# Section 17A Mental Health Act 1983 – Supervised Community Treatment (Community Treatment Orders) – CLP050

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Why we need this Policy

Supervised Community Treatment (SCT) provides a framework for the management of patient care in the community and gives the Responsible Clinician the power to recall the patient to hospital for treatment if necessary. It is principally aimed at preventing the “revolving door” scenario and the prevention of harm which could arise through relapse. The key feature of supervised community treatment is where the patient no longer needs further treatment as a detained in-patient, but the Responsible Clinician (RC) reasonably believes there is a need to be able to recall the patient to hospital.

SCT must be a planned measured response based on the needs of the patients, and the criteria for SCT.

The Mental Health Act 2007 makes amendments which include the introduction of new sections 17A-17G which effectively replace Section 25A -25J.


What the Policy is trying to do

This policy is designed to provide multi agency staff with sufficient guidance; in order to ensure effective compliance with providing leave to detained patients in accordance with S.17 MHA and Code of Practice.
Which stakeholders have been involved in the creation of this Policy

- Lead AMHP, Police Liaison Officer, Community Consultants, Modern Matrons in-patients, Mental Health Act Scrutiny Committee
- Trust Policy Board attendees

Any required definitions/explanations

- **NHFT**
  Northamptonshire Healthcare NHS Foundation Trust

- **SCT**
  Supervised Community Treatment

- **CTO**
  Community Treatment Order

- **MHA**
  Mental Health Act

- **AMHP**
  Approved Mental Health Practitioner

- **GP**
  General Practitioner

- **MDT**
  Multi-Disciplinary Team

- **IMHA**
  Independent Mental Health Advocate

- **RC**
  Responsible Clinician

- **CPA**
  Care Programme Approach

Key duties
• Chief Executive
  Is responsible for ensuring the principles of this policy and procedures and other associated policies are implemented across the organisation.

• Director of Specialty Services
  Is responsible for ensuring the implementation of this policy across clinical areas.

• Inpatient Members of Staff (including Responsible Clinician and Multidisciplinary Team)
  Are responsible for ensuring that they comply with the s.17A MHA Supervised Community Treatment.

• Head of Communications
  Where media publicity is required the Northamptonshire Healthcare NHS Foundation Trust Head of Communications will co-ordinate this.

• Head of Risk and Patient Safety
  Is responsible for notifying Commissioners of all s.17 MHA Incidents that are classified as Serious Incidents

• The Head of Service Development for Mental Health
  Is responsible for ensuring that ‘Learning Lessons’ forums are facilitated.

Policy detail

• Criteria for Supervised Community Treatment
  To be eligible for SCT the patient must be liable to be detained under s.3, s.37, s45A, s47, s48 and s.51 MHA 83. The relevant criteria, as set out in the new section 17A (5), are that:

  • The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
  • It is necessary for the patient’s health or safety or the protection of other persons that the patient should receive such treatment
  • Subject to their being liable to be recalled, 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 to recall the patient to hospitals and
  • Appropriate medical treatment is available for the patient.

• When should Supervised Community Treatment be considered?
  SCT must be considered for the patient when:

  • Reviewed under s.117
  • When authorising s.17 leave of absence for a period greater than 7 consecutive nights.
  • the Tribunal recommends consideration for supervised community treatment
  • the patient has a known history of relapse
• **Process for Supervised Community Treatment**
  The decision as to whether SCT is the right option for any patient is taken by the RC (this will be the most appropriate AC at the time of application, (for example the Community Consultant or NSTEP Consultant) and requires the agreement of an Approved Mental Health Professional (AMHP). However the Code of Practice advocates wider consultation when SCT is being considered.

  Local advice is that in order to facilitate full and frank discussion, process for discussion and consultation should be through a multi-disciplinary conference to include all of the following: (Good Practice Questions to be considered see Appendix 1.)

