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SCOTTISH EXECUTIVE

Health Department

NHS Management Executive
St Andrew's House
Regent Road
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17th December 1999.

Dear Colleague

THE MENTAL HEALTH (SCOTLAND) ACT 1984 AS AMENDED BY THE MENTAL HEALTH (PATIENTS IN THE COMMUNITY) ACT 1995
UPDATED GUIDANCE ON THE PROVISIONS OF THE 1995 ACT

Addressees

For action:
General Managers, Health Boards
General Manager, State Hospitals Board for Scotland
Chief Executives, NHS Trusts
Chief Executives of Local Authorities

For information:
General Manager, Common Services Agency
Directors of Social Work
Sheriff Principal
Regional Sheriff Clerks
Secretary, Mental Welfare Commission for Scotland
SHAS
Appropriate Professional and Voluntary Bodies

Summary

1. In 1996, the Mental Health (Patients in the Community) Act 1995 amended some provisions of the Mental Health (Scotland) Act 1984. The 1995 Act applies to Scotland and to England and Wales. Draft Guidance on the Scottish provisions was issued in 1996; this MEL encloses updated guidance which takes into account experience of practitioners since then.

Background

2. An overview of the 1995 Act's provisions is attached, for ease of reference, as an Appendix to this letter.

Action

3. **Mental health care providers** should:

- ensure that the revised guidance is brought to the immediate attention of those responsible for its implementation;
- draw up, or revisit as appropriate, local protocols on Community Care Orders jointly with purchasers and local authorities (see Annex A of the guidance);
- establish, or revisit as appropriate, local audit and monitoring systems for Community Care Orders;
- discuss any issues of common concern with purchasing and local authorities.

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4. **Health Boards** should:

- ensure that their contracts for mental health services, and specifically for the provision of services under section 8 of the Mental Health (Scotland) Act 1984, include the necessary arrangements for implementing the system of Community Care Orders;

- in co-operation with mental health care providers and local authorities, monitor and evaluate the implementation of the guidance.

5. **Local Authorities** should:

- ensure that the guidance is brought to the immediate attention of those responsible for its implementation;

- draw up local protocols on Community Care Orders jointly with mental health providers and purchasers (see Annex A of the guidance);

- ensure that the local management structures necessary for the management and provision of services under section 8 of the Mental Health (Scotland) Act 1984, to implement the new system of Community Care Orders, are in place;

- discuss any issues of common concern with health purchasers and local mental health providers.

6. The NHS Management Executive and the Social Work Services Inspectorate will monitor the continued functioning of the arrangements.

Associated Statutory Instruments

7. Regulations under the Act are:

The Mental Health (Patients in the Community) (Transfer from England and Wales to Scotland) Regulations 1996 (S.I. 1996 No. 742).

The Mental Health (Prescribed Forms) (Scotland) Regulations 1996 (S.I. 1996 No. 743).

Yours sincerely

DR KEVIN WOODS

APPENDIX

THE MENTAL HEALTH (SCOTLAND) ACT 1984 AS AMENDED BY THE MENTAL HEALTH (PATIENTS IN THE COMMUNITY) ACT 1995

The Mental Health (Patients in the Community) Act 1995

1. The Mental Health (Patients in the Community) Act 1995 ("the 1995 Act") came into effect on 1 April 1996.

2. The Act applies to Scotland and to England and Wales. The Scottish provisions in sections 4-6 amended the existing Mental Health (Scotland) Act 1984 ("the 1984 Act") and provided 3 sets of provisions for Scotland:

- Firstly, it introduced Community Care Orders;
- Secondly, it changed the arrangements for patients who are detained in hospital or subject to guardianship and who go absent without leave; and
- Thirdly, it introduced a limit to the length of time for which detained patients may be granted "leave of absence" from hospital.

3. This Appendix provides a reminder of the 1995 Act's provisions and should be read in conjunction with the detailed guidance enclosed.

Community Care Orders (Sections 35A to 35K inserted by the 1995 Act, section 4)

4. Community Care Orders (CCOs) provide a legal framework for the care and treatment in the community of a limited group of patients with a mental disorder who are no longer ill enough to be detained in hospital, but who may find it difficult to cope in the community without special support. The aim in introducing CCOs was to ensure that these potentially vulnerable patients receive the medical treatment from the health service, and the after-care from local authorities, to which they are entitled. CCOs are necessary in part because of the changes made to leave of absence (see paragraphs 14-17 below).

5. The Orders are made by the sheriff. An application can be made if a patient is liable to be detained in hospital under Section 18 of the 1984 Act or under a hospital order without the special restrictions set out in section 62(1) of the 1984 Act. The application is made by the patient's responsible medical officer (ie the doctor in charge of the patient's treatment in hospital) and must be supported by a second medical opinion and the recommendation of a local authority Mental Health Officer (ie a social worker with special training in the care of people with a mental disorder). The medical practitioners must be satisfied that while the patient does not need to be detained in hospital, their mental disorder warrants a CCO and that the Order is necessary with a view to ensuring that the patient receives medical treatment and after-care services, and that it is required in the interests of the patient's health or safety or with a view to the protection of other persons.

6. The Order names the Special Medical Officer (the medical practitioner in charge of the patient's treatment while the Order is in force) and the social work department's After-Care Officer (the Mental Health Officer responsible for co-ordinating the delivery of after-care services).

7. The Order has conditions. These are not defined by the Act, as they should be tailored to meet the specific needs of each patient. They might, for example, include a requirement on the patient to reside in a certain place; to attend certain places for education and/or training; or to attend certain places to check continued compliance with the treatment regime prescribed by the Special Medical Officer.

