

**Discharge from Hospital and the Continuing Care in
the Community of People with a Mental Disorder who
could Represent a Risk of Serious Physical Harm to
Themselves or Others.**

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1. Purpose of this Guidance

Services Users* have the right to lead full meaningful lives and to be responsible for their own health and wellbeing. All service users, in whatever setting, should have a care plan appropriate to their needs. The specific aim of this guidance is to ensure that people with a mental disorder who are being discharged from hospital, and who could represent a risk of serious physical harm to themselves or others, receive appropriate continuing support in the community. In the drawing up of this guidance account was taken of the statutory duties imposed on public bodies following the introduction of Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998.

2. Background

- 2.1 Concerns have existed for some time about incidents of suicide and violence to others by people with a mental disorder after their recent discharge from psychiatric hospitals. Some individuals with a mental disorder pose a significant risk to themselves, however only a small number pose a significant risk to other people, and then it is mostly to their carers or families. Effective risk management, including the co-operation and involvement of service users and carers, in both assessment and the provision of an appropriate care package aims to decrease such incidents. Since these incidents will occur it is important to avoid a culture of blame with consequent scape-goating of mental health professionals.
- 2.2 Risk assessment and management must become an integral part of routine practice for all mental health services. However, risk assessment carries uncertainties and the prediction of future behaviour of an individual may not be completely accurate. In addition, some individuals pose a significant risk but fall outside the remit of the Mental Health (N.I) Order 1986 and may decide to disengage from services. Thus agencies must aim, within available resources, to minimise risk through good professional practice, while accepting it is not possible to eliminate risk entirely.

****To avoid confusion the term service user is used throughout this document to encompass other terms such as patient or client.***

- 2.3 Stigmatisation of service users, contributed to by the small minority with mental illness who are violent, must be avoided. Instead recognition should be given to the factors that predispose some people with a mental disorder towards harming themselves or others. Such factors include disengagement from services, substance abuse, non-compliance with medication, history of violence and also, particularly in relation to suicide, the immediate period following discharge. A recognition of all these factors will go some way to promoting an Equality and Human Rights culture.

3 Definition of People with a mental disorder (for the purpose of this guidance)

People with a mental disorder in all age groups should include people with a mental illness, people with a learning disability, and people with any other disorder of mind, including those with a personality disorder or a co-morbid dependency on alcohol or drugs. For this guidance to apply the person must have a mental disorder and also be considered to represent a risk of serious physical harm to themselves or others.

4. Identification of those at-risk prior to discharge

- 4.1 Ideally discharge planning should begin as soon as possible after the service user is admitted, and should include an assessment of risk of self harm and/or violence. This assessment, involving the service user and their carers and/or advocate, should be multi-disciplinary and include medical, nursing, psychology, occupational therapy and social work inputs where relevant.

- 4.2 It is important the necessary information is available for the assessment to be carried out, and services should facilitate this by ensuring any relevant information available accompanies the service user on transfer between wards community teams or hospitals. Assessments should at least include:

- History of deliberate self-harm.
- History of violence.
- Personal history.
- Forensic history.
- Past psychiatric history.
- Socio-environmental factors.
- Protective factors/ supports and resources.
- Risk of non-compliance with treatment/management.
- Alcohol or drug misuse.
- Current mental state.
- Physical health.
- History of neglect.

- History of sexual offences.
 - Access to means of self-harm or violence.
- 4.3 An assessment of the risk of self-harm should take account of relevant risk factors, such as those found by the Confidential Inquiry into Suicide and Homicide. These include previous suicide attempts, serious depressive illness, being single, being male, alcohol or drug misuse, recent adverse life events (such as bereavement, unemployment, or relationship problems), and history of non-compliance with treatment or follow-up.
- 4.4 An assessment of the risk of violence should identify the nature of the risk, its degree, persons at risk, associated factors (both potentiating and protective) and warning signs, with actions to be taken in response to warning signs. A history of violence is important, and should be recorded in as much detail as possible, together with information about those present and mental state of the service user at the time.
- 4.5 An assessment should identify, where possible, effective interventions that are likely to result in either a direct reduction in the risk of violence or in the vulnerability of the person concerned, or in the development of management strategies that in themselves reduce, risk and/or, more effectively and safely, manage violence if it were to occur.
- 4.6 The outcome of the assessment process should be recorded in the service user's notes, and following assessment, where the service user is deemed by the multi-disciplinary team to represent a significant risk, a care plan must be drawn up. Other agencies e.g. Voluntary agencies, PSNI, Probation, Prison Service, NIHE, should be involved where appropriate.