  • **The patient** (for SCT to be a viable option the patient must be involved in the decisions and be prepared to accept and comply with the proposed treatments)
  • The Responsible Clinician
  • The Nearest Relative (unless the patient objects) The Nearest Relative does not have the power to object to the making of the Community Treatment Order (CTO), however where there is dissent due regard must be taken of their reasons.
  • Any involved carers/friends/family members (unless the patient objects)
  • Anyone authorised under the MCA to act on the patients behalf
  • Patients General Practitioner (GP)
  • Inpatient Key Worker
  • Community Consultant
  • Care Co-ordinator and any other member of the Multi-Disciplinary Team (MDT)
  • Independent Mental Health Advocate (IMHA)
  • Any other relevant professionals

  Supervised community treatment may be used only if it would not be possible to achieve the desired objectives for the patients care and treatment without it.

  If the AMHP does not agree with CTO, the CTO will not go ahead.

• **Conditions of Supervised Community Treatment**
  Section 17B (1) MHA 83 states that a CTO shall specify conditions to which the patient is to be subject. Under section 17B(3), a CTO must contain ‘mandatory conditions’ specifying:

  • That the patient make her or himself available for examination under section 20A (to see if the community treatment order needs to be extended); and
  • That the patient makes her or himself available for examination where it is proposed that a certificate for treatment be issued under Part 4A of the MHA 1983.

  Section 17B (2) states that, subject to the above, the RC and AMHP must agree that any condition is necessary and appropriate and provided in the least restrictive way, with the minimum conditions consistent with achieving their purpose and a clear rational linked to one or more of the purposes.

  Conditions must not cumulatively amount to a deprivation of the patient’s liberty.
• **Treatment**

Once the patient is placed under SCT, if the patient has the capacity to consent to the treatment then the RC must complete a form regarding this. However, if the person lacks capacity to consent to treatment then the RC must complete a form to request a second opinion from the Care Quality Commission. The form will be forwarded to the Mental Health Administration Department who will action the request. It is necessary that the RC states the treatment required in the community but also to include what treatment will be required in the event the patient is recalled to hospital. If the patient is recalled the second opinion will provide authority for specified treatment in hospital for up to 72 hours even without the patient’s consent.

If the CTO is revoked a further request will be required, in the absence of consent s.62 (2) will be relied upon for continued lawful authority to treat the patient. As soon as the discontinuation of treatment would no longer result in serious suffering to the patient, medication must be stopped, unless the patient has the capacity to provide informed consent to the treatment.

• **Recall**

Section 17E MHA 83 and Regulation 6 authorises patients to be recalled to hospital. The power of recall is intended to provide a means to respond to evidence of relapse or high risk behaviour relating to mental disorder, before the situation becomes critical and leads to the patient or other people being harmed.

**Recall must be proportionate to the level of risk.**

Reasons for Recall:

Supervised Community Treatment patients may be recalled to hospital if:

- Their Responsible Clinician decides that they need to receive medical treatment for their mental disorder in a hospital and that, if they were not recalled to hospital to receive treatment there would be a risk of harm to their health or safety, or to other people.
- They fail to comply with one of the mandatory conditions. (unless there was a valid reason for non-compliance)
- The patient’s condition is deteriorating despite compliance with treatment, if the risk could not be managed by other means.

Patients recalled to hospital do not have to be admitted as in-patients, they could be recalled for out-patient treatment. (The recall could be to a hospital out-patient department)

Patients may be recalled to any hospital (if the hospital is willing to accept them)

Patients may be recalled even if they are an Informal patient in hospital refusing to stay in hospital and accept treatment.
• **Recall Process**
  Responsible Clinicians must recall patients by giving them written notice by issuing them with a copy of Form CT03. Prior to any recall notice being served to the patient the CRHT staff will be informed, therefore affording them the opportunity to determine if the patient can remain at home with additional support from their input. A full risk assessment will be completed by the Community RC and recorded on SystmOne prior to the recall notice being served.

• **Bed Availability for CTO patients:**
  Every effort should be made to ensure that patients subject to CTO are recalled to the Hospital who has responsibility for them. This is essential to provide the consistency in care and provide the RC the opportunity to be involved with the decision to discharge or revoke, within the 72 hour period, namely discharge or revocation.

