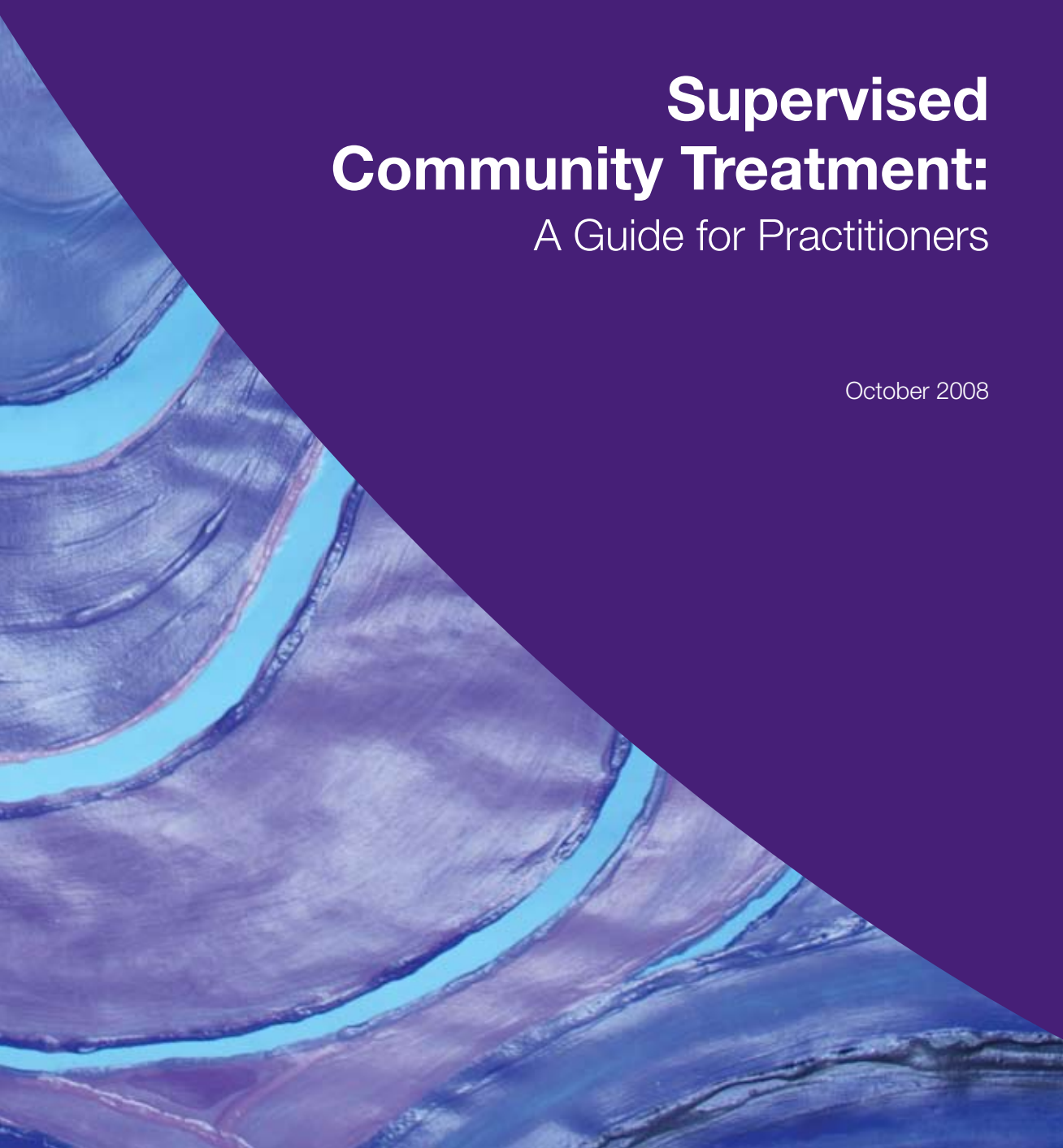
National Institute for
Mental Health in England

Supervised Community Treatment:

A Guide for Practitioners

October 2008



DH INFORMATION READER BOX

Policy HR / Workforce Management Planning / Performance Clinical	Estates Commissioning IM&T Finance Social Care / Partnership Working
Document Purpose	For Information
Gateway Reference	10432
Title	Supervised Community Treatment: A Guide for Practitioners
Author	DH / National Institure for Mental Health in England
Publication Date	01 Sep 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA Ces, Foundation Trust CEs, Medical Directors, Directors of Nursing, Local Authority CEs, Directors of Audit SSs, Allied Health Professional, GPs, Directors of Childrens SSs
Circulation List	
Description	Operational guidance and good practive recommendations to assist practitioners in implementing supervised community treatment, a new sytem introduced by the Mental Health Act 2007
Cross Ref	Code of practice on Mental Health Act 1983 as amended
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	Jim Symington London Development Centre National Institure for Mental Health in England 11-13 Cavendish Square London, W1G 0AN 020 7307 2431 jim.symington@ldc.org.uk
For Recipient's Use	

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Introduction

Introduction

This Guide is for all those who are involved with patients who are being considered for, or are on, Supervised Community Treatment (SCT). First and foremost, it is intended to be useful to mental health professionals who will be working directly with patients, for hospital managers and members of tribunals. It should also assist service users, carers, advocacy services, housing providers and others involved in supporting any person's recovery which might include a period of SCT. I believe that readers will find this to be a simple, clear Guide to SCT.

It describes the stages involved in deciding whether SCT is suitable and appropriate for the patient, what conditions should be attached, what care plan should be available for the patient in the community, how the patient will be monitored and supported, and what the processes are for recalling the patient, revoking the order and ending their time on SCT.

At all times the Guide is based upon the guiding principles which should be considered when making any decision under the Act.wThe principles are in Chapter 1 of the Code of Practice and for ease of reference they are set out in Annex A to this Guide.

The Guide reflects the Department of Health's commitment to promoting equality and to eliminating discrimination. In line with that commitment it aims to foster responsiveness to the needs of different groups and the involvement of people in decisions regarding their health and social care and their access to services. These issues, in relation to the Act as a whole, have been explored in the Equality Impact Assessment for the Code of Practice (link at page 50).

The Guide is not intended as a substitute for consulting the Act and Regulations, nor for the Code of Practice and Reference Guide, but rather as a quick reminder of all the issues, with references to the documents mentioned above for further information and with NIMHE's suggestions for good practice. Thanks to the very many practitioners, service users and others who contributed their expertise and views to this Guide.

We hope you will find it useful.

Jim Symington, National Lead for Legislation
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Throughout the rest of this document:

- the Mental Health Act 1983 will be referred to as 'the Act' , and
- individual Sections of the Act will be abbreviated ,e.g. 'Section 8' will appear as 's8'.
- The Mental Health Act 2007, which amends the 1983 Act, will be called 'the 2007 Act', and
- the new Code of Practice, which takes account of these amendments, will be referred to as 'CoP'
- The Regulations referred to are The Mental Health (Hospital, Guardianship and Treatment) Regulations 2008

Patient Pathway: Professionals' Checklist

Section **A**

Patient Eligibility and Suitability for Supervised Community Treatment

The initial assessment will take place whilst the patient is an in-patient and should involve discussion with all of the patient's professional team, the patient and any carer(s), where appropriate.

Section **B**

Supervised Community Treatment: Agreement

Agreement needs to be reached on the following before a Community Treatment Order (CTO) is made:
What treatment will be given and where?
What conditions, if any, should be attached to the CTO?

Section **C**

Setting Up Treatment/Care Planning

Will involve co-operation between agencies regarding services and support, plus good liaison with family and carers.

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Section

A

Patient Eligibility and Suitability

A Patient Eligibility and Suitability for Supervised Community Treatment

Patient Eligibility

Supervised Community Treatment (SCT) increases the range of options for mental health treatment in the community. SCT is implemented through the making of a Community Treatment Order (CTO). It offers a new kind of contract between the patient and clinicians which can be closely tailored to the personal needs of the patient. It can help to reduce stays in hospital, while protecting the safety of the patient, their family and the public, and services and treatment can be offered close to home. SCT gives the opportunity for patients to continue with their daily lives in the community while having treatment, thus giving the stability they need for their improved mental health. It also provides the back-up of speedy recall, leading to earlier treatment, if required, which in turn is likely to contribute to a faster recovery.

There should never be anything **automatic** about SCT. It will be right for some patients, but not others; in some circumstances and not others. The questions which follow are designed to encourage the patient's core professional team to reflect on whether SCT is the right course for that individual.

When should SCT be considered for a patient?

SCT will be one of the treatment options to be considered when:

- a detained patient's progress is reviewed; or
- a detained patient is being considered for s17 leave for over seven consecutive days. It **must** be considered before any eligible detained patient is given leave for more than seven consecutive days (or has their leave extended so it lasts more than seven consecutive days); or
- a formerly detained patient suffers a relapse after discharge and has been re-admitted to hospital and their condition is again stabilised; or
- the Tribunal makes a recommendation that it should be considered for a patient, although the decision to proceed with SCT remains with the RC, even in this situation. **See Code of Practice (CoP) 25.15**

Which patients are eligible for SCT?

A patient is only eligible for SCT after a period of detention and treatment in hospital, usually under s3 of the Act. Patients detained under an unrestricted hospital order (s37) or an unrestricted hospital direction (s45A) or transfer direction (s47 or 48) will also be eligible. No-one detained under s2 of the Act is eligible, nor is anyone who is subject to a restriction order.

Does this eligibility include children and young people?

SCT is available for patients of any age. It may be suitable for some children in some circumstances. (See Page 45 of this guide)

Does the eligibility extend to mentally disordered offenders?

If the patient is detained under an **unrestricted** hospital order, hospital direction or transfer direction and the criteria for SCT apply.

However, for any mentally disordered offender, it is important to check whether they have committed a violent or sexual offence which means that the victim has rights under the Domestic Violence, Crime & Victims Act 2004 (DCVC Act). This victim may have made representations on the subject of the conditions which should apply if the patient goes onto SCT, or have asked to be told if the patient is to go on it. It will be of particular importance if there are to be any conditions placed on the patient as part of the CTO concerning contact with the victim or their family.
(**See CoP 30.29 - 30.31, & 25.37**)

Which patients are suitable for SCT?

SCT is particularly designed to support people with a history of non-compliance, relapse and re-admission cycles. For these people, and some other patients, SCT offers a chance of re-establishing their lives in the community with the support and monitoring of the team which works with them.

Some of those suitable may be 'revolving door' patients – people who are often well-known to local teams, and caught in a long-term cycle of relapse and re-admission. Others may be patients who, during a period of detention in hospital, are identified by their responsible clinician (RC) as needing the support and structure which SCT offers, to pre-empt relapse in the community and avoid further lengthy admissions to hospital under the Act.

What are the important factors in deciding if SCT is appropriate?

Practitioners must assess risk and how to manage risk when setting up SCT. The Code of Practice refers in more detail to good risk assessment. (**See CoP 25.8 – 25.14**)

Criteria which must be met before a Community Treatment Order (CTO) is made:

The patient is detained under s3 of the Act or on an unrestricted order.

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment.
- It is necessary for the patient's health or safety, or for the safety of other persons, that the patient should receive such treatment.
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital.
- It is necessary that the responsible clinician should be able to exercise the power, under s17E(1), to recall the patient to hospital. (**See CoP 25.47 – 25.33**)
- Appropriate medical treatment is available for the patient.

