

Use of Supervised Community Treatment - MHA Section 17(a)

Document Summary

This policy sets out the framework for the operation of an order made under Section 17A of the Mental Health Act (known as a 'Community Treatment Order') and the required standards of compliance within the organisation.

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1 SCOPE

This document sets out procedural requirements, where these are explicit in the Mental Health Act 1983 (the Act)¹ or the Code of Practice to the Mental Health Act (the Code)² but additional guidelines may be produced locally which, while complying with this policy, provide advice on more specific matters. Where appropriate, reference should be made to other Trust policies.

The purpose of this policy is to ensure that there is lawful and appropriate use of Supervised Community Treatment (SCT) and that the legal rights of any patient subject to a Community Treatment Order (CTO) are upheld at all stages. There is no lower age limit for SCT.

2 INTRODUCTION

From 3 November 2008, the Mental Health Act 1983, as amended by the Mental Health Act 2007 introduced powers to provide Supervised Community Treatment (for treatment of mental disorder but not physical disorders which are covered by the Mental Capacity Act 2005 ('MCA'))³. These guidelines set out the legal framework for the operation of an order made under Section 17A of the Act which is known as a 'Community Treatment Order'.

These guidelines should be read in conjunction with relevant chapters of the Code which offers guidance on the operation of the Act. In particular, the five guiding principles set out in Chapter 1 of the Code should be considered when making decisions about a course of action under the Act. The term 'patient' is used throughout to reflect the language of the Code but terms such as 'community patient' or 'service user' may be preferred locally.

3 STATEMENT OF INTENT

The purpose of this policy is to ensure that there is lawful and appropriate use of SCT and that the legal rights of any patient subject to a CTO are upheld at all stages in compliance with the Code.

4 DEFINITIONS AND ABBREVIATIONS

The Act defines medical treatment for mental disorder as medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to,

¹ Mental Health Act 1983 c20

² Code of practice: Mental Health Act 1983, Department of Health 2015

³ The MCA makes provisions for the medical treatment of people who lack capacity to consent.

treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

In the Act, “medical treatment” also includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

AC	Approved Clinician
AMHAHM	Associate Mental Health Act Hospital Manager
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
CoP	Code of Practice
CrtP	Court of Protection
CTO	Community Treatment Order
LSSA	Local Social Services Authority
MDT	Multi-disciplinary team
MHA (83)	Mental Health Act 1983
MHAA	Mental Health Act Administrator
MHAHM	Mental Health Act Hospital Manager
MHLO	Mental Health Legislation Officer
MHLU	Mental Health Legislation Unit
MHT	Mental Health Tribunal
MoJ	Ministry of Justice
RC	Responsible Clinician
RMN	Registered Mental Nurse
RMNH	Registered Mental Handicap Nurse
SCT	Supervised Community Treatment

5 DUTIES

5.1 Mental Health Act Hospital Managers

The Mental Health Act (1983) requires the Trust’s Mental Health Act Hospital Managers have in place policy, procedures and guidelines in respect of the use of powers of Supervised Community Treatment under Section 25(a) under the Act

5.2 Executive Director of Nursing and Quality

The Executive Director of Nursing and Quality is the accountable Director for this policy.

5.3 The Responsible Clinician and Unit/Ward/Team Manager

The Responsible Clinician and Unit/Ward/Team Manager have management responsibility for ensuring this policy is implemented.

5.4 All staff working with patients subject to a CTO

The Mental Health Act Hospital Managers as defined by the Act are responsible for ensuring compliance with the relevant legislation. All staff must follow the best practice guidance given in the Code of Practice when carrying out their duties in respect of the Act to ensure such compliance is maintained at all times.

6 THE USE OF SCT WITHIN CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST

6.1 Criteria for Use

The following criteria must be met in all cases before a CTO can be made by the patient's Responsible Clinician ('RC'):

- The patient must be currently liable to detention for treatment under Section 3 or an unrestricted Section under Part III of the Act, including a patient currently on Section 17 leave from hospital.⁴ It is not applicable for patients on restriction orders
- In the RC's opinion, the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment
- It is necessary for the patient's health or safety or the protection of other people that such treatment should be received
- Such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment
- It is necessary that the RC should be able to recall the patient to hospital (*The RC must confirm that he or she has considered risk of deterioration if the patient were not detained in hospital, with regard to their history of mental disorder and any other relevant factors*)⁵
- Taking account of the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient

6.2 Mandatory Conditions

The following conditions are mandatory in all cases:

- The patient must make him or herself available for examination to determine whether to extend the community treatment period⁶

⁴ For a full list of eligible sections see Department of Health (2015) *Reference Guide to the Mental Health Act 1983* (published electronically at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf) para.26.9

⁵ Code of practice: Mental Health Act 1983, Department of Health 2015 para 26.10

⁶ Form CTO1 contains a statement to this effect: 'The patient is to make himself or herself available for examination under section 20A, as requested.'