8. The Order lasts initially for up to 6 months, after which it can be renewed by the Special Medical Officer for a further period of up to 6 months (and subsequently for periods of one year at a time) if the criteria for the making of the Order continue to be met. Patients have a right to be heard at the making of a CCO and to appeal to the sheriff against the subsequent renewal of the Order. The Mental Welfare Commission's protective functions were extended at the time of the 1995 Act to include patients subject to CCOs.

9. If the patient's mental state deteriorates, the care team may arrange to have him or her returned to hospital for reassessment for up to 7 days. This re-admission can occur before the usual criteria for detention in hospital are met. It is hoped that this proactive provision will reduce the need for lengthy admissions of these patients under the current procedures.

10. The Order requires full consultation between professionals, and with the patient and carers, at each stage.

Absence Without Leave (Sections 31, 31A and B inserted by the 1995 Act, section 5)

11. Before the introduction of the 1995 Act, if a patient detained in hospital or subject to guardianship absconded and remained at large for over 28 days then, under section 28 and 44 of the 1984 Act, he or she was deemed to be free and could not be retaken.

12. The new provision ensures that where such people abscond, they remain liable to be retaken either until their current period of detention or guardianship would have expired, or for 6 months, whichever is later. The provisions do not apply to detentions under sections 24, 25 or 26.

13. This provision also allows the return of patients subject to hospital orders who abscond and then go abroad.

Leave of Absence (Section 27(2A), (2B) and 2C) inserted by the 1995 Act section 6)

14. Before the introduction of the 1995 Act, a patient who was detained in hospital could be granted "leave of absence" for specified occasions or periods under section 27 of the 1984 Act. During this time, although not in hospital the patient remained "liable to be detained in hospital". The provision was therefore used to maintain people in the community for long periods, although it was probably not intended for this purpose.

15. However the lawfulness of this long-term use of leave of absence was called into question and it was decided that there was an unacceptable risk of a successful legal challenge to such long-term use. The question was whether a person who is well enough to live in the community on a long-term basis can, at the same time, meet the very strict criteria for detention in hospital (including the need to receive treatment which cannot be provided unless the patient is "detained" in hospital). For these reasons the new provision limited use of continuous or consecutive periods of leave of absence to 12 months – which is the maximum period under the 1984 Act for which a patient may be detained in hospital without a statutory review.

16. (A transitional provision provided that all patients who had been on leave of absence for more than 6 months on 1 April 1996 could have their leave of absence renewed for one further period of up to 6 months **from the expiry of their then current leave of absence period)**.

17. Those patients who still require formalised supervision and treatment in the community at the end of a 12 month period of leave of absence could be candidates for Community Care Orders, as described above.

GUIDANCE ON THE MENTAL HEALTH (SCOTLAND) ACT 1984

AS AMENDED BY THE MENTAL HEALTH (PATIENTS IN THE COMMUNITY) ACT 1995

INDEX

1. INTRODUCTION

1.1 This document gives guidance on the provisions inserted into the Mental Health (Scotland) Act 1984 (the 1984 Act) by the Mental Health (Patients in the Community) Act 1995 (the 1995 Act). The guidance became effective from 1 April 1996, on the date of coming into force of the 1995 Act.

1.2 This guidance is not to be taken as an authoritative statement of the law. In the event of uncertainty regarding procedure, legal advice should be obtained.

1.3 The 1995 Act introduced three new Scottish provisions:

- Community Care Orders;
- a limit (of 12 months) to the length of time a patient may be granted "leave of absence" from hospital; and
- changes to the arrangements for patients who are detained in hospital or subject to guardianship and who go absent without leave.

2. PURPOSE OF COMMUNITY CARE ORDERS (Sections 35A to 35K)

2.1 Community Care Orders (CCOs) introduced into the 1984 Act a new concept: formalised multi-disciplinary care in the community for people with a mental disorder. While such care existed previously, it was not provided within a specific legal framework. CCOs introduced such a framework. Their purpose is to ensure that a patient who has immediately previously been liable to be detained in hospital under the 1984 Act without special restrictions and who might benefit from treatment and after care be given the opportunity to receive medical treatment from the Health Service and the after-care from Local Authorities to which he or she is entitled under section 8 of the 1984 Act.

2.2 The provisions take account of the key principles of the Care Programme Approach for people with severe and enduring mental illness including dementia, as defined in circular SWSG16/96:DD38/96 (which replaced SWSG1/11992, Index Ref F13). They also reflect the general guidance given in MEL(1992)55 (and the accompanying letter to Chief Executives of Regional, District and Island Councils dated 15 September 1992) and MEL(1996)22.

2.3 The Care Programme Approach (CPA) is directed at people with long-term and/or enduring mental disorder who require structured arrangements for their health and social care, including accommodation, in the community. It aims to ensure that these people receive effective health and after care services which meet their individual needs and, if these people have been in hospital, that these services are in place in the community before they are discharged from hospital.

2.4 In particular, before a patient is discharged from hospital to a CCO:

- a multi-agency and multi-disciplinary assessment of their continuing health and social care needs must be carried out;
- a multi-agency care plan should be drawn up and agreed on the basis of that systematic assessment of need;
- a key worker should be appointed from the multi-agency care team to monitor the patient's progress and the delivery of the agreed package of care services; and
- clear arrangements should be agreed for reviewing the patient's subsequent progress.

2.5 It is good practice for the care plans of all patients on leave of absence or subject to a CCO to comply with the requirements of the Care Programme Approach.

2.6 CCOs are intended to be used for those patients who:

- need supervised support on being discharged from hospital but are at risk of not complying with proposed after-care and treatment plans, or

- have shown a pattern of relapse after discharge from hospital which results in serious risk to themselves or others and may need a period of hospitalisation.