Difference between SCT and s17 leave

It is usually envisaged that a patient who is on s17 leave is likely to need further in-patient treatment within a relatively short period of time, but is able to live in the community for a while. A patient on SCT is seen as someone who does not need further in-patient treatment at that time, and whose stay in the community will be long term, so long as they keep to the conditions attached to their CTO and do not meet the criteria for recall to hospital for treatment.

Patients on s17 leave can be recalled to hospital for as long as the RC wants and do not have a new right to go to the Tribunal, whereas SCT patients can only be recalled for 72 hours without the CTO having to be revoked and conferring the right to apply to the Tribunal .

It is important to consider carefully which option is more appropriate for a patient as they are clearly not interchangeable. (**See CoP 28.1 – 28.6**) The Code of Practice gives a very useful table of factors to consider when deciding whether s17 leave or SCT is the more appropriate option for a particular patient. (**See CoP 28.6**)

Good practice questions

- **Is SCT right for this particular patient?**
- **Will it provide the best route to improving and sustaining their mental health and well-being?**
- **Have you considered all the alternatives?**
- **Have you considered all the issues in light of the guiding principles of the Act?**
  - Has there been a comprehensive risk assessment made, both for the risks to the patient and regarding the safety of others in the community?
  - What alternatives have you considered as a team?
  - What are the pros and cons?
  - Is the compulsory element of SCT a proportionate way of responding to your assessment of the patient's needs?
  - What are your objectives and the patient's objectives for the next phase of treatment? Could they equally or better be met by one of the following:
    - s17 leave;
    - guardianship;
    - discharge from compulsion;
    - continuing detention for the time being?
  - Is there any disagreement in the team about what would be the best next step? If so, have managers been involved? What is your local procedure for dealing with disagreements of this kind?

- **Communication**
  - Is English the patient's first language?
  - Have you arranged for any necessary translation or interpretation?

- Does the patient have particular communication needs?
- Have all the options been fully explained?
- Is the patient clear about their rights?
- Is the patient being offered/supported by an independent advocate?
  After April 2009, when the service is expected to commence, this may be an Independent Mental Health Advocate (IMHA).
- If nearest relative, other family and carers are to be consulted, with patient's agreement, how will communication be made with them?

- **Is the patient able to make decisions about their own situation?**
  - If there is someone who has authority to act for the patient under the Mental Capacity Act 2005 (MCA), then they should be consulted.
    (**See CoP 25.17**)
  - If everything that needs to be done to provide the patient with treatment in the community can be safely done on the basis of the MCA, then it is unlikely to be necessary to use SCT.

Responsibilities of the Responsible Clinician

Patient Status: Making the decision as to the patient's eligibility and suitability for SCT:

The responsible clinician (RC) is likely to be the senior clinician who has worked most closely with the patient during their detention in hospital. The RC will have overall responsibility for the patient, and will be an approved clinican (AC), but might belong to any of the following professions: nurse, psychiatrist, psychologist, occupational therapist or social worker. The RC, who should be the most appropriate available AC to meet the patient's needs at that time, will be allocated to take responsibility for the patient's treatment in the community, calling on other professionals to provide areas of treatment which are not within the RC's professional competence. It may be agreed in some circumstances that it would be more appropriate for another RC to take over the role when the patient is being treated in the community. However, a patient can only have one RC at any given time.

SCT will be one of the options which the RC considers when reviewing the patient's treatment.

It is the RC's responsibility to:

1. undertake a risk assessment – assess the risk of relapse in the community or the possibility that recall may be needed for other reasons, on the basis of the patient's progress and history;
2. establish whether the criteria for SCT are met and seek the agreement of an approved mental health professional (AMHP) in accordance with local policy;
3. consult with the patient and all interested parties;
4. consider SCT as an option where the Tribunal has recommended it.

If the Approved Mental Health Professional (AMHP) does **not** agree at stages 2) or 4) above, SCT **cannot go ahead**. If that happens, the views of a different AMHP **should not** be sought in order to get agreement. (**See CoP 25.27**)

Local policy and protocol will determine how the RC accesses the AMHP.

The next stage is to agree the conditions of SCT.

If the AMHP agrees, SCT can be put in place. The RC must complete the Community Treatment Order (CTO), (Form CTO1). Copies of the Statutory Forms can be found in Annex B.

The RC must specify:

- the date and time when the CTO comes into effect. (If it is not to come into effect immediately, delay should be for only a short period);
- the reasons why the patient meets the criteria;
- the conditions which the patient will be expected to keep to once placed on SCT.

It is good practice to attach to the CTO a copy of the care plan to be provided in the community. If the patient agrees, then a copy of their care plan should also be sent to their GP, if the GP is involved in delivering part of that care plan.

- The GP will be notified in the usual way about the patient's medication.
- The responsible clinician does not have to take personal charge of prescribing medication (and some responsible clinicians may not be

qualified to prescribe). Arrangements can be made for someone else to prescribe, including a GP. It should be noted that if an SCT patient lacks capacity to consent to treatment for mental disorder and no-one else is eligible to consent on their behalf, the treatment can normally only be administered to the patient by or under the direction of an AC who is qualified to prescribe that treatment. GPs will not usually be approved clinicians.

- Once a Part 4A certificate (Form CTO 11) is needed for the patient's treatment, unless the treatment is immediately necessary, no medicinal treatment for mental disorder can be given by anyone to an SCT patient in the community unless the certificate covers it.
- Where it has been agreed that GPs will prescribe medication, they should not prescribe anything for the patient's mental disorder which is not covered by the certificate. If the certificate needs to be changed, they should discuss that with the responsible clinician.
- GPs can of course treat the patient as they see appropriate for any condition not related to their mental disorder.

The CTO1, completed and signed by both the RC and the AMHP, must be sent to the hospital managers. The patient must be informed orally and in writing about the reasons for SCT, the conditions, how SCT works and of their right to apply to the Tribunal. It is the responsibility of the hospital managers to inform the patient about the Independent Mental Health Advocacy (IMHA) service, when this service commences. The information must be copied to the nearest relative, unless the patient requests otherwise.

Responsibilities of the Approved Mental Health Professional

Patient Status – Making the decision as to the patient's eligibility and suitability for SCT

The Approved Mental Health Professional's (AMHP's) formal role in setting up a CTO involves determining with the RC whether the criteria are met and that it is appropriate to make the CTO. The AMHP must also agree the conditions to be attached to the CTO, or they may disagree and suggest a variation in or additional conditions. The agreement of an AMHP is also necessary before an RC can extend or revoke a CTO.

In making these judgements, the AMHP is expected to bring knowledge of the patient's social situation into the discussion. This may require discussion with the patient's care co-ordinator or key worker so that information about the patient's home, family, informal support networks, cultural background, and so on can all form part of the decisions which are taken about SCT.

Are the criteria met?
See page 11 above for checklist of criteria
(**See CoP. 25.24 – 25. 27**)

If the AMHP does not agree with the RC that the criteria are met, **then the CTO cannot go ahead**. If that happens, the views of a different AMHP should **not** be sought in order to get agreement. The AMHP should ensure that a record is made of their decision, with the full reasons for it, in the patient's notes. (**See CoP 25.27**)

The next step in this situation would be a further review of the patient's case, which might involve the patient plus all relevant professionals and carers, so that an alternative plan may be made. However, depending on the AMHP's reasons for disagreeing with the making of a CTO, it may be that agreement can be reached fairly simply between the patient and the professionals that detention might continue for the time being or that a full discharge is appropriate.

If the AMHP agrees that the criteria are met, then the next stage is to agree the conditions.

B Supervised Community Treatment: Agreement

Responsibilities of the Responsible Clinician

What conditions can be attached to SCT?

SCT must contain two conditions: that the patient will make themselves available for examination to consider the extension of the CTO **and**, when and if needed, for examination by a Second Opinion Appointed Doctor (SOAD) for a Part 4A certificate.

It **may** contain other conditions related to the patient's compliance with treatment, their health or safety or the safety of others. Conditions should be kept to a minimum. (Factors to be considered are in **CoP 25.29 – 25.35**)

The Responsible Clinician (RC) and AMHP should have the guiding principles in mind when setting conditions. The conditions are likely to focus on the arrangements for treatment. Conditions may not be imposed for any reason other than those indicated above. It may, for example, be reasonable to make avoiding some kinds of behaviour or situations a condition but this can **only** relate to the patient's treatment, health or safety, or the safety of others. (**See CoP 25.34**)

Is the patient's agreement necessary?

In practice, SCT is a kind of contract between patients and the clinical teams working with them. SCT will only work if the patient accepts the conditions. Where a patient **explicitly consents to treatment in the community**, they can receive that treatment in any local healthcare setting or at home. Treatment cannot be given in the community to a patient with capacity to consent, without getting their consent. (**See CoP 23.11 – 23.20, particularly 23.14**)

What does the patient think?

- Have you made sure that the patient understands what SCT involves and discussed any fears they may have?
- Does the patient have any objections to what you propose?
- Can the plan be adapted to satisfy their objections?

- Have the conditions attached to the CTO been fully discussed with the patient?
- Will the objections undermine the effectiveness of SCT?
- Have opportunities for appeal against SCT been fully explained?
- Have the patient's views been fully recorded?
- Does the patient have any objections to your contacting and consulting their nearest relative/family/carer(s)?

If there is no objection to consulting them:

What does the family think?

- Does the patient have carers or a family network which may support them in the community?
- Have you explained to the family exactly what SCT is and asked for their views?
- Have you taken these views into account as far as possible?
- If the family/carers are against the use of SCT, will this undermine its effectiveness for the patient?
- Have their views been recorded?
- Carers' needs should also be assessed (good practice is once annually). (See Mental Health NSF Standard 6 and 'Refocusing the Care Programme Approach – Policy & Positive Practice Guidance' Page 25.)

Have all the appropriate professionals involved in the provision of care to the patient been consulted?

- Have discussions about using SCT been part of the development of the patient's Care Programme Approach (CPA) or equivalent?
- Have carers been involved in these discussions, subject to the wishes of the patient?
- Have all relevant professionals been involved or informed: the patient's GP, the Multi-Disciplinary Team (MDT), the Assertive Outreach Team (AOT)?
- Patients on SCT are entitled to s117 services and this entitlement continues for the duration of the CTO, after which an assessment should be carried out in the normal way as to the necessity for s117 services continuing. Have the authorities responsible for s117 services in the patient's area agreed the care package, where necessary?
- Is there agreement within the team on the roles of individual

professionals and carers for the patient's care and has this been clearly communicated to the patient?

- How will you arrange to monitor the patient's progress in the community, including compliance with the conditions and early identification of any risk arising which might mean a need to recall the patient to hospital?

Planning the ongoing review of SCT

- Are dates for review known to all relevant stakeholders: the patient, nearest relative, other family/carers, where appropriate, and professionals?
- Have you been able to set up services which empower the patient and look towards their future?
- Has the patient been offered inclusive day services, education, training or work-related activities?

Once agreement is reached with all of the care team and the patient, then the CTO is made – see AMHP and RC responsibilities.