- The patient must make him or herself available for examination by a second opinion appointed doctor when requested⁷

6.3 Role of the AMHP

An AMHP (who could be working in the same team as the RC⁸) must agree in writing that the patient meets the criteria for a CTO, a CTO is appropriate and any conditions made are necessary or appropriate for one or more of the following:

- To ensure the patient receives medical treatment,
- To prevent risk of harm to patient's health or safety,
- To protect other persons.

If the AMHP does not agree, it is not appropriate (as detailed in the Code of Practice) for the RC to seek another AMHP for an alternative view. The Code prescribes Best Practice in this area, however, decisions may be challenge provided there are sufficient and cogent reasons to do so.

6.4 Making an Oder

An order is made by the RC completing Parts 1 & 3 with the AMHP completing Part 2 of form CTO1. These must be accompanied by a Risk Assessment, Care Plan and Contingency Plan. When signed by the RC, the CTO automatically takes effect on the date and time specified for a period of up to six months. All forms should be presented to the local MHA Administration Office as soon as practicable, who will receive them on behalf of the Hospital Managers.

As there is no mechanism for retrospectively amending or rectifying a defective form CTO1 once handed to the Hospital Managers, it is essential that where practicable, the form (or a copy of it) is seen by or at least discussed with the MHA Administration Office before acting on it.

6.5 Care Planning

A care plan should be prepared and subject to the usual considerations of patient confidentiality the following parties should be consulted:

- The nearest relative
- Any carers
- Any individual who will be acting in the role of the Approved Clinician (AC)

⁷ Form CTO1 contains a statement to this effect: 'If it is proposed to give a certificate under Part 4A of the Act in the patient's case, the patient is to make himself or herself available for examination to enable the certificate to be given, as requested.'

⁸ Statutory Instrument 1205 (2008) Mental Health, England. *The Mental Health (Conflicts of Interest)(England) Regulations 2008*, regulation 6(1)(b) does not apply to the making of a Community Treatment Order as a CTO does not fall within the scope of section 11(1) of the Act.

- An Attorney (authorised by Lasting Power of Attorney – Personal Welfare) or Court Appointed Deputy under the Mental Capacity Act 2005
- Members of the multi-disciplinary team involved in the patient's care
- The patient's GP. Where there is none, encouragement and help should be given to enable the patient to register with a practice.

The Care Plan should address the arrangements for meeting the assessed needs of the patients in the following categories

- Supervision and Monitoring
- Arrangements for the provision of their rights under Section 132
- Appropriate accommodation
- Provision of Occupational Therapy service
- Day time activities
- Personal support, counselling and advocacy requirements
- Carer and family support
- Welfare rights and other financial assistance required
- Cultural issues
- Physical health needs
- Section 117 Aftercare needs

The Contingency Plan should as a minimum include clarification of the circumstances which would indicate a developing crisis or relapse, how recall will be managed if required and any advance statement or wishes. It should also clearly state how the patient and where appropriate their family or carers, seek assistance from our services. All Contingency plans should with the patients permission be circulated to the appropriate people involved in the provision of their care including the CRHT.

In common with other CPA arrangements, a care coordinator needs to be identified for patients subject to SCT. Where appropriate, this could be the inpatient RC although this may be an exceptional arrangement.

To reflect the development of community based services and ensure best practice AC's may be Community Consultant Psychiatrists providing treatment to the individual in the first instance. The Inpatient Consultant Psychiatrist should remain the RC until the first CPA review as a minimum. The role can then be transferred to the AC. Change of RC should be formally communicated to the MHA Administration Office utilising the Change of RC form.

Were the patient has the capacity to consent to the CTO and the RC/AC has completed form CTO12 or they are subject to the existing powers under the 3 month rule there is no need to make a referral. Otherwise all initial referrals should be completed by the RC as part of the CTO process in order to ensure compliance with the required timeframes. Good practice would suggest that both the RC as well as AC meet with the SOAD to discuss the treatment options.

6.6 Attachment of Conditions

There are two conditions set out in 3 above which are mandatory in all cases. An RC may with the agreement of the AMHP, set other conditions which they think are necessary or appropriate to achieve one or more of the main goals of the order.

Advice on setting other conditions is provided by the Code which the RC and AMHP should always consider.⁹ It is important that the reason for any condition is explained to the patient and others, and a record of such kept in the clinical notes. In all cases, there should be a link between the person's mental disorder and any condition imposed on a CTO.