Relapses sometimes follow the breakdown of arrangements for care in the community and a failure to comply with medication.

2.7 The legal framework provided by CCOs should help prevent such relapses. For the CCO to be successful it is essential that the care arrangements have been fully agreed between the agencies concerned and the purposes of the CCO have been fully explained to the patient. In addition, the patient must understand that by not complying with the conditions specified in the Order they might place themselves at risk of relapse which might require hospitalisation, possibly on a formal basis.

2.8 Under section 8(1) and 8(2) of the 1984 Act, a local authority is obliged to co-operate with the health board and concerned voluntary organisations in providing after-care services to mentally disordered people. The provisions of the 1995 Act extended this duty to patients subject to a CCO. If a patient meets the Act's eligibility criteria (see paragraph 5.1 – 5.6) they may be made the subject of a CCO with a view to ensuring that they are provided with and accept medical treatment and aftercare services which they might not otherwise agree to.

Advocacy Services

2.9 It would be good practice to ensure that all patients being offered services, for instance, through the Care Programme Approach, on a CCO or on guardianship, should be made aware of the availability of advocacy services and the type of assistance these services can offer. Patients should be given some guidance, and, if necessary, assistance in contacting such services. It is for local authorities to decide on the appropriate manner to do this depending on the availability of such services in their area.

Confidentiality

2.10 Information on a patient should be exchanged between members of the care team on a 'need to know' basis and on the clear understanding that personal information concerning the patient which has been obtained in this context must be treated in strict confidence by persons who have access to it and that the information must be used solely for the purpose of the patient's treatment, social welfare and after care. Patients should be made aware at the outset that information about them will be shared in this way and they must be told the name of the doctor in charge of their treatment (if they do not already know this) and the names and responsibilities of the other professional people who are principally involved in this treatment. The Code of Practice on Confidentiality of Personal Health information should be referred to when issues arise.

Definitions

2.11 There are two terms introduced in the Act which merit some explanation. (A fuller glossary of terms used can be found at the end of this guidance.)

2.11.1 **The Special Medical Officer (SMO) [S35A(4)(b)]** - This refers to the medical practitioner who is to be principally concerned with the patient's medical treatment while the order is in force. The Special Medical Officer should be a practitioner approved by a Health Board for the purposes of section 20 of the 1984 Act as having special experience in the diagnosis and treatment of mental disorder. The Special Medical Officer will take over from the Responsible Medical Officer while the patient is in the community and subject to a CCO. (In practice the Special Medical Officer and the Responsible Medical Officer may be the same person.) The Special Medical Officer has powers to renew and terminate the CCO taking into account views expressed during consultation with a range of people specified by the Act.

2.11.2 **The After-Care Officer (ACO) [S35A(4)(c)]**- This term is used for the person whose role it is to co-ordinate the provision of the after-care services to be provided for the patient under section 8 of the 1984 Act. The After-Care Officer must be a Mental Health Officer of the local authority providing the services - i.e. a social worker experienced in mental health, in accordance with section 9 of the 1984 Act.

2.12 The following two terms are also used in this guidance although not specifically defined in the Act:

2.12.1 **Informal Carer** - This term is used to describe any person who the Responsible Medical Officer believes will play a substantial part in the care of the patient after the order comes into force but who will not be professionally concerned with the after-care services. Such a person may be the nearest relative or another close relative but may be a friend or other person who assists the person in their daily routine. It would be good practice to ensure that both the patient and the carer are content that the carer is so named.

2.12.2 **Key Worker** - The key worker's main responsibility is to co-ordinate an individual's care programme in close collaboration with the individual, their carer and other members of the care team including the Special Medical Officer, and the After-Care Officer. The key worker is usually a mental health professional.

3. LEAVE OF ABSENCE AND COMMUNITY CARE ORDERS

3.1 A patient who is liable to be detained in hospital (under section 18) may be granted leave of absence from hospital for a period of up to six months (under section 27), which can be extended. Good practice suggests that before leave of absence is granted for other than a specific occasion the patient should be the subject of an agreed care programme (see paragraphs 2.2 and 2.3).

3.2 The 1984 Act did not limit leave of absence. However, doubts were raised about the lawfulness of leave of absence being used as a long-term care and treatment option. Accordingly provisions in the 1995 Act amended section 27 of the 1984 Act to restrict the total period of leave of absence for specified consecutive periods to a maximum of 12 months. (Part 18 of this guidance explains this more fully.) The 1995 Act also introduced Community Care Orders to provide for formalised community-based care and treatment beyond this period.

Transitional Provision to 1 October 1996

3.3 A transitional provision was provided so that all patients who had been on leave of absence for more than 6 months on 1 April 1996 might have their leave of absence renewed for one further period of up to six months **from the expiry of their then current leave of absence period as recorded in the most recent Form F1** – notification of Leave of Absence from hospital (see paragraph 18.5).

5. APPLYING FOR A COMMUNITY CARE ORDER (Section 35 B)

Eligibility for Community Care Orders

Patients formally detained in hospital

5.1 An application for a CCO can only be made by a Responsible Medical Officer (RMO) in respect of a patient liable to be detained in hospital and for whom an application for admission has been made under Section 18 of the 1984 Act (section 35B(1)). That includes patients subject to a hospital order without restriction, but excludes patients detained under Section 24 (Emergency procedures), section 26 (short term detention) and section 26A (interim detention) of the 1984 Act. The patient must have been liable to detention in hospital for at least 28 days under Section 18.