Summary

Overview of what needs to be done at this stage, in the in-patient setting

- Consult the patient
- Talk and listen to the patient's family, advocate (or IMHA when this service is available) and carers, if appropriate
- Make a full clinical assessment and assess the risk of deterioration if the patient is discharged from in-patient care
- Decide that the SCT criteria are met and that this is the best option for this patient
- Inform the patient
- Determine with the patient the conditions which the CTO will contain
- Involve the Community Mental Health Team (CMHT) and family/carers, as appropriate, in the care planning process
- Involve the patient's GP in care planning process
- Up-date the patient's CPA plan (or equivalent) and make contact with the right agencies for providing after-care

- Make the CTO by completing the necessary statutory form (CTO1) and informing the hospital managers
- Arrange for the patient's transfer to the community with support agreed in the care plan
- Agree whether the role of the RC will be transferred to a community-based AC once the patient is settled in the community
- Set up the SOAD to provide the Part 4A certificate (CTO11) (if the patient needs medicinal treatment)

SCT: Getting Agreement

Agreement needs to be reached on the treatment to be given and where, and what conditions, if any, should be attached to the CTO.

Conditions attached to CTOs:

1) must include:
• that the patient makes him/herself available for examination when the CTO is up for extension; and, if necessary, to allow a SOAD to authorise treatment in the community.

2) may include conditions which are designed to:
• ensure the patient receives medical treatment,
• prevent a risk of harm to the patient's health or safety;
• protect other persons.

3) must not include
• conditions made for any other reason.

If the AMHP does not agree with the RC about the conditions, **then the CTO cannot go ahead**. **The first course of action would be to see if the RC and AMHP's difference of opinion can be resolved**. If not, the views of a different AMHP should **not** be sought in order to get agreement but the patient's case should be reviewed again in light of this decision, to agree an alternative treatment option.

If the AMHP agrees with the conditions, SCT can be put in place.

The RC must complete and sign the CTO1 form, which should then be signed by the AMHP and sent to the hospital managers.

It is good practice to attach to the CTO a copy of the care plan to be provided in the community
With the patient's consent, a copy of their care plan should be sent to their GP.

It would be good practice for the care plan to include details of who is responsible for prescribing medication and who has clinical responsibility for the patient's physical health.

Responsibility of hospital managers

- Hospital managers have a duty to ensure that patients understand what SCT means for them and their rights to apply for discharge. This means they should give patients information about this as soon as practicable after the patient goes on SCT. The information must be given orally, and also in writing. **(See CoP 2.8 – 2.15)**
- A copy of the written information must also be given to the nearest relative, unless the patient requests otherwise, or it would be impractical for any reason (including the risk of breaching the patient's rights under the Human Rights Act – see **CoP 2.32 – 2.33)**
- There should be a clear policy within each hospital as to who should provide this information to the patient and to the nearest relative (subject to the conditions above), i.e. whether it should be the RC or someone else.
- The hospital managers, for example, are required to inform the patient about the IMHA service (once it has begun).

Effect of a CTO (Section 17D)

- A CTO is an order for the patient's discharge from detention in hospital, subject to the possibility of the patient being recalled to hospital for further medical treatment, if necessary. As with any other discharge from detention, the patient does not necessarily have to leave hospital immediately or may already have done so, on leave of absence.

- While a CTO is in force, the application for admission for treatment, or order or direction under Part 3, on the basis of which the patient was detained immediately before going onto SCT remains in force, but the hospital managers' authority to detain the patient is suspended.
- The authority to detain the patient does not need to be renewed while it is suspended and so will not expire while the patient remains an SCT patient. (An order or direction under Part 3 may, however, come to an end for another reason e.g. if the patient's conviction is quashed on appeal, in which case so too will the CTO.)
- When a patient's CTO ends (for any reason except it being revoked), the patient will be discharged absolutely both from SCT and the underlying authority for detention.
- Where the Act refers to patients who are "detained" or "liable to be detained," this does not include SCT patients. Likewise, references in other legislation to patients detained or liable to be detained under the Act do not include SCT patients.
- A CTO may be extended from its expiration, or from the expiration of any period of extension, as provided in s20A of the Act. (**See CoP 29.10-29.14**)

C Setting Up Treatment/Care Planning

Moving from in-patient care to SCT

Planning the move to the community begins in hospital, where the managers should have in place a policy for liaising with the local health service commissioners and providers about the provision of after-care to patients. The team developing the CPA or equivalent plan should include representatives of the hospital care team, community mental health and social services plus the patient's GP. (**See CoP 25.16 – 25.23**)

The team should specify:

- which agency (preferably a named individual) will take responsibility for supplying elements in the package;
- the arrangements for re-assessment and review;
- timescales for the provision of services and review of the package.

After-care planning is the responsibility of the hospital managers, the Primary Care Trust (PCT) and the Local Social Services Authority (LSSA). At local level, good practice would mean an agreed policy for the implementation of SCT including amending existing policies such as those regarding conveying a patient. In practice, much of the detail will be worked out locally between the teams who have worked with the patient in hospital, the community team and the relevant agencies.

Neither the Act nor the Code of Practice is prescriptive about the **patient's management and support in the community**, once the CTO is made, recognising that this will vary considerably depending on the needs of individual patients and on the availability of local facilities and services. However, hospital managers, PCTs and LSSAs will wish to revisit local guidelines within CPA to ensure that points in the Care Plan checklist below are covered.

Confidentiality

Throughout the process, patient confidentiality must be taken into account, with due regard given to balancing this with any risk. There may be situations where it will be necessary for particular people from other agencies to know,

for example, one or more of the conditions of the CTO but this information should not be given automatically to all agencies involved.

It is important that all professionals familiarise themselves with Chapter 18 of CoP, where confidentiality and information sharing is discussed at length.

D Managing in the Community

Throughout the process of arranging SCT and planning the move to the community, the patient and (with their permission) their family and/or carer(s) will have been kept fully informed and involved. This means that, when patients on SCT are discharged to the community, nothing about their situation should be surprising or ambiguous to them or to the people they live with, or those they regard as family or their carers. This includes their carers in homes and hostels where relevant.

The patient **should either:** have a copy of the form CTO1, which specifies the reasons why they meet the criteria and the conditions which they need to meet; or the equivalent information. The aftercare package, which results from the planning process, should be discussed and, if possible, agreed with the patient and their carer(s). Where a patient resists or refuses the aftercare package, the RC and the AMHP will need to assess which elements in the plan are fundamental to the conditions set out in the CTO. It would be best practice to conduct such a review in collaboration with the care co-ordinator or equivalent and the patient's care team.

It is also **good practice** to ensure that the patient has:

- a copy of the CPA or equivalent care plan;
- a copy of the arrangements made for aftercare;
- the name and telephone number of their RC, their care co-ordinator or other named team member and a written appointment for their first visit;
- the name and telephone number of their GP;
- written details of how and where treatment will be given (if already agreed with the patient);
- a 24-hour mental health crisis helpline number;
- information on how to contact the out-of-hours services for physical health care/emergency GP care.

Varying conditions in the community:

It may be appropriate to suspend one or more of the conditions from time to time due to a temporary change in a patient's circumstances, e.g. while the patient is on holiday or if there is illness or bereavement in their family. The

conditions might also be appropriately varied if, for example, there is a change in the patient's needs or living situation. If a condition is no longer required, it should be removed. Although the RC does not need to consult the AMHP to make these variations, it would be good practice to do so, especially if the original conditions had only recently been agreed. (See CoP 25.41 – 45)

Many different agencies may be involved in commissioning or providing services to meet the specific needs of each patient living in the community on SCT. The following checklist considers the setting up of SCT and suggests which agencies and practitioners are involved at each point. The CPA or equivalent care plan should cover how the various elements of SCT will work for that patient, and how carers and family members are to be involved, as per the participation principle.

Care Plan Checklist

The Care Plan should be a clear statement of the patient's needs for future treatment in the community, often related to the conditions set out in the CTO. Details of how and where patients are to receive treatment are central to the plan. This will include medication (captured on the Part 4A certificate) and therapies. In cases of dual diagnosis or physical health problems, disability or sensory impairment, plans for the treatment of the patient's other conditions should be co-ordinated with this statement.

The following checklist names all those who might be involved in each element of the plan.

Supervision and monitoring

The monitoring should be principally concerned with the patient's health, well-being and general situation, rather than focussed solely on the conditions of the CTO. However, the plan should make clear who will be monitoring the patient and what to do if there are concerns that the patient is not complying with the CTO's conditions or that the patient may need to be recalled to hospital. With the permission of the patient, the care co-ordinator should make sure that family members/ carers understand how recall works and when it might be necessary. See CoP 25.38 – 25.40. **CMHT, care co-ordinator (CC-O**).

Appropriate accommodation

Prompt and successful transition to the community depends heavily on the availability of accommodation which suits the patient's needs. A range of suitable accommodation, including residential accommodation offering different levels of support, will be a key resource for patients on SCT. **Housing services, third sector specialist housing, care, nursing and residential home managers, social work support.**

Occupational Therapy services

Occupational Therapists working in the community may be particularly important in supporting patients to develop their involvement in socially-valued roles and in resisting social exclusion. **Primary care mental health, community occupational therapists (OTs), specialist community services e.g. support time recovery (STR) workers.**

Day-time activities

These may include day care services, leisure opportunities, life-long learning and/or activities providing a pathway to training and employment. **Day care, leisure services, third sector pre-work training, occupational therapy (OT).**

Personal support, counselling and advocacy

Patients may need support in re-establishing relationships with family, friends or in their communities. Contact with authorities may pose problems for them and language or cultural differences may cause extra difficulties for them. They may need access to Primary Care mental health advice and advocacy services, where this is available. **Service user organisations, social work, counselling service, independent mental health advocacy (IMHA), CMHT, CC-O.**

Carer and family support

Patients' carers will (with the permission of the patient) need information and support. If they live with the patient, they should, where practicable, be consulted before agency staff enter their home. Please note, responsibility for complying with the SCT conditions rests with the patient not with carers. **CMHT, carer support workers.**

Welfare rights and other financial assistance

An assessment of how a patient will gain access to welfare benefits, where needed, should form part of the plan. **Welfare rights and benefits service, third sector welfare rights advice.**

Particular cultural requirements

Throughout the transition process, the planning team should be aware of any particular cultural, religious or linguistic factors which affect the patient's service needs. **Black and minority ethnic (BME) community development workers, BME community organisations.**

Crisis support

Every plan should clarify the circumstances which would indicate a developing crisis or relapse and the patient's route to help (for example, a 24-hour contact number) and how recall will be managed if necessary, including where possible any advance decision or statement of wishes. This should also be communicated to carers and family members, where appropriate, with the patient's permission. **CMHT, crisis team, assertive outreach team (AOT).**

Physical health needs

These should be considered and agreements made as to who should take responsibility for their day-to-day management if necessary. It should be ensured that the patient is aware how to contact emergency services at weekends and out of hours. **CC-O, primary care.**

Responsibility of the RC

- If a patient on SCT requires treatment in the community, the RC should ensure that the patient receives this from an appropriate person, who may either be a member of the CMHT, or the patient's GP.
- If medicinal treatment is still required after the first month, then the RC must ensure that a Part 4A certificate signed by a SOAD is obtained (Form CTO 11) (see below).

Responsibility of the SOAD

Advice on how to arrange and prepare for a SOAD visit, and detailed information about the SOAD's responsibilities is discussed at length in chapter 24 of CoP.