5. The Care Plan

- 5.1 The care plan for this specific at-risk client group must be drawn up following comprehensive assessment of the service user's health and social care needs, and agreed by the multi-disciplinary team responsible for following up the service user in the community prior to discharge taking place. The service user and his/her carer, relative, or advocate should be offered the opportunity to actively contribute to the drawing up of the care plan. The involvement of service users, their carers or advocates in the development of this plan positively recognises the obligations of the Human Rights Act. All care plans should be countersigned by the service user indicating they have read and understood the plan. Appropriate measures should be available for those who cannot read. In the absence of a signature the care plan should contain a statement indicating why the service user has not signed. Where the service user is hostile to involvement then a note

should be made that every attempt has been made to seek their views, so preserving their rights to fair and equal treatment.

- 5.2 All mental health service users have a range of needs which no one treatment, service or agency can meet. It is necessary therefore for a co-ordinated approach from the relevant agencies and self help/support groups, with service users themselves providing the focal point, in order to deliver timely, efficient and effective care. Consideration should be given to the provision of assistance with housing, education, employment and leisure, and to establishing appropriate links with the criminal justice agencies and the benefit agency. To aid the delivery of the care plan a key worker (section 7) and a care co-ordinator (section 8) should be named in consultation with the user and, if appropriate, carer and/or advocate.
- 5.3 Care plans should contain in a separate section an explicit plan of action for implementing in a crisis situation, including the arrangements to be used where, at short notice, either the key worker or care co-ordinator are not available or part of the care plan cannot be provided. Care plans should include the information necessary to continue implementing the care plan in the interim, for example telephone numbers of service providers and the name and contact details of substitutes who have agreed to provide interim support. They should also include how the key worker and care co-ordinator can access support when required.
- 5.4 Care plans must specify timing of follow-up of the service user after discharge. While the timing of follow-up is an issue to be decided by local clinicians they should however be aware of national guidance. For example the National Confidential Inquiry's Safer Services Report recommends follow-up within 48 hours for all service users who have been at significant risk and who are discharged from inpatient care, and also recommends follow-up within 1 week for all discharges, including those who discharge themselves. Similarly the Department of Health's document Effective Care Co-ordination suggests care plans for service users with severe mental illness, who are at significant risk of suicide, should include specific follow-up in the first week after discharge.
- 5.5 Close liaison and effective communication over care arrangements, including ongoing risk assessment and management, are essential for services users who are the shared responsibility of statutory and voluntary agencies in the mental health and criminal justice systems and the care plan should reflect this need. If the service user is a life licensee or a serving life sentence prisoner on temporary release the relevant prison service contact details are contained in Annex A.
- 5.6 The care plan must reflect diversity through proper attention to the service user's age, gender, ethnicity, sexuality, disability and culture. Where the service user's first language is not English, or where they have a known visual or hearing impairment, service providers should

take all reasonable steps to ensure that appropriate support is provided and also that the service user fully understands the content of the written care plan. Care plans should take particular account of the needs of children, other dependents, and carers of people with mental health problems. These obligations are reflected in Section 75 of the Northern Ireland Act 1998 and proper attention should be given to what information is required within the care plan to promote equality of opportunity in service delivery.

5.7 An example of good practice is contained in The National Service Framework for Mental Health which recommends a written care plan should include:

- Arrangements for mental health care, including medication and access to services 24 hours a day, 365 days a year.
- An assessment of the nature of any risk posed and the arrangements for the management of this risk to the service user and to others including carers and the wider public; including the circumstances in which defined contingency action should be taken.
- Arrangements for physical healthcare.
- Action needed to obtain accommodation appropriate to the service users needs.
- Arrangements to provide domestic support.
- Action needed for employment, education or training.
- Arrangements for adequate income.
- Action to provide cultural and faith needs.
- Arrangements to promote independence and sustained social contact, including therapeutic, leisure activity.
- Date of next planned review.