Where there is disagreement between the RC and AMHP about the necessity or appropriateness of a particular condition or conditions, it would not be acceptable for an RC to use his or her right to significantly vary conditions shortly after discharge to overcome a legitimate objection by an AMHP.¹⁰

The RC may vary the conditions of the CTO (using form CTO2) or suspend any of them where appropriate (e.g. to allow temporary absence of patient) but must record, with reasons, any decision to suspend in the clinical records. In either case, a decision to vary or suspend should be relayed to the MHA Administration office holding the CTO documentation to enable them to update their records. Any condition no longer required must be removed. It is not necessary to seek the agreement of an AMHP to vary or suspend conditions.

6.7 Provision of Information

The RC should inform the patient and others who were consulted, of the decision to discharge a patient onto SCT, including any conditions applied to the CTO and services available for the patient. This will normally include making a copy of the CTO documentation available to the patient and any professional who was consulted as part of the process.

The Hospital Managers will ensure that the patient is provided with information verbally by the care co-ordinator or other appropriate person. This will be recorded on a Section 132 Rights form, which is then copied to the MHA Administration Office. An Information leaflet will be provided in writing to the patient by the MHA Administration Office and to the nearest relative unless the patient objects.

Information in writing given to the patient (and where copied to the nearest relative) will include reference to their rights and the following matters:

- Appeals to the Mental Health Review Tribunal ('MHT')
- Recall, Revocation or Discharge by RC

⁹ Code of practice: Mental Health Act 1983, Department of Health 2015, paras. 29.27 – 29.33

¹⁰ It is held that such an action may be in breach of the Public Law Principle of 'Propriety of Purpose' which requires that a statutory power can only be exercised for a legitimate purpose which Parliament intended.

- Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours' notice requirement), MHT or Hospital Managers
- Independent Mental Health Advocacy Services
- The role of the Care Quality Commission (CQC)
- Treatment rights while subject to CTO in the community

6.8 Recall

Where a change of RC of a patient subject to Recall is anticipated, best practice requires that they should be made aware of and involved in any of the following actions required of the RC as soon as practicable.

The RC will receive regular feedback from the care co-ordinator including any evidence that the conditions of the CTO are not being met. Note that the CoP states that particular attention should be paid to carers and relatives views when they raise concerns relating to deterioration. Also that failure to meet any one condition is not in itself justification for recall but must be taken into account by the RC in considering if recall is necessary.

The RC has the responsibility under the provisions of the Act for the co-ordination of any Recall to hospital and that any such hospital is ready to receive the patient and provide treatment

Where a patient breaches a condition of their CTO, refuses necessary treatment which is leading to relapse or engages in high-risk behaviour as a result of mental disorder, the RC may review the conditions of the CTO. Having done so, if he or she believes it is no longer safe or appropriate for the person to remain in the community the RC may recall the patient to hospital.

To ensure compliance with the Code,¹¹ recall should only be considered if:

- The patient needs to receive treatment for mental disorder in hospital (either as an in-patient or as an out-patient) and
- There would be a risk of harm to the health or safety of the patient or to other people if the patient were not recalled.

Or

- The patient has broken one of the two mandatory conditions above unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered.

The RC must complete a written notice of recall to hospital (form CTO3) which is effective only when served on the patient. Where possible, this notice should be handed to the patient personally, or otherwise be sent by first-class post or delivered by hand to the patient's usual or last known address. If access cannot be gained to the patient, consideration should be given to obtaining a warrant under Section 135(2) of the Act. Table 1 below summarises the reasons for and effect of each

¹¹ Code of practice: Mental Health Act 1983, Department of Health 2015, paras. 29.52 – 29.62

method of Serving a Notice of Recall. The RC may delegate the delivery of the Recall Notice to any appropriate member of staff

The RC should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide treatment although this may be given on an out-patient basis, if appropriate. Conveyance to that hospital should be in the least restrictive manner possible. Reference should be made to Joint Assistance Protocol (**POL/001/005/002**). The use of Police vehicles should be restricted to those instances where there are significant risks of harm to others.

If the hospital is under the management of the same organisation as the patient's detaining hospital immediately before making the CTO (e.g. Cumbria Partnership NHS Foundation Trust), a copy of the completed form CTO3 will provide authority for detention. Form CTO6 is not required for transfers within the same organisation but the receiving hospital must complete form CTO4 recording the date and time of the patient's initial recall to hospital.