- If medicinal treatment is still required after the first month, then ensure that a Part 4A certificate signed by a SOAD (Form CTO 11) is obtained, unless the original 3 month period for medicinal treatment (which starts from the time the patient was first provided with medication under the Act) is still in force.
- In signing, the SOAD is certifying that it is appropriate for the treatment to be given to the patient. (**See CoP 24 25 - 24.27**)
- It is good practice for the RC to review the Part 4A certificate at regular intervals. (**See CoP 24.72**)

Capacity, Competence and Consent

'Treatment in the community' means that the SCT patient may be treated at home, in another community-based setting or even in hospital if they have agreed to go and have not been recalled there. The patient must consent to the treatment, or if they lack capacity (and no-one else can consent on their behalf) must not object to the treatment. If the patient lacks capacity to consent – and no-one else can consent on their behalf – the treatment can normally only be given by, or under the direction of, an approved clinician.

No patient can be treated forcibly in the community under SCT, **except** in very limited emergency situations where a patient

- lacks capacity,
- the treatment is immediately necessary,
- it needs to be given to prevent harm to the patient
- and any force used is proportionate to the risk to the patient. (See CoP 23.24 – 23.25)

Otherwise, SCT patients must be recalled to hospital for the treatment to take place (other than in the emergency situation mentioned above). The usual criteria for recall must be met before this can happen.

Emergency situations – When the treatment is immediately necessary:

- to save the patient's life;
- to prevent serious deterioration or alleviate serious suffering; and/or
- is the least intrusive way to prevent the patient from being a danger to themselves or to others.

In the case of emergencies, treatment may be given to a patient who lacks capacity to consent to it without an approved clinician and despite (for adults) any contrary advance decisions, or decisions made on the patient's behalf by eligible people as defined by the MCA or by the Court of Protection. As above, if force is needed to give the treatment this must be proportionate to the danger to the patient. (See CoP 23.21– 23.25)

Unless the treatment is to save the patient's life it must not be 'irreversible or hazardous', although 'hazardous' (but not irreversible) treatments may be used to prevent a serious deterioration in the patient's condition.

Even in emergencies, an SCT patient cannot be given treatment in the community for mental disorder if they have the capacity to consent to it but do not do so.

Advance decisions:

Patients may have made an advance decision or statement of wishes about treatment to which practitioners need to have regard. Patients who lack

capacity cannot be given treatment in the community which goes against a valid and applicable advance decision, unless it is an emergency (as defined above). To be given the treatment, they would have to be recalled to hospital. (See CoP Chapter 17)

Capacity:

'Capacity' in adults (aged 16 or over) should be decided in accordance with s2 of the MCA and all the principles of the MCA. All practitioners working directly with patients on SCT should be familiar with the provisions of the MCA.

Guidance on assessing 'competence' in children is included in CoP 36.38 Where a child is judged to lack competence and lives with his or her parents, the practitioner treating the child should consult with the parents about the treatment.

A donee or deputy appointed under the MCA who has the necessary authority, or the Court of Protection, may consent to treatment on behalf of adult SCT patients who lack capacity. Otherwise, **apart from emergencies** (see above), an adult or child (under 16) who lacks capacity or 'competence' to consent may only be treated under SCT in the community if:

- the treatment is delivered by an approved clinician or someone working under his/her direction;
- the patient, if over the age of 18 years, has not made a valid & applicable advance decision refusing the treatment;
- giving the treatment would not go against the decision of someone else with the authority to make treatment decisions on the patient's behalf under the MCA;
- the patient does not object to the treatment, or if the patient does object, force is not needed to give the treatment.

Force cannot be used to give a treatment if the patient objects to it, except in an emergency (see above).

In principle, **ECT** may be given to SCT patients living in the communjty, although this is likely to happen only rarely (and only when the patient is in hospital voluntarily). It is important that anyone proposing this is familiar with the rules regarding ECT for SCT patients. (See CoP 23.22 and 24.26)

Key Points

The safeguards built into the provisions below clearly relate to the patient's human rights and the Mental Capacity Act and should be implemented carefully.

Generally, an SCT patient will have agreed to the treatment as part of agreeing to the conditions of the CTO but there may be situations where the patient changes their mind and does not want treatment. In those circumstances, practitioners will need to consider the following:

- Has this come about because of a change in treatment/ an emergency?
- Does the patient have capacity (or competence) to consent?

If the patient has capacity, the treatment cannot be given unless the patient is recalled to hospital. If the patient lacks capacity, the approved clinician will need to go on to consider:

- if the patient is an adult who lacks capacity, have they recorded objections to this treatment in a valid and applicable advance decision?
- is there someone else authorised to make decisions on the patient's behalf? If so, would the treatment be contrary to a decision they have made?
- does the patient object to treatment which they need? If so, is force needed to give the treatment?
- does what you know of the patient's history, opinions, personality or culture suggest that they would object, if they had capacity?
- if the patient is under 16, have the parents been consulted about what the patient's view of the treatment would be?
- if the treatment could not normally be given, is the treatment immediately necessary? If it is, is it needed to prevent harm to the patient and is any force that would have to be used justified in the terms laid down by law?

When considering the patient's views, it is the clinician's job to establish whether a patient has or would have objections to the treatment, not how reasonable the objections are.

E Recall/Revocation

Considering recall to hospital

The purpose of the power of recall is to enable the RC to treat the patient in hospital. The recall does not have to be to the hospital from which the patient was discharged, but can be to any hospital appropriate for the patient and their treatment. Recall provisions help provide a safety net when there is a risk of harm to the health or safety of the patient or to other persons. It also provides a breathing space, when relapse seems imminent, in which the patient may quickly receive treatment and the situation be stabilised.

Throughout the duration of SCT, the care co-ordinator or another member of the community mental health team will be routinely monitoring progress, including the extent to which the patient is complying with the conditions set out in the CTO. The RC will receive regular feedback including any evidence that the conditions are not being met. Note that the Code of Practice states that particular attention should be paid to carers and relatives when they raise a concern that the patient's mental health appears to be deteriorating. (See CoP 25.46)

There are clear criteria laid down in s17E(1) of the Act which set limits to the power of recall.

Criteria for recall:

The RC may recall a patient on SCT to hospital for treatment if:

- the patient needs to receive treatment for a mental disorder in hospital; and
- there would be risk of harm to the health or safety of the patient, or to other persons, if the patient was not recalled.

Failure to meet a condition is not in itself enough to justify recall but the RC can take such non-compliance into account when considering if recall

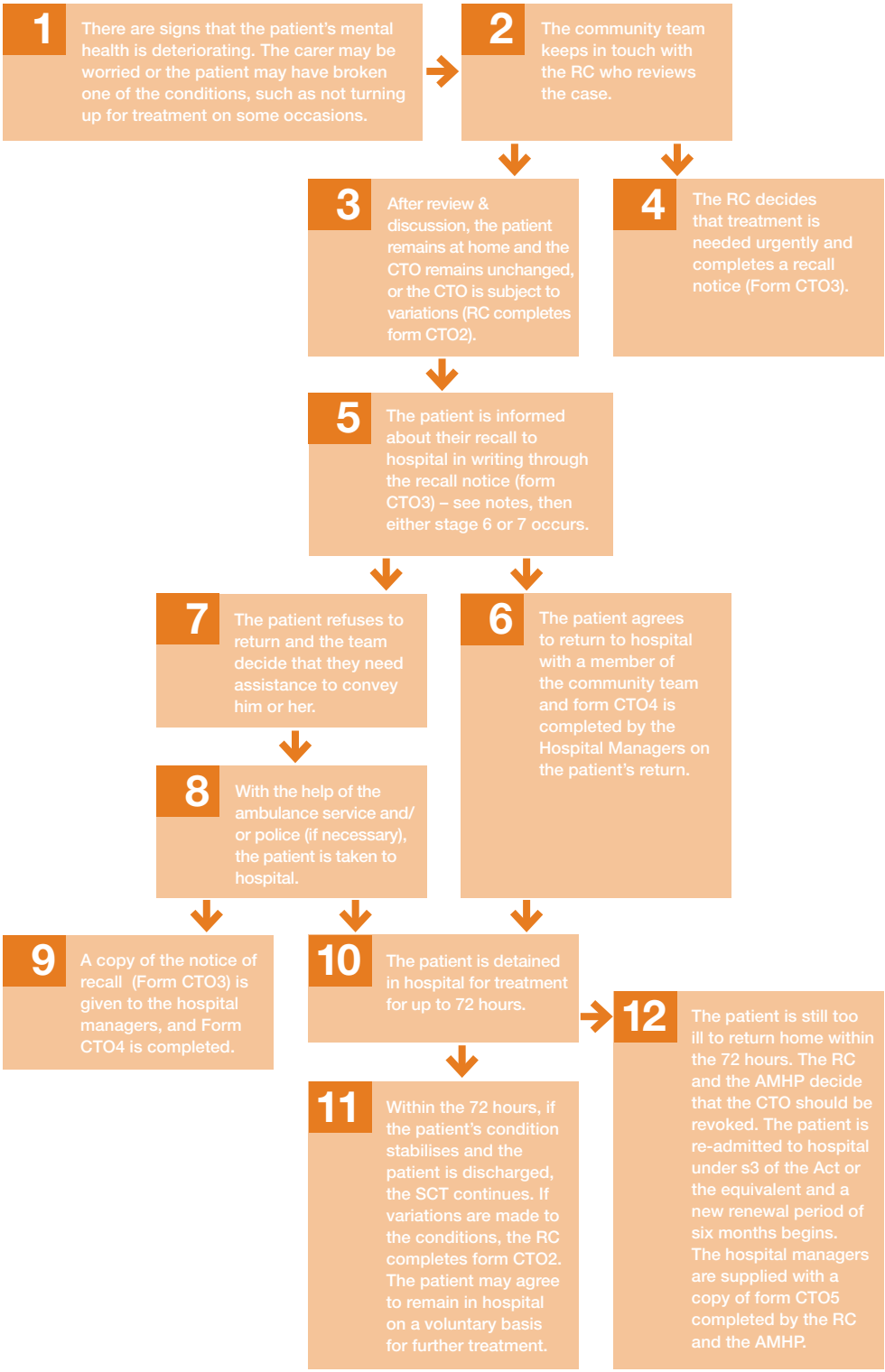
is necessary. **However, if the failure to comply means immediate risk of harm to the patient or to someone else, then the patient falls under the criteria for recall. (See boxed text overleaf.)**

- A patient may be recalled if one of the two mandatory conditions to make themselves available to examination is broken, but this should be the last resort. (**See CoP 25.49**)
- In cases where any other condition has been ignored or broken but the criteria are not met, recall **must not** be used. The RC should review the need for the condition. If it remains necessary, the RC or the community team should negotiate with the patient about his or her compliance. There will be a need to monitor the patient carefully if the condition is still thought to be needed.
- There may be cases where the conditions have been met but the patient's health has deteriorated to the point where the criteria apply. In that instance, the patient **may** be recalled.
- Recall is not expected to be used regularly. When a patient is being considered for subsequent recalls, the RC should review whether the CTO is working in the best interests of the patient.