6. General Issues

6.1 No case can be made for the premature discharge, without adequate support, of one service user deemed to be at risk, to create a bed for another, however needy that other. Instead different arrangements need to be made for the second service user. All services need to be aware that it is unacceptable for the duty psychiatrist to be asked to discharge a service user deemed at risk because of a bed shortage. Such an action could potentially raise serious Human Rights breaches.

- 6.2 In some circumstances the use of mental health legislation may be appropriate to allow the enforced treatment of a service user who has become non-compliant with treatment and as a result shows indications of significant risk to themselves or others. Any interference with individual's Human Rights in these circumstances must be lawful, legitimate, necessary and proportionate.
- 6.3 Admissions and discharges "out of Area" require particular attention. For service users discharged "out of Area" responsibility should be retained by the original team until the service user is formally transferred to the local clinical services in the area to which the service user has moved. For service users deemed to be at significant risk catchment area services should proactively seek to resume responsibility for their care at the earliest opportunity following discharge. If possible the accepting multi-disciplinary team should be involved in planning aftercare, and in any event receive all relevant information at the time of transfer. Aftercare planning should also ensure clear and open communication between statutory and voluntary agencies.
- 6.4 Among other factors, service user non-compliance with medication can be related to the side effects of the medication. Therefore, modern drug treatments, such as atypical anti-psychotic drugs and newer antidepressants, should be considered for service users with severe mental illness who are non-compliant due to concerns about treatment side-effects and service users and their carers/advocates should be involved in this process.
- 6.5 It is also important to recognise that the information in a care plan is considered "sensitive" under the regulations of the Data Protection Act 1998. Its collection, use and disclosure must also be in accordance with this Act. People's consent for the collection and inclusion of this information must be sought and the purpose to which the information will be put needs to be clearly identified.

7. The Key Worker

- 7.1 The appointment of the key worker should be a formal item on the agenda of the initial care planning meeting. Decisions about who should be a key worker should be based on considerations of the service user's needs, the service user's wishes, staff availability within the community multi-disciplinary team, and the workloads of members of the team. The key worker may be from any professional background within the multi-disciplinary team e.g. community psychiatric nurse, social worker, psychiatrist, psychologist, occupational therapist etc. Alternative contact points must be identified for when the key worker is not available and it is the responsibility of the care co-ordinator, in liaison with the key worker, to have in place arrangements for a deputy who will cover both planned and also unplanned absences.

- 7.2 The key worker should draw up the written care plan with the involvement of the service user and, where appropriate, their carer and/or advocate. It should include explicit contingency arrangements so that the service user or their carer can contact mental health services if they need to. Copies should be given to members of the multi-disciplinary team, the service user (in a language/form he or she understands), the carer(s) where appropriate, and his or her GP. The key worker is responsible for updating the service users care plan.
- 7.3 While the consultant psychiatrist (Responsible Medical Officer) retains overall responsibility for the service user's medical care, the key worker should ensure before discharge that the elements of the plan necessary for discharge are put in place in accordance with the multidisciplinary team decisions. This will include the service user's need for medication, therapy, supervision and accommodation. Responsible Medical Officers taking decisions on discharge have a duty to consider both the safety of the service user and protection of other people. In light of the serious nature of this category of service user they should be reviewed by the Responsible Medical Officer at intervals not exceeding six months.
- 7.4 The key worker is responsible for keeping in close contact with the service user and for advising the other members of the multidisciplinary team of changes in the circumstances of the user, especially changes which might require a review or modification of the care plan. Where appropriate, keeping in contact should be proactive, and the key workers shouldn't rely on the service user contacting them. Staff should discuss arrangements for this process with the service user and their carer/advocate.
- 7.5 The key worker must check that the service user is registered with a GP and if not assist them to become registered. The service user's GP should be invited to discharge planning meetings and systems for informing them of discharge arrangements should be prompt. Service users sent home on leave remain under the care of the psychiatrist, however, the GP should be informed as they may well visit and request medication or other medical intervention.
- 7.6 In cases of non co-operation, for example failure to take medication or to attend a clinic, all practical and reasonable efforts should be made by the key worker and/or other members of the multidisciplinary team to ascertain the cause and to overcome the problem. Where a service user loses contact with services all practical and reasonable efforts must be made to locate him or her. In each case the key worker has a crucial role in initiating the necessary remedial action, in alerting members of the multidisciplinary team and others (e.g. GP, carers, family members, probation, voluntary sector agencies etc) who could be of assistance and anyone who may be in danger. Where there are serious concerns regarding the safety of the service user or the public then immediate consideration should be given to informing the police.