Patient's Circumstances	Appropriate Method of Serving form CTO3	Notice effective
Patient can be approached in person and may be at or in hospital already	Deliver form by hand personally	Effective Immediately
Patient not available in person e.g. has failed to attend requested appointment to see Second Opinion Appointed Doctor but situation is not urgent	Deliver form by 1 st class mail to address where patient is believed to be	Served on the 2 nd <u>working</u> day after posting (e.g. posted Friday effective from Tuesday)
Need for recall is urgent but not possible to hand notice to patient personally as their whereabouts are unknown, patient is unavailable or refuses to accept the notice	Deliver form by hand to patient's usual or last known address <u>If appropriate, consider whether s135(2) warrant should be sought</u>	Notice deemed to be served after midnight on the day it was delivered. It does not matter whether it is a working day, a weekend or a holiday. It does not matter whether it is actually received by the patient or not

Table 1. Appropriate Method by which to Serve a Notice of Recall

Transfer after recall, to a hospital managed by another organisation requires that arrangements for the transfer are properly in place and that form CTO6 is completed to provide authority to transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to.¹²

As soon as practicable, the patient shall be given information verbally and in writing about their rights following recall and the impact, if any on their treatment rights which are set out in a separate Section below. The provision of SCT rights must be recorded in the same manner used for other detained patients.

Following recall, the RC and clinical team will consider the circumstances of the recall and in particular, whether SCT remains the right option for the patient. They must consult the patient and (subject to usual considerations about involving a nearest relative) any other carer, to decide whether a variation in the conditions or change in the care plan – or both – is appropriate. The RC may allow the patient to go on leave outside the hospital at any time during the 72 hour recall period.

If recall is not appropriate or necessary because a patient with capacity agrees to come into hospital on an Informal basis or to attend for treatment in a community setting, there is no statutory reason why that should not happen. Recall is permissible in relation to an existing inpatient¹³. To avoid confusion or failure to adhere to the intended statutory scheme, it is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in the clinical records.

6.9 Revocation

In order to ensure consistency and continuity of care community RC's will retained responsibility for their patients until the end of the Recall period or Revocation (whichever comes first) at which point RC responsibility may be transferred to the Inpatient AC, the change of RC form completed and forwarded to MHA Administration.

If in-patient treatment is required for longer than 72 hours from arrival in hospital, the RC must consider revoking the CTO. Although not specifically covered by the legislative scheme or the Code, there is no impediment to a patient agreeing to remain in hospital on a voluntary basis where they have the capacity to choose to do so for a brief period. Such a decision will require the RC to reconsider the appropriateness of SCT and document that they have done so.

To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. An AMHP, having considered the wider social context for the patients, must also agree with the RC's assessment. This need not be an AMHP already involved in the patient's care and treatment.

¹² Statutory Instrument 1184 (2008) Mental Health, England. *The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008*, regulation 9(3)-9(5)

¹³ This position is confirmed by s17E(4), *The Act*

If the AMHP does not agree that the CTO should be revoked, their decision and the reasons for it must be fully documented in the clinical records, the patient must be discharged from hospital at the end of the 72 hours and the CTO continues. It is not appropriate for an RC to approach another AMHP for an alternative view.

Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 & 3 and the AMHP completing Part 2 of form CTO5. The revocation takes effect immediately once signed. The form must be forwarded to the MHA Administration Office as soon as practicable.

The effect of completing form CTO5 is that the patient reverts to being detained under whichever Section of the Act they were subject to immediately before the CTO was made. However, in all cases they are subject to a new period of detention of up to six months beginning with the day of revocation.

On revocation, form CTO5 must be copied to the managers of the hospital to which the patient was recalled, if the patient was transferred during the period of recall.

6.10 Extension

A CTO can be extended following examination of the patient by the RC within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met.¹⁴ These mirror the criteria and mandatory conditions described at 3 above with the additional requirement that the RC must also consult one or more other person who has been professionally concerned with the patient's medical treatment.

As when making the original CTO order, the RC must obtain the written agreement of an AMHP that the conditions for extending SCT are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1 but where the RC is not a registered medical practitioner, they should consult a doctor¹⁵

The RC completes and signs Parts 1 & 3, the AMHP completes Part 2 of form CTO7 addressing the report to the Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital's internal mail system. It is then received by the MHA Administration Office who will complete Part 4.

Once received, the Managers must undertake review of the report provided on form CTO7 which may vary in uncontested cases¹⁶. Where practicable, this should be done before the new period of extension takes effect but the completed form CTO7 itself provides lawful authority for the patient's continued SCT. Such reports will be dealt with in the same way as existing reports made to renew detention under the Act (in that a Managers Review Panel will be held) although it may be appropriate to

¹⁴ The Mental Health Act 1983, s20A(6)

¹⁵ Although this is not an explicit requirement of the Act currently, this is a safeguard against potential future challenges to the validity of 'medical evidence'.

¹⁶ Code of practice: Mental Health Act 1983, Department of Health 2015, *paras* 38.41 – 38.46

arrange the review at a more convenient location than the hospital in which the patient was originally detained.

The Code sets out questions that a Panel of Managers should address in the order given whenever they review a report made using form CTO7:¹⁷

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interest of the patient's health or safety or the protection of other people that the patient should receive such treatment?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed?