  If the recall occurs outside of normal working hours, the on call Consultant will request that the on call Staff Grade assesses the patient and contacts CRHT team to see if they are able to provide additional support at home and then the RC will conclude whether the patient should:

  - return home with CRHT support
  - return home without additional support
  - Accept informal admission to hospital
  - CTO recall to Hospital.

  If recall becomes necessary the staff grade will inform the on call Consultant who will need to make necessary arrangements to ensure that the patient is immediately served with the recall notice (this may be by way of fax).

  If a local bed is unable to be identified the advising nurse will be required to complete a CTO10 form, after they are assured by the receiving Trust that they are able to comply with the recall procedure in their Trust (the fact that they have Approved Clinicians working for them and access to a local Approved Mental Health Professional). Original CTO paperwork and s.3 detention paperwork will be provided by the Mental Health Act Administration Team on the following working day, photocopies will be obtained by the file held on either Harbour/Kingfisher Ward in the interim period.

  When the patient complies with the recall, they will be admitted to hospital for the minimum period necessary and where this period is under 72 hours, they remain a supervised community treatment patient.

  If the patient does not comply with the recall process, they will become Absent Without Leave – see NHT Section.18 AWOL Policy.

  The recall notice can be served on the patient in one of three ways (in only exceptional circumstances will the notice be issued by post)
### Method of Serving the recall notice

<table>
<thead>
<tr>
<th>Method of Serving the recall notice</th>
<th>Noticed deemed to have been served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering the notice by hand to the patient</td>
<td>As soon as it is given to the patient</td>
</tr>
<tr>
<td>Delivering the notice by hand to the patient usual or last known address</td>
<td>At the start of the day which follows the day on which it is delivered to that address. For example, if delivered at noon, it is deemed to have been served immediately after midnight that night, even if it is a weekend or bank holiday.</td>
</tr>
<tr>
<td>Sending it by pre paid first class post, or recorded delivery to the patient at the patients usual or last known address</td>
<td>At the start of the 2nd business day after it is posted. For example if posted on Monday, it is deemed to have been delivered on Wednesday but, if posted on Friday it is deemed to have been delivered on Tuesday. Weekends and Public Holidays do not count as business days.</td>
</tr>
</tbody>
</table>

The Community Responsible Clinician will retain responsibility for the 72 hour recall period or until the decision has been made to revoke or discharge the patient back into the community. The only exception would be if the patient is admitted to an out of area hospital, at which point the CTO will be transferred to the receiving hospital (with their agreement). The decision for revocation, discharge or Informal admission will rest with the new Hospital RC.

- **Revocation of Community Treatment Order**
  - The CTO may be revoked if:
    - The patient requires in-patient treatment for over 72 hours
    - The RC considers the patient needs to be admitted to hospital for medical treatment under the MHA 83 and the AMHP agrees with that assessment.

At that point the community treatment order will be revoked and the patient will become subject Section 3 on the original s.3 application and will commence for an initial period of 6 months.

The Hospital Managers will have a duty to ensure that a referral to the First-Tier Tribunal Service will be made.

- **Note:**
  - A patient may also be admitted to a ward informally as long as they have capacity to consent to this and do consent.

- **Review of Supervised Community Treatment**
  - Good practice indicates that review of supervised community treatment will be considered as part of the CPA process under Section 117 MHA 83.

Discharge of Supervised Community Treatment
Supervised community treatment patients may be discharged:

- By Responsible Clinician (s.3 MHA 83, Regulation 18)
- By a MHRT (Part 5)
- By Hospital Managers(s.23 MHA 83)
- By Nearest Relative (s.23 & s.25 MHA 83, Regulations 3 & 25)

**Information Sharing**

Section 132 & 133 MHA 83 requires that patients and nearest relatives are given:

- Information regarding the scope and remit of the detention
- Their individual rights
- Aftercare arrangements
- Community treatment order conditions

The above information must be given to the patient orally and in writing.