8. The Care Co-ordinator

- 8.1 The care co-ordinator should be a manager in the Community Trust where the service user resides and which is therefore responsible for providing appropriate health and social care to the service user on their return to the community. A care co-ordinator will oversee several key workers, with each of the key workers having their own specific caseload. The care co-ordinator's role is to support and facilitate the key worker and multidisciplinary team in the delivery of the agreed care plan. The care co-ordinator should have knowledge of community services, relevant legislation, the role of other statutory and voluntary agencies and have access to resources. The care co-ordinator should also be available to chair multi-agency reviews for each service user at intervals of six months or more frequently when required.
- 8.2 The care co-ordinator requires to be accessible to the key worker and other members of the multidisciplinary team. This is particularly important where the risk posed by the service user has increased and the care plan requires amendment.

9. Review of Care Plan

- 9.1 The review and evaluation of the care plan should be regarded by the multi-disciplinary team as an ongoing process, and at each review meeting the date of the next review must be set and recorded. Service users and their carers and/or advocates should be involved and any member of the care team, or the user or carer, must be able to ask for a review at any time. Following a request from the service user or carer for a review if the team decides such a review is not necessary the reasons for this must be recorded and explained to the user or carer, with a possible suggested timeframe for reconsideration of this request. Annual audit by the multidisciplinary team should ensure that reviews are carried out in both an effective and timely manner. Service shortfalls identified should be noted and fed back to management to help in the planning process.
- 9.2 However effective the care planning and follow-up in the community there will be service users who need readmission. Effective monitoring in the community by the key worker would aim that, where admission is necessary, it occurs at as early a stage as possible in a crisis or deteriorating situation and thereby aids a more rapid discharge than otherwise likely. A measure of the effectiveness of care planning might, in some cases, be how quickly a service user is discharged again after readmission.

10. Disclosure of Information

- 10.1 There is a distinction to be made between personal information, relating specifically to the management of an individual service user, and general information which could include background information regarding particular clinical conditions, such as schizophrenia or depression, or how service users attending a particular service are generally treated. It is the personal information that may present real dilemmas about disclosure due to the need for consultation and discussion with relatives, carers, advocate and people from other disciplines and agencies (including the police). It should be recognised that there may at times, due to conflicting pressures, be no correct decision and that disclosure of personal information is a matter of individual professional judgement, taking appropriate codes of professional conduct into account. Accurate clear record keeping is therefore essential.
- 10.2 This dilemma has been increased by the rights afforded to service users and their carers through the Human Rights Act, especially Article 8 (The right to respect for private and family life, home and correspondence). However, interference with these rights may be deemed necessary to achieve an important objective such as protecting public health or safety.
- 10.3 The following principles, which also take account of the requirements of the Data Protection Act 1998, should be considered:
- Only in exceptional circumstances will personal information be disclosed without the consent of the service user.
 - Any confidential information which is disclosed is limited to that which is necessary for the purpose.
 - It should be explained to the service user why, when, and with whom, information will be shared.
 - If the service user is unable or unwilling to consent to the sharing of information, disclosure must be in their best interest and they will be informed where possible. It should be noted that no one can consent on behalf of another adult.
 - Disclosure of information may be necessary in the public interest if failure to disclose would result in the risk of death or serious harm to the service user or others.
 - Consideration should be given to provision of an information leaflet in an accessible format, which explains to service users and carers the importance of sharing information whilst also respecting confidentiality.

