O. MENTAL HEALTH (PATIENTS IN THE COMMUNITY) ACT 1995
– GUIDANCE ON SUPERVISED DISCHARGE
(AFTER-CARE SUPERVISION)
AND RELATED PROVISIONS

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pursuant to Section 118 of the Mental Health Act 1983

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[This document is not yet included – it is awaiting ratification]
1. Introduction

1.1 This supplement to the Mental Health Act Code of Practice\(^1\) gives guidance on the new provisions for after-care under supervision, referred to throughout as \textit{supervised discharge}. This became effective from 1\textsuperscript{st} April, 1996 on the implementation of the Mental Health (Patients in the Community) Act 1995 which amends the Mental Health Act 1983 (referred to in this guidance as “the Act”).

1.2 The 1995 Act contains two other main provisions (apart from amendments to the equivalent Scottish legislation). The first is to remove the previous six-month time limit on the period for which a detained patient may be given leave of absence under Section 17 of the Act. The effect of this is explained in paragraph 71 below. The second is to extend the period during which a patient who is absent without leave from detention or guardianship may be returned.

2. Supervised Discharge

2.1 The Purpose Of Supervised Discharge

2.1.1 Supervised discharge is an arrangement by which a patient who has been detained in hospital for treatment under the provisions of the 1983 Act may be subject to formal supervision after he or she is discharged. Its purpose is to help ensure that the patient receives the after-care services to be provided under Section 117 of the Act. It is available for patients suffering from any of the four forms of mental disorder in the Act but is primarily intended for those with severe mental illness (see paragraph 14). The provisions incorporate the key principles of the Care Programme Approach, as defined in circular HC(90)23/LASSL(90)11, and those set out in the Welsh Office Mental Illness Strategy (WHC(95)40, Draft Guidance on the Care of People in the Community with Mental Illness). They also reflect the Department of Health’s Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community (HSG(94)27/LASSL(94)4).

2.1.2 The above initiatives are directed to ensuring that there are effective after-care services for all discharged patients, based on close co-operation between all the agencies concerned at local level. In particular, before a patient is discharged from hospital, a risk assessment should be carried out, a care plan established based on a systematic assessment of need and a key worker identified to monitor the patient’s progress and the delivery of care in the community. The services provided should then be kept under regular review in the light of the patient’s needs. The relationship between Section 117 after-care, the Care Programme

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\(^1\) The guidance contains a number of references to existing paragraphs of the Code. This means that the general principles underlying those paragraphs apply to the operation of supervised discharge, even though their wording was drawn up before it was introduced.
Approach, and local authority arrangements for care management is explained in “Building Bridges – A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people” (DH 1995).

2.1.3 These principles apply to all patients receiving care from the specialist psychiatric services in the community, whether or not it follows a spell in hospital. Supervised discharge is 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 after discharge from hospital. Relapses often follow the breakdown of arrangements for care in the community, for example when a patient stops taking medication. The legal framework which supervised discharge provides should help to prevent such failures provided that the care arrangements that it underpins have been fully agreed between the agencies concerned. Its purpose is to complement and reinforce existing arrangements under the Care Programme Approach, and supervised discharge procedures should be integrated with those operating under the CPA.

2.1.4 Patients who are placed under supervised discharge will have been assessed as presenting a substantial risk of serious harm to themselves or other people, or of being seriously exploited, if they do not receive suitable after-care. They should normally be included in the supervision registers established in England in accordance with HSG(94)5 (and the corresponding local lists in Wales) to identify patients in the care of the psychiatric services who are at significant risk. However, not all patients who are on supervision registers will be suitable for supervised discharge. For example, the registers will also includes patients who have not been detained – and indeed may not have been in hospital at all – and cannot therefore be subject to supervised discharge under the Act.

2.1.5 The duty to provide after-care services under Section 117 extends to all patients who have been detained for treatment under the relevant sections of the Act (see paragraph 15). Patients should not be placed under supervised discharge simply with a view to ensuring that these services are provided for them, but only if they meet the criteria set out in paragraphs 13 and 15 below.

2.2 Supervised Discharge And Guardianship

2.2.1 Guardianship under Section 7 of the Act remains available as an option when considering the arrangements to be made for a patient’s care in the community. Where a patient is detained in hospital and meets the criteria, supervision discharge has advantages in the specific legal provision it offers for making and review after-care arrangements and the roles assigned to the community responsible medical officer and supervisor. Where a patient needs a degree of formal structure in his or her after-care arrangements but does not fully meet the criteria for supervised discharge responsible medical officers and their
professional colleagues may well want to consider proposing guardianship. This may be particularly suitable for patients with learning disability, providing they meet the Mental Health Act definition of “mental impairment” or “severe mental impairment”.