Hospital Order Patients

5.2 An application may be made for patients who are transferred to hospital under a hospital order without restrictions in terms of section 58 of the Criminal Procedure (Scotland) Act 1995. (It is not available for patients subject to an Order restricting to Scottish Ministers decisions on their discharge i.e. sections 58 and 59 of the Criminal Procedure (Scotland) Act 1995). (NB from 1 July 1999, decisions on discharges under sections 58 and 59 of the Criminal Procedure (Scotland) Act 1995 are the responsibility of the Scottish Ministers. This is because community care is a matter which from 1 July 1999 is within the legislative competence of the Scottish Parliament. Any future legislation in this area will be considered by the Scottish Parliament rather than by the Westminster Parliament.)

Patients on Leave of Absence

5.3 Patients who are on leave of absence may be considered eligible for a CCO. Indeed it is likely that many patients will be on leave of absence when an application for a CCO is made on their behalf.

"Supervised Discharge" Patients

5.4 Supervised discharge is the equivalent provision to Community Care Order in England and Wales. A Community Care Order application may be made on behalf of a patient who is subject to supervised discharge in England or Wales under the Mental Health Act 1983 and who wishes to live in Scotland (see paragraph 15.4).

Considering making an application

5.5 The Responsible Medical Officer's role is crucial in the initiation of an application for a CCO. The Responsible Medical Officer should consider making an application if he or she is satisfied that:

- the patient is suffering from a mental disorder, as defined in section 1(2) of the 1984 Act, of a nature or degree which makes it appropriate for him or her to receive medical treatment, but that the grounds for admission to and detention in hospital set out in section 17(1) of the 1984 Act do not apply; and

- the patient requires to be subject to a CCO:

  (i) with a view to ensuring that he or she receives medical treatment and the after-care services which it is the responsibility of the local authority under section 8 of the 1984 act to provide for him or her as a mentally disordered person ; and

  (ii) in the interests of his or her health or safety or with a view to the protection of other people; and

- the proposed After-Care Officer agrees that a CCO is necessary to ensure that the patient receives such after-care and medical treatment and it is in the interests of the patient's health or safety or for the protection of the public.

5.6 **All** of these conditions must be met. If they are not, the Responsible Medical Officer must give consideration to what other action, including discharge, might be appropriate for the patient.

The Conditions proposed in the application for a CCO

5.7 In making a CCO the sheriff may impose such conditions as he or she thinks are necessary to ensure that the patient receives medical treatment and aftercare. The arrangements for the health and after-care services needed by a patient being considered for a CCO should be drawn up as part of the normal discharge planning process, following the principles of the Care Programme Approach and the formal consultations required by the new provisions (see paragraphs 5.13 to 5.20). The multi-agency team providing care in the community and the multi-disciplinary team in the hospital will need to consider and plan the services to be provided. They will also need to consider how often the patient is likely to need to use particular services which might include:

- Accommodation;
- daytime activities;
- treatment regime;
- primary care;
- personal and practical support;
- 24-hour emergency cover;
- assistance in welfare rights and financial matters; and
- advocacy and representation services.

5.8 The after-care plan must include details of any requirements to be placed on the patient and the conditions to which the patient is to be subject under the CCO. However, the after-care plan is likely to be more detailed than the formal conditions which are set out in the CCO application itself.

5.9 For example, a patient may be required to:

- live in a particular place;

- attend a particular place at set times for occupation, education or training;
- follow the treatment regime prescribed by the Special Medical Officer, or anyone authorised by the Special Medical Officer; and
- allow access to his or her place of residence to the After-Care Officer, or anyone else authorised by the After-Care Officer.

5.10 A requirement to comply with a treatment regime cannot carry with it any power **to impose medication** or other treatment against the patient's wishes while he or she is living in the community. However, any evidence that the patient is not taking prescribed medication should trigger a multi-disciplinary reconsideration of the care arrangements. (See part 9 of this guidance)

5.11 The After-Care Officer should, therefore:

- establish that all services to which the patient is to be referred have agreed to provide the necessary care before including them in the after-care plan; and

- ensure that the views of the patient are taken into account;

5.12 In framing an Order the care team's aim should be:

- to achieve benefits which could not reasonably be achieved in any other way;

- to make the conditions the least restrictive to the patient's freedom necessary to achieve the purpose of the Order;

- to identify the medical, nursing and social care resources necessary to implement the Order; and

- to take account of the present and past wishes of the patient.

Consultation (section 35B(2))

5.13 The Responsible Medical Officer is responsible for ensuring that both the current and proposed care team (if different) are consulted about the arrangements to be made for the patient's care after discharge from hospital, and about the conditions to be imposed in the Order; the Responsible Medical Officer is also responsible for ensuring that agreement about the care plan has been reached between all involved. It would be good practice for the Responsible Medical Officer to satisfy him or herself that the after-care and treatment the patient requires cannot be provided in any way other that by a CCO.

5.14 The new provisions specify certain people who must always be consulted about the making of a community care application. These are:

- the patient;

- the people who have been principally concerned with the patient's treatment in hospital, for example, junior doctors and charge nurses who have had day to day contact with the patient on the ward;

- the Mental Health Officer who is to be the patient's After-Care Officer;

- the doctor who is to be the patient's Special Medical Officer, and any other appropriate person who will be concerned with the patient's medical treatment under the CCO. This will usually include the patient's GP;

- any other appropriate member of the professional team who will be responsible for the after-care services provided for the patient under the CCO;

- any informal carer; and

- the patient's nearest relative (if practicable and the patient does not object - but see paragraph 5.25).

5.15 The purpose of an application is to permit a patient to be discharged within a statutory framework which ensures, as far as possible, that the patient receives the medical treatment and after-care services that the Responsible Medical Officer considers appropriate. It is, therefore, essential at the earliest practicable stage in this process to involve the Special Medical Officer and After-Care Officer and secure their agreement to and support for the proposed care plan. The formal agreement of the local authority to the proposed care plan (after agreement by the After-Care Officer) should be obtained before the application is made. The procedure for doing this needs to be agreed as part of local liaison arrangements.