The Code then requires that if three or more members of the panel (being a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is "no", the patient should be discharged.

Where the answer to all these questions is "yes", but the RC has made a report under Section 25 barring discharge by the nearest relative (discussed further below) the following question must then be addressed:

- Would the patient, if discharged, be likely to act in a manner that is dangerous to other people or to him or herself?

Where three or more members of the panel (being a majority) disagree with the RC and conclude that the answer is "no", they should usually discharge the patient. However, they retain a residual discretion not to discharge in such cases, so should always go on to consider whether there are exceptional reasons why the patient should not be discharged.

Special provisions for extending the community treatment period apply to patients who have been unlawfully at large ('absent without leave') which are set out in Sections 21A & 21B of the Act. After an absence of more than 28 days, form CTO8 must be completed to extend the CTO period.

Where the criteria for extending SCT are not met and consequently, the RC does not plan to make a report to the Managers using form CTO7 (or where applicable, form CTO8) the patient should be discharged by the RC rather than waiting for the current CTO to expire. This does not apply to a case where an AMHP does not agree to extension. In such a case, the RC may choose to exercise his or her right of discharge or may allow the CTO to lapse.

Extension periods for SCT mirror the renewal scheme for Section 3 patients: the initial CTO lasts for up to six months, if extended lasts for a further six months and thereafter, up to one year on each extension. The new period of SCT is calculated from the day after the date on which the current order would have otherwise come to an end if it had lapsed.

¹⁷ *Code of practice: Mental Health Act 1983, Department of Health 2015, paras 38.15 - 38.23*

6.11 Discharge from compulsion

'Discharge' for a CTO patient, regardless of who orders it, means complete release from liability to detention under the Act in hospital or in the community. It is not the same as 'recall' or 'revocation' which are described at 7 and 8 above nor the process of 'discharge subject to...being liable to recall'¹⁸ which follows the making of a CTO order.

The RC can discharge a patient from SCT at any time in writing by completing the local discharge from liability to detention form under Section 23 of the Act¹⁹ and providing it to the Managers of the responsible hospital. There is local non statutory form for this purpose but no statutory requirement to consult with any other person.

A Part II SCT patient's nearest relative (there is no available power in relation to Part III SCT patients) can order their discharge in the same way as they can for Section 2 or 3 patients. An order must be put in writing giving at least 72 hours notice but need not be in any specific form. To assist this process, a standard letter is available from the MHA Administration Offices.

Within the permitted 72 hours, the RC may sign a report barring discharge under s25 of the Act. In doing so he or she has concluded that 'the patient, if discharged, would be likely to act in a manner that is dangerous to other people or to him or herself'. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness (see 9. above). Where a report is made, the nearest relative must be advised of their right to apply to the MHT.

If the RC does not sign such a report, discharge by the nearest relative takes effect after 72 hours or at a point shortly after that which they have specified. Where a patient has been recalled to hospital, only the RC can discharge him/her during the period of 72 hours following recall. During the same period, there is no power of discharge available to the nearest relative, Hospital Managers or MHT.

The Hospital Managers have the power to discharge an SCT patient exercisable by 3 or more members of a panel (being a majority) on agreement that one of the criteria for a CTO or its extension is no longer met and consequently, CTO is no longer appropriate or necessary. Where a patient's CTO has been revoked, the review will be essentially the same as that for any patient liable to detention under the Act.

The MHT can discharge an SCT patient other than during the 72 hour period of recall of such a patient. If following recall, a patient's CTO is revoked, the Mental Health Act/Law Administrator (or equivalent) must refer the patient's case to the MHT as soon as possible. All circumstances where there is a duty to refer a case to the MHT are set out in Section 68 of the Act.²⁰

¹⁸ The Mental Health Act 1983, s17A(1)

¹⁹ An order for discharge is made under s23(2)(a) if SCT has been revoked or s23(2)(c) if SCT still in force

²⁰ They are conveniently set out in the form of a table in Code of practice: Mental Health Act 1983, Department of Health 2015, para. 37.39

An application for discharge can be made once by a patient to the MHT during any period of SCT. Any withdrawn application is disregarded and does not interfere with this right. The MHT cannot vary conditions on an SCT imposed by the RC and although it can make a recommendation, cannot oblige an RC to make an SCT order for a detained patient. The MHT application rights of both patients and their nearest relatives are set out in Section 66 of the Act.

Managers Appeals, Renewals and MHTs will normally be held in a hospital setting however, it may be appropriate for the hearing to be held in an alternative setting such as a community facility by prior discussion with the patient and others involved and agreement if there are practical reasons for doing so.