### 2.3 Statutory Responsibilities

2.3.1 The Act places a number of responsibilities for the supervised discharge procedure – particularly relating to the initial application – on the Health Authority which is to be responsible for the health element of the after-care services to be provided under Section 117 of the Act. Some other responsibilities relating to the operation of supervised discharge are placed jointly on that Health Authority and the corresponding local authority responsible for the social services element of the Section 117 after-care (who the Act defines together as the “responsible after-care bodies”). It is recommended that health and local authorities develop local protocols on the implementation and working of supervised discharge. Some suggested issues for inclusion are set out at Annex C.

2.3.2 The Mental Health (After-Care Under Supervision) Regulations 1996 allow the Health Authority’s responsibilities under the 1995 Act, and the joint responsibilities of the Health Authority and local authority in their capacity as the “responsible after-care bodies”, to be delegated to a body with whom the Health Authority has contacted to provide Section 117 services. Such a body is referred to throughout this guidance as the provider unit. This would in most cases be an NHS Trust, but could be an independent or voluntary sector provider. Otherwise (for example where a small provider unit does not have the administrative back-up to fulfil all the documentary requirements) the powers may be delegated to an officer of the Health Authority itself, or to an officer of another Health Authority if there are joint purchasing agreements in place and it has been agreed that such functions should be undertaken by only one of the parties. The functions may also be delegated by a committee of the Health Authority.

2.3.3 These provisions make it possible for a single body to fulfil the procedural requirements of supervised discharge on behalf of the health and local authorities. The functions that may be delegated are listed in Annex D. It is for each authority to decide whether its functions should be delegated to the health service provider, and if they are, to satisfy itself that there are suitable arrangements for fulfilling its statutory obligations. The actual provision of Section 117 after-care services cannot be delegated under the regulations – though in the case of the Health Authority this will normally be secured through NHS contracts, and in practice the services will be delivered jointly by health and social services staff working as members of the patient’s care team.
2.3.4 The new Act does not assign any functions to the hospital managers, though it would be open to a Trust to assign a monitoring role to a committee similar to that formed to exercise the managers’ functions under the Act.

2.4 Applying For Supervised Discharge (Section 25A)

2.4.1 An application for supervised discharge (a supervision application) may be made only by the patient’s responsible medical officer (RMO) at a time when the patient is liable to be detained under the Act. The RMO’s key role is a key point of difference with the procedure for applications for admission to hospital under the Act, which are usually made by an approved social worker (ASW). In supervised discharge cases the ASW makes a recommendation in support of the application (see paragraph 30 below). The RMO should consider making an application if he or she is satisfied:

- that the patient is suffering from one of the four categories of mental disorder defined in Section 1(2) of the Act; and

- that there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other people, or of the patient being seriously exploited, if the patient did not receive after-care services under Section 117 of the Act; and

- that supervision is likely to help ensure that the patient receives those services.

All three of these conditions must be met.

While the duty to make the application rests solely with the RMO, this does not preclude others with professional knowledge of the patient’s condition and needs proposing supervised discharge to the RMO for his or her consideration.

2.4.2 Supervised discharge is primarily intended for severely mentally ill people but may be suitable for some patients suffering from other forms of mental disorder. In the case of those suffering from mental impairment or severe mental impairment the question of potential exploitation may be particularly relevant, though the RMO should then always consider whether guardianship might offer a better option for the patient’s after-care.

2.4.3 The RMO must also be satisfied:

- that the patient is 16 years of age or over;
that he or she is currently liable to be detained under Sections 3, 37, 47 or 48 of the Act (this includes patients who have been granted leave of absence under Section 17); and

that he or she is an unrestricted patient, that is not subject to restrictions under Section 41 or 49 (conditional discharge under Section 42 of the Act is available for restricted patients). An application may however be made if the patient was formerly subject to restrictions which have been lifted or have expired.

Patients who have been admitted under Section 2 of the Act may be considered for supervised discharge only if they have subsequently been detained under Section 3. The difference should not influence the choice between admissions under these two sections, the criteria for which are set out in Chapter 5 of the Code.

2.4.4 A patient must be liable to be detained in hospital at the time when the application is made. Supervised discharge takes effect when the patient leaves hospital or, in the case of patients on Section 17 leave, at the point when he or she is discharged from liability to detention. If for any reason a patient remains in hospital on an informal basis after ceasing to be liable to be detained, the supervision application may still take effect when he or she eventually leaves provided this is within six months of the application being accepted. However, it is preferable to avoid long delays as a patient’s circumstances may change. Where a patient’s liability to be detained would end before the after-care arrangements can be implemented the RMO should consider whether the criteria in Section 20 of the Act are met and if so whether the detention should be renewed. Otherwise there will be nothing to prevent the patient from leaving hospital without the after-care arrangements having been completed (and there is no provision for such a patient to be treated as absent without leave).