The whole process of recall may be frightening or distressing for the patient and the family and it is important that it is handled sensitively. The patient's residence may be shared by other family members including children and elderly relatives or friends. It is good practice to ensure that, where appropriate, everyone whose residence it is knows broadly what is going on and that their privacy is respected, as far as possible. Information and reassurance should be given to the patient at every stage.

Recall to hospital

A simplified version of the process is shown in the flowchart which follows. Further detail is included in the Notes below. For a full account of the process see **CoP 25.47–25. 64**


1
There are signs that the patient's mental health is deteriorating. The carer may be worried or the patient may have broken one of the conditions, such as not turning up for treatment on some occasions.
2
The community team keeps in touch with the RC who reviews the case.
3
After review & discussion, the patient remains at home and the CTO remains unchanged, or the CTO is subject to variations (RC completes form CTO2).
4
The RC decides that treatment is needed urgently and completes a recall notice (Form CTO3).
5
The patient is informed about their recall to hospital in writing through the recall notice (form CTO3) – see notes, then either stage 6 or 7 occurs.
7
The patient refuses to return and the team decide that they need assistance to convey him or her.
6
The patient agrees to return to hospital with a member of the community team and form CTO4 is completed by the Hospital Managers on the patient's return.
8
With the help of the ambulance service and/ or police (if necessary), the patient is taken to hospital.
9
A copy of the notice of recall (Form CTO3) is given to the hospital managers, and Form CTO4 is completed.
10
The patient is detained in hospital for treatment for up to 72 hours.
12
The patient is still too ill to return home within the 72 hours. The RC and the AMHP decide that the CTO should be revoked. The patient is re-admitted to hospital under s3 of the Act or the equivalent and a new renewal period of six months begins. The hospital managers are supplied with a copy of form CTO5 completed by the RC and the AMHP.
11
Within the 72 hours, if the patient's condition stabilises and the patient is discharged, the SCT continues. If variations are made to the conditions, the RC completes form CTO2. The patient may agree to remain in hospital on a voluntary basis for further treatment.

Notes on the Flow Chart – Responsibilities

CMHT (Box 1)

- Identifying changes in the patient's condition may be designated as the responsibility of the care co-ordinator, key worker or other named practitioner but this responsibility is shared with the rest of the community team and is the overall responsibility of the RC.
- Those with this responsibility will need to maintain good contact with the patient's family or carers, their GP, managers of any day service the patient uses and with any other teams, such as the Assertive Outreach or drugs and alcohol team, with which the patient has contact.

RC (Boxes 2 –12)

- The RC is responsible for the decision about what happens next and should conduct a review and risk assessment in light of the events leading up to this situation. They will consult the practitioners who are in daily contact with the patient and also, if practicable, the patient and their carers.
- The RC may decide that the patient's reasons for non-attendance for treatment were reasonable or unlikely to be repeated, or that the patient is broadly complying with the SCT conditions and that their mental state can be readily stabilised at home.
- Failure to comply with a condition is not in itself enough to justify recall.
- If the RC decides that treatment is urgent, then the RC completes the statutory form CTO3 (see Annex B) and recalls the patient to hospital.
- **N.B. Unless it has been agreed locally that someone else will be responsible, the RC has responsibility for co-ordinating the recall process.**
- It is important that careful consideration, in each case, should be given as to how the process should take place e.g. how the notice will be served etc.
- The notice of recall, once served, provides the authority to take and convey the patient to hospital, if necessary. (See Chapter 11 of the CoP for guidance on conveying patients under the Act.)
- The written notice of recall should be delivered to the patient at their address. The notice is not effective until handed to the patient personally or, if the patient cannot be contacted and their whereabouts are unknown, a notice of recall can be served on the patient by sending

or delivering it to their last known address. In these circumstances, this would commence the power to treat the patient as absent without leave (AWOL), and a copy of the notice of recall should be sent to the hospital managers.

- The notice will not come into effect until the next day immediately after midnight, if it is delivered by hand to the address, rather than being handed to the patient personally. However, if it is delivered by mail (which must be done by first class post to the patient's usual or last known address), it is then not effective until the second business day after posting. Clearly, this latter delivery method would only be appropriate when the recall was not considered to be urgent.
- The RC should ensure that the hospital to which the patient is to be recalled is ready to receive the patient and to provide treatment.
- The patient does not have to be admitted to the hospital as an in-patient but can be treated in an outpatient clinic, for example, where this meets the patient's needs.
- The patient may agree to return voluntarily to hospital with someone from the team or even with a family member, if this is appropriate. The member of the community team who delivers the notice of recall form to the patient is responsible for ensuring that the patient's home is closed up – potentially for three days and possibly longer.
- The patient may resist recall and if so, the team's assessment may be that they need help, which may be provided, as necessary, by the ambulance service and/or police following local protocols.
- The ambulance service or police will need an accurate assessment of the level of risk – to the patient, to staff or to others – and of the resources which are required.
- A copy of the notice of recall form is given to the hospital managers.
- When the patient arrives at hospital, Form CTO4 (see Annex B) is completed by the member of staff who admits the patient on behalf of the hospital managers and this is sent to the office monitoring the use of the Act on behalf of the managers.
- The 72 hours of possible detention run from the time indicated on this form.
- If the Part 4A certificate (Form CTO11) authorises treatment on recall, the patient may be treated on that basis. Otherwise, the normal rules under Part 4 of the Act apply. (**See CoP 24.28 – 24.30**)
- During the 72 hour period when the patient may be kept in hospital on recall, the RC must make the decision whether the treatment has been

sufficient for the patient to have gone back on track for SCT and may return home.

- If the RC feels this is not the case, then they should recommend that the CTO be revoked and that the patient be re-admitted under s3 (or their original detaining section).
- The RC must then ask for an assessment from an AMHP as to whether the AMHP agrees that it is appropriate to revoke the CTO and that the criteria for re-admission are met.
- If the AMHP agrees that the CTO should be revoked, Form CTO5 is completed and the patient and hospital managers are informed, and the patient is treated as if they had been admitted for further treatment under s3 (or equivalent). (**See CoP 24.31**)
- If the AMHP disagrees with the RC's assessment, then the patient must be allowed to return to the community.

RC/AMHP

If the patient is admitted and if it is necessary, the RC and AMHP should agree who will take responsibility for 'closing' the patient's residence – that is, for doing everything which a resident would need to do before leaving home for an indefinite period, as the recall could be for up to 72 hours or become an in-patient episode. The patient may be leaving behind responsibilities: Do they care for children or older people? Are there pets to be cared for? Does the housing authority have to be informed? Perhaps the patient has an employer who will need to be contacted about sick leave. The team may need to close windows, turn off heating, clear refuse, cancel milk. It should be the aim to plan for this eventuality within the CPA to make it easier.

Ambulance, Police (Box 8)

- It is important that local protocols are established to determine how practitioners should ask for help in recall situations and that both services are aware of the legal position for patients in these circumstances i.e. they need to be aware that the notice of recall gives authority to take and convey the patient to hospital if necessary.
- The CoP makes it clear that policies and procedures should be agreed which enable both hospital managers, plus local ambulance services and police, to plan for these occasions and depend on each other's co-operation. Prompt action and a smooth transition to hospital are crucial to the effective treatment of the patient. (**See CoP Chapter 11**)

Hospital Managers (Box 10)

- They will need to ensure that they have the appropriately completed forms CTO3 (copy) and CTO4 (see Annex B).
- They will need to note the time for the beginning of the 72 hour period, during which the patient may receive treatment whilst still on SCT and carefully monitor the length of stay.
- They must ensure that no patient is detained following recall for longer than 72 hours from the time of admission, without revocation of the CTO.
- If the hospital managers are informed that the patient's CTO has been revoked, then they must immediately refer the case to the Tribunal.
- Hospital Managers should ensure regular review of local agreements as SCT provisions, when patients are recalled to hospital, could give rise to possibly very urgent calls for assistance from ambulance services or police.
- Hospital managers, at all times, have ongoing responsibility to safeguard the rights of the patient and to ensure that all administrative matters, in relation to the procedures and paperwork for SCT, are correct.

AMHP (Box 11)

- The AMHP must assess the patient to ascertain whether they agree with the RC's assessment that the patient meets the criteria for detention, and that it is appropriate to revoke the CTO.
- If the AMHP agrees, then the CTO is revoked and the patient can be treated under the normal rules for patients detained for treatment under the Act.
- If the AMHP does not agree, then the patient cannot be detained in hospital after the maximum period of 72 hours and must be discharged back onto SCT.

Expiry and extension of CTOs (sections 20A and 20B and regulations 13 and 23)

1. Unless extended, a CTO expires at the end of the six months starting on the day on which it is made. (So, if it is made on 1 January, it expires at the end of 30 June.) It can be extended for a further six months and then for a year at a time. At some point during the final two months of the first and each subsequent period for which the CTO is in force, the responsible clinician must examine the patient in order to decide whether the patient meets the criteria for extension. The responsible clinician may recall

the patient to hospital for this purpose because being available for this examination is one of the mandatory conditions to be included in all CTOs.

2. The criteria for extension (which mirror those for making a CTO in the first place) are that:
   a. the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;
   b. it is necessary for the patient's health or safety, or for the protection of other persons, that the patient should receive such treatment;
   c. subject to the patient continuing to be liable to be recalled as mentioned below, such treatment can be provided without the patient being detained in a hospital;
   d. it is necessary that the responsible clinician should continue to be able to exercise the power of recall under s17E(1) to recall the patient to hospital; and
   e. appropriate medical treatment is available for the patient.
3. In determining whether criterion d. above is met, the factors which responsible clinicians consider must include the same factors they are required always to consider when making CTOs initially. (See page 11 above, and **CoP 25.5**)
4. If responsible clinicians think the conditions are met, they must make a report to that effect to the hospital managers. But responsible clinicians:
   - must first consult one or more other people who have been professionally concerned with the patient's medical treatment; and
   - may not make the report unless an AMHP, acting on behalf of an LSSA, confirms in writing that the criteria are met and that it is appropriate to extend the CTO.
5. The report (and the AMHP's statement of agreement) must be made using Form CTO7 and sent to the managers of the responsible hospital.
6. The effect of the report is to extend the CTO for a further six months, or a year (as applicable), from the date it would otherwise expire (not the date of the report itself).
7. Unless the managers decide to discharge the patient, they must arrange for the patient to be told about the extension. They must also take reasonable steps to arrange for the person they think is the patient's nearest relative to be informed, as soon as practicable after their decision, unless the patient has requested otherwise (or does not have a nearest relative).

See CoP 29.10–29.14 for detailed discussion on extension of SCT.

F Discharge from Supervised Commuity Treatment

Procedures to be followed to end Supervised Community Treatment

Discharge planning from SCT should begin from the time a patient is first considered for SCT and be updated at every change in his or her circumstances. It would be good practice to review SCT as part of every CPA review, and the criteria for SCT to be confirmed. A patient who no longer meets the criteria **must** be discharged from SCT and the RC can reach this conclusion at any time. A patient's CTO should not simply be allowed to lapse.

The patient should have the reasons for discharge explained to them and any concerns that the patient has, or which their relatives or carers express, should be considered and dealt with as far as possible. The patient will of course be entitled to any section 117 after-care services they may require.