If a patient is detained in another hospital under Section 3 or equivalent, other than by their CTO being revoked, this will automatically discharge the existing CTO and its underlying Section. SCT can only be recommenced by starting a fresh assessment again. Detention under Section 2 will not affect a current CTO.²¹ Detention in prison or elsewhere of less than six months' duration will allow a CTO to continue or to be extended in accordance with the provisions set out at 6.10 above. Detention in custody for a period of more than six months will automatically bring the CTO to an end.

6.12 Transfers

Paragraphs 6.8 above, describe the process for the physical transfer of a patient between hospitals following recall which requires the completion of form CTO6 where the hospitals are managed by different organisations. It does not necessarily mean that there is a transfer of the patient's responsible hospital.

The responsible hospital for a patient subject to a CTO in the community (who may have been recalled to hospital) may be assigned to another hospital managed by a different organisation, with their agreement on completion of form CTO10. This process does not include the physical transfer of a patient which is dealt with above. It is referred to as an 'assignment of responsibility for community patients'²²

Clinicians are not authorised to accept the transfer of patients subject to CTO from hospitals outside of the Trust. Further clinicians are not authorised to make an application for CTO for patients who are not currently detained to the Trust. In both cases advice should be sought from MHA Administration.

Assignment of responsibility for community patients between hospitals within the Trust requires no statutory paperwork but the Managers of the hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give their name and address.

²¹ Admission under section 2 should not normally be considered as a legitimate alternative to recall or revocation of a CTO but its appropriateness as a temporary alternative might be argued where a patient has been admitted for assessment under s2 to an out of area hospital without their knowledge that he or she was subject to SCT. The least restrictive option in that situation might be to briefly continue with s2 rather than revoking the CTO if discharge back to SCT is imminent.

²² The Mental Health Act 1983, s19A

In any case, the new hospital becomes the responsible hospital and as such is treated as if it were the detaining authority when the patient was originally detained in hospital (and is now subject to recall to) prior to going onto a CTO.

In the case of any transfer or reassignment of responsibility, the Code requires that the needs and interests of the patient are considered to ensure compatibility with the patient's rights to privacy and family life under Article 8 of the European Convention on Human Rights.

Once a CTO has been revoked, transfer between hospitals under different managers is the same as for any other patient who is currently liable to detention using form H4.

Where a community patient under broadly equivalent legislation in Scotland, the Isle of Man or any of the Channel Islands is removed to England, their arrival in England is recorded using form M1 (date of reception of a patient in England) and where they are to be treated as if they were subject to a CTO, form CTO9 is completed by the RC (Part 1) and an AMHP (Part 2). As when making a new CTO, any conditions must be specified on form CTO9 and have the written agreement of an AMHP.

6.13 Section 17 leave

Section 17 (relating to leave of absence from hospital) of the Act requires that when considering granting longer term leave, an RC must consider whether SCT is the more appropriate way of managing the patient in the community. This applies to s17 leave for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days). Refer to **POL/001/005/006** for further guidance on the use of Section 17 Leave of Absence within the Trust.

These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for SCT. An RC may still legitimately authorise longer-term leave where it is the more suitable option but must prove that he/she has considered whether SCT is more appropriate.

The RC must record in the clinical records that he/she has considered whether longer-term leave or SCT is appropriate with reasons when authorising or reviewing such leave. This question should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, Section 17 leave forms will carry a tick-box statement to the effect that SCT has been considered where appropriate.

The Code sets out a table of pointers for SCT or longer-term leave of absence which may be of assistance to RCs and is replicated below. (A further table contrasting SCT and guardianship can also be found in the Code from Para. 31.2)

6.14 Treatment on Recall

For patients liable to detention under the Act other than SCT patients, the administration of medication for the treatment of mental disorder after three months is authorised by a valid consent certificate (form T2) or second opinion certificate

(form T3). The former is only valid as long as the patient is able and willing to give consent, the latter permits specified medication to be given even in the absence of consent or lack of capacity to consent.

When a patient on SCT is recalled, they will become subject to the provisions of those Sections of the Act governing treatment for detained patients.²³ If treatment does not include psychotropic medication or Electroconvulsive Therapy ('ECT') and a patient with capacity consents to it, it may be given under the direction of the RC.

If a Second Opinion Appointed Doctor ('SOAD') has approved any treatment (on form CTO11) in the event of the patient's recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the SOAD has indicated otherwise, the certificate will authorise treatment (other than ECT) whether the patient has or does not have capacity to refuse it.

On recall, treatment that was already being given as described on form CTO11, may continue to be given if the approved clinician in charge of the treatment considers that stopping it would cause the patient serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

It is not good practice on recall, to rely on a certificate that was issued while a patient was detained prior to going onto SCT even if it remains technically valid. A new certificate should be obtained.²⁴

6.15 Treatment under Part 4 in the community

The treatment of SCT patients, who have not been recalled to hospital, including patients who are in hospital on a voluntary basis not having been recalled, is dealt with under Part 4A of the Act. The Code refers to them for convenience as 'Part 4A patients' and provides detailed guidance on their treatment in chapters 23 and 24.