2.4.5 A supervision application may be made on behalf of a patient who is subject to a Community Care Order under the Mental Health (Scotland) Act 1984 – the equivalent provision to supervised discharge in Scotland – and who wishes to live in England or Wales. This is governed by a separate procedure, which is explained (with the corresponding arrangements for patients wishing to move from England to Scotland) in paragraphs 55 and 56 below.
2.5 After-care Arrangements

2.5.1 The arrangements for after-care under supervision will need to be drawn up as part of the normal discharge planning process, following the principles of the Care Programme Approach in England and WHC(95)40 in Wales and in accordance with the formal consultation requirements in the Act (see below). Chapter 27 of the Code is also relevant. The professional team providing care in the community will need to consider and plan the services to be provided, including as may be appropriate daytime activities, accommodation, treatment, personal and practical support, 24-hour emergency cover and assistance in welfare rights and financial advice. They will also need to consider how often the patient is likely to need particular services. Support for informal carers should not be overlooked, as the care plan may be to some degree dependent on their role.

2.5.2 The Act defines requirements, which may be imposed when a patient is subject to supervised discharge. These are:

- that the patient should live in a particular place;
- that the patient should attend a particular place at set times for medical treatment, occupation, education or training;
- that the supervisor, or a person authorised by the supervisor, should be allowed access to the patient at his or her place of residence (see paragraph 51 below).

The reasons for imposing requirements should be explained to the patient, and details of them should be included in the care plan. A requirement to attend for medical treatment does not carry with it any power to impose medication or other treatment against the patient’s wishes.

2.6 Consultation (Section 25B)

2.6.1 The RMO is responsible for ensuring that both the current and proposed future care team (if different) are consulted about the arrangements to be made for the patient’s care after discharge from hospital, and about any requirements to be imposed (see paragraph 29 above) and that agreement about the care plan is reached between all involved.

2.6.2 The Act specifies certain people who must be consulted about the making of the supervision application. These are:

- the patient;
- one or more members of the team caring for the patient in the hospital;
one or more members of the team who will be caring for the patient in the community (if different from the hospital care team). It will be important to involve and secure the agreement of the social services representative to the care plan;

- the person, if anyone, who will be acting as an informal carer; that is someone who the RMO believes will play a substantial part in the care of the patient in the community but will not be professionally concerned in the provision of after-care services (for example spouse, relative, or friend);

- the patient’s nearest relative, as defined in Section 26 of the Act, unless there is no practicable way in which he or she can be contacted. Except where the nearest relative is also to be an informal carer this is subject to the provision for a patient to object explained in paragraph 27 below.

2.6.3 The Act stipulates that the local social services authority, which has the duty to provide after-care under Section 117, must be consulted by the health authority about the application after it has been made. But since the application must be accompanied by a statement of the after-care services which will be provided it follows that the local authority’s agreement to the care plan and the supervision arrangements will in fact need to be secured before the application is made. The procedure for this needs to be agreed as part of local liaison arrangements. The care team in the community is likely to include local authority staff and the most straightforward arrangement may be for consultation with the authority to be channelled through them. It is important that any other agencies who will be involved in providing after-care services to the patient but who may not be part of the care team – for example voluntary agencies or a housing department – are also consulted (subject to the necessary safeguards for confidentiality of patient information).

2.6.4 The RMO is responsible for ensuring that all those whom the Act specifies are consulted. While he or she is not obliged to undertake all the consultation personally this responsibility should be delegated only with the RMO’s express agreement. Those who are consulted must be given a genuine opportunity to comment on the proposed arrangements and account must be taken in making the application of any views they have expressed. The arrangements clearly will not work without a substantial measure of agreement on the part of those responsible for them and this also needs to be taken into account.

2.6.5 While the Act does not require the patient’s agreement to supervised discharge it is unlikely to be effective unless the patient, and any informal carer, has understood and accepted its terms. The RMO must ensure that the patient has a genuine opportunity to take part in discussions about the proposals for after-care.
The patient should always be given a copy of the care plan in its final form, preferably at least three days before discharge.

2.6.6 The patient, any informal carer and the nearest relative (subject to paragraph 27 below) should have the opportunity to speak to the RMO, or any person the RMO has agreed should undertake the consultation, alone if they wish. The patient may wish a friend, relative or advocate to be present during the discussion and such a wish should be respected unless there are exceptional reasons for excluding a particular person.

