraph 6* below on the confidentiality of information, agreed between, communicated to and understood by the patient and all others involved. These may include the patient's carers and, to the extent that they are directly involved in the delivery of care, social workers, community mental health nurses, the patient's general practitioner and other community, residential, and day care staff.

5. In the case of patients who have committed offences or been involved with the criminal justice agencies, consideration should also be given to whether these agencies (for example the probation service) have a part to play in their further care. In these cases the circumstances of any victim of the offence should be borne in mind when considering placement in the community. For those patients detained under the Act who are subject to restriction orders and are conditionally discharged, reference should also be made to the joint Home Office/Department of Health Guidance Booklets on "*Supervision and After-care of Conditionally Discharged Restricted Patients*".

Confidentiality of information

6. In following this guidance, it should be borne in mind that all information relating to the patient is confidential. Such information should be disclosed within the NHS only to those who are involved in the care and treatment of the patient and then only on a strict need-to-know basis. Disclosure outside the NHS (for example to social workers, the police, or the probation service) should occur only if the patient has expressed or implied consent, or where disclosure can be justified as being in the public interest. Obtaining consent is essential in most cases.

THE CARE PROGRAMME APPROACH

7. The basic principles governing the discharge and continuing care of all ***mentally ill*** people, including those with dementia, are embodied in the *Care Programme Approach*, which authorities were required to

introduce in 1991 (*Health Circular (90)23/Local Authority Social Services Letter (90)11*). The same approach should be applied, so far as it is relevant, to the after-care of other mentally disordered patients: see *paragraphs 20–21* below.

8. The Care Programme Approach applies whether or not a patient has been detained under the Mental Health Act, but health and local authorities also have a statutory duty under ***section 117 of the Act*** to provide after-care services for patients (in all categories of mental disorder) who have been detained in hospital under sections 3, 37 (whether or not with restrictions under section 41), 47 or 48 of the Act. To fulfil this duty authorities will need to ensure that the Care Programme Approach is fully implemented for mentally ill patients who have been detained, and that its principles are applied so far as they are relevant to the after-care of other detained patients. Authorities will need to establish mechanisms to monitor the application of the Care Programme Approach as a whole and should report on progress at regular intervals to authority members.

9. The purpose of the Care Programme Approach is to ensure the support of mentally ill people in the community thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention. It also applies to all mentally ill people who are accepted by the specialist psychiatric services without having been treated in hospital, including those released from prison.

10. The essential elements of an effective care programme are:

- *systematic assessment* of health and social care needs (including accommodation), bearing in mind both immediate and longer term requirements;
- a *care plan* agreed between the relevant professional staff, the patient, and his or her carers, and recorded in writing;
- the allocation of a ***key worker*** whose job (with multi-disciplinary managerial and professional support) is:
  - to keep in close contact with the patient;
  - to monitor that the agreed programme of care is delivered; and
  - to take immediate action if it is not;
- *regular review* of the patient's progress and of his or her health and social care needs.

Those taking the decisions must be satisfied that these conditions are fulfilled before any patient is discharged.

11. It is essential for the success of a continuing care plan that decisions and actions are systematically recorded and that arrangements for communication between members of the care team are clear. 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 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 (prominently identified in, eg, clinical notes, computer records and the care plan)*;
- *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.*

12. The Care Programme Approach lays great emphasis on ensuring continuity of care for patients in the community:

> Every reasonable effort should be made to maintain contact with the patient and, where appropriate with his/her carers, to find out what is happening, to seek to sustain the therapeutic relationship . . . Often patients only wish to withdraw from part of a care programme and the programme should be sufficiently flexible to accept such a partial rather than a complete withdrawal.

Any such change to the care programme should as far as practicable be agreed with all those involved.

13. Where a patient moves from one area to another it is essential to maintain continuity of care. The patient remains the responsibility of the original team until a handover has taken place and has been recorded in writing. If there is any doubt about where responsibility lies for purchasing after-care services for a discharged patient, reference may be made to the Department of Health's guidance booklet on "*Establishing District of Residence*" published in 1993 and, where appropriate, Local Authority Circular (93)7 on "*Ordinary Residence*" and care assessment.

14. In a number of cases where something has subsequently gone wrong, poor coordination of services or communication between those involved has been a major factor. For example, one inquiry report[2] noted that

> it was not that there was wilfulness in the lack of coordination, but that information that one practitioner had might not reach another practitioner in the same or a different discipline.