Other routes to discharge, which are spelt out in **CoP 25.77–79**, are:

- a discharge order by the patient's nearest relative for Part 2 patients (see below);
- an application by the patient to the hospital managers and/or the Tribunal;
- if the patient's responsible hospital is an independent hospital, the Secretary of State may at any time make an order to discharge the patient and if the patient is an NHS patient, a discharge order may be made at any time by the relevant NHS body, i.e. the one which has contracted with the independent hospital to act as the responsible hospital.

On discharge from SCT, the patient has the same right to aftercare services as all other previously detained patients eligible for Section 117 aftercare.

Discharge of SCT patients by their responsible clinicians (Section 23 and regulation 18)

Responsible clinicians may discharge SCT patients (including Part 3 SCT patients) at any time, by doing so in writing and notifying the managers of the responsible hospital.

Discharge of Part 2 SCT patients by their nearest relatives (Sections 23 and 25; regulations 3 and 22)

- Nearest relatives may discharge Part 2 SCT patients from CTOs – and therefore from the underlying application for admission for treatment as well – in the same way as they can discharge patients detained in hospital on the basis of an application for admission for treatment.
- Nearest relatives must give a written discharge order (under section 23) but before doing so, they must give the managers of the responsible hospital not less than 72 hours notice, in writing, of their intention to discharge the patient. In practice, hospital managers will treat a discharge order given without prior notice as both notice of intention to discharge after 72 hours and the actual order to do so.
- **See CoP 29:22 – 29.23** for an illustrative standard letter.
- Like a notice of discharge from detention, the notice (and the order for discharge itself) must either be delivered to an officer of the managers of the responsible hospital authorised by them to receive it, or sent by pre-paid post to those managers at that hospital. The 72 hour period starts to run from the time when the notice is received by the managers (or by an authorised person on their behalf) or is delivered by post at the hospital to which it is addressed.
- If the responsible clinician considers that, if discharged from a CTO, the patient is likely to act in a manner dangerous to other persons or themselves, they may make a 'barring report' to that effect using Form M2 and send it to the managers of the responsible hospital, before the end of the 72 hour notice period. (**CoP 29.20 – 21**)
- The effect of such a report is to veto the nearest relative's decision to discharge the patient. It also prevents the nearest relative from discharging the patient from the CTO at any time in the six months following the date of the report.
- If the responsible clinician issues this report, the managers must arrange for the nearest relative to be informed in writing without delay. The nearest relative may then apply to the Tribunal for the patient's discharge instead.

- If the responsible clinician does not make a report within the 72 hour notice period, the patient must be discharged from the CTO in accordance with the nearest relative's order. If the patient happened to be recalled to hospital at the time, they would have to be released from the hospital because the authority to recall them would no longer exist.
- Nearest relatives cannot order the discharge of Part 3 SCT patients but can apply to the Tribunal instead, in certain circumstances.
- Nearest relatives cannot order patients to be released from hospital when they have been recalled by their responsible clinicians (rather than to be discharged from SCT itself).

Discharge of SCT patients by the hospital managers (Section 23)

- The managers of the responsible hospital may also discharge SCT patients at any time by making a written order. They must always consider doing so when the responsible clinician makes a report extending the authority for SCT, as described in **CoP 31.11**.
- Where the managers are an NHS body or another body of persons (e.g. a company), they may only delegate the discharge function to the same three or more people to whom they can delegate decisions about discharging detained patients (**see CoP 31.3–31.9**). As with detention:
  - the three people to whom the discharge function is delegated must be unanimous in their decision to discharge.
  - If the decision is taken by more than three people, there must be at least three people in favour of discharge before a decision to discharge can be made.
- Like nearest relatives, the managers cannot order patients to be released from a specific recall to hospital (rather than to be discharged from SCT itself).

Discharge of SCT patients by the Tribunal (Part 5)

- SCT patients may also be discharged from SCT by the Tribunal. For information on this and an explanation of the rights of patients, and their nearest relatives, to apply for discharge, please see **CoP Chapter 32**
- In certain circumstances, the managers of the responsible hospital have a duty to refer a patient's case to the Tribunal (for example, when a patient's CTO is revoked). The Secretary of State for Health may also refer cases to the Tribunal at any time. (**See CoP 30.39**)
- The Tribunal cannot release patients from specific periods of recall to hospital (rather than discharging them from SCT generally).

Discharge of SCT patients whose responsible hospital is an independent hospital – powers of the Secretary of State and NHS bodies (Section 23(3))

- The Secretary of State may at any time make an order to discharge an SCT patient, if the patient's responsible hospital is an independent hospital.
- If the patient is an NHS patient, the relevant NHS body may also make a discharge order at any time. The relevant NHS body is the one which has contracted with the independent hospital to act as the responsible hospital. The same rules about the delegation by NHS bodies of this function apply in this case as they do when the NHS body is itself acting as the managers.

Discharge from SCT– general points

- Discharge from SCT means discharge from the CTO and the underlying authority for detention (whether it is an application for admission for treatment under Part 2 or an order or direction under Part 3).
- In other words, the patient can no longer be recalled to hospital or required to stay in hospital.
- In all cases, with the patient's permission, it would be good practice if the GP was promptly informed that the patient has been discharged.
- Hospital managers have a duty to inform the nearest relative of the discharge of an SCT patient.

G Children and Adolescents

When decisions are being made about suitable treatment options for children and young people, the best interests of the child or young person should always be a significant consideration and the child or young person's views, wishes and feelings should always be considered.

The CoP, Chapter 36, which considers how children and young people should be regarded under the Act, states that *'any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the option that is least restrictive and least likely to expose them to the risk of any stigmatisation, consistent with effective care and treatment, and it should also result in the least possible separation from family, carers, friends and community or interruption of their education, as is consistent with their wellbeing.'* (**CoP 36.4**)

It is likely that there will only be a small number of children and young people whose circumstances are suitable for SCT to be a possible option for their treatment after a period of detention, but where it is appropriate it should be used.

In some situations SCT could enable the child or young person to have a shortened hospital stay, returning to the stability and security of their usual surroundings, and to an appropriate educational setting, if this would be conducive to the recovery or maintenance of good mental health. It could reduce the stigma particularly associated with hospital care for young people, and reduce their isolation from their peer group.

However, the care plan should take account of the patient's age and this raises the issue of the availability of appropriate medical care in the community. The most appropriate care may be that provided by child and adolescent mental health services (CAMHS) and the RC should, wherever possible, be from within CAMHS. If this is not possible, then it would be good practice for the patient's care team to consult the CAMHS specialists for their advice on the patient's care. This may not be appropriate if for example the young person had psychosis and an Early Intervention Team could offer more

appropriate care. Young service users who are eligible for SCT may well transfer to adult services when they become 18, and it is essential that there are robust transition protocols to ensure that they get the best possible treatment which continues to support them through the transition and beyond.

Depending on the age of the young person, it may also be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they are willing and able to provide the patient with the support they may need. If the SCT patient under 18 is living with one or more of their parents then, subject to the normal considerations of patient confidentiality, the parents should be consulted about particular treatment. It would cause a difficult situation for all concerned if a parent was not in agreement with some aspect of their child's treatment, or the conditions attached to SCT. If a child is not competent to consent to treatment, the patient's care team will need to review their case, involving the parents or guardians, to decide if SCT is appropriate.

Parents (or other people with parental responsibility) may not consent on a child's behalf to treatment for mental disorder (or refuse it) while the child is on SCT, but the parents' co-operation is likely to be essential for the success of the treatment.

See **CoP 36.78** for further information on confidentiality and children and young people.

In an emergency a child can be treated in the community without reference to a CAMH specialist but it is best practice for this treatment to be carried out by a CAMH specialist, or for a member of the CAMH team to advise the adult specialist treating the child. See **CoP 36.51** for information about emergency treatment for patients under 18.

Ap Useful Links

Code of Practice for Mental Health Act 1983
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

The Equality Impact Assessment for the Code of Practice
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

MCA Information Booklets
http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm

MCA COP
http://www.dca.gov.uk/menincap/legis.htm#codeofpractice

Mental Health Act 2007: Patients on After-Care Under Supervision (ACUS): Transitional Arrangements
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084604

The Mental Health (Hospital, Guardianship and Treatment) Regulations 2008, including Statutory Forms
http://www.opsi.gov.uk/si/si2008/pdf/uksi_20081184_en.pdf

National Institute for Mental Health microsite for Mental Health Act Implementation
http://www.mhact.csip.org.uk/

Reference Guide to the Mental Health Act 1983 – when published, this will be available by accessing the Department of Health's Mental Health website
http://www.dh.gov.uk/en/Healthcare/nationalServiceframeworks/Mentalhealth/index.htm

SCT Pathway
http://www.mhact.csip.org.uk/workstreams/the-mental-health-act-amendment-workstreams/supervised-community-treatment.html

SCT System Model
http://www.mhact.csip.org.uk/workstreams/the-mental-health-act-amendment-workstreams/supervised-community-treatment/sct-model.html

Readers are advised that all of the above links were correct at the time of going to press. If you have problems accessing the documents through the direct links detailed above, they should be readily located via a search from the relevant site's home page.

Ap Glossary of acronyms and abbreviations

AC	Approved Clinician
AMHP	Approved Mental Health Professional (2007 Act)
AOT	Assertive Outreach Team
AWOL	Absent Without Leave
BME	Black and Minority Ethnic
CC-O	Care Co-ordinator
CoP	Code of Practice
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CTO	Community Treatment Order
ECT	Electro Convulsive Therapy
GP	General Practitioner
IMHA	Independent Mental Health Advocate
LSSA	Local Social Services Authority
MCA	Mental Capacity Act
MHA	Mental Health Act

MDT	Multi-Disciplinary Team
NIMHE	National Institute for Mental Health in England
OT	Occupational Therapy/Therapist
PCT	Primary Care Trust
RC	Responsible Clinician
s	Section of an Act
SCT	Supervised Community Treatment
SOAD	Second Opinion Appointed Doctor
STR	Support, Time and Recovery Worker
Tribunal	Mental Health Review Tribunal

Part 2 SCT patient
A patient who was detained on the basis of an application for admission for treatment (section 3) immediately before becoming an SCT patient.

Part 3 SCT patient
A patient who was detained on the basis of an unrestricted hospital order, hospital direction or transfer direction immediately before becoming an SCT patient.

Responsible hospital
The hospital whose managers have responsibilities in relation to the SCT patient in question. Initially, at least, this will be the hospital in which the patient was liable to be detained immediately before becoming an SCT patient.

Ap Annex A: The fundamental principles

The Act requires that:

"**118 (2A)** *The code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act.*

(2B) *In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed—*
(a) respect for patients' past and present wishes and feelings,
(b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006),
(c) minimising restrictions on liberty,
(d) involvement of patients in planning, developing and delivering care and treatment appropriate to them,
(e) avoidance of unlawful discrimination,
(f) effectiveness of treatment,
(g) views of carers and other interested parties,
(h) patient wellbeing and safety, and
(i) public safety.

(2C) *The Secretary of State shall also have regard to the desirability of ensuring–*
(a) the efficient use of resources, and
(b) the equitable distribution of services.

(2D) *In performing functions under this Act persons mentioned in subsection (1) (a) or (b) shall have regard to the code."*

Chapter 1 of the code of practice provides the following set of guiding principles which should be considered when making decisions about a course of action under the Act.

"Purpose principle
1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least restriction principle

1.3 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect principle

1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation principle

1.5 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity principle

1.6 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken."

