HM Prison & Probation Service

Mental Health Casework Section

Conditionally Discharged Patients: Supervision and Reporting

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Any enquiries regarding this publication should be sent to us at: MHCS Casework Performance and Support Team Mailbox mhcscpst@justice.gov.uk

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Section 1 – Introduction

1. This Guidance has been created to assist Clinical Supervisors and Social Supervisors working out of various teams (Mental Health, Specialist Forensic, Learning Disability, Autism and Adult Social Care Teams) in completing the conditional discharge reports for restricted patients allocated to their team, these reports can be found at Submit a conditional discharge report or request a change of discharge conditions - GOV.UK (www.gov.uk)[1]. The effective completion of conditional discharge reports (CDRs) are an essential tool for the Secretary of State, and the Mental Health Casework Section (MHCS) acting on their behalf, to ensure that the need to protect the public is given due weight following a patient's conditional discharge from hospital.

2. This document should be read in conjunction with following documents: 'Mentally Disordered Offenders – The restricted patient system' which is available on the following link; MHCS_The_Restricted_Patient_System_v1_Dec_2017.doc (live.com)[2] and Submit a discharge request for restricted patients - GOV.UK (www.gov.uk)[3]. This guidance replaces the 2019 Guidance for Social Supervisors and 2009 Guidance for Clinical Supervisors.

3. The Mental Health Casework Section (MHCS) expects all professionals working with restricted patients in the community to adopt a high level of professional curiosity. This should be maintained throughout the period of discharge, regardless of its duration. Supervising teams must use the full range of their knowledge, abilities and opportunities to engage with patients in the community, actively reviewing their compliance with conditions of discharge and not become complacent that because a patient has been discharged for some time, and appears settled, that their risk has dissipated.

4. Restricted patients discharged into the community are considered to have recovered from their mental disorder to the extent that treatment in hospital is no longer required. However, supervisors (clinical and social) should continue to be mindful that the Court has passed an order that includes restrictions (without limit of time) due to the potential risk of serious harm (to themselves or the public) that individual presents.

[1] https://www.gov.uk/government/publications/conditionally-discharged-restricted-patient-report

[2] https://www.gov.uk/government/publications/mentally-disordered-offenders-the-restricted-patient-system

[3] https://www.gov.uk/government/publications/submit-a-conditional-discharge-request-for-restricted-patients

Section 2 – Restricted Patients

5. Restricted patients are those who are subject to the special restrictions set out in section 41 of the Mental Health Act 1983 (the 1983 Act) After being discharged from hospital. Only restricted patients can be conditionally discharged.

6. Under section 37 of the 1983 Act, the Court may, where a convicted[4] offender (not including those who have committed offences for which the sentence is fixed by law) is reported to be suffering from mental disorder for purposes of the 1983 Act, by order authorise their admission to, and detention in, a hospital for psychiatric treatment. When such an order, known as a hospital order, is made by the Crown Court or the Court of Appeal, and the Court concludes that it is necessary to protect the public from serious harm, it may make a further order known as a restriction order under section 41 of the 1983 Act. The principal effect of a restriction order is that the patient may not be allowed leave from the hospital or be transferred to another hospital without the authority of the Secretary of State and may not be discharged from hospital except by the Secretary of State or the Tribunal. MHCS has the delegated authority to act on behalf of the Secretary of State in respect to those patients who are subject to restriction orders.

Discharge and Recall

7. Under section 42(2) of the 1983 Act, the Secretary of State may by warrant, discharge a patient subject to conditions at any time while a restriction order is in force. This is known as a conditional discharge. Further guidance on Secretary of State discharges can be found here: Submit a discharge request for restricted patients - GOV.UK (www.gov.uk)[5]

8. Under section 73 of the Act, where an application to the First-tier Tribunal (Mental Health) or the Mental Health Review Tribunal for Wales (collectively referenced in this guidance as the 'Tribunal') has been made by a patient or their case referred by the Secretary of State, the Tribunal shall discharge a restricted patient absolutely or conditionally if it is not satisfied that the criteria for detention set out in the 1983 Act[6] are met.

9. Where the Tribunal has directed the conditional discharge of a patient, the Secretary of State or the Tribunal may add to or vary any conditions imposed under section 73(4) at any time after discharge, and the Secretary of State retains the power to vary any condition imposed either by them or by the Tribunal (section 73(5)).

10. Under section 75(3), the Tribunal may, on application by a patient conditionally discharged by either the Tribunal or the Secretary of State, vary any condition on discharge, impose fresh conditions or direct an absolute discharge. Section 73(5) additionally provides the Secretary of State with the facility to vary conditions of discharge at any time after discharge.

11. The Secretary of State may by warrant recall a conditionally discharged patient to hospital under section 42(3) of the Act, regardless of whether it was the Secretary of State or the Tribunal who directed conditional discharge. Following recall, a patient once

[4] 37/41s can also be handed down to those under disability and unfit to plead or not guilty by reasons of insanity where they have been found to have done the act or omission as set out at https://www.legislation.gov.uk/ukpga/1964/84/section/5
[5] https://www.gov.uk/government/publications/submit-a-conditional-discharge-request-for-restricted-patients
[6] https://www.legislation.gov.uk/ukpga/1983/20/section/73

again becomes subject to detention with restrictions. The Tribunal has no power to direct the recall of a conditionally discharged patient. Further guidance on recall can be found here: The recall of conditionally discharged restricted patients[7]

12. Those working with conditionally discharge patients should not hesitate to contact MHCS if they are concerned that recall may be required. Supervisors should not wait until the next conditional discharge report is due in order to raise such concerns. Contact can be made on: MHCSmailbox@justice.gov.uk or **07812 760 248**

The purpose of conditional discharge

13. Where the Tribunal or the Secretary of State is considering the conditional discharge of a restricted patient the clear expectation is that there will be appropriate after care arrangements in place at the point of discharge. This after-care will include provision for appropriate accommodation, healthcare, social care, where necessary employment services and other services, to ensure a smooth transition into a permanent community setting. The multi-disciplinary team must arrange meetings between themselves, the patient and the proposed community social and clinical supervisor to build the relationships which will be essential for successfully underpinning any conditional discharge.

14. MHCS are of the view that prior to discharge at least one case conference should be held between the hospital multi-disciplinary team and the proposed clinical and social supervisors. The hospital multi-disciplinary team must assist the proposed social supervisor visiting the patient at the detaining hospital to help build the pre-discharge links with the supervisor who will have the closest contact with the patient in the community. MHCS consider that the responsibility to provide social supervision is a pre-requisite under section 117 of the 1983 Act and the failure to provide either clinical or social supervision will be escalated, by MHCS, to the Chief Executives of the respective Responsible Authorities.