The Care Programme Approach, with its emphasis on systematic assessment of health and social care needs, requires close inter-disciplinary and inter-personal working, particularly at critical times such as when

discharge from hospital is being considered. The aim should be to ensure that timely and coordinated responses can be made to individual needs. The inter-agency arrangements necessary to ensure continuity of care and to prevent people "falling through the net" (*eg* contact points, knowledge of each other's roles, contingency arrangements, needs assessments) should be clear and easily understood by all parties. They should include the police, courts and probation service so far as they are involved in the management of people with a mental disorder and so far as is compatible with obligations on confidentiality (*see paragraph 6*).

15. There must also be effective links between local agencies and supra-district services such as special hospitals and medium secure units, as well as prisons, so that agencies know for which patients they will eventually have to accept responsibility and can work jointly with the discharging unit to develop effective arrangements for continuing care.

Care management

16. Social Services Departments have duties under the *NHS and Community Care Act 1990* to assess people's needs for community care services. Multi-disciplinary assessment under the Care Programme Approach, if properly implemented, will fulfil these duties. Health Authorities and Social Services Departments will need to ensure that the Care Programme Approach and care management arrangements are properly coordinated. The detailed arrangements will depend on the type of care management system the Social Services Department has implemented, but in all cases there should be an allocated key worker as required under the Care Programme Approach.

Supervised discharge

17. The Secretary of State's proposals on supervised discharge were announced as part of the ten point plan. This power is intended to apply to non-restricted patients who have been detained in hospital under the Mental Health Act and who would present a serious risk to their own health or safety, or the safety of other people, unless their after-care was supervised. Subject to Parliamentary approval, it is proposed that supervised discharge from hospital comply with the treatment plan they need to ensure that they can live safely in the community. If a patient did not comply with the terms of supervised discharge, the care team would reconvene to review the case and whether the patient needed to be recalled to hospital.

18. The conditions attached to supervised discharge would reflect the principles of the Care Programme Approach, as well as including some of the key features of Mental Health Act guardianship. These proposals will reinforce the approaches set out in the present guidance. Services for patients subject to supervised discharge, as for all others

receiving care from the specialist mental health services in the community, will be organised and provided in accordance with the Care Programme Approach. Supervised discharge will give legal backing and a power of enforcement to arrangements for patients at risk to themselves or to others and help ensure that they do not get lost to care. Legislation to implement supervised discharge will be introduced as soon as possible.

Mental Health Review Tribunals

19. Patients detained under the Mental Health Act have the right to have their detention reviewed, at specified intervals, by a Mental Health Review Tribunal. The Tribunal must discharge the patient if the statutory criteria specified in section 72 (1) of the Act are met, and has discretion to discharge patients in other cases. If the patient is subject to a restriction order the Tribunal may direct that he or she is discharged subject to conditions. Where a patient has applied for a Tribunal it is important that the essential elements of the Care Programme Approach (*as outlined in paragraph 10*) 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.

People with personality disorders

20. The Care Programme Approach circular applies only to mentally ill people. However the good practices the Care Programme Approach promotes and the guidance contained in the present document are equally relevant to those patients with personality (or psychopathic) disorders who can safely and suitably be looked after by the specialist psychiatric services in the community.

People with learning disabilities

21. Similar arrangements may also need to be considered for some people with *learning disabilities* discharged from in-patient care (*eg* the Special Hospitals Service Authority applies the Care Programme Approach to all its patients, including those with mental/severe mental impairment). General guidance on learning disability services, including the importance of providing for essential needs on a life-long basis, is contained in *Health Service Guidelines (92)42* and *Local Authority Circular (92)15*.

LEGAL REQUIREMENTS

22. The legal requirements relating to services in the community for discharged patients are summarised at ***Annex B***. Where these apply they must be taken into account in decisions about discharge and future care.

PATIENTS WHO PRESENT SPECIAL RISKS

23. Patients with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking 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 the patient presents.

24. *Before discharge* there must be a careful assessment by both the multi-disciplinary team responsible for a patient in hospital and those who will be taking responsibility for his or her care in the community. Those involved must agree the findings of a risk assessment (see below), the content of a care plan, and who will deliver it. In accordance with good practice in the delivery of the Care Programme Approach generally, there must be a contemporaneous note of the outcome of any risk assessment and of any management action deemed necessary and taken.