2.6.7 Patients, informal carers and nearest relatives must be consulted in a suitable and sensitive manner. Where those involved cannot understand each other’s language sufficiently, recourse to a trained interpreter who understands the terminology and conduct of a psychiatric interview is to be preferred. Where anyone involved has a hearing or speaking difficulty, help should be enlisted from someone with relevant communication skills (if practicable a professional or trained interpreter). The RMO and the other professionals involved must take into account the possibility of misunderstandings resulting from assumptions based on a person’s gender, social background, ethnic origin, sexual orientation or religion or from other medical/health conditions including deafness. Further guidance on suitable interviews is given in paragraph 2.11 of the Code.

2.7 Nearest Relatives

2.7.1 The Act requires a patient’s nearest relative to be consulted (unless it is impracticable to do so) about the initial application for supervised discharge and subsequently about its review, renewal or ending. A patient may however object to consultation with the nearest relative, unless he or she will also be acting as the patient’s informal carer. The RMO may then consult the nearest relative only if the patient is known to have a propensity to violent or dangerous behaviour towards others and the RMO thinks such consultation appropriate. The patient’s objection should not lightly be set aside and it is for the RMO to judge whether the patient has a propensity to violent or dangerous behaviour (which must be directed to other people) and if so whether consultation with the nearest relative is advisable in all the circumstances. Matters which the RMO is likely to want to consider include what is known about the patient’s history, the seriousness of any past violence, against whom it has been directed, how the patient has responded to treatment and how much consultation with the nearest relative is likely to help in the assessment of the patient’s present condition and needs. RMOs may also want to refer to the general discussion of risk assessment in the Department of Health’s “Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community” published in May 1994 (HSG(94)27) and LASSL(94)4. The RMO should record the reasons for his or her decision.
2.8 Submitting The Supervision Application (Section 25B)

2.8.1 The application for supervised discharge should be made on Form 1S. The application must include the names of the supervisor and community responsible medical officer (these roles are explained in paragraphs 43 and 44 below) as well as those of the nearest relative (if any) and of any informal carer who has been consulted about the application.

2.8.2 The supervision application will normally be submitted to the provider unit, which is responsible for the health component of the after-care services (see paragraph 10 above). The provider unit needs to identify an individual officer who will be responsible for handling the documentation. This would be a suitable role for a Mental Health Act Administrator where there is one appointed.

2.9 Supporting Documentation (Sections 25B & 25C)

2.9.1 The application must be supported by the written documentation of an approved social worker (using Form 3S) and another doctor (using Form 2S). The Act requires the latter should if possible be a doctor who will be professionally concerned with the patient’s medical treatment in the community. This should normally be the community responsible medical officer (see paragraph 44 below) unless the patient’s RMO in hospital will also be acting in that role. In the latter case it is preferable for the recommendation to be given by the patient’s general practitioner. If the RMO is unable to identify another doctor who will be involved in the patient’s treatment after he or she leaves hospital the recommendation may be made by any other doctor, including a member of the hospital staff (but not one who works under the direction of the RMO). The ASW making the recommendation may also be the patient’s proposed supervisor.

2.9.2 For the purpose of deciding whether to make a recommendation, the doctor and the approved social worker each visit and interview the patient and the doctor should also examine the patient following the guidance in paragraphs 2.19 to 2.22 of the Code. Wherever possible the ASW and the doctor should visit the patient within a week of each other and it is good practice for them to see the patient together. To ensure that their recommendations are based on a fully informed judgement they should examine any records relating to the patient’s detention or treatment in hospital, and the after-care services to be provided.

2.9.3 A written recommendation in support of the supervision application may not be made by:

- the RMO or a close relative of the RMO;
- anyone who would have a financial interest as specified in Chapter 4 of the Code;
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- a close relative of the patient or of the other professional supporting the recommendation.

“Close relative” for these purposes are defined as husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister or sister-in-law.

2.9.4 A supervision application must also be accompanied by:

- signed statements from the community RMO and the supervisor that they are willing to act in those capacities (these are included in the application Form 1S);

- a statement of the after-care services to be provided (as in the care plan);

- details of any requirements to be imposed on the patient (see paragraph 19).

2.10 Accepting The Supervision Application (Sections 25A & 25C)

2.10.1 Supervised discharge can only come into effect after the application is accepted. By this time the after-care arrangements should have been agreed between all those involved and there should be no question of the application being rejected unless it appears not to have been properly made – for example, if it does not have the required signatures, or if there are inconsistencies either in the application itself or in any of the accompanying information. The scrutiny of the application may be undertaken by suitably experienced members of staff of the provider unit or Health Authority, provided that account is taken of the principles set out in Chapter 12 of the Code. A defective application or supporting recommendation may be amended within 14 days of being accepted.