15. Annex A of this guidance sets out a check list for the community supervisors to follow when preparing a restricted patient for conditional discharge.

16. Conditions imposed at the point a restricted patient is discharged are designed for the protection of the discharged patient and the public and to enable the patient's safe management in the community. They are not measures for social control to manage anti-social behaviour. Breaches of conditions do not, in themselves, justify recall to hospital, but it should act as a trigger for considering what action is necessary in response.

17. The Secretary of State will consider recalling a patient under section 42(3) of the Act where there has 'been such a material change of circumstances since the Tribunal's previous decision that he could reasonably form the view that the detention criteria were now satisfied. *R. (on the application of Munday) v Secretary of State for the Home Department [2009] EWHC 3638 (Admin)*. The Secretary of State will direct the recall of a restricted patient to manage an imminent risk of serious harm to the public or themselves. In these cases, the decision may be made to recall the patient without medical evidence of a change in the patient's mental state and even where the social and clinical supervisors do not support recall. The warrant recalling the patient under

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/614569/recall-of-conditionally-discharged-restricted-patients.pdf

section 42(3) will set out the circumstances of the recall and whether this is for treatment or an urgent assessment in hospital.

18. The purpose of the formal supervision resulting from conditional discharge is to protect the public from further serious harm. There are two aspects to this. The first is by assisting the patient's successful reintegration into the community after what may have been a long period of detention in hospital. Secondly for the Secretary of State to exercise their statutory powers to protect the public they are dependent on the discharge reports submitted by the social and clinical supervisors about the patient's condition and behaviour in the community. Close and effective monitoring of the patient's mental state and any perceived changes in the risk the patient poses to the public or themselves, provides for timely steps to be taken to manage those risks.

19. Conditional discharges do not have a defined life span and can remain in place for the rest of a patient's life. Nevertheless, provided the patient has not been recalled; the patient, the patient's legal representatives or the community supervisors can apply either to the Tribunal between 12 months and two years from the date of the conditional discharge, and every two years after that (section 75(2) of the 1983 Act) or the Secretary of State for consideration of granting an absolute discharge. The effect of an absolute discharge is to extinguish the restriction element of the original detention order; no formal conditions would remain, the patient cannot be recalled to hospital by the Secretary of State and there are no further requirements for statutory reporting.

20. It will be the case that both the Tribunal and the Secretary of State will wish to see evidence of how the patient has managed outside a hospital, potentially for the first time in many years, without concerns being raised in relation to their compliance with treatment, supervision and their risk to the public or themselves.

21. Details of what the Secretary of State will consider for any absolute discharge request can be found in both the guidance and application form which is obtained on the following link: Submit a discharge request for restricted patients [8]

22. The effect of an absolute discharge is that the patient will not have to declare their convictions in the future as they will be 'spent' under the Rehabilitation of Offenders Act 1974, as set out in the guidance on the following link: Guidance on the Rehabilitation of Offenders Act 1974 and the Exceptions Order 1975

23. However, a permanent record of the patient's previous offending will remain on the Police National Computer and therefore maybe subject to disclosure, under circumstances set out in Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended), which can be found on the following link: The Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (legislation.gov.uk)[9]

[8] https://www.gov.uk/government/publications/submit-a-conditional-discharge-request-for-restricted-patients
[9] https://www.legislation.gov.uk/uksi/1975/1023/contents/made

Section 3 – Completing the Conditional Discharge Report (CDR)

24. MHCS expects that CDRs should be submitted one month after discharge and then on a quarterly basis thereafter. If a patient has been discharged for a number of years and the CDRs have consistently been positive as the patient has clearly demonstrated in their adherence to conditions and progression in the community, then a request for a reduction in reporting frequency can be applied for through the change of conditions application form.

25. MHCS will send reminders if CDRs are outstanding or late. Nevertheless, the onus is on the social and clinical supervisors to adhere to the schedule of reporting established at the point of discharge. However, if two reports are missed and there is no clear indication of when the next complete report will be received, MHCS will seek to escalate the matter to the Chief Executive Officer of the responsible authority.

26. The social and clinical supervisors should be mindful of the potential need to disclose the reports to the patient or their legal representative under a subject access request under the Data Protection Act 2018 at any point in the future (although any request will be assessed at the time of receipt, and disclosure may be subject to exemptions). This should not prevent the supervisors from providing full and frank information to MHCS to ensure that the Secretary of State's public protection function is maintained.

Completing Part A:

27. Part A of the report must be completed in full. One must not assume that this section has remained static and it should be carefully checked to ensure it reflects the most up to date position for the patient in respect to conditions, MAPPA levels, names and other important information contained herein. This section does provide MHCS, the supervisors and other agencies with a clear summary of the patient's position, their offences, conditions, victim involvement, MAPPA level, any additional orders which apply to the patient and the involvement of other agencies or bodies in the patient's case.

Conditions

28. It Is best practice to ensure that the conditions are set out in full on the CDR form even where they have remained substantively unchanged for a considerable period of time. It is important that both MHCS and the social and clinical supervisors are aware of the conditions of discharge. This also ensures that if the community team are recording them incorrectly that MHCS can provide the correct conditions in full.

Deprivation of Liberty Safeguarding Orders

29. Where a Deprivation of Liberty Safeguarding Authorisation (DoLS) exists this should be recorded in Part A. Where a patient is subject to restrictive measures in the community, such as to be supervised at all times then it is important that the expiry date of the DoLS is properly recorded on the CDR. If the DoLS has expired then the implication will be that the Secretary of State will seek the recall of the patient to hospital due to the risks the patient may pose to themselves or others if they were not subject to the restrictive measures imposed by the DoLS authorisation. Please refer to Section 8 of this guidance for further actions where the DoLS has lapsed and will not or cannot be renewed and restrictive measures are still required to keep the patient and the public safe.

Index offences

30. The proper recording of the index offence provides a clear reminder on the gravity of the offence both to MHCS, supervisors and other agencies. The type of the offence should be correctly recorded with an accurate summary of the circumstances. If supervisors do not have the details of the offence these can be obtained from MHCS at MHCSMailbox@justice.gov.uk

Further offending on discharge

31. Information concerning any arrests, investigation by the police, further convictions or sentences following the patient's discharge should be set out here. This information assists MHCS in making determinations on whether further offending, in light of the patient's previous history or reports, should trigger recall

32. If a patient has been remanded or imprisoned for a further offence when subject to a conditional discharge, this does not necessarily mean they will be recalled. Depending on the circumstances of the offence or the length of sentence MHCS may change the conditions of discharge to reflect that the patient is now in prison. At the point the patient is being considered for release or their automatic release date is imminent then community supervisors will be required to assess the patient and determine if the conditional discharge should continue, or the patient should be recalled for further treatment.