25. Although the progress of many mentally disordered people *after discharge* from hospital 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. Which members of the team need to come together for any particular case will be a matter of judgement, but at least the consultant; the nurse, social worker or care manager; and always the key worker should be involved. The patient's general practitioner should be informed in all cases even if it is not practical to involve him or her in the immediate consideration. 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 wider consultation as soon as possible.

The responsibilities of those assessing future risks

26. 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 involved need to recognise these difficulties and make an honest and thorough assessment based on best current practice and taking account of all the known circumstances of each case.

Assessing potentially violent patients

27. Patients who have a history of aggressive and risk-taking behaviour present special problems and require very careful assessment. They pose particular challenges to clinicians who have to try to predict their future behaviour and the risks of further violence.

28. It is widely agreed that assessing the risk of a patient acting in an aggressive or violent way at some time in the future is at best an inexact science. But there are some ways in which uncertainty may be reduced:

a. 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. As well as the treatment team and the patient, sources may include relatives, carers, friends, the police, probation officers, housing departments, and social workers, and also local press reports and concerns expressed by neighbours. Proper regard must be paid to legal and other obligations relating to confidentiality. However, wherever possible, information that is relevant to forming an overall view of a case should be made available in the interests of the patient. Too often it has proved that information indicating an increased risk existed but had not been communicated and acted upon.

b. conducting a full assessment of risk

The Panel of Inquiry into the case of Kim Kirkman[3] concluded that the following all played a part in arriving at a decision about risk:

- 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.

*[*by a chartered psychologist or under the supervision of one]*

In the words of the panel:

> 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 [or she] suffers.

It is particularly important to know about the past history of risk-taking and dangerous behaviour. As the Kim Kirkman panel again noted: "Nothing predicts behaviour like behaviour".

c. defining situations and circumstances known to present increased risk

While judgements about future overall risk posed by individual patients can be difficult, research has indicated that there are particular situations and circumstances which may indicate an increased level of risk. For instance, one American study of over 10,000 respondents[4] showed that violence was reported more often when drug or alcohol misuse co-exist with a major mental disorder or when a patient has multiple psychiatric diagnoses.

It is often possible to identify circumstances under which, based on past experience, 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, *eg* in the context of a close relationship enters another such relationship.

d. Seeking expert help

There is a considerable body of expertise on risk assessment within forensic psychiatry. Expert forensic help should always be accessible to local psychiatric teams and should be used in difficult or doubtful cases.

An effective risk assessment will identify relevant factors involved in past violent behaviour, will indicate the circumstances which may influence a patient's tendency to violence in the future and will estimate the likelihood of these recurring. All members of the multi-disciplinary team and the patient's formal or informal carers will need to be aware of the results of the assessment. Prompt action must be taken in response to any evidence of increased risk.

Assessing the risk of suicide

29. *Paragraph 2* points out that mentally disordered people are more likely to be a danger to themselves than to other people. Serious mental disorder and alcohol misuse greatly increase lifetime suicide rates.

Knowing how to assess the risk of suicide is very important in the successful management of mentally disordered people whether in hospital or in the community.

30. All members of the multi-disciplinary team should be aware of the underlying risk factors for suicide and be able to make enquiries of patients about possible suicide intent. As one widely-used medical textbook[5] put it:

> The first requirement is a willingness to make tactful but direct enquiries about a patient's intentions. The second is an alertness for the general factors that signify an increased risk.
>
> Asking a patient about suicidal inclinations does not make suicidal behaviour more likely. On the contrary, if the patient has already thought of suicide he will feel better understood when the doctor raises the issue, and this may reduce the risk. If a person has not thought of suicide before, tactful questioning will not make him behave suicidally.

and

> The most obvious warning sign is a **direct statement of intent** . . . There is no truth in the idea that people who talk about suicide do not enact it.