2.10.2 Before accepting the application, the Health Authority (or provider unit) must consult the local authority named in the application to confirm that those elements of the after-care services for which it will be responsible have been agreed. This should be a check that the arrangements, on which the local authority should already have been consulted, will be in place in time for the patient’s discharge. The officer who is to act for the local authority should be identified as part of the local liaison arrangements.

2.10.3 Supervised discharge cannot take effect until the patient is discharged from hospital. But, for the purpose of determining when supervision would expire (unless renewed), it will be defined to have effect from the date the application was accepted.
2.11  Informing The Patient (Section 25B)

2.11.1 The Act sets out specific requirements governing information to be given to patients and other people. But in any case the patient should as a general principle be given as much information as he or she needs to exercise rights and understand requirements.

2.11.2 The RMO must inform the patient (both orally and in writing) and anyone else who has been consulted that an application is being made; what after-care services it is required to impose and the names of the community RMO and supervisor.

2.11.3 The Health Authority (or provider unit) must inform the patient (orally and in writing) that the supervision application has been accepted and the implications of this for the patient. In particular the patient’s right to apply to a Mental Health Review Tribunal must be explained. A patient’s information leaflet will be available for this purpose, and the general guidance in paragraphs 14.13C of the Code on informing patients of their Tribunal rights also applies. The local authority and anyone else who has been consulted must be told when the application is accepted. Copies of the patient’s information leaflet should also be sent to the patient’s nearest relative (where he or she has been consulted) and any informal carer.

2.12  The Operation Of Supervised Discharge

2.12.1 The following paragraphs explain how the new powers will work once an application has been accepted and the patient discharged from hospital (or liability to detention).

2.13  Professional Responsibilities (Schedule 1)

2.13.1 The Act gives specific responsibilities to designated individual members of the care team, namely the supervisor and the community responsible medical officer. The principle of allocating responsibilities to individuals is not new since the Act already defines the responsibilities of approved social workers, responsible medical officers when a patient is detained in hospital and guardians. Staff undertaking duties defined in the Act remain professionally and managerially accountable for them in the normal way. The possibility of personal legal liability would only arise if there were a culpable professional failure, which fell outside the protection afforded by Section 139 of the Act.

2.13.2 Suitable training should be provided for members of the care team who are to fulfil specified roles in relation to supervised discharge.
2.13.3 The **supervisor** is responsible for monitoring the supervised discharge arrangements and for liaising with other members of the community team and coordinating their work where necessary. He or she must be a suitably qualified and experienced member of the patient’s care team in the community who has agreed to take on this role. In England, the supervisor would normally also fulfil the role of key worker under the CPA. The supervisor should ensure that the team reviews the patient’s after-care plan well before the date when it falls to be reviewed, and whenever any shortfall in the arrangements is identified (see paragraphs 46 and 47 below). The supervisor has powers to require entry to the patient’s place of residence and to convey the patient to a place where he or she is required to live or attend (see paragraphs 48 – 50). The supervisor performs a key role in supervised discharge and it is important that this is supported by a proper framework of training, accountability and clear reporting lines within his or her employing organisation. Close working links between the supervisor and the community responsible medical officer are essential.

2.13.4 The **community responsible medical officer** (CRMO) is responsible for the patient’s psychiatric treatment in the community. He or she must be a registered medical practitioner approved by the Secretary of State for the purposes of Section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder. The right person to undertake this will usually be a consultant psychiatrist. Often he or she may also have been the patient’s RMO in hospital, but if not there must be a handover of responsibility when the patient leaves hospital (or, if already on leave of absence, ceases to be liable to be detained). The CRMO has powers (set out in paragraphs 57 – 66 below) to renew and terminate supervised discharge, and to reclassify the patient’s mental disorder, in each case after taking into account views expressed during consultation with a range of people as set out below.