5.16 The proposed After-Care Officer's role is crucial. The After-Care Officer is the primary person who must be consulted in considering a CCO, as an application cannot proceed until the After-Care Officer has agreed to it.

5.17 It is also important that any other agencies who will be involved in providing after-care services to the patient, but who may not be part of the care team - for example, the housing department - are consulted in good time to secure their agreement to the provision of the necessary service in advance of the patient leaving hospital.

5.18 Voluntary agencies who will be involved in providing services should be consulted and asked for their agreement in principle to the provision of certain services even though it may not be possible or appropriate to obtain their formal agreement to this.

5.19 The Responsible Medical Officer is responsible for ensuring that all those whom the Act specifies should be consulted are indeed consulted. Those who are consulted must be given a genuine opportunity to comment on the proposed arrangements and, in making the application, account must be taken of any views they have expressed.

The arrangements clearly will not work without a substantial measure of agreement on the part of those responsible for them.

5.20 Where it is decided that it is not practicable to consult a person as required by the Act, it would be good practice to make a statement on the application form to indicate what efforts were made to contact the individual.

5.21 A CCO also cannot operate successfully unless the patient, and any informal carer, understands its terms and the possible implications of not complying with the Order. The Responsible Medical Officer must ensure that the patient, and where appropriate their carer, has a genuine opportunity to take part in discussions about the proposals for their after-care. The Responsible Medical Officer should always give the patient a copy of the care plan, including the proposed conditions of the CCO in their final form, before the making of the application.

5.22 The patient, any informal carer and the nearest relative (subject to paragraph 5.25) should have the opportunity to speak to the Responsible Medical Officer alone if they wish. The patient may wish a friend, relative or other advocate to be present during these discussions and such a wish should be respected unless there are exceptional reasons for excluding a particular person. It would be good practice to record in writing in case notes the reason for any such exclusion.

5.23 Patients, nearest relatives and any informal carers must be consulted in a suitable and sensitive manner. Where anyone involved has a hearing or speaking difficulty, or there are language difficulties, the assistance of a professional with the relevant communication skills should be considered. The Responsible Medical Officer and the other professionals involved must take into account the possibility of misunderstandings resulting from assumptions based on a medical or health condition (including deafness) or on a person's gender, social background, ethnic origin, sexual orientation or religion.

Consulting the Patient's Nearest Relative

5.24 Before lodging the application, the Responsible Medical Officer must take such steps as are reasonably practical to inform all the people who were consulted, including the patient's nearest relative, that an application for an Order is to be made, and that he or she has a right to be heard by the sheriff before the Order is made.

5.25 Section 35B(3)(9) of the Act allows a patient to object to his or her nearest relative being consulted. If the patient objects then the Responsible Medical Officer may only consult the nearest relative if the patient is known to have a propensity to violent or dangerous behaviour and the Responsible Medical Officer thinks such consultation appropriate (section 35B(4)). The patient's objection should not be set aside lightly and it is for the Responsible Medical Officer to judge whether the patient has a propensity to violence towards himself or other people and, if so, whether consultation with the nearest relative is advisable in all the circumstances. Matters which the Responsible Medical Officer is likely to want to consider include the patient's history, the seriousness of any past violence, against whom it has been directed, how the patient has responded to treatment and to what extent consultation

with the nearest relative is likely to shed light on the assessment of the patient's present condition and needs. The patient should be informed by the Responsible Medical Officer of their right to object to their nearest relative being consulted and of the Responsible Medical Officer's right in certain circumstances to overrule that objection.

6. THE APPLICATION (Section 35B)

6.1 An application for a CCO cannot be made within the first 28 days of detention under section 18 or equivalent hospital order provision (see Section 35B(1)). This is because within the period of 7 days expiring on the 28th day after admission, reports must be produced to inform a decision as to whether the patient is liable to detention in hospital under section 22(4) of the 1984 Act (see also paragraphs 5.1, 5.2 and 5.4).

6.2 All CCO forms are set out in Schedule 2 of the Mental Health (Prescribed Forms) (Scotland) Regulations 1996. Annex B of this guidance contains a list of the form names and titles for ease of reference.

6.3 The application should be made on **Form CCO 1**. Section 35B(6) sets out that the application must include the following information:

- the conditions which should be specified in the Order;
- the name of the Special Medical Officer;
- the name of the After-Care Officer; and
- the period for which the Order should have effect. Initially this may not be longer than 6 months (see paragraphs 7.2 and 11.1).

6.4 The Responsible Medical Officer must submit the following documents with the CCO :

- two medical recommendations (**Form CCO 2**); and
- a report from the patient's After-Care Officer (**Form CCO 3**).

6.5 It should be noted that the provisions of sections 21(1), (2)(a) and (b), (3), (4) and (5) and section 113 of the 1984 Act, which apply to submission and approval of an application to the sheriff and appeals to the sheriff, also now apply to applications for Community Care Orders. These provisions specify where and when applications should be made, set out the role of the sheriff in considering applications and allow for appeals against the application to be heard by the sheriff.

Medical Recommendations

6.6 The medical recommendations must be the result of a personal examination of the patient. At least one of the recommendations must be given by a medical practitioner who has been approved by the local Health Board under section 20 of the 1984 Act as having special experience in the diagnosis or treatment of mental disorder; normally this will be the Responsible Medical Officer. The other recommendation should, if it is possible, be made by a medical practitioner who has some knowledge of the patient. This might be the Special Medical Officer, i.e. the doctor who will be professionally concerned with the patient's medical treatment in the community. If the Responsible Medical Officer will be taking on that role, then

the second recommendation should be given by the patient's GP, or another medical practitioner who has had previous contact with the patient. The examinations leading to the medical recommendations should, wherever possible, be carried out within 5 working days of each other.