11. Mental Health Review Tribunals

- 11.1 Service users detained under the Mental Health (Northern Ireland) Order 1986 have the right to have their detention reviewed, at specified intervals, by a Mental Health Review Tribunal. The Tribunal must discharge the service user if the statutory criteria specified in Article 77 of the Order are met, and has discretion to discharge service users in other cases. If the service user is subject to a restriction order the Tribunal may direct that he or she is discharged subject to any conditions which the Tribunal may specify.
- 11.2 This discharge guidance will also apply to appropriate service users on discharge by a Tribunal. It follows, therefore, that where a service user is to appear before a Tribunal, the possibility of discharge must be recognised and an assessment and care management process in place so that arrangements for the service user's care in the community can be put into effect without delay. Any delays in making necessary arrangements could result in a violation of Article 5(4) of the Human Rights Act (the right to liberty and security).

12. Discharged Prisoners

Although it is the responsibility of the Prison Service to routinely co-ordinate arrangements for prisoners who are being released, it is important to recognise the possibility that a prisoner on remand, or who has appealed against sentence, may be released without warning. Following such a release the prompt activation of the assessment and care management process within the relevant HSS Trust where the service user will reside is necessary so that arrangements for the service user's care in the community can be put into effect without delay. This process is, of course, dependant on the Prison Service informing the relevant HPSS staff as soon as possible and a clear duty rests with the prison service to have procedures in place to ensure that this is done.

13. Voluntary Inpatients

- 13.1 Where a voluntary inpatient deemed to be at risk of serious physical harm to themselves or others indicates an intention to discharge himself or herself, and a package of care has not been arranged, every effort should be made to persuade the service user to remain in the hospital until a package is agreed. In some cases the use of holding powers and detention may be appropriate.
- 13.2 Where such powers cannot be invoked, e.g. where a service user has been diagnosed as having a personality disorder only, and the service user leaves the hospital before a suitable package of care can be put in

place, it is essential that the hospital alerts those in the community who should be aware of the situation. The responsible multi-disciplinary team should agree a care plan in retrospect and identify a key worker and a care co-ordinator. The care plan should include what to do in a crisis and also ongoing plans for review. Service users who take their discharge against medical advice may still require and accept aftercare.

14. If Things Go Wrong

- 14.1 Serious incidents will occur and it is important to respond to the immediate needs of the service user, the service user's family, carers, staff, and the public while also learning lessons for the future. Action by local Health and Personal Social Services (HPSS) management must include:
- An immediate investigation should be carried out by the relevant Trust to identify and rectify possible shortcomings in operational procedures. Where court proceedings in relation to the incident have started or are thought likely, legal advice should be sought with a view to ensuring that the investigation does not prejudice those proceedings.
 - The Trust must inform the relevant Health and Social Services Board and the Mental Health Commission.
 - If the victim is a child, i.e. under 18 years of age, the report of the investigation should be forwarded to the Area Child Protection Committee within one month of the incident.
 - If the service user is a Life Licensee, or a Life Sentence prisoner on temporary release prior to release on license, then the Prison Service must be contacted. (Contact details in Annex A).
 - Incidents involving a death should be reported to the Confidential Inquiry into Homicides and Suicides by Mentally Ill People and to the DHSS&PS Disability and Mental Health Unit.
- 14.2 Additionally, after the completion of any legal proceedings it may be necessary to hold a separate inquiry. In most cases it will be appropriate for the commissioning HSS Board to set up the inquiry. In cases of suicide of mentally disordered people in contact with specialist mental health services a local multi-disciplinary audit should be carried out. In cases of homicide it will always be necessary to hold an inquiry, which is independent of the service providers involved. The only exception is where the victim is a child and it is considered that the report by the Area Child Protection Committee (see above paragraph) fully covers the remit of an independent inquiry as set out below.

14.3 In setting up an independent inquiry following a suicide or homicide the following points should be taken into account:

- i. The terms of reference for a Review Team and its methodology must reflect the task it is asked to undertake. The remit of the inquiry should encompass at least:
 - the care the service user was receiving at the time of the incident;
 - the suitability of that care in view of the service user's history and assessed health and social care needs;
 - the extent to which that care corresponded with statutory obligations, relevant guidance, and local operational policies;
 - the exercise of professional judgement; and
 - the adequacy of the care plan and its monitoring by the care co-ordinator.
- ii **Composition of the inquiry panel.** Members should have appropriate experience and include a legal professional, service user or advocate, a psychiatrist, a senior social services manager, a senior mental health nurse and a representative of the Health and Social Services Councils. Other health and social care professionals may be co-opted as appropriate. No member of the panel should be employed by bodies responsible for the care of the service user.
- iii **Distribution of the inquiry report.** Although it will not always be desirable for the full final report to be made public, an undertaking should be given at the start of the inquiry that its main findings will be made available to assist in the prevention of further such incidents.