2.13.5 A patient’s **general practitioner** does not as such have a statutory role defined in the Act in the operation of supervised discharge (though a GP who is approved under Section 12 may be appointed as the CRMO). Nevertheless good practice requires that the CRMO and the supervisor ensure that the GP is involved in decisions, which affect the patient’s medical treatment in the community. As with anyone leaving hospital steps should be taken to ensure that the patient is registered with a GP, not least because severely mentally ill people often have substantial physical health needs. The GP should receive a copy of the care plan before the patient’s discharge and know who are the patient’s supervisor and CRMO and which member of the care team can be contacted in an emergency. The GP should be kept up-to-date with any developments. A patient’s GP may make the medical recommendation, which is required to support a supervision application (see paragraph 30 above).
2.14 Review And Modification Of Supervised Discharge (Section 25E)

2.14.1 The supervisor needs to maintain sufficiently close contact with the patient to be satisfied that he or she is receiving the agreed after-care services and is complying with any requirements. If for any reason either is not happening the supervisor must convene a meeting of the after-care team to review the case and consider whether any changes to the care plan are needed, or whether supervised discharge is still appropriate. The supervisor and the care team should also be alive to signs of deterioration and other warning signals which may require the services to be reviewed. They should make themselves accessible to people with whom the patient is living and be ready to listen to concerns they may express. Good practice requires close contact between the members of the team, especially between the supervisor and the CRMO who has the power to terminate supervised discharge (see paragraphs 65 and 66 below). The review and monitoring arrangements should be integrated with those established under the Care Programme Approach.

2.14.2 If the care team consider that any part of the care plan, or any requirement placed upon the patient, needs to be changed they must (on behalf of the health authority and local authority who are responsible for Section 117 after-care) consult the following people about the modifications:

- the patient;
- any informal carer;
- the patient’s nearest relative, where practicable and unless the patient objects, subject to what is said in paragraph 27 above;

and take their views into account. If changes are made the patient and any person consulted should be informed. The patient must be told both orally and in writing, and should be given a copy of the revised care plan and requirements. The patient’s nearest relative (if consulted) must be told in writing about the modifications. Those concerned must be informed in the same way if there is a change of CRMO or supervisor for any reason – including the case where the patient has moved from one area to another (see Paragraph 54 below).

2.15 Power To Convey A Patient (Section 25D)

2.15.1 The Act gives the supervisor the power to take and convey a patient to a place where he or she is required to reside or to attend for medical treatment, occupation, education or training. It follows that the power is available only where the supervised discharge arrangements includes such requirements.
2.15.2 The circumstances in which this power should be used need to be carefully considered and those concerned may find it helpful to draw up a local inter-agency protocol defining the circumstances in which it may (or may not) be used and the records which should be kept. The supervisor may decide to use the power if a patient has got into a situation, which is putting him or her, or other people, at risk and needs to be taken home urgently. The supervisor may also wish to consider using the power if the patient is not attending for medical treatment and it is thought that this might be overcome by taking him or her to the place where treatment is to be given. The patient cannot then be required to accept medical treatment and the powers should only be used in these circumstances if the supervisor is satisfied (where necessary in the light of consultation with other members of the care team) that it is likely to lead to the patient co-operating with the services being provided. The supervisor should record the reason for using the power. The supervisor should also consider (again, consulting other members of the team as necessary) whether the problem might be overcome by some adjustment to the package of services, or conversely whether it may point to a need to reassess the patient for possible readmission to hospital under the Act.

2.15.3 If the power is used, the supervisor may authorise any responsible adult to convey the patient. Given the potential difficulties it will normally be advisable to obtain the support of the ambulance service and the supervisor may also seek the help of the police. The patient should always be accompanied by the supervisor or another duly authorised adult, preferably a member of the health or social services staff who is known to the patient. Any person authorised must carry some form of documentary evidence to that effect. The care team may wish to maintain a list of people who can be called upon in an emergency to fulfil this role. Unreasonable force must never be used when conveying a patient, and neither should the power (or the threat of using it) be used to coerce a patient into accepting medication or treatment. Where a patient has been conveyed medical and other staff need to be satisfied that his or her consent to any subsequent treatment is genuine and not forced. A patient who has been conveyed to a clinic and then insists on leaving cannot be kept there or given treatment against his or her will (except in the circumstances allowed by common law where it may be permissible to administer treatment in order to deal with the immediate emergency).

2.16 Access To The Patient (Section 25D)

2.16.1 The terms of supervised discharge may include a requirement to allow access to the patient, as his or her place of residence, by the supervisor, a registered medical practitioner, an approved social worker or a person authorised by the supervisor. Any person who seeks access to the patient must carry some form of documentary evidence of his or her entitlement. If a patient refuses to allow access it would lead to a review of the case (see paragraph 46 above). It would be an offence under Section 129 of the 1983 Act for any other person to prevent access to the patient (see paragraph 13.7C of the Code). If the supervisor considered that forced
entry to the premises was justified because the patient was at risk, this could only be authorised by a warrant from a magistrate, which would need to be executed by the police.