6.7 Section 35B(8) sets out that the medical recommendations should satisfy the conditions that:

- the patient is suffering from a mental disorder which makes it appropriate for him or her to receive treatment, but which is not severe enough to warrant his detention in hospital; and

- a CCO is required with a view to ensuring that the patient receives medical treatment and after-care services, **and** that the Order is necessary either in the interests of the patient's health or safety, or with a view to the protection of other persons (or both).

After-Care Officer's Report

6.8 In preparing his or her report the After-Care Officer should interview the patient and those to be principally involved in the proposed after-care. The After-Care Officer's enquiries should be carried out at the same time as the medical examinations and the necessary report completed in time to allow the application to be submitted to the sheriff within 7 days of the date of the second medical recommendation (as set out in section 21(1) of the 1984 Act). The report should include relevant information about:

- the patient's social background;

- the patient's after-care needs;

- the services which the local authority have agreed to provide for the patient; and

- any other after-care which is to be provided for the patient.

In preparing the report the After-Care Officer may find it useful to refer to Community Care Circular 1-1999 "The role of Social Circumstance reports in planning the care of people detained in hospital" – issued on 9 August 1999 which gives guidance on the writing of reports on people's social circumstances.

6.9 It must also contain a statement by the After-Care Officer that:

- a CCO is required with a view to ensuring that the patient receives medical treatment and after-care services;

- the Order is the only way that the proposed after-care can be provided given the patient's reluctance or refusal to agree to the care plan on a voluntary basis; and

- the Order is necessary either in the interests of the patient's health or safety, or with a view to the protection of other persons (or both).

6.10 For the purposes of deciding whether to make a recommendation, the doctors and the After-Care Officer should each visit and interview the patient at any reasonable time. The doctors should examine the patient, following the guidance on assessment of a person's mental state set out in Part I of the Code of Practice on the 1984 Act. Whenever possible, the After-Care Officer and the doctors should visit the patient within 5 working days of each other. They should also inspect any records relating to the patient's detention or treatment in hospital, and to any after-care which may be being provided where, for example, the patient is currently on leave of absence, to ensure that their recommendations are based on fully informed judgements.

6.11 An application should be accompanied by signed statements from the Special Medical Officer and the After-Care Officer, confirming that they are willing to act in these capacities. This consent may be included in the application form or in the statement/report provided by these officers.

6.12 No written recommendation in support of a community care application should ever be made by:

- anyone for whom there would be a conflict of interest, financial or otherwise, or a close relative of such a person;

- a close relative of the patient or of a professional giving a written recommendation in support of the application.

Submitting the Application

6.13 The application should be submitted to the sheriff of the sheriffdom for either:

- the hospital in which the patient is detained, or

- the address at which the patient is resident at the time of the application (if on leave of absence). It must be submitted within 7 days of the last date on which the patient was examined for the purposes of any accompanying medical recommendation. (See section 21 of the 1984 Act.)

6.14 The Responsible Medical Officer should ensure that the patient is aware of his or her right to be heard by the sheriff considering the application (and to call witnesses), and encourage the patient to attend the hearing, which should be heard in private. A patient whose mental illness is too severe to allow attendance at a hearing should not be considered for a CCO.

6.15 The sheriff has the same jurisdiction and powers as if acting in the exercise of his civil jurisdiction. The sheriff may make relevant enquiries, and these may include

listening to the patient, the applicant, the patient's nearest relative if he or she objects to the application, and any witness he or she calls.

6.16 Ideally there should be no administrative or technical reason for the application being queried or rejected if the guidance has been properly followed. Any evidence of the effectiveness of after-care arrangements, for example, where the patient is or has already been on leave of absence, can be helpful. In any event it should be agreed by all those involved that the arrangements proposed are effective.

6.17 The sheriff may:

- make the Order either subject to the conditions in the application or to such other conditions as he or she considers appropriate. (It is unlikely that the sheriff would vary a condition without some evidence before him or her on which to impose the variation - this may flow from medical recommendations and reports lodged and any other evidence given at the hearing);

- defer the making of the Order to ensure that all arrangements for the patient's medical treatment and after-care are in place; or

- refuse the application.

Continuing detention

6.18 Section 35A(7) allows that where a patient's liability to detention in hospital is due to expire while an application for a CCO is pending, or where an Order is made but not yet in force, the patient remains liable to be detained in hospital until the Order comes into force or the application is refused.

6.19 Section 35A(8) states that a patient who is subject to a CCO ceases to be liable to be detained in hospital on the day the Order comes into force.

7. THE ORDER (Section 35A)

Content of Community Care Order

7.1 When the sheriff makes the Order as set out in section 35A(3) it will specify:

- the conditions to which the patient will be subject;
- the name of the Special Medical Officer who is primarily responsible for the patient's medical treatment; and
- the name of the patient's After-Care Officer, who will be responsible for co-ordinating the after-care services to be provided to the patient.

Part B of the application form will record the details of the making of the Order.

Duration of a Community Care Order

7.2 A CCO will apply initially for a period of up to six months and can thereafter be renewed for a further six months and then for periods of a year at a time (see paragraph 11.1).

Informing People about the making of an Order

7.3 The Act sets out at section 35A(9) and (10) specific requirements governing information to be given to patients and other people. However, as a general principle, patients should be given as much information as they need to exercise their rights and to understand the requirements imposed by the Order.

7.4 Within 7 days of the Order coming into force, the patient's Responsible Medical Officer must send a copy of the Order to:

- the patient;
- the patient's nearest relative (if he or she has been consulted about the making of the Order) and any other informal carer consulted;
- the Mental Welfare Commission for Scotland;
- the patient's Special Medical Officer (see paragraph 8.4); and
- the patient's After-Care Officer (see paragraph 8.5).