The code of practice gives the following guidance on the use of the principles:

"Using the principles

1.7 All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

1.8 The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

1.9 That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision."

Ap Annex B: SCT Forms

The references below to 'Reference Guide' are to the Reference Guide to the Mental Health Act 1983.

CTO1	Section 17A – community treatment order 6(1)(a), (b) and 6(2)(a)	6(1)(a), (b) and 6(2)(a
The RC completes and signs Part 1, confirming that the patient meets the criteria for SCT, and setting out the conditions. The RC completes and signs Part 3 to make the order after an AMHP has completed Part 2 confirming they agree with the RC's opinion and with any conditions under section 17B(2), and that it is appropriate to make the order. The RC must specify the date and time from which the order is to be effective. The order is not valid unless all three parts are completed, dated and signed. The order is to be sent to the managers of the hospital where the patient has been detained, as soon as practicable. (See Reference Guide 15.12 – 15.19) See Page 14		

Form CTO1 ***Regulation 6(1)(a), (b) and 6(2)(a)***

Mental Health Act 1983 section 17A—community treatment order

(Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional)

PART 1

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of patient].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment,

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<delete any phrase which is not applicable>

that the patient should receive such treatment;

(c) 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;

(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account 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.

My opinion is founded on the following grounds–
……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were not detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Conditions to which the patient is to be subject by virtue of this community treatment order

The patient is to make himself or herself available for examination under section 20A, as requested.

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.

The patient is also to be subject to the following conditions (if any) under section 17B(2) of the Act:
……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I confirm that I consider the above conditions to be made under section 17B(2) of the Act are necessary or appropriate for one or more of the following purposes:

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

Signed…….
Date……...……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the above patient meets the criteria for a community treatment order to be made

(ii) it is appropriate to make a community treatment order, and

(iii) the conditions made above under section 17B(2) are necessary or appropriate for one or more of the purposes specified.

Signed:…….
Approved mental health professional
Date:…….

PART 3

I exercise my power under section 17A of the Mental Health Act 1983 to make a community treatment order in respect of the patient named in Part 1 of this Form.

This community treatment order is to be effective from [date] at [time].

Signed:……
Responsible clinician
Date:……

THIS COMMUNITY TREATMENT ORDER IS NOT VALID UNLESS ALL THREE PARTS ARE COMPLETED AND SIGNED IT MUST BE FURNISHED AS SOON AS PRACTICABLE TO THE MANAGERS OF THE HOSPITAL IN WHICH THE PATIENT WAS LIABLE TO BE DETAINED BEFORE THE ORDER WAS MADE

CTO2	Section 17B – variation of conditions of a community treatment order	6(2)(b)

The RC completes this form setting out the new conditions (not only those which have changed, but also those which are remaining the same), and confirms that they are necessary or appropriate for one or more of the purposes shown. The form is then to be sent to the managers of the responsible hospital as soon as practicable.

(See Reference Guide 15.20)

See Page 26 & 35

Form CTO2 *Regulation 6(2)(b)*

Mental Health Act 1983 section 17B – variation of conditions of a community treatment order

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of the community patient].

I am varying the conditions attaching to the community treatment order for the above named patient.

The conditions made under section 17B(2), as varied, are: [List the conditions as varied in full (including any which are not being varied) or state that there are no longer to be any such conditions.]

……
……
……

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

The variation is to take effect from [date].

I confirm that I consider the above conditions to be necessary or appropriate for one or more of the following purposes:

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

Signed…….
Responsible clinician
Date…… ……

THIS FORM MUST BE FURNISHED AS SOON AS PRACTICABLE TO THE MANAGERS OF THE RESPONSIBLE HOSPITAL

CTO3	Section 17E – community treatment order: notice of recall to hospital	6(3)(a)

The RC completes this form & hands or delivers it to the patient. A copy must be sent to the managers of the hospital to which the patient is to be recalled as soon as possible after it has been served on the patient. If that hospital is not the responsible hospital, then the RC should inform the hospital of the name & address of the responsible hospital.

(See Reference Guide 15.30 –15.38)

See Page 35 & 36

Form CTO3 *Regulation 6(3)(a)*

Mental Health Act 1983 section 17E – community treatment order: notice of recall to hospital

(To be completed by the responsible clinician)

I notify you, [PRINT name of community patient], that you are recalled to [PRINT full name and address of the hospital] under section 17E of the Mental Health Act 1983.

Complete either (a) or (b) below and delete the one which does not apply.

(a) In my opinion,

(i) you require treatment in hospital for mental disorder,

AND

(ii) there would be a risk of harm to your health or safety or to other persons if you were not recalled to hospital for that purpose.

This opinion is founded on the following grounds—

……
……
……

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

(b) You have failed to comply with the condition imposed under section 17B of the Mental Health Act 1983 that you make yourself available for examination for the purpose of: *<delete as appropriate>*

(i) consideration of extension of the community treatment period under section 20A

(ii) enabling a Part 4A certificate to be given.

Signed…….
Responsible clinician
PRINT NAME……
Date……
Time……

A COPY OF THIS NOTICE IS TO BE FORWARDED TO THE MANAGERS OF THE HOSPITAL TO WHICH THE PATIENT IS RECALLED AS SOON AS POSSIBLE AFTER IT IS SERVED ON THE PATIENT. IF THAT HOSPITAL IS NOT THE RESPONSIBLE HOSPITAL, YOU SHOULD INFORM THE HOSPITAL MANAGERS THE NAME AND ADDRESS OF THE RESPONSIBLE HOSPITAL.

This notice is sufficient authority for the managers of the named hospital to detain the patient there in accordance with the provisions of section 17E of the Mental Health Act 1983.

CTO4	Section 17E – community treatment order: record of patient's detention in hospital after recall	6(3)(d)

This form must be completed by someone authorised to do so by the hospital managers when the patient is detained after recall to hospital.

(See Reference Guide 15.39–15.42)

See Page 35 & 37

Form CTO4 *Regulation 6(3)(d)*

Mental Health Act 1983 section 17E — community treatment order: record of patient's detention in hospital after recall

[PRINT full name and address of patient] ('the patient') is currently a community patient.

In pursuance of a notice recalling the patient to hospital under section 17E of the Act, the patient was detained in [full name and address of hospital] on [enter date and time at which the patient's detention in the hospital as a result of the recall notice began].

Signed…….
on behalf of the hospital managers
PRINT NAME……
Date……
Time……

CTO5	Section 17F(4) – revocation of community treatment order	6(8)(a) and (b)

The RC completes and signs Part 1, confirming that the patient meets the criteria as set out in the form, necessitating medical treatment in hospital, and giving reasons for that opinion. The RC also confirms that he or she is of the opinion that appropriate medical treatment is available to the patient at the hospital named on the form.
The AMHP completes Part 2 to confirm that the patient meets the criteria for detention in hospital and that it is appropriate to revoke the order. Part 3 is then signed by the RC to exercise the power to revoke the order.
The revocation order is not valid unless all three parts are completed and signed. It must be sent as soon as practicable to the managers of the hospital to which the patient has been recalled. If this is not the responsible hospital, then the managers must send a copy of the CTO5 to the managers of the hospital which was, until then, the responsible hospital.

(See Reference guide 15.55 – 15.62)

See Page 35 & 38

Form CTO5 ***Regulation 6(8)(a) and (b)***

Mental Health Act 1983 section 17F(4)—revocation of community treatment order

(Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional)

PART 1

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of community patient] who is detained in [name and address of hospital] having been recalled to hospital under section 17E(1) of the Act.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,

AND

(b) it is necessary for
  (i) the patient's own health
  (ii) the patient's own safety
  (iii) the protection of other persons
  <delete the indents not applicable>

that this patient should receive treatment in hospital,

AND

(c) such treatment cannot be provided unless the patient is detained for medical treatment under the Act,

because— [Your reasons should cover (a), (b) and (c) above. As part of them: describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of treatment or care (eg out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.]

……
……
……

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I am also of the opinion that taking into account 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 at the hospital named above.

Signed…….
Responsible clinician
Date…… ……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the patient meets the criteria for detention in hospital set out above and

(ii) it is appropriate to revoke the community treatment order.

Signed…….
Approved mental health professional
Date……..……

PART 3

I exercise my power under section 17F(4) to revoke the community treatment order in respect of the patient named in Part 1 who has been detained in hospital since [time] on [date], having been recalled under section 17E(1).

Signed…….
Responsible clinician
Date…… ……

THIS REVOCATION ORDER IS NOT VALID UNLESS ALL THREE PARTS ARE COMPLETED AND SIGNED

IT MUST BE SENT AS SOON AS PRACTICABLE TO THE MANAGERS OF THE HOSPITAL IN WHICH THE PATIENT IS DETAINED

CTO6	Section 17F(2)–authority for transfer of recalled community patient to a hospital under different managers	9(3)(a) and (5)

Part 1 is completed on behalf of the managers of the hospital in which the patient is detained by virtue of recall. This form is then sent to the managers of the hospital to which the patient is to be transferred, together with a copy of Form CTO4. The copy of the CTO4 must be sent before or at the time that the patient is transferred. The managers of the new hospital must record the time of the patient's admission there using Part 2 of the same form CTO6. If the patient is transferred from a hospital in Wales to a hospital in England, then it must be done in accordance with Welsh regulations, and so the equivalent Welsh statutory form should be used rather than Form CTO6.

NB. Form CTO6 does not need to be used if both hospitals are under the same managers.

(See Reference Guide 15.45 – 15.54)

Form CTO6 ***Regulation 9(3)(a) and (5)***

Mental Health Act 1983 section 17F(2)—authority for transfer of recalled community patient to a hospital under different managers

(To be completed on behalf of the managers of the hospital in which the patient is detained by virtue of recall)

PART 1

This form authorises the transfer of [PRINT full name of patient] from [name and address of hospital in which the patient is detained] to [name and address of hospital to which patient is to be transferred] in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

I attach a copy of Form CTO4 recording the patient's detention in hospital after recall.

*The hospital in which the patient is currently detained is the patient's responsible hospital.

*The hospital to which the patient is to be transferred is the patient's responsible hospital.

*The patient's responsible hospital is [name and address of responsible hospital].
*<*Delete the phrases which do not apply>*

Signed…….
on behalf of managers of the first named hospital
PRINT NAME……
Date…… ……

PART 2

RECORD OF ADMISSION

(This is not part of the authority for transfer but is to be completed at the hospital to which the patient is transferred)

This patient was admitted to [name of hospital] in pursuance of this authority for transfer on [date of admission to receiving hospital] at [time].

Signed…….
on behalf of managers of the receiving hospital
PRINT NAME……
Date…… ……

CTO7	Section 20A – community treatment order: report extending community treatment period	13(6)(a) and (b) and 13(7)

The RC completes and signs Part 1, confirming that they consider the patient meets the criteria, as set out in the form, for extension of the community treatment order. An AMHP then completes and signs Part 2 to say they agree with that opinion, and that it is appropriate to extend the community treatment order. The RC completes and signs Part 3 confirming that he or she has consulted with a person professionally concerned with the patient's treatment before making the report (ie this form CTO7), and sends it to the hospital managers. The report is not valid unless all three parts are completed and signed.

Part 4 is then completed by or on behalf of the managers of the responsible hospital.