31. Two thirds of suicides have mentioned their suicidal ideas and a third have expressed clear suicidal intent. Most of those who kill themselves have had recent contact with health care professionals. Two thirds have recently consulted their GP, 40% in the week before their suicide. A quarter are current psychiatric out-patients, of whom half have seen a psychiatrist in the previous week. There are some risk factors associated with particular groups: for example, young Asian women have a suicide level significantly above that of the general population, while 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, emphasising the need for proper assessment prior to discharge and effective follow-up afterwards.***

32. The Health Advisory Service is issuing guidance on suicide prevention. This will include more detailed information about risk factors and risk assessment. The Department of Health is publishing the report of a major conference held last year. The *Health of the Nation Mental Illness Key Area Handbook* suggests a range of ways in which health and social services and other agencies can work together to promote better suicide prevention programmes locally. The first in a series of booklets on mental health for public information and education have been published on mental illness, suicide and mental health in the workplace.

IF THINGS GO WRONG

33. If a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event, action by local management must include:

- an immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach. Where court proceedings in relation to the incident have started or are thought likely, legal advice should be sought with a view to ensuring that the investigation does not prejudice those proceedings;
- if the victim was a child, ie under 18 years of age, the report of the investigation should be forwarded to the Area Child Protection Committee within one month of the incident;
- incidents involving a death should be reported to the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (telephone 071 823 1031; fax 071 823 1035).

34. Additionally, after the completion of any legal proceedings it may be necessary to hold an independent inquiry. ***In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved.*** The only exception is where the victim is a child and it is considered that the report by the Area Child Protection Committee (*see paragraph 33*) fully covers the remit of an independent inquiry as set out below.

35. In cases of suicide of mentally ill people in contact with the specialist mental health services, there must be a local multi-disciplinary audit as specified in the *Health of the Nation*.

36. In setting up an independent inquiry the following points should be taken into account:

i. *the remit of the inquiry* should encompass at least:

- the care the patient was receiving at the time of the incident;
- the suitability of that care in view of the patient's history and assessed health and social care needs;
- the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the exercise of professional judgement;
- the adequacy of the care plan and its monitoring by the key worker.

ii. *composition of the inquiry panel.* Consideration should be given to appointing a lawyer as chairman. Other members should include

a psychiatrist and a senior social services manager and/or a senior nurse. No member of the panel should be employed by bodies responsible for the care of the patient;

iii. *distribution of the inquiry report.* Although it will not always be desirable for the final report to be made public, an undertaking should be given at the start of the inquiry that its main findings will be made available to interested parties.

SUPERVISION REGISTERS

37. The Department's *Health Service Guidelines (94)5* requires all health authorities, from 1 April 1994, to ensure through their contracts for mental health services that providers draw up, maintain and use supervision registers of those patients who are most at risk.

RESPONSIBILITIES OF DISTRICT HEALTH AUTHORITIES AND OTHER PURCHASERS OF HEALTH CARE

38. Purchasers of mental health services are responsible, (in co-operation with local social services, local housing departments, and voluntary organisations) for ensuring that there is an adequate range of community based services to meet local need. Services should meet medical, nursing, social, and therapy requirements; supervised accommodation is likely to be an important component of local provision. There must also be services that will meet effectively the varying needs of mentally disordered offenders and similar patients, including discharged prisoners with continuing mental health care needs (*see paragraph 41*). The *Mental Illness Key Area Handbook* gives further advice on planning community services.

39. Purchasers have a key responsibility to ensure successful local implementation of the Care Programme Approach. The contracts placed with providers should include:

- explicit and clear requirements to implement the Care Programme Approach;
- explicit and clear arrangements for management accountability for the Care Programme Approach;
- explicit and clear requirements for Care Programme Approach information (including the number of people covered by Care Programme Approach, collected at least quarterly);
- explicit and clear processes for monitoring and auditing Care Programme Approach;
- explicit and clear mechanisms to review the facilities necessary for the discharge of patients; which are reflected in subsequent purchasing plans.

40. In addition purchasers must ensure that the following key elements are *implemented through contracts*:

- the maintenance or development of a mental health information system, including supervision registers;
- staffed adequately trained in the Care Programme Approach and in risk assessment and management;
- suitable arrangements for the management and clinical supervision of staff in community mental health terms;
- audit of suicides (see *paragraph 35* above);
- agreed procedures in the event of a homicide or assault by a patient subject to the Care Programme Approach.

Purchasers are responsible for ensuring, through these arrangements, that the necessary priority is given to the most severely mentally ill patients.