It would be good practice to ensure that the patient's GP is aware of the CCO and its conditions.

7.5 When the After-Care Officer receives a copy of the Order as in section 35A(10) he or she must explain to the patient, orally **and** in writing:

- the purpose and effect of the Order and the conditions that are specified in it;

- the patient's right of appeal to the sheriff (as set out in section 35F) against the Order following its first renewal. (There is no right of appeal until after the first renewal of an order); and

- that the patient may make representations to the Mental Welfare Commission for Scotland at any time.

7.6 A copy of the written explanation of these facts must also be sent to the patient's nearest relative (if he or she has been consulted about the making of the Order) and to any informal carer (who has been consulted about the making of the order), if different.

8. OPERATION OF A COMMUNITY CARE ORDER

8.1 The following paragraphs explain generally the effect of a CCO once it has been made by the sheriff and the patient discharged from liability to detention.

Professional Responsibilities

8.2 The Act gives specific responsibilities to designated individual members of the care team, namely the After-Care Officer and the Special Medical Officer. The principle of allocating responsibilities to individuals is not new. The 1984 Act already defines the responsibilities of Mental Health Officers and Responsible Medical Officers when the patient is detained in hospital, and of guardians when the sheriff has appointed a guardian to a patient under that Act. Staff undertaking duties defined in the Act remain professionally and managerially accountable in the normal way. The possibility of personal legal liability would arise, as it would at present, if there were a culpable professional failure which fell outside the protection offered by section 122 of the 1984 Act.

8.3 Suitable joint training should be provided for members of the care team who have to fulfil specified roles in relation to the giving of medical care and after-care treatment under a CCO.

The Special Medical Officer

8.4 The Special Medical Officer is principally responsible for the patient's medical treatment in the community while the Order is in force. He or she must be a registered medical practitioner approved by the Health Board for the purposes of section 20 of the 1984 Act as having special experience in the diagnosis or treatment of mental disorder. The Special Medical Officer has powers (set out in parts 11 and 13 of this guidance) to renew and terminate the CCO taking into account views expressed during consultation with a range of people specified by the Act.

The After-Care Officer

8.5 The After-Care Officer's role is to co-ordinate the provision of the after-care services to be provided for the patient under section 8 of the 1984 Act. The After-Care Officer must be a Mental Health Officer, i.e. a social worker experienced in mental health, in accordance with section 9 of the 1984 Act. Before taking on the role of After-Care Officer, a Mental Health Officer should ensure that:

- he or she has managerial support and sanction to do so; and
- the appropriate resources will be available to meet the after-care needs of the person to be the subject of the Order.

Care Team Responsibilities

8.6 The Special Medical Officer and the After-Care Officer should be part of a multi-disciplinary multi-agency care team representing all the agencies which have agreed to contribute medical treatment or after-care services. The care team must appoint a "key worker" (as identified in the Care Programme Approach - see paragraphs 2.2 and 2.3) to co-ordinate the delivery of the agreed care service and to liaise with the other

members of the care team and co-ordinate their work as necessary. This key worker may appropriately be the After-Care Officer, but could be another member of the care team.

8.7 The key worker (if he or she is not the After-Care Officer) should work with the After-Care Officer and Special Medical Officer to help ensure that the patient complies with the requirements of the Order, whether these are to live in a particular place or to attend for treatment, occupation, education or training. The key worker should also ensure that the care team collectively considers the patient's after-care plan well before the date when it falls to be reviewed, and whenever any shortfall in the arrangements is identified (see paragraph 9.1). Close working links between the key worker, the After-Care Officer (where different) and the Special Medical Officer are essential.

8.8 The After-Care Officer and key worker play central roles in the operation of the CCO and it is important that they are supported by a proper framework of joint training, accountability and clear reporting lines with their employing authority. This framework should also take account of the needs of any professional, who need not be a Mental Health Officer, with whom an After-Care Officer may agree an allocation of functions, for example, taking on the day to day supervision of the patient in the community.

8.9 To this end:

local authorities need to ensure that:

- the CCOs operate within the framework of assessment and care management;
- individual Mental Health Officers have the appropriate professional, administrative and legal support in carrying out their After-Care Officer duties;
- as required by the Act, written guidance is developed to be forwarded to patients, relatives and carers, and that this guidance is drafted in a clear, straightforward manner, easily accessible to patients and their families;
- they maintain records of persons subject to CCOs in their area; and

health and local authorities need to ensure that:

- their staff have the appropriate training, procedures and resources in place to facilitate the use of CCOs.

A suggested list of issues for local inter-agency agreement is at Annex A.

The General Practitioner

8.10 A patient's general practitioner does not have a statutory role as such in the operation of a CCO. Nevertheless good practice requires that the Special Medical Officer, the After-Care Officer and the key worker ensure that the GP is involved in decisions which affect the patient's medical treatment in the community. As with anyone leaving hospital, steps should be taken to ensure that the patient is registered with a GP, not least because mentally disordered people often have substantial physical health needs. The Special Medical Officer should provide the GP with a copy of the care plan and ensure that he knows who are the patient's After-Care Officer and Special Medical Officer and how the care team can be contacted in an emergency. (The GP may also be asked by the Responsible Medical Officer to provide one of the medical recommendations to accompany the application for the CCO to the sheriff.)