2.17 Readmission To Hospital (Section 25E)

2.17.1 If at any time the team believe that the patient’s condition warrants his or her readmission to hospital under the Act they should either contact an approved social worker for this purpose or, if the patient agrees, seek an informal admission. If the patient is readmitted under Section 3 of the 1983 Act supervised discharge will be terminated. If the patient is readmitted under Section 2 or is admitted informally supervised discharge is suspended (see paragraphs 68 – 70).

2.17.2 If the team concludes that supervised discharge is no longer appropriate and the patient does not need to be readmitted to hospital the CRMO has the power to terminate the arrangements. This is explained more fully in paragraphs 65 – 67 below.

2.18 Patients Moving Within England And Wales (Section 25E)

2.18.1 If the patient wishes to move to an area of England or Wales covered by a different health and local services authority, the supervisor will need to take the lead, before the patient moves, in contacting the professionals who will be responsible for Section 117 after-care services in the new home area. There will need to be direct contact between the present CRMO and his or her counterpart in the new area. It will be for the health and local authorities in the new area to decide whether to continue the supervised discharge arrangements. If so the arrangements set out in paragraph 47 above for consulting and informing the patient and others about modifications to the care plan will apply.

2.19 Patients Moving To Or From Scotland (Section 25J)

2.19.1 A supervision application may be made for a patient who is subject to a community care order (the Scottish equivalent of supervised discharge) under the Mental Health (Scotland) Act 1984 and who wishes to move to England or Wales. In these cases the application will normally be made by the prospective CRMO in England and Wales. The details are set out in the Mental Health (Patients in the Community) (Transfers from Scotland) Regulations 1996. The applicant will be responsible for consulting members of the care team in Scotland, the person (if anyone) who will be acting as the patient’s informal carer and the nearest relative (subject to paragraph 27 above) as well as members of the care team in England and Wales. It will be essential before making the application to ensure that both the health authority and the local authority agree to provide Section 117 aftercare
for the patient. In practice the initiative is likely to be taken by the care team in Scotland and the application should if possible be supported by recommendations from the patient’s special medical officer (the equivalent in Scotland of the CRMO) and the patient’s after-care officer in Scotland. If (exceptionally) a recommendation cannot be obtained from either the special medical officer or the after-care officer it may be given by, respectively, another registered medical practitioner or an approved social worker. Once the application is accepted and the patient has moved the arrangements are as for anyone else subject to supervised discharge.

2.19.2 There are similar arrangements for patients subject to supervised discharge wishing to move from England or Wales to Scotland. In that event the special medical officer in Scotland will be required to consult the English or Welsh care team, any informal carer and the patient’s nearest relative about the proposed community care order.

2.20 Reclassification Of A patient (Section 25F)

2.20.1 The CRMO may submit a reclassification report, using Form 4S, the Health Authority (or the provider unit), stating that the patient is suffering from a mental disorder other than that shown on the supervision application, provided that he or she has ensured that at least one other person concerned with the patient’s medical treatment (unless there is none) has been consulted. Medical treatment is defined in paragraph 15.4 of the Code. The supervision application will then be treated as if the revised classification had been specified in the first place. The patient must be informed both orally and in writing and his or her nearest relative must be informed in writing (if practicable and unless the patient objects). The patient has the right to apply to a Mental Health Review Tribunal against the reclassification, as does his or her nearest relative within 28 days of the reclassification report being furnished.

2.21 Renewal Of Supervised Discharge (Section 25G)

2.21.1 Supervised discharge will apply initially for a maximum period of six months, and can thereafter be renewed for a further six months and then for periods of a year at a time.

The CRMO must examine the patient in the two months preceding the expiry date. The CRMO must also ensure that the following are consulted and their views taken into account:

- the patient;
- the supervisor;
- one or more persons professionally concerned with the patient’s medical treatment in the community;
- at least one member of the patient’s care team (preferably a representative of the local social services);
- any informal carer;
- the patient’s nearest relative (if practicable and unless the patient objects, subject to what is said in paragraph 27 above).

Consultation with the care team will normally take place as part of the regular, review process (see paragraphs 46 and 47 above) and should be integrated with existing CPA procedures.

2.21.2 If supervised discharge is to be renewed, the CRMO must submit a renewal report (using Form 5S) to the Health Authority (or provider unit) stating:

- that the patient is suffering from one of the four categories of mental disorder defined in section 1(2) of the Act; and
- that there is still a substantial risk of serious harm to the health or safety of the patient or to the safety of other people, or of the patient being seriously exploited, unless the after-care is supervised; and
- that supervision will help to ensure that the patient continues to receive the Section 117 services.