33. MHCS understands that discharged patients in prison custody will generally have their treatment overseen by the prison Mental Health Team, rather than the Community Team. In such cases, it is not necessary for discharge reports to be completed by the Community Team when a discharged patient is in custody for a prolonged period of time. However, whilst the conditional discharge remains in place the supervisors are still responsible for the continued operation of that discharge, and they must ensure that contact with prison Mental Health Teams is maintained and provide updates to MHCS and eventually an assessment when the patient is nearing their release or at the conclusion of any criminal trial.

34. The pre-release assessment should provide MHCS with advice on whether a recall to hospital is necessary or that the conditional discharge can continue. The assessment should also recommend the continuation of previous conditions or the imposition of new conditions, taking into consideration the background and nature of the recent offending, the past risk and the long-term treatment needs of the patient.

Victim Liaison Officers / victim issues

35. HM Prison and Probation Service operate the Victim Contact Scheme (VCS) which provides support and information to victims of crime. VCS arises from sections 35-45 of the Domestic Violence, Crime and Victims Act (DVCVA) 2004. Since April 2001, victims of a specified sexual or violent offence, where the sentence is 12 months or more imprisonment, have a statutory right to be offered contact by the Probation Service. This includes victims of offenders made subject to a restricted hospital order for a specified

offence. More information on VCS can be found on the link below: Information about the Victim Contact Scheme[10]

36. The Code of Practice for Victims of Crime in England and Wales (Victim's Code)[11] sets out the statutory boundaries of the VCS, and the victims who **statutorily** qualify for the VCS. These are;

    - victims of offenders who have been made subject to a hospital order with restrictions for a specified sexual, violent or terrorism offence, under the Mental Health Act (MHA) 1983 (restricted patients)[12];
    - the next of kin or close family member(s) of a victim, who died as a result of the restricted patient's offence; and
    - the parent, guardian or carer of a child or vulnerable adult who was a victim as specified in one of the above categories (unless this is not considered to be in the victim's best interests). Once the child turns 18, contact must either be provided to them directly or their consent obtained to continue providing information to the parent/guardian or carer on their behalf.

    VCS has now been extended to cover victims of offences which pre-date the creation of the scheme.

37. Where there are victims of the patient's index offence there may be conditions which exclude a person from an area or prohibit contact with the victim, in which case a Victim Liaison Officer (VLO) will ordinarily be assigned the case. If a case has active victim involvement it is expected that the social and clinical supervisors are engaged with the VLO. These VLO contact details must be obtained from MHCS at MHCSMailbox@justice.gov.uk if the social and clinical supervisors do not have that information.

38. Circumstances may arise that conditions relating to victim contact or non-contact may be sought when they have not previously been imposed. MHCS will act with due caution in the event of such requests to ensure the location of the victims does not become obvious through the introduction of new exclusion zones and that such conditions are proportionate as defined in the case law: *Craven, R (on the application of) v Parole Board [2001] EWHC Admin 850 (5th October, 2001).*

MAPPA Status

39. The MAPPA statutory guidance requires[13] mental health services to identify all MAPPA offenders within 3 days of sentence, admission or transfer and once a patient has been identified as such, a formal notification to the relevant MAPPA coordinator for the local area of the patient's home address should be made. It will be the case that, by virtue of the index offence or the nature of the hospital direction, most restricted patients will be a MAPPA eligible offender. Therefore, MHCS must be advised of the MAPPA level, and

[10] https://www.gov.uk/government/publications/get-support-as-a-victim-of-crime/information-about-the-victim-contact-scheme

[11] https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime/code-of-practice-for-victims-of-crime-in-england-and-wales-victims-code

[12] Specified offences are listed in Schedule 18 of the Sentencing Act 2020 as found here: https://www.legislation.gov.uk/ukpga/2020/17/schedule/18

[13] MAPPA_Guidance_May_22__002_.docx (live.com)

where appropriate, referred to contacts where the patient is assessed as a MAPPA level 2/3 case. For MAPPA level 2/3 patients MHCS will expect the clinical and social supervisor to provide updates to MHCS from the MAPPA meetings to ensure that they are abreast with any areas of concern or emerging risks and what actions should follow.

40. Where the offence and detention have pre-dated the creation of MAPPA, a notification should be made . More information on the interaction between the restricted patient system and MAPPA can be found at the following link: multi-agency-public-protection-arrangements-mappa-and-the-restricted-patient-system

41. Supervisors must also be aware of the Terrorist Risk Offenders: Independent Review of Statutory Multi-Agency Public Protection Arrangements carried out by Jonathon Hall KC in the wake of terrorist attacks by ex-offenders. The review highlighted the need to ensure that restricted patients were not missed as a cohort of offenders who could exhibit an extremist risk. Following the review a 4th category of offender will now exist which is specific to managing those offenders who may pose an extremist or terrorist risk[14]. The full review of MAPPA can be found at the following link; Multi-agency public protection arrangements (MAPPA): Guidance [15]

Information about other Civil or Criminal Orders

42. MHCS must be informed of the full range of criminal or civil orders that have either been imposed at the point of the order or direction to hospital or have been subsequently imposed due to further offending or a change in the patient's risk profile. Such information additionally informs MHCS where other authorities / agencies are involved in a case when responsible Mental Health Trust are the lead agency for a MAPPA Level 1 case. The contravention of such orders may not result in a recall of a patient to hospital but they will form part of any such consideration, if the patient is posing a risk to others or themselves. The Secretary of State expects that any contravention of orders that amount to a criminal offence should be pursued through the criminal justice system.

[14] Further information is set out in the May 2022 MAPPA Guidance, page 35 ; MAPPA_Guidance_May_22__002_.docx (live.com)

[15] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

Section 4: Completing Part B - The Social Supervisor's Report

Changes since the last CDR

43. This section does not have to include extensive detail but should provide headline changes, such as; a proposed accommodation move has taken place, the patient has been arrested or anything significant since the last report, including positive changes. This will enable MHCS to focus on what that potentially means for the patient and, where appropriate, escalate this to a senior official at the earliest opportunity.

Supervision

44. All reports should detail the frequency of contact the social supervisor has had with the patient and set out provisional plans for contact over the succeeding reporting period.

45. For the Secretary of State, and MHCS on their behalf, to fulfil their public protection function they will rely on accurate reports, experience and the properly informed views of the clinical and social supervisors when considering any actions to manage risk, such as changing conditions of discharge or a recall to hospital. Social supervisors will therefore need to be in frequent and close contact with the patient to assure themselves and MHCS that any concerns or changes of situation are not leading to an increase in risk.

46. MHCS strongly recommends that following discharge the patient should be seen at least once a week for the first month. If appropriate this may be moved to once a fortnight for the next six months and then final consideration can be given to reducing this to contact on a monthly basis. Any reduction in the frequency of contact must be reported to MHCS and should be dictated by the individual circumstances of the patient and not simply by virtue of the passing of time. An independent investigation into the care and treatment provided to 'Mr. Y'[16], a conditionally discharged restricted patient who went onto commit a homicide, highlighted the lack of frequent, close and effective supervision as a contributory factor to the patient's risks increasing to a catastrophic level of offending.

47. Some patients will require very close monitoring throughout the course of their conditional discharge because of their risk or the complexity of their case. In addition, the frequency of contact may change depending on the individual circumstances. A traumatic event in the patient's life or a change in accommodation would potentially be examples where consideration should be given for closer and more frequent contact.

48. The primary contact with the patient should be face to face. Ideally this contact would take place at the patient's accommodation if this is safe and appropriate. If it is determined that it is more appropriate to meet the patient at a clinic or at the Local Authority's office, then this is also acceptable. Nevertheless, the Secretary of State will expect there to be some face-to-face contact with the patient at their place of residence as this can, at times, be a key indicator of the patient's stability and compliance with conditions, particularly those around intimate relationships and drugs use.

49. Where a patient has left the country for more than a short holiday, the Secretary of State does not consider effective supervision possible and consideration will be given to

[16] https://www.england.nhs.uk/wp-content/uploads/2014/12/mr-y-sha-lg-rep.pdf

recalling the patient for an urgent assessment at the point of their return to the United Kingdom. It would not be acceptable for telephone contact or supervision to be continued on the basis that the patient is in the community whilst they remain outside the jurisdiction of the 1983 Act. Where foreign travel is agreed by the supervising team essential steps and contingency plans should be put in place including an assessment arranged on return.

50. Social supervisors must also consider the possibility of disguised compliance from the patient and their support networks. Disguised compliance will manifest itself with the outward appearance that the patient is cooperating with supervision and complying with conditions of discharge so not to generate any concerns. It is therefore essential that social supervisors satisfy themselves that there is sufficient evidence available to corroborate that the patient's risk profile has not changed over the course of their discharge.

Accommodation

51. The suitability of the patient's accommodation is one of the key facets for a safe and prolonged discharge. It is rare that at the point of discharge a patient will not have spent some time at the proposed placement and MHCS will expect that a view will be taken as to whether the accommodation remains suitable over the course of the discharge. In some cases, the level of support provided by the accommodation may help to mitigate against non-compliance with treatment or help provide structure to the patient's day. Independent accommodation for a patient who has successfully integrated into the community will be understandable but not inevitable.

52. It is important for MHCS to know who the patient is residing with when on discharge and whether this may be a stressor for the patient. This will also be relevant when considering the patient's index offences or previous risks. Especially, where there is no formal support to act as mediators or to assist the patient at times of stress.

53. If the patient is sharing a private residence then consideration should be given to disclosing the nature of the patient's previous offending with other residents. However, the purpose for that disclosure should be recorded. More information on when it is appropriate to disclose information about the patient to third parties is set out in Chapter 10 of the MAPPA Guidance: Multi-agency public protection arrangements (MAPPA): Guidance [17]

54. If a patient is planning to move accommodation then MHCS should be informed as soon as possible through the following application Submit a conditional discharge report or request a change of discharge conditions - GOV.UK (www.gov.uk)[18]. It is expected that the accommodation should be in the area where the community supervisors are based. If the patient moves out of area then formal arrangements for the transfer of supervision should be made. If the transfer of supervision is not possible then MHCS should be advised as soon as possible.

55. Restricted patients are not excluded from taking holidays in the UK or remaining away from their accommodation for short periods of time to have a holiday, but it .is important

[17] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance
[18] https://www.gov.uk/government/publications/conditionally-discharged-restricted-patient-report

that patients comply with any residence conditions imposed. MHCS must be informed of any period amounting to more than one full calendar week away from the place of residence with reasons clearly explained.

Supervision outside of England and Wales

56. Patients cannot move accommodation to Northern Ireland, Scotland, the Isle of Man or the Channel Islands without the formal permission and the agreement to the transfer of supervision from the Secretary of State and the devolved administrations or Governments as set out in Part VI of the Act[19]. Failure to obtain agreement, in advance of any move, regarding the transfer of supervision and the consequent inability to continue effective supervision will make the patient liable for recall.

57. As referenced in paragraph 49 those patients who leave the UK with no indication that they are likely to return or it is unclear when they will return, will be liable for a recall for urgent assessment. The patient will remain the responsibility of the current supervising team and must not be discharged from that team.

58. Where a patient intends to leave the UK for a holiday then MHCS must be informed. Social and Clinical supervisors will also need to aware if the patient is subject to any notification orders which restrict foreign travel or where travel should be reported to other agencies, such as the police. Travel outside of the UK must not inhibit or prevent effective supervision of the patient, consequently, periods of time amounting to more than four weeks outside the UK will, in the main, be opposed by MHCS.

59. Where foreign travel does go ahead, it is important the patient has insurance cover if they become unwell. In addition, patients may need to disclose any previous offences for 'entry clearance purposes' to another country. Failure to be truthful about their past or seeking to evade or break immigration regulations or rules of another State can lead to the patient being detained in a foreign jurisdiction for an indefinite period of time prior to their removal/deportation from that jurisdiction.

60. For any patient travelling outside of the UK MHCS recommends that the clinical supervisor provides a letter to accompany the patient explaining their health background and setting out any treatment they are receiving in the UK. This will help the patient receive appropriate treatment if they become unwell when outside of the UK.

Relationships

61. The close relationships the patient has with partners, friends or family can be an integral part of a successful and prolonged discharge. Positive social networks can be instrumental in a patient successfully reintegrating into the community and remaining committed to treatment.

62. In contrast to the advantages of positive relationships, a patient may have negative relationships with people who are a maligned influence on them due to drug use, domestic violence, criminality or a lack of understanding around the patient's mental disorder or risk, (this list is not exhaustive). Negative relationships are not always immediately obvious, supervisors should be aware of the potential for families not to disclose concerns about a patient out of a mis-guided attempt to support the patient. As with all situations, professional curiosity must be applied, and all evidence should be

[19] https://www.legislation.gov.uk/ukpga/1983/20/part/VI

triangulated.

63. The social and clinical supervisors must become familiar with the patients support networks. Supervisors should be mindful of who is closest to the patient and where they can assist in highlighting changes to a patient's presentation or risks. Friends and family members can be crucial in highlighting concerns at an early point.

Domestic Abuse

64. The legislative definition of domestic abuse is set out in section 1 of the Domestic Abuse Act 2021[20]

65. Where patients have a history of perpetrating domestic abuse supervisors must maintain an investigative approach when conducting supervision and verify, as far as is possible, the information given, and not rely solely or predominantly on self-reporting. This is particularly relevant where the patient has a specific condition in relation to reporting relationships.

66. Verification of information from the patient may include:

- unannounced visits to the patient's accommodation;
- Investigating all available sources of information;
- taking into account prior known incidents of domestic abuse (e.g. police domestic abuse information)
- identifying changes to dynamic risk factors and acting upon changes to risk;
- liaison with people and organisations with an interest in the individual and/or the victim and any children, to gather and share information to aid our risk assessment; monitor the individual's relationships and any changes in behaviour or changes in circumstances that might indicate either an increase or a reduction in risk. Support staff at the patient's accommodation also have an important role to play in the assessment and monitoring domestic abuse perpetrators, they will often be in a position to identify changes in risk, given their increased contact with the people in their premises.

67. The above list is not exhaustive and supervisors must also be alert to the potential for patients to be both a victim as well as a perpetrator of domestic abuse irrespective of any previous behaviours. Supervisors should be familiar with the 'Domestic Abuse: Statutory Guidance' published in July 2022 when supervising patients with history of domestic abuse or who may be vulnerable to becoming the victims of domestic abuse. Domestic Abuse: statutory guidance (accessible version) - GOV.UK (www.gov.uk)[i21]

68. Where the patient has a history of perpetrating domestic abuse, and particularly where there are related conditions of discharge, MHCS must be informed immediately of any breach of condition, and consideration should be given to convening professionals meeting under the MAPPA framework along with other risk management responses such

[20] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

[21] https://www.gov.uk/government/publications/domestic-abuse-act-2021/domestic-abuse-statutory-guidance-accessible-version

as increasing the levels of supervision and frequency of appointments. The impact of prior behaviours of coercion and control should not be underestimated, and mental illness recovery should not automatically equate to an assumption the patient poses no risk of domestic abuse.

69. The social and clinical supervisors should take particular note of the resources available through the use of Multi Agency Risk Assessment Conferences (MARAC) to protect victims or potential victims of domestic abuse within the Domestic Abuse statutory guidance. It is also important that where a patient has posed a risk to partners, children or other potentially vulnerable persons that consideration is given to disclosing the patient's previous offending. Chapter 10 of the MAPPA guidance provides clear guidance on when disclosure is appropriate; Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK (www.gov.uk)

Behaviours and Risk

70. Supervisors will be best placed to advised MHCS on any potential changes in behaviour or risk profile. These do not have to amount to overt signs of aggression or drug use or disengagement but can also include more subtle changes such as being less responsive to supervision, presenting with an abnormally low mood or reported lack of engagement with friends or family. It is important that these changes are reported to enable MHCS to build a picture of the patient from report to report. This may not mean the patient suddenly becomes eligible to be recalled but it will help highlight any patterns or trends and make it more obvious for MHCS where there may be genuine concerns arising.

71. For completeness MHCS will need to understand what have been the primary risks and/or behaviours of concern in the past and what has been done to manage these. It may be that the patient's risks of reoffending are based on their substance misuse or non-compliance with medication or accommodation issues. Therefore, the supervisors will need to set out what the concerns have been to enable MHCS to consider whether any further action is appropriate.

72. All risks and behaviours need to be set out in context of the patient's diagnosis, offending history and other relevant factors. This may include highlighting differences of professional opinion in the case – these can be reported to MHCS. MHCS are not clinically trained, and their assessment of any report will be based upon the evidence being reported and the implications explained. For example, a small shift or change, leading to increased anxiety, for a patient with a learning disability or autism may be indicative of something to be concerned about in a way that it would not be for another patient whose mental stability and risk management is heavily reliant upon their on-going medication compliance.

Risk of Extremism or Radicalisation

73. In 2020 MHCS introduced a system of flags to identify those patients who have an extremist or terrorist footprint. It also ensures that those who have been convicted of terrorism related offences are overseen by a senior manager in MHCS. The flags do not necessarily mean that the patient will be subject to additional restrictions following discharge, but they do mean MHCS can call on the resources of other Agencies to manage any emerging risks, such as Counter-Terrorism Police or Probation colleagues.

74. As set out in paragraph 41, restricted patients who appear to be engaging with groups with extreme religious, political, racial, sexual and gender centric views should be highlighted outside of the reporting schedule by supervisors. It should be made clear

whether referral to PREVENT or MAPPA have been considered or what else is being undertaken to manage those risks, such as the involvement of Counter-Terrorism Police.

75. Where a patient has been exploited or seen as vulnerable to radicalisation then particular consideration should be given to their associations or changes in their beliefs, through conversations, changes to their routine, attire or demeanour. The risk of harm in respect to the cohort of extremist offenders is not always obvious or overt and may manifest in more subtle changes and social and clinical supervisors should be alert to these changes.

Substance misuse Risk

76. This section is divided into two parts; the risks that may emerge as someone engages with substance misuse versus those who are already regular drug or alcohol users. MHCS expects where the conditions of discharge require abstinence from substances then this condition is monitored by regular testing and the contravention of the conditions should be reported and supervisors provide a view on whether the risk is likely to escalate, or a relapse is either in train or pending.

77. Notwithstanding the concerns around substance misuse the Secretary of State is cognisant of a small cohort of patients who were, and remain, regular substance misusers. In such cases MHCS request that the position of the patient in relation to substance misuse is still reported with an indication of how the risk is managed if there was an escalation of substance misuse or the patient was engaging in criminality to finance their habit.

Past and Potential Victims

78. It is the expectation of MHCS that supervisors must be aware of the patient's index offences, behaviours of concern, their previous level of offending and identity of the victims of those offences. Supervisors should consider the likelihood of the risk reoccurring due to the presence of persons or groups who the patient has historically harmed. The obvious examples may be the risk the patient poses towards children or vulnerable men or women where their offences are either grooming in their nature or violent and sexually driven or a history of coercion and control. However, this may also be based on race, gender, sexuality or where the patient has included associates in a delusional framework. If the patient is displaying paranoia or a degree of malevolence towards others, even in passing, then this information should be reported, whether or not it is a longstanding issue.

79. If Conditions of discharge which are victim related, such as not contacting the victim or adhering to exclusion zones then these must be monitored through the use of professional curiosity and reported to MHCS in case of any breaches. MHCS will alert the VLO to these breaches.

80. Where the patient is excluded from a specified area and can only enter with the permission of the social supervisor or responsible clinician then the request for entry should be reported to MHCS and the Victim Liaison Officer (VLO). It is crucial that the VLO is involved in this process, and it must not be assumed that this is simply the role of the MHCS to maintain that contact. In the case of requests for permanent changes to the conditions then these should be formally applied for Submit a conditional discharge report or request a change of discharge conditions - GOV.UK (www.gov.uk).

81. MHCS must be notified whenever a patient enters an exclusion zone, even when the conditions does not specify the necessity to inform this Department. MHCS can either be

contacted by the section contact numbers on the CDR or emailed at MHCSMailbox@justice.gov.uk

82. For those patients who have committed sexual offences they will be subject to statutory notification requirements under the Sexual Offences Act 2003 and in some cases Sexual Harm Prevention[22] Orders (previously known as Sexual Offences Prevention Orders)[1]. These orders may have been imposed by a court at the point of the original conviction or disposal and they can also be applied for at a later date. MHCS expects that supervisors are aware of any notification requirements and further public protection orders when supervising the patient. Whilst the contents of those offence related orders may not specifically be part of any conditions of discharge and breaches of such orders are a criminal justice matter, MHCS must also be advised of the patient's adherence to any court authorised orders, such as restraining orders.

Financial Risk

83. The ability of a patient to appropriately budget and manage their finances remains a part of a successful discharge. The stress of debts and formal or informal recovery of debts may be a destabilising factor for the patient and should be reported. It is also important for MHCS to understand whether the patient is financially independent or reliant on family and friends to supplement their income. If they are reliant on others then MHCS will need to understand the implications if this financial support is withdrawn or stops.

84. Patients who have been detained in hospital for a number of years can accrue considerable savings as they will not have the financial responsibility as others in the community and this should be factored into discharge planning. Access to large amounts of money can also make them vulnerable to exploitation from others, inclusive of close relatives. The social and clinical supervisor must to familiarise themselves with the patient's financial situation on discharge to ensure this potential area of stress or risk is managed.

85. At the point of discharge patients will be required to effectively manage their income and savings to ensure their financial commitments are met on a day to day basis. This can be stressful and missed payments or bills can easily escalate to threats of legal action or debt collection. Where a patient is financially independent but does accrue debts then MHCS will need to know what is being done to help the patient manage these potential problems, be that through additional support from the community team or referrals to debt counsellors/charities. The views of the supervisor as to the potential effects of any money issues are crucial in order for MHCS to determine whether this changes the risk profile of the patient.

Activities and Employment

86. Community integration and social support networks can be protective and MHCS wish to know what activities the patient undertakes when on discharge inclusive of any employment. If the patient does not undertake any activities then MHCS will need to know, as far as possible, how the patient occupies their time as changes in routine can be a pre-cursor to relapse or a change in risk profile.

87. Employment, either paid or voluntary, is generally a protective factor for a successful discharge and should be encouraged. Nevertheless, supervisors must make the patient

[22] https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021-factsheets/police-crime-sentencing-and-courts-bill-2021-sex-offender-management-factsheet

aware of the need to disclose details of their offending to any employer (voluntary work or paid employment). If it is not clear whether or not the patient has disclosed this information then the community team should consider a full disclosure in line with Chapter 10 of the MAPPA Guidance[23]

Further Comments

88. This section is an opportunity to capture any other information which may not be covered by the report but is relevant for the continued supervision of the patient in the community. Supervisors may also wish to use this section to reflect positive changes and the patient's achievements. Whilst for MHCS the over-riding concern is protecting the public, supervisors have a holistic role and will want to celebrate the patient's progress as well as monitoring and responding appropriately to concerns along the patient journey.

Line Manager Comments

89. This section is for the social supervisor's line manager to confirm that they have reviewed the report prior to its submission and that they are content with the contents of the report. MHCS will expect that reports are submitted to the Secretary of State are subject to the appropriate quality assurance procedures of the responsible authority.

[23] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

Section 5 - Completing Part C: The Clinical Supervisor's Report

90. This section does not have to include extensive detail but should provide headline changes in the patient's mental state or compliance with treatment which, in tandem with the social supervisor's report, will enable MHCS to focus on what that potentially means for the patient and where appropriate escalate this to a senior official at the earliest opportunity. If there are any grave concerns, contact should be made by phone in the first instance and not left to the reporting schedule.

Diagnosis

91. Please set out here the primary diagnosis and any co-morbid disorders. It would be helpful to also highlight any changes in diagnosis and how these have come about. MHCS will want to be made aware of those patients whose cognition may be deteriorating through age or other factors.

92. MHCS will need to understand whether the mental state of the patient is more or less likely to be behind any potential increase in risk. It will also assist in informing MHCS of the significance of the patient disengaging with supervision or treatment.

Treatment

93. For many conditionally discharged patients the continuation of medication is crucial to avoid a relapse and the attendant possibility of a reversion to potentially dangerous behaviour. It is important, therefore, that the clinical supervisor is fully informed, before discharge, of the patient's medical history including details of current medication and what is known of its effects, side-effects and the effect on the patient's condition and behaviour if medication is stopped. The supervision of medication after a patient's discharge is the responsibility of the clinical supervisor but the social supervisor, the patient's general practitioner and, where appropriate, the community psychiatric nurse and community placement staff will also need to have basic information about medication.

94. Medication should be one of the subjects covered in periodic discussions about a patient between the supervisors. Immediately after discharge and again when any change or cessation of medication has been made, the clinical supervisor must inform other members of the multi-disciplinary team and MHCS of the arrangements made, including when, where and by whom medication is to be given. Unless this information is clearly understood by all concerned, there is a danger of confusion which can prompt a relapse of a patient's mental disorder and an increase in the risk they will pose to the public.

95. Identify any other interventions that the patient is undertaking in the community and whether these have recently been undertaken or are long running. The clinical supervisor should set out why the interventions are necessary. These can include attendance at Alcoholics Anonymous or Narcotics Anonymous as well as more formal therapies arranged by the community team.

96. MHCS do not need to have sight of a care plan but a summary of the plan including any agreed position with regard to recall would be of assistance to enable us to take into account any changes to that plan when reviewing the reports. Where a care plan has restrictive measures imposed, these should be highlighted to MHCS, especially where the patient has capacity and there is no deprivation of liberty authorisation. If the patient

has a care plan that has restrictive measures, please refer to :Discharge conditions that amount to a deprivation of liberty[24]

Physical Health

97. MHCS will need to be aware of any changes or developments in respects to the patient's physical health. However, it is not necessary to report any minor ailment but rather those conditions which may affect the patient's compliance with treatment or their risks.

Risk Concerns

98. This is an opportunity to identify and highlight any concerns you may have had over the course of the last reporting period. MHCS expect that any concerns would have been discussed with the social supervisor prior to the report being submitted. Where concerns over risk appear to be escalating then the clear expectation from MHCS is that we should be contacted immediately on 07812 760 248 and recall considered. It should not be left to the report to alert this Department towards any immediate concerns.

Admissions to Psychiatric Hospital

99. MHCS expects that whenever the patient is admitted to a psychiatric hospital either voluntarily or when subject to detention under Part II of the 1983 Act that we should be notified at the point of admission and not simply by a subsequent report. Notification should be by email to MHCSMailbox@justice.gov.uk. MHCS understands circumstances will occur where an admission is necessary for respite, changes in medication or where concerns may have arisen. However, where a patient is detained under Part II powers with no definitive end point then a recall will be considered by the Secretary of State in line with his powers under section 42 as maintaining a restricted patient under 'civil' provisions of the 1983 Act to manage risk is an unacceptable position to the Secretary of State.

Supervision

100. As indicated in paragraph 44 onwards, MHCS are of the view that contact with the patient immediately after discharge should be frequent and in person. The direct contact with the patient should only be reduced following a thorough assessment of their progress on discharge rather than simply due to the passing of time. Both the social and clinical supervisors must be satisfied that the contact with the patient is sufficient to capture any signs of relapse or an increase in risk. Consequently, the level of supervision may vary throughout the time the patient is in the community with increased supervision at times of change, such as moving accommodation or a change in supervisor, personal stress etc. stress, such as the death of a relative. MHCS expect that both the clinical and social supervisors are in close contact, so the reports properly reflect the joint supervision of the patient, as is so crucial with restricted patients.

101. The clinical supervisor's role in the oversight of the patient's progress is as essential as that of the social supervisor and the same level of professional curiosity expected from the social supervisor should be exercised in the clinical context. This is important for patients who have a history of non-compliance with treatment or have masked symptoms in the past. Clinical supervisors should remain in close contact with their social supervisor colleagues to ensure a clear overall picture of the patient's mental state and risks are properly reported.

[24] https://www.gov.uk/government/publications/discharge-conditions-that-amount-to-a-deprivation-of-liberty

Consideration for Further Action

102. This last section refers the social and clinical supervisors to guidance on absolute discharge, and guidance, with application forms for changes of conditions of discharge. The latter has been created to ensure any new change of condition request or variation / reductions in reporting frequency are formally requested. MHCS will no longer consider change of conditions request which are submitted by the report form or informally by correspondence.

Changes to Supervisors

103. Where plans are for supervisors to change then MHCS must be informed prior to the change, provided with the details of who will be the new supervisors and their full telephone and email contact details. MHCS does not expect the changeover to affect the timing of the reports and this should be suitably planned as part of the handover of responsibility. If changes in supervisors do disrupt the reporting schedule MHCS will raise this with the Chief Executive Officers of the Responsible Authorities.

104. MHCS should be informed if the patients are being ‘stepped down’ from forensic to general adult community teams. MHCS will also wish to be informed why the decision has been made and on what evidence. MHCS will wish to be assured that the level of supervision will not change for the patient and that the new supervisors are fully appraised of the background and risks of the patient prior to any change of teams.

Section 6 - Patient's comments on their discharge progress

105. All conditionally discharged patients should be made aware that the social and clinical supervisors will be submitting reports to MHCS on a regular basis. This will include any updates submitted to MHCS outside of the reporting schedule. To enable the patient to contribute their views on their progress on discharge MHCS has added an annex to the discharge report form to be completed by the patient.

106. The annex provides the patient with an opportunity to give their views on the progress of their discharge and potentially address any concerns raised in the report or they may have about the conditional discharge. Nevertheless, the patient is not compelled to complete the annex and the report's submission should not be delayed facilitating the completion of the annex. Even where the patient does not wish to comment it is a helpful prompt for the supervisor to remind the patient of their right to apply to the Tribunal for review and also their obligations to comply with the conditions of discharge.

107. MHCS expects that the reports should be a frank, detailed and a contemporaneous update on the patient's risks and/or progress on conditional discharge. Consequently, there may be times that the contents of the reports cannot be shared with the patient as they contain sensitive information which should not be disclosed to the patient. The clinical and social supervisors should be mindful of the need to disclose the reports and their contents where the appropriate data protection provisions allow for this.

Section 7 – Disputes over supervision

108. Where a patient has moved areas and placed themselves outside of the area of the original supervisory team then MHCS expects the supervision to be undertaken by the current team until handover arrangements are complete. Any move to a different area should be carefully planned to ensure that the agreement of the new home area is obtained to continue the supervision. The Secretary of State does not consider it acceptable for a restricted patient to remain unsupervised or subject to reduced supervision at any time whilst practical arrangements are made.

109. If necessary MHCS may choose to escalate any disputes to the Chief Executive Officers of both the originating and receiving responsible authorities to seek a swift resolution – however, it is ultimately the responsibility of those providing supervision to resolve this issue. MHCS have no power to force a 'new' area to accept the supervision of a restricted patient.

110. Where no agreement for continuing supervision can be reached and the originating team can no longer effectively supervise the patient MHCS will consider, as a last resort, recalling the patient to hospital for urgent assessment.

Section 8 – Patients subject to Deprivation of Liberty Authorisation or Restrictive Conditions

111. A small number of patients who are deemed to be lacking capacity to consent about their accommodation care and support may be discharged with an authorization of the Deprivation of Liberty either from a local authority (DoLS) or authorised by the Court of Protection through an order. In such cases MHCS will expect that confirmation is provided that the authorisation of the deprivation of liberty remains valid and, where it is available, MHCS will be provided with a copy.

112. If the authorisation has expired MHCS will need confirmation that a renewal is being sought and timescales for the renewal. The default position will not be to recall the patient to hospital if the renewal is in train. However, the supervisors must keep MHCS abreast with the renewal of the authorisation and report as soon as this ihas been renewed or not.

113. More information about practice consideration for practitioners that oversee this cohort of patients can be found at the following link: Mental Health Act Restricted Patients and Conditional Discharge: Practice Considerations[25]

114. Where the deprivation of liberty authorisation cannot be renewed but there may be a requirement to restrict the patient's liberty, when in the community, supervisors should refer to the guidance Discharge conditions that amount to a deprivation of liberty - GOV.UK (www.gov.uk)[26] to consider the next steps for the patient and discuss this with a senior manager on **07812 760 248.**

[25] https://static1.squarespace.com/static/5bbb8206af4683ee4fa3c43f/t/62f20cb633a00e737403ea4b/1660030138486/2022+08+07+MM+Practice+Guidance+Version+2+FINAL.pdf

[26] https://www.gov.uk/government/publications/discharge-conditions-that-amount-to-a-deprivation-of-liberty

Section 9 – Actions by the Secretary of State

115. The Secretary of State's primary function within the context of the conditional discharge framework is to recall a patient to hospital for either treatment or urgent assessment where there has been a change in mental state and proportionate change in risk profile. Circumstances may also arise where the Secretary of State may recall a patient on the basis of risk alone, such as the risk of harm to the patient or the public from the patient is imminent. However, recall should be used as a last resort. MHCS recommend that if supervisors have concerns about a patient, they should contact the Department as soon as possible on **07812 760 248 or** MHCSMailbox@justice.gov.uk even where recall is not an obvious solution.

116. MHCS can consider other actions such as sending the patient a warning letter highlighting that because of their actions or contravention of the conditions of discharge the patient will be at risk of recall. MHCS can consider changes to the conditions of discharge to impose abstinence conditions, where substance misuse is a problem, limit where the patient may reside or visit or simply reinforce conditions relating to complying with supervision or treatment.

117. Nevertheless, where a patient is engaging in low level criminality or anti-social behaviour, but remains mentally stable, then MHCS can clarify with the relevant police or justice authorities the limits of the Secretary of State's powers about when the section 42 of the 1983 Act recall powers can be exercised. Supervisors should not simply assume that recall is not appropriate – they should seek advice from MHCS on an urgent basis through the contact details on the CDR.

118. MHCS regularly hold learning sessions for stakeholders on the restricted patient system and supervisors or other practitioners involved in the management or supervision of restricted patients can attend these by submitting a request at the Gov.UK website: An Introduction to the Restricted Patient System - GOV.UK (www.gov.uk)[27]

[27] https://www.gov.uk/guidance/an-introduction-to-the-restricted-patient-system

Section 10 – Links to documents to support this guidance

Code of practice: Mental Health Act 1983:
Mental Health Act 1983 (publishing.service.gov.uk)

Information on conditional discharge for patients on their rights, for families and for Independent Mental Health Advocates:
https://advocacyfocus.org.uk/services/independent-mental-health-advocacy-imha/

Information about the Victim Contact Scheme:
Information about the Victim Contact Scheme - GOV.UK (www.gov.uk)

Multi-Agency Public Protection Authority (MAPPA) Guidance:
Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK (www.gov.uk)

Terrorist Risk Offenders: Independent Review of Statutory Multi-Agency Public Protection Arrangements:
supervision-terrorism-and-terrorism-risk-offenders-review.pdf (publishing.service.gov.uk)

Domestic Abuse: Statutory Guidance:
Domestic Abuse: statutory guidance (accessible version) - GOV.UK (www.gov.uk)

MHCS Guidance on MAPPA and Restricted Patients:
https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-and-the-restricted-patient-system

MHCS Guidance: Setting and Changing Conditions of Discharge
Submit a conditional discharge report or request a change of discharge conditions - GOV.UK (www.gov.uk)

MHCS Recall to hospital guidance:
Recall of conditionally discharged restricted patients - GOV.UK (www.gov.uk)

MHCS Discharge Guidance:
Submit a discharge request for restricted patients - GOV.UK (www.gov.uk)

MHCS guidance on discharge conditions that amount to a deprivation of liberty:
Discharge conditions that amount to a deprivation of liberty - GOV.UK (www.gov.uk)

MHCS Out of hours guidance:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1035562/Mental_health_casework_out-of-hours_service_.pdf

Annex A: Summary of recommendations for good practice for staff of the discharging hospital

a. Preparation for discharge should begin as soon as such an outcome seems likely.
b. 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.
c. 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.
d. The multi-disciplinary team should have a clear idea of the arrangements in the community which will best suit the patient.
e. 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.
f. 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.
g. The responsible clinician, after consultation with the other members of the multi-disciplinary team, is responsible for arranging psychiatric supervision by a local consultant psychiatrist.
h. Responsibility for arranging suitable accommodation should be allocated by the multi-disciplinary team to a named social supervisor.
i. 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.
j. It is important to identify suitable accommodation and to specify which types of accommodation would not be appropriate for individual patients.
k. 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 independent accommodation or supported accommodation.
l. A member of staff of a proposed hostel should meet the patient and discuss the patient's needs with hospital staff.
m. The patient should visit and possibly spend a period of leave in a supported accommodation or other accommodation before the decision is taken to accept an available place.
n. There are a number of important factors to be considered in the selection of supported accommodation or other accommodation for a particular patient.
o. The manager of the supported accommodation should be given detailed information about the patient, including information which they may need about medication. He should be encouraged to contact the two supervisors and, if necessary, the social worker of the discharging hospital, for further information or advice.
p. Written information about the patient taken on admission as set out in should be sent by the hospital social worker to supervising and after-care agencies as soon as discharge is in view and when nomination of a social supervisor is requested. Collateral information about the patient can also be obtained from the Mental Health Casework Section, such as about previous discharges, recalls, court orders or other information which will ensure the community
q. Supervisors should receive comprehensive, accurate and up-to-date information about a patient before they are discharged to their supervision. A standard package of information should be provided to both social and clinical supervisors as soon as they have been nominated.
r. Copies of supervisors' reports to the Ministry of Justice should be sent to the discharging hospital for a period of one year after discharge, for information.

s. After the conditional discharge of a patient, supervisors may sometimes seek information, guidance or support from those who know the patient well. Discharging hospitals should respond helpfully to such requests.

ANNEX B: CDR

The latest version of the report can be found here:
Submit a conditional discharge report or request a change of discharge conditions - GOV.UK (www.gov.uk)[28]

[28] https://www.gov.uk/government/publications/conditionally-discharged-restricted-patient-report