The nearest relative, where practicable must be informed with at least 7 days advance notice of the patients discharge from detention onto supervised community treatment. They must also be informed of discharge from supervised community treatment.

**Audit and Review**

The use of supervised community treatment will be reported through the MHA/MCA Scrutiny Committee. Patients subject to a community treatment order will be monitored by the Care Quality Commission and any reports of concern will be addressed to the MHA/MCA Scrutiny Committee.

**Training requirements associated with this Policy**

- **Mandatory Training**
  MHA training has been identified as a role specific requirement for all clinical staff working within mental health in-patient settings. Certain sections of the MHA and Code of Practice have been identified as an appropriate requirement for community mental health staff and includes training in relation to supervised community treatment.

- **Specific Training not covered by Mandatory Training**
  Specific MHA training around the use of supervised community treatment will be provided by senior MHA Administration staff to doctors and qualified nursing staff as required.
How this Policy will be monitored for compliance and effectiveness

The table below outlines the Trust’s monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Method of monitoring</th>
<th>Individual responsible for the monitoring</th>
<th>Monitoring frequency</th>
<th>Group or committee who receive the findings or report</th>
<th>Group or committee or individual responsible for completing any actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>To be addressed by the monitoring activities below.</td>
<td>MHA/MCA Manager</td>
<td>Ongoing - at the point of commencing, extending, recall &amp; revocation</td>
<td>MHA/MCA scrutiny committee &amp; governance committee</td>
<td>As required</td>
</tr>
<tr>
<td>The use of s.17A &amp; any exceptions are monitored by the MHA/MCA Manager.</td>
<td>At the point of commencing, extending, recalling and revoking s.17A paperwork and process will be scrutinised by the MHA Administration Team.</td>
<td>MHA/MCA Manager</td>
<td>Ongoing - at the point of commencing, extending, recall &amp; revocation</td>
<td>MHA/MCA scrutiny committee &amp; governance committee</td>
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</tr>
</tbody>
</table>

For further information

Please contact the MHA/MCA Manager

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of ‘protected characteristics’ including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

NHFT follow the guidance of the MHA 1983 additionally we follow the Code of Practice and Care Quality Commission guidance and place people in age appropriate services. If there is a need to detain children on adult acute wards, these exceptions are reported to the Chief Operating Officer and the Care Quality Commission. NHFT ensures that when a patient is detained, circumstances take into account physical access issues, and wherever possible all considerations and possible changes will be put in place. Due regard will be given to alternatives. NHFT provide services in the form of mixed and single gender accommodation. Admission wards, older adults, ICU, community hospitals and children wards are mixed gender and are managed using single gender corridors & segregated areas to ensure single gender facilities are available within that environment. Treatment wards, rehab wards and forensic wards are single gender environments. NHFT ensure to provide a safe environment for all patients on mixed gender wards.

This policy relates to community treatment, therefore patients will not be admitted to NHFT services when subject to supervised community treatment. Transsexual patients are placed to meet their needs. NHFT do not stereotype and treat all patients with respect and dignity regardless. Staff are required to help and support patients and ensure that abuse of individuals does not take place. Staff will challenge all inappropriate behaviour and tackle any issues of unfair treatment relating to sexual orientation.

NHFT do not stereotype and treat all patients with respect and dignity regardless. Staff are required to help and support patients and ensure that abuse of individuals does not take place. Staff will challenge all inappropriate behaviour and tackle any issues of unfair treatment relating to the persons race or ethnic background.

Interpreters are provided for all detained patients to ensure effective communication. NHFT do not stereotype and treat all patients with respect and dignity regardless. Staff are required to help and support patients and ensure their personal religious beliefs are respected.

Reference Guide

Mental Health Act 1983 (as amended 2007)

Document control details
Appendix 1: Considerations for Supervised Community Treatment

Is SUPERVISED COMMUNITY TREATMENT 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 SUPERVISED COMMUNITY TREATMENT 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?
    - 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 SUPERVISED COMMUNITY TREATMENT