There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria set out at 10 above.

The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 ('MCA') including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give SCT patients any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for an SCT patient.

²³ The Mental Health Act 1983, s57, 58, 58A and 63,

²⁴ Code of practice: Mental Health Act 1983, Department of Health 2015, para. 25.85

The MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is 'Gillick competent' in accordance with a ruling of the House of Lords²⁵. This is sometimes referred to as 'Fraser competency' acknowledging the Law Lord who set out the principles to be applied in determining such competency.

Part 4A patients over the age of sixteen, who lack capacity may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient's behalf. If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under MCA.²⁶

If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in Section 64G which reflect the similar scheme in the MCA²⁷. The alternative mechanism is via recall to hospital but the recall criteria set out at 10 above apply equally to patients lacking capacity.

In an emergency, treatment for Part 4A patients who have not been recalled can be given by anyone (it need not be an Approved Clinician or the RC) but only if the treatment is immediately necessary to:

- Save the patient's life
- Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;
- Alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- Prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

For ECT (or medication administered as part of ECT), only the first two categories apply.

In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the MCA.²⁸ **These are the only exceptional circumstances in which force can be used to treat an objecting SCT patient without first recalling them to hospital.**

²⁵ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)

²⁶ See Chapter 9 of Code of practice: Mental Health Act 1983, Department of Health 2015

²⁷ See conditions set out in section 6 *Mental Capacity Act 2005*

²⁸ Code of practice: Mental Health Act 1983, Department of Health 2015, paras 24.24 – 24.28

In non-emergency situations (excluding ECT for which reference should be made to paragraphs 24.18-24.24 of the Code and the Trust's ECT policy) a patient may lack capacity and object to treatment but where physical force is not required he or she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO.

After the first month, a SOAD must certify that such treatment is appropriate on a Part 4A certificate (form CTO11). The SOAD certifies the appropriateness of treatment and any conditions attached to it,²⁹ not whether a patient has or lacks capacity or is refusing.

The SOAD will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply. See paragraph 13. above.

Form CTO11 should be kept with the original SCT and detention papers but a copy must be kept in the clinical records.

The arrangements surrounding the SOAD's examination will be complicated by the fact that the patient is in the community so an appropriate person should be asked to confirm arrangements with the SOAD and coordinate the process. This will be care coordinator in liaison with the MHA Administration Office

Other than in exceptional circumstances, SOAD examinations will be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit an SCT patient in a hostel or home, the SOAD will always be accompanied by an appropriate member of the care team.

7 TRAINING

Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Learning and Development Policy

8 MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed

²⁹ Code of practice: Mental Health Act 1983, Department of Health 2015, para 25.32

There is documented evidence within the care plan of consideration of the 5 principles	Audit	MHLU	Annually	MHAHA	Network Compliance/Governance
AC is identified in the community prior to application	Audit	MHLU	Annually	MHAHA	Network Compliance/Governance
Transfer of RC status has taken place at a CPA meeting minimum of 1 month post implementation of the order	Audit	MHLU	Annually	MHAHA	Network Compliance/Governance
No patient is detained for longer than 72 hours unless the CTO is revoked	Audit	MHLU	Annually	MHAHA	Network Compliance/Governance
All individuals have their S132 Rights recorded as described in the policy	Audit	MHLU	Annually	MHAHA	Network Compliance/Governance

9 REFERENCES/ BIBLIOGRAPHY

Mental Health Act 1983 c20

Code of practice: Mental Health Act 1983, Department of Health 2015

Mental Health Act 1983: reference guide, Department of Health 2015

Mental Capacity Act 2005 c9

Mental Capacity Act Code of Practice, Department of Health 2016

Mental Health Act 2007 c12

Convention for the Protection of Human Rights and Fundamental Freedoms
 (European Convention on Human Rights, as amended)