41. The essential requirements for services for ***mentally disordered offenders*** are set out in *The Health of the Nation* and in *NHS Management Executive Letter (93)54* which requires NHS authorities to work with personal social services and criminal justice agencies to develop strategic and purchasing plans based on the joint Department of Health/ Home Office ("Reed") review of services.[6] These must include:

- an effective range of non-secure and secure services (including those for patients with special or differing needs, such as people with learning disabilities or psychopathic disorder, ethnic minorities, young people and women);
- arrangements for the multi-agency assessment and, as necessary, diversion of offenders from the criminal justice system;
- meeting the mental health care needs of transferred or discharged prisoners;
- the placement within six months of special hospital patients who no longer require high security.

Arrangements for the placement of special hospital patients must take full account of the requirements of the Care Programme Approach and the guidance in this document.

References:

1. See statement by the Secretary of State for Health, 28 December 1993 (DH Press Release 93/1144); Department of Health (1993) *Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review*, paragraph 7.9.

2. DHSS (1988, Cm 440) *Report of the Committee of Inquiry into the Care and After-Care of Miss Sharon Campbell.*

3. West Midlands RHA (1991) *Report of the Panel of Inquiry Appointed to Investigate the Case of Kim Kirkman.*

4. Swanson *et al* (1990) *Hospital and Community Psychiatry* **41** 761–770.

5. Gelder, Gath and Mayou (1989) *Oxford Textbook of Psychiatry (2nd ed)*.

6. Department of Health/Home Office (Cm 2088, 1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services: Final Summary Report.*

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FURTHER INFORMATION

HC(90)23/LASSL(90)11 (The Care Programme Approach)

HC(89)5/LAC(89)7 (Dsicharge from hospital)

Caring for People (Cm 849, 1989)

The Health of the Nation (Cm 1986, 1992)

Home Office/Department of Health (1987) *Supervision and After-Care of Conditionally Discharged Restricted Patients: Notes for the Guidance of Social Supervisors*

The Health of the Nation Key Area Handbook: Mental Illness (1993)

The Mental Health Act *Code of Practice* (2nd ed, 1993)

Department of Health (1993) *Legal Powers on the Care of Mentally Ill People in the Community: Report of the Internal Review*

Department of Health/Home Office *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (HMSO):

(1992) *Final Summary Report* (Cm 2088)
(1993) Volume 2: *Service Needs*
(1993) Volume 5: *Special Issues and Differing Needs*

Social Services Inspectorate/ Department of Health (1991):

Assessment Systems and Community Care
Case Management and Assessment: Summary of Practice Guidance
Case Management and Assessment: Practitioners' Guide
Case Management and Assessment: Managers' Guide

[Griffiths *et al* (ed) (1994) *Prevention of Suicide* (HMSO)]

DISCHARGED PATIENTS TO WHOM LEGAL REQUIREMENTS APPLY

Some discharged patients will be subject to statutory provisions. These include:

- ***patients discharged from detention under Mental Health Act 1983. Section 117*** of the Act requires health and local authorities to provide, in cooperation with relevant voluntary agencies, after care services for those discharged following detention under sections 3, 37 (whether or not with restrictions under section 41), 47 or 48 of the Act until they are satisfied that this is no longer necessary;
- ***restricted patients conditionally discharged under section 42 or 73 of the Mental Health Act***. The main effect of a restriction order is that a patient (who will have been subject to a hospital order made by a court) may not be allowed leave outside the hospital, or be transferred to another hospital, without the authority of the Home Secretary or an independent Mental Health Review Tribunal. Such patients are generally discharged from hospital subject to conditions of residence and supervision by a doctor and a social worker or probation officer;
- people subject to a ***guardianship order under section 37 of the Mental Health Act***. The purpose of such orders is primarily to ensure that a person receives care and protection rather than medical treatment, although the guardian (the local authority or a person approved by it) can require attendance for medical treatment, occupation, education or training and residence at a specific place;
- people subject to ***guardianship under Section 7 of the Mental Health Act 1983*** on the grounds that it is in the interests of their welfare or the protection of others;
- people subject to a ***probation order with a condition of psychiatric treatment under section 3 of the Powers of the Courts Act 1973***. Such treatment will normally be on an out-patient basis, but a condition of residence at a hospital can be attached to the probation order;
- people subject to ***Section 3 of the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991*** which introduced a supervision and treatment order for patients living in the community.