The Act requires the renewal report to be submitted to the responsible health and local authorities. However, if both the health and local authorities have delegated their functions to the provider unit or another body (see paragraph 10 above) the CRMO will need to submit the report only to that body.

2.21.3 The body receiving the report must ensure that the following people are informed:

- the patient, orally and in writing. The implications of renewal for the patient must be made clear. In particular, the right to apply to a Mental Health Review Tribunal must be explained (see paragraph 14.13C of the Code);
- any informal carer;
- the nearest relative, in writing (if practicable and unless the patient objects, subject to what is said in paragraph 27 above),

that supervised discharge has been renewed.
2.22 Appeals Against Supervised Discharge (Schedule 1)

2.22.1 A patient, and his or her nearest relative, have the right to appeal to a Mental Health Review Tribunal against the imposition or renewal of supervised discharge during each period of supervision. Legal representation for the patient is free of charge under the legal aid scheme. The patient and the nearest relative also have the right to apply to a tribunal when the patient’s mental disorder has been reclassified. As with guardianship there is no provision for appeal to the managers of the service.

2.22.2 The tribunal must terminate supervised discharge if it is satisfied that the patient does not meet the criteria defined in the Act, and has discretion to terminate it in other cases. To help it make its decision, the tribunal will be given full access to records including the detailed care plan.

2.22.3 Where a tribunal does not terminate supervision it has the power to reclassify the patient’s mental disorder if this is appropriate (see paragraph 57 above).

2.22.4 A tribunal considering an application for a patient’s discharge from hospital may also recommend that consideration should be given to making him or her subject to supervised discharge.

2.23 Ending Of Supervised Discharge (Section 25H)

2.23.1 The CRMO may at any time direct that the patient should cease to be subject to supervised discharge. Before doing so, he or she must ensure that the people who would have had to be consulted if a renewal application were being made (see paragraph 58) are consulted and must take their views into account. The CRMO should make the direction on Form 6S to the Health Authority (or provider unit). The Health Authority (or provider unit) must inform the local authority that supervised discharge has been done. A possible option may be to transfer the patient from supervised discharge to guardianship if, say, compliance with medication has been achieved but the delivery of social care still requires a degree of legal backing in the patient’s interests.

2.23.2 When a patient ceases to be subject to supervised discharge the same people must be informed as if supervision were being renewed (see paragraph 60 above).

2.23.3 The duty upon the health authority and the local social services authority to provide after-care services under Section 117 does not end simply because the supervision arrangements have been terminated. That duty continues until the two authorities are satisfied that after-care services are no longer needed.
2.24 Readmission To Hospital, Etc.

2.24.1 Supervised discharge will automatically be ended if a patient is readmitted to hospital for treatment (under Section 3 of the Act) or is received into guardianship. It also ends when a patient has been detained in prison or remanded in custody for more than six months, beginning on the date of the relevant court order.

2.24.2 When a patient is imprisoned or remanded in custody for six months or less or is detained in hospital under Section 2 of the Act, the arrangements for supervised discharge will be suspended. On the patient’s release or discharge, supervised discharge will be re-activated and continue for the remainder of the original period. If supervised discharge would have lapsed whilst the patient was detained in custody or in hospital, it will be deemed to have been extended for 28 days after his or her release or discharge. Any renewal (and associated examination) must be made during this period.

2.24.3 An emergency admission under Section 4 of the Act, or admission to a hospital as a “place of safety” under Section 136, will not end supervised discharge unless the patient is then detained under Section 3 for treatment. If a patient subject to supervised discharge is admitted to hospital on an informal basis, the arrangements for supervision are put into suspense and reactive when the patient leaves hospital.

3. Leave Of Absence

3.1 Section 3 of the 1995 Act removes the previous six-month limit on the period within which a detained patient who has been given leave of absence may be recalled under Section 17 of the Act. The effect of this, for unrestricted patients, is that the patient may be given leave for as long as he or she remains liable to detention; that is for up to six months or one year. The period during which a restricted patient may be recalled is increased from six months to a year. The purpose of these changes is to increase the flexibility available to enable those patients who are not yet ready for supervised or unsupervised discharge to start adjusting to life in the community while remaining under the care of the hospital team. As at present a patient may not be recalled to hospital for the purpose of renewing his or her liability to detention. The new provisions will apply to patients already on leave of absence on 1st April 1996 – that is the period may be extended, within the limits of the current authority for the patient’s detention, to a maximum of 12 months including any leave in the period up to 1st April.
4. **Appendix 1: Devon Partnership NHS Trust**  
   – **Section 25A Policy**

   [This document is not yet included – it is awaiting ratification]