15. Responsibilities/Role of Commissioners and Providers of Services

15.1 Commissioners and providers together should ensure that for this particular at risk client group there are an adequate range of community based services available. Due to the perceived risk the services should be seen as a priority when planning, commissioning and providing community mental health and personal social services. Community Forensic Mental Health Services and supervised accommodation are likely to be important components of local provision. Commissioners and providers should ensure sufficient staff from the various disciplines are available.

15.2 Written policies with agreed procedures should be in place to cover:

- Suicide, homicide, or violent incidents.
- Communication and sharing of client information in accordance with Data Protection Act 1998, Human Rights Act 1998, and professional guidance.
- Non compliance with medication or other aspects of the care plan.
- Disengagement and loss of contact with service users including those who are homeless.
- Co-morbid alcohol or drug misuse.

These policies should be made known to staff, service users and carers where appropriate.

15.3 All multidisciplinary staff, including relevant staff in primary care, should receive approved training in the recognition, assessment and management of risk (both suicide and violence) at intervals of no more than three years. This training should include indicators of risk, recognition of high risk periods, managing non-compliance and loss of contact, sharing of information, and the use of the Mental Health Order. Staff should also receive training in the management of personal risk and safety.

15.4 Local audit within the Trust should focus on assessing the quality of the care plan implementation, including the quality of care plans, the attainment of treatment goals and, particularly for those with multiple needs, the effectiveness of interagency working. Promotion of Human Rights and Equality, including issues raised by implementation of this guidance, should also be assessed. The views of service users, carers and advocates are an effective indicator of the quality of services and must be included in any audit or review of service delivery.

16. The Human Rights Act 1998

16.1 The Human Rights Act 1998 came into effect on 2 October 2000. Its immediate effect is to allow people to claim their rights under the European Convention on Human Rights in local courts and tribunals, instead of having to go to the European Court in Strasbourg. The Act requires that all legislation, Acts of Parliament, Acts of the Northern Ireland Assembly, Regulations, Orders in Council etc so far as is possible, be read and given effect in a way which is compatible with the Convention Rights.

16.2 The Human Rights Act is a powerful tool whose use is obligatory, however, its' reach is not unlimited. This is apparent from the opening

words of Section 3(i) "so far as it is possible to do so". The difficulties for courts will be in identifying the limits of interpretation of legislation in a particular case. This limitation should not however be read as meaning that this is the only circumstance in which an interpretation of incompatibility with convention rights may arise.

- 16.3 A key element of the Human Rights Act is that public authorities now have a positive obligation to ensure that respect for human rights is at the core of their day to day work. It requires activity that positively reinforces the principles of the Human Rights Act. It covers all the activities of a public authority including rules, regulations, administrative procedures and guidance, issues affecting personnel, policy implementation and interaction with the public. Section 6 provides a wide definition of a "public authority" for the purposes of the Human Rights Act. The definition includes courts, tribunals and any persons whose functions are functions of a public nature. A person or organisation is not a public authority if the nature of their acts is private. In the case of bodies, such as some charities, which perform some public and some private functions, then the provisions of the Human Rights Act will apply to their public functions only.
- 16.4 In the development of this guidance human rights considerations were taken into account. A number of Articles have particular relevance:
- Article 2 – the right to life.
 - Article 3 – the right not to be subjected to torture or inhumane or degrading treatment; where a treatment regime is particularly negligent.
 - Article 5 (1) e – the right of persons of "unsound mind" not to be deprived of their liberty except in accordance with a procedure prescribed by law.
 - Article 5 (4) – the right of a detained person to take legal proceedings by which the lawfulness of his/her detention shall be decided speedily by a court.
 - Article 6 – the right to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law.
 - Article 8 – the right to respect for private and family life, home and correspondence.
 - Article 10 – freedom of expression.
 - Article 12 – the right to marry and found a family.
 - Article 14 – freedom from discrimination.
- 16.5 The development of the written Care Plan provides an opportunity for the promotion of human rights, equality and good practice. Active engagement of service users, and their advocate or carer if appropriate, in decisions about discharge from hospital will enable service users to have the opportunity to present their views in a fully satisfactory manner and in so doing adhere to the "equality of arms" principle in human rights legislation.