Changing the Special Medical Officer or the After-Care Officer

8.11 A change of Special Medical Officer or After-Care Officer may take place after consultation provided the new officer agrees with the outgoing officer that he or she will take over on an agreed date. A new Special Medical Officer will assume principal responsibility for the patient's medical treatment and a new After-Care Officer will assume responsibility for co-ordinating the provision of after-care services. The following people must be consulted prior to a change:

- the patient;
- the nearest relative (if practicable and the patient does not object, subject to what is said in paragraph 5.25);
- the present Special Medical Officer or After-Care Officer as appropriate;
- the proposed new Special Medical Officer or new After-Care Officer, as appropriate;
- the other persons concerned with the patient's medical treatment or, on a continuing and professional basis, with the local authority after-care services for the patient;
- anyone else concerned or to be concerned with the patient's care.

8.12 Where unforeseen circumstances necessitate a change in Special Medical Officer or After-Care Officer good practice suggests that the remaining Officer should carry out the required consultation.

8.13 Where the Special Medical Officer or After-Care Officer are changed the new officer must, within 7 days of assuming responsibility, send **Form CCO 6 (SMO)** or **Form CCO 7 (ACO)** as appropriate, to:

- the patient;

- his or her nearest relative (if consulted about the change), and the informal carer, if different;
- the After-Care Officer or Special Medical Officer (as appropriate); and
- the Mental Welfare Commission for Scotland.

8.14 The CCO remains in force as if the new Officer had been named in the original Order.

9. REVIEW AND MODIFICATION OF A COMMUNITY CARE ORDER [Sections 35 C and D]

9.1 The Special Medical Officer and After-Care Officer (particularly when the After-Care Officer is not the key worker) need to maintain sufficiently close contact with the patient to be satisfied that he or she is receiving the agreed after-care services and is complying with the conditions of the order. They should be alert to:

- any difficulties in providing services;
- any deterioration in the patient's mental condition; or
- any difficulty in ensuring treatment and aftercare.

The Special Medical Officer and After-Care Officer should make themselves accessible to people with whom the patient is living and be ready to listen to concerns they may express.

9.2 When concerns are uncovered the After-Care Officer should consider calling a review of the case with the care team. This should try to establish the cause of the difficulties and identify what action is necessary. It may be that changes are needed to the care plan or that the CCO is no longer appropriate. Good practice requires close contact between the members of the team. This is particularly important between the After-Care Officer and the Special Medical Officer as it is only the Special Medical Officer who has the power to renew the order, to seek variations in its conditions and to terminate the order (Section 35C).

9.3 Where any part of the care plan, or any of the conditions placed upon the patient, needs to be changed, the After-Care Officer and the Special Medical Officer should consult the other members of the care team. If they consider it is necessary then under section 35D of the Act the Special Medical Officer may propose a modification to the conditions of the Order (on behalf of the care team and the authorities who are responsible for the provision of the after-care). The After-Care Officer's agreement should be secured before the Special Medical Officer proposes any modification of conditions. Such modifications might be any combination of adding further conditions, deleting existing conditions or amending existing conditions.

9.4 The Special Medical Officer must also consult and take into account the views of the following people about the proposed modifications:

- the patient;
- any informal carer;
- the patient's nearest relative (where practicable and the patient does not object, subject to a power allowing the Special Medical Officer to override such an objection - see paragraph 5.25).

Consultation with the care team should take place as part of the regular review process and the After-Care Officer and all those involved in the patient's care or treatment must also be consulted.

Note: The reference in section 35C(4) of the Act to "responsible medical officer" should be to "special medical officer".

9.5 If, following the consultation, the Special Medical Officer considers that changes should be made, he or she should prepare a note of the proposed variation using **Form CCO 5** and deliver that form to the sheriff clerk of the sheriff in the sheriffdom within which the patient is resident, together with the community care order to which that application for variation relates, or a certified copy thereof. A copy of Form CCO 5 should also be sent to:

- the patient;
- the nearest relative (if he or she was consulted about the variation) and the informal carer if different; and
- the After-Care Officer.

9.6 The Special Medical Officer should advise the patient, preferably orally and in writing, of his or her right to object. The patient may object to any proposed variation by advising the sheriff clerk of the sheriffdom within which he is resident within 7 days of receiving the note of the proposed variation (Form CCO 5A). If the patient objects, the sheriff may not approve the application without a hearing.

9.7 Where a variation of conditions is approved by the sheriff, the Special Medical Officer must send a copy to:

- the patient;
- the After-Care Officer;
- the nearest relative (if he or she were consulted about the variation);
- the informal carer, if different; and
- the Mental Welfare Commission for Scotland.

9.8 It would be good practice to ensure that others involved in the care of the patient, including the patient's GP, are informed of any variations of the conditions of the CCO which have implications for their care of the patient.

9.9 When the After-Care Officer receives a copy of the variation he or she must explain them and their purpose to the patient both orally **and** in writing. If the informal carer and the nearest relative were consulted about the variation, they should each receive a copy of the written explanation of these facts.

10. REASSESSMENT IN HOSPITAL (SECTION 35G)

10.1 Where the care team consider that a patient's mental state is showing signs of deterioration since a CCO was made (or renewed - see paragraph 11.1) and is giving or is likely to give grounds for serious concern regarding his health or safety or the protection of other persons, they may take steps to have the patient returned to hospital for reassessment for up to 7 days. The purpose in providing such a power is to allow re-admission to take place **before** the section 17(1) criteria for admission to and detention in hospital are met, so that proactive support can reduce the need for re-admissions under the section 18 procedures.

10.2 The reassessment provision for CCOs under section 35G is in addition to the emergency admissions power available under section 24 of the Act and is the preferred route for a CCO patient to be returned to hospital.

10.3 Where readmission is required without immediate urgency a section 18 application may still take place from the community. However if a patient is admitted under the section 18 procedures this will have the effect of terminating the CCO (Section 35H(6)).

10.4 Where a member of the care team