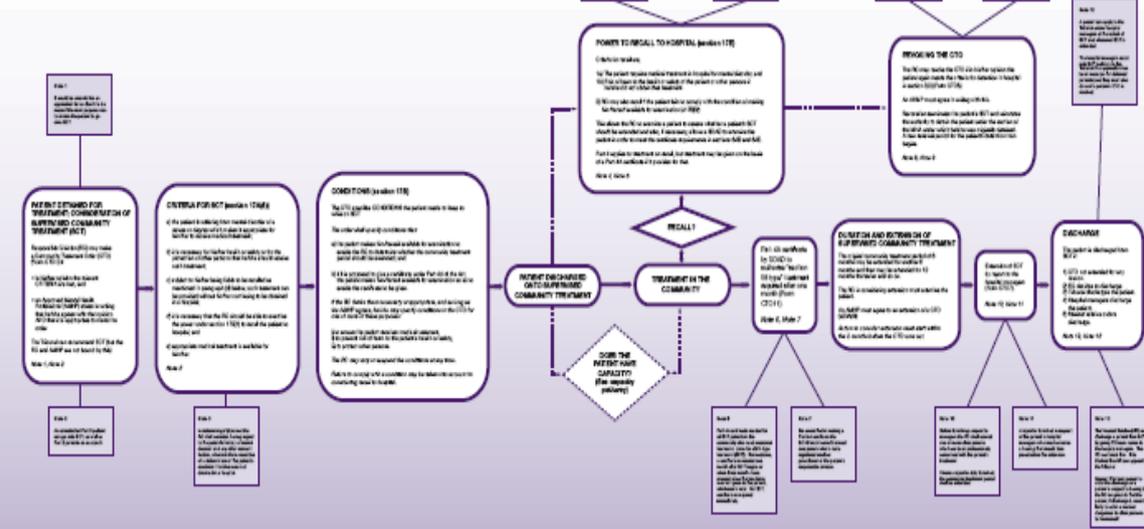
10 RELATED TRUST POLICY/PROCEDURES

POL/001/005/014	Age Appropriate Admissions Policy
POL/001/005/017	Children Visiting Detained Patients Guidance
CCC Guardianship	Guardianship Policy, Procedures and Guidance (Interim Joint Cumbria County Council Policy)
POL/001/005/004	Guidelines on Section 5 (4) Nurses Six Hour Holding Power
POL/001/005/005	Informal Patients Leave Arrangements Guidelines
POL/001/005/016	Management of Mental Health and Learning Disabilities Patients Policy
POL/001/005/012	Mental Act Guideline on the Exclusion of Visitors to Detained Patients
POL/001/005/009	Mental Health Act Guidelines for the Exercise of Powers to Withhold Outgoing Mail
POL/001/005/007	Mental Health Act Guidelines on Receipt and Scrutiny of Section Papers
POL/001/005/003	Mental Health Act Guidelines on Section 5 (2) 72 Hour Holding Power (2013)
POL/001/005/011	MHA Section 117 Aftercare Policy
POL/001/005/006	Section 17 Leave of Absence MHA (1983) Guidelines

11 FLOW CHART

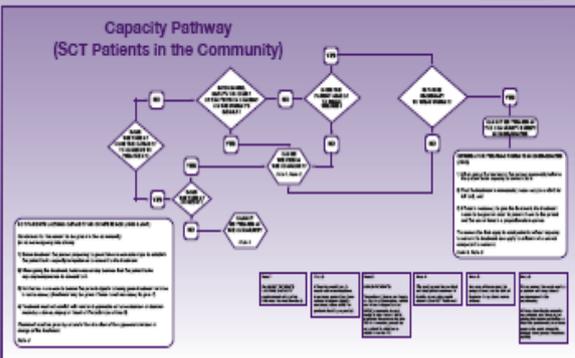
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May 2008

Case Services Improvement Partnership **CSIP**
National Institute for
Mental Health in England



GENERAL NOTES

- CRUCIAL PRINCIPLES:** Important to remember that the Guiding Principles, as set out in the Code of Practice, underpin all SCT decisions.
- The pathway uses the term 'CTO' where a reference is made to the actual order rather than to the system of SCT consent.
- RMA, RMA Teams and Local Social Services Activities** will have to consider and decide on:
 - Consent to an arrangement for an individual;
 - Resources, identifying the likely patients, the range of services to be provided, planning capacity to deal with mental patients; if also need to be taken into account in planning and resource services.
- It is important to involve patients, nearest relative and advocacy services at all stages (subject to patient's agreement).
- Continue to engage patients, family, carers and social networks in line with the Case Programme Approach (CPA).
- PURPOSE OF SCT:** Applications for admission for treatment in respect of a patient shall not be granted unless the patient gives or the SCT, but while the patient remains on SCT the manager's activity to ensure that he is supported.
- STATUS OF PATIENTS FROM HOSPITAL:** Longer term leave may not be granted unless the SCT has considered whether the patient should go onto SCT. For these patients, longer term leave is granted to a patient if:
 - leave of absence is granted to a patient either 'half-stay' or for a specified period of leave that is commensurate with the specified period; or
 - in a specified period is granted leave that the total period for which leave of absence will have been granted in a period exceeds 7 consecutive days.



This pathway has been produced solely to help you understand the procedures involved in Supervised Community Treatment and shall not be relied on for any other purpose. It should be read in conjunction with the Mental Health Act 1983, as amended by the Mental Health Act 2007, and the Code of Practice.

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