(See Reference Guide 15.71 – 15.78)

Form CTO7 ***Regulation 13(6)(a) and (b), and 13(7)***

Mental Health Act 1983 section 20A — community treatment order: report extending the community treatment period

Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional. Part 4 is to be completed by or on behalf of the managers of the responsible hospital.

PART 1

To the managers of [name and address of the responsible hospital]

I am [PRINT full name and address of the responsible clinician] the responsible clinician for [PRINT full name and address of patient].

The patient is currently subject to a community treatment order made on [enter date].

I examined the patient on [date].

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<delete any indent which is not applicable>

that the patient should receive such treatment;

(c) 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;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account 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.

My opinion is founded on the following grounds—

……

……

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were to continue not to be detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Signed…….
Responsible clinician
Date…… ……..……

PART 2

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that:

(i) the patient meets the criteria for the extension of the community treatment period and

(ii) it is appropriate to extend the community treatment period.

Signed…….
Approved mental health professional
Date……..……

PART 3

Before furnishing this report, I consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

I am furnishing this report by: *<Delete the phrase which does not apply>*

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed…….
Responsible clinician
Date……..……

THIS REPORT IS NOT VALID UNLESS PARTS 1, 2 & 3 ARE COMPLETED AND SIGNED

PART 4

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers on [date].

Signed……..
on behalf of the managers of the responsible hospital
PRINT NAME…….
Date…… …….

CTO8	Section 21B – authority for extension of community treatment period after absence without leave for more than 28 days	14(3)(a) and (b)

The RC completes Part 1 of this form to confirm or extend a patient's community treatment order if the patient has been taken into custody or attends hospital voluntarily after more than 28 days' absence without leave. The RC's report does not need to be confirmed by an AMHP, but the RC must consult an AMHP and a person professionally concerned with the patient's treatment.

Part 2 is then completed by or on behalf of the managers of the responsible hospital.

(See Reference Guide 15.85 –15.96)

Form CTO8 ***Regulation 14(3)(a) and (b)***

Mental Health Act 1983 section 21B—authority for extension of community treatment period after absence without leave for more than 28 days

PART 1

(To be completed by the responsible clinician)

To the managers of [enter name and address of responsible hospital]

I am [PRINT full name and address of the responsible clinician] the responsible clinician for [PRINT full name and address of patient].

I examined the patient on [date of examination] who:

(a) was recalled to hospital on [date] under section 17E of the Mental Health Act 1983;

(b) was absent without leave from hospital beginning on [date absence without leave began];

(c) was/is <*delete as appropriate*> subject to a community treatment order for a period ending on [date community treatment order would have expired, apart from any extension under section 21, or date on which it will expire]; and

(d) returned to the hospital on [date].

I have consulted [PRINT full name of approved mental health professional] who is an approved mental health professional.

I have also consulted [PRINT full name and profession of person consulted] who has been professionally concerned with the patient's treatment.

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;

(b) it is necessary for
(i) the patient's health
(ii) the patient's safety
(iii) the protection of other persons
<*delete any indent which is not applicable*>

that the patient should receive such treatment;

(c) 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;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account 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.

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were to continue not to be detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

My opinion is founded on the following grounds—
……..
……..
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

The community treatment order is/is not* due to expire within a period of two months beginning with the date on which this report is to be furnished to the managers of the responsible hospital. <**Delete the phrase which does not apply*>

Complete the following only if the authority for detention is due to expire within that period of two months.

This report shall/shall not* have effect as a report duly furnished under section 20A(4) for the extension of the community treatment period for this patient. <**Delete the phrase which does not apply*>

Complete the following in all cases.

I am furnishing this report by: <*Delete the phrase which does not apply*>

today consigning it to the hospital managers' internal mail system.

sending or delivering it without using the hospital managers' internal mail system.

Signed…….
Date……

PART 2

(To be completed on behalf of the managers of the responsible hospital)

This report was <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers on [date].

Signed…….
on behalf of the hospital managers
PRINT NAME…….
Date……..……

CTO9	Part 6 – community patients transferred to England	16(4) and (5)

The RC completes and signs Part 1 & the AMHP completes and signs Part 2. This form is used when a patient who has been treated under comparable legislation in Scotland transfers to England. It allows the RC and AMHP to set conditions to apply to the patient in England in the same way as for other SCT patients. Both parts of the form must be completed for the conditions to be valid.

(See Reference Guide, Chapter 25)

Form CTO9 *Regulation 16(4) and (5)*

Mental Health Act 1983 Part 6—community patients transferred to England

PART 1

(To be completed by the responsible clinician)

I [PRINT full name and address of the responsible clinician] am the responsible clinician for [PRINT full name and address of patient] who is treated as if subject to a community treatment order having been transferred to England.

The patient is to be subject to the following conditions by virtue of that community treatment order:

> The patient is to make himself or herself available for examination under section 20A, as requested.
>
> 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.

The patient is also to be subject to the following conditions (if any) under section 17B(2) of the Act:

……

……

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I confirm that I consider the above conditions to be made under section 17B(2) of the Act are necessary or appropriate for one or more of the following purposes:

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

Signed…….
Responsible clinician

Date……

PART 2

(To be completed by the approved mental health professional)

I [PRINT full name and address] am acting on behalf of [name of local social services authority] and am approved to act as an approved mental health professional for the purposes of the Act by *<Delete as appropriate>*

that authority
[name of local social services authority that approved you, if different].

I agree that the conditions made above under section 17B(2) are necessary or appropriate for one or more of the purposes specified.

Signed…….
Approved mental health professional
Date……..……

THE PATIENT IS NOT SUBJECT TO THE CONDITIONS SET OUT IN THIS FORM UNLESS BOTH PARTS OF THE FORM ARE COMPLETED.

CTO10	Section 19A – authority for assignment of responsibility for community patient to a hospital under different managers	17(3)(a) and (d)(i) and (ii)

This form is used when the patient's responsible hospital is changed. It is completed on behalf of the hospital which was originally responsible for the patient.
NB: Form CTO10 does not have to be used if both hospitals are under the same managers.

(See Reference Guide 15.128 –15.135)

Form CTO10 ***Regulation 17(3)(a) and (d)(i) and (ii)***

Mental Health Act 1983 section 19A—authority for assignment of responsibility for community patient to hospital under different managers

(To be completed on behalf of the responsible hospital)

This form gives authority for the assignment of responsibility for [PRINT full name and address of patient] from [name and address of responsible hospital] to [name and address of hospital to which responsibility is to be assigned in accordance with the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

This assignment was agreed by the managers of the hospital to which the responsibility is to be assigned on [date of confirmation]

The assignment is to take place on [date].

Signed……..
on behalf of managers of first named hospital
PRINT NAME……
Date…… ……

CTO11	Section 64C(4) – certificate of appropriateness of treatment to be given to community patient ("Part 4A certificate")	28(1)

This is completed by the SOAD to confirm the appropriateness of the treatment of an SCT patient, both in the community and on recall, and allows the SOAD to specify any conditions to apply to the giving of treatment.

(See Reference guide 15.17 and Chapter 17)

See Page 29 & 37

Form CTO11 ***Regulation 28(1)***

Mental Health Act 1983 section 64C(4) — certificate of appropriateness of treatment to be given to community patient (Part 4A certificate)

(To be completed on behalf of the responsible hospital)

I [PRINT full name and address] am a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD).

I have consulted [PRINT full name and profession] and [full name and profession] who have been professionally concerned with the medical treatment of [PRINT full name and address of patient] who is subject to a community treatment order.

I certify that it is appropriate for the following treatment to be given to this patient while the patient is not recalled to hospital, subject to any conditions specified below. The treatment is: [Give description of treatment or plan of treatment.]

……
……
……

I specify the following conditions (if any) to apply: [Conditions may include time-limits on the approval of any or all of the treatment.]

……..
……..
……..

I certify that it is appropriate for the following treatment (if any) to be given to this patient following any recall to hospital under section 17E of the Act, subject to any conditions specified below. The treatment is: [Give description of treatment or plan of treatment].

……
……
……

I specify the following conditions (if any) to apply to the treatment which may be given to the patient following any recall to hospital under section 17E: [Conditions may include time-limits on the approval of any or all of the treatment.]

……...
……...
……

My reasons are as below/I will provide a statement of my reasons separately. <*Delete as appropriate*> [When giving reasons please indicate if, in your opinion, disclosure of the reasons to the patient would be likely to cause serious harm to the physical or mental health of the patient, or to that of any other person.]

……...
……...
……...

[If you need to continue on a separate sheet for any of the above please indicate here [ ] and attach that sheet to this form.]

Signed ……
Date……

M1	Part 6 – date of reception of a patient in England	15(2), (4)(a) and 16(2)

This form is used when a patient who is subject to the equivalent of SCT in Scotland, the Channel Islands or the Isle of Man to England, is transferred to SCT in England.

The patient is treated as if their responsible clinician had immediately made a CTO putting them onto SCT. The managers of the responsible hospital use this form to record the date on which the patient arrived at the place where they are to live while on SCT.

(See Reference Guide, Chapter 25)

Form M1 *Regulation 15(2), (4)(a) and 16(2)*

Mental Health Act 1983 Part 6 — date of reception of a patient in England

[PRINT full name of patient]

*was admitted to [name and address of hospital] at [time] on [date]

*was received into the guardianship of [name and address of guardian] on [date]

*became a community patient as if discharged from [name and address of responsible hospital], on [date].
<*Complete as appropriate and delete the others*>

Signed…….
on behalf of the hospital managers/
on behalf of the local social services authority/
the private guardian
<*Delete whichever do not apply*>
PRINT NAME……
Date…… ……

M2	Section 25 – report barring discharge by nearest relative	25(1)(a) and (b)

This form is used (in addition to its use in respect of detained patients) when a patient's nearest relative applies for a Part 2 patient's discharge from SCT, but the RC considers that , if discharged from SCT, the patient is likely to act in a manner dangerous to other persons or themselves. The RC uses Part 1 of the form to make a report to that effect, (including the date & time at which the report was made) and must then send it to the managers of the responsible hospital before the end of the 72 hour notice period which the nearest relative has to give the hospital managers of their intention to discharge the patient. The managers must then complete Part 2 to confirm their receipt of the RC's report.

(See Reference Guide 15.104 –15.113)

See Page 42

Form M2 ***Regulation 25(1)(a) and (b)***

Mental Health Act 1983 section 25—report barring discharge by nearest relative

PART 1

(To be completed by the responsible clinician)

To the managers of [name and address of hospital]

[Name of nearest relative] gave notice at [time] on [date] of an intention to discharge [PRINT full name of patient].

I am of the opinion that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself or herself.

The reasons for my opinion are—
……
……
……
[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

I am furnishing this report by: <*Delete the phrase which does not apply*>

consigning it to the hospital managers' internal mail system today at [time].

sending or delivering it without using the hospital managers' internal mail system.

Signed…….
Responsible clinician
PRINT NAME……
Date…… ……
Time……

PART 2

(To be completed on behalf of the hospital managers)

This report was: <*Delete the phrase which does not apply*>

furnished to the hospital managers through their internal mail system.

received by me on behalf of the hospital managers at [time] on [date].

Signed…….
on behalf of the hospital managers
PRINT NAME……
Date…… ……

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Front and back cover
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