- 16.6 Active engagement means working in partnership. This model of working requires that service users are kept fully informed throughout the process and that their consent is obtained. These basic principles if followed will contribute to what is a more just and fair decision making process. It is the decision making process that will be subjected to much scrutiny by the courts should things go wrong.
- 16.7 Where any interference with service user's rights, as protected by the Human Rights Act, is challenged the nature and level of the violation will be examined to see if it is "in accordance with the law", "pursues an aim or aims that are legitimate" can be regarded as "necessary in a democratic society" is "proportionate" and that there is "equality of arms" for victims should they wish to pose a challenge to large organisations such as health and social services. Each case will be examined on its own merits.

17. Equality Consideration – Section 75 Northern Ireland Act 1998

- 17.1 Section 75 of the Northern Ireland Act 1998 requires the Department of Health, Social Services and Public Safety (DHSSPS) in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity:
- Between persons of different religious belief, political opinion, racial group, age, marital status and sexual orientation.
 - Between men and women generally.
 - Between persons with a disability and those without.
 - Between persons with dependants and those without.
- 17.2 In addition without prejudice to the above obligation DHSSPS should also, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.
- 17.3 In order to minimise the risk of either self harm or harm to others it is particularly important for some service users to maintain contact with mental health services following discharge. The aim of this guidance is to promote appropriate support of such service users in the community.
- 17.4 The proposals outlined within this discharge guidance suggest a number of ways which allow health and social care organisations to promote equality of opportunity. The development of a person centred care plan will promote the engagement of service users and carers in the process and is a pro-active measure. Care planning will also assist professionals in responding appropriately to service user's needs and in so doing help minimise potential delays in the discharge process. The guidance acknowledges that such a care plan needs to recognise diversity and the multi-identities of individuals with mental health problems and also makes reference to the rights of individuals to

privacy and the need for personal information to be kept confidential. These issues are essential in promoting a culture of equality.

- 17.5 Although the guidance is intended to improve the care the individual receives and therefore impact positively it is important that particular attention is paid to where the guidance may disproportionately impact on any of the nine equality groups mentioned in 17.1.
- 17.6 Our local political situation has had an effect on the mental health of the local population and may also have a bearing on service users accessing appropriate follow-up care.
- 17.7 Implementation of the guidance will promote a consistency of approach across all HPSS organisations and seek to ensure good practice in the discharge of all people with a mental disorder who may represent a risk of serious physical harm to themselves or others. Mental health services in their routine audit procedures should assess any adverse impacts of this guidance.

ANNEX A

Prison Service contact details for life licensee and serving life sentence prisoners on temporary release.

A **serving life sentence prisoner on temporary release** is the responsibility of the Lifer Management Unit (LMU) at HMP Maghaberry. Any notable problems therefore which arise with such persons when in the community should be notified to the LMU. Relevant contact points would be the Lifer Governor (LG) or if unavailable the Lifer Management Governor (LMG) who is directly responsible for the LMU. Out-of-hours contact should be made through the Duty Governor. Relevant contact numbers are:

- (i) LG - 028 92 614977
- (ii) LMG - 028 92 617088
- (iii) LMU - 028 92 617085
- (iv) HMP Maghaberry – for Duty Governor - 028 92 611888

A **life licensee** is the responsibility of the Life Sentence Unit (LSU). Should any such problems arise with a licensee LSU should be notified. After hours contact should be made through the NIO's Duty Officer who should be asked in turn to contact the Duty Director of Prisons Operations (DDPO). The DDPO will arrange for a member of LSU staff to be contacted. Relevant contact numbers are:

- (i) LSU - 028 90 525331/2, 525130, 525110
- (ii) NIO Duty Officer - 028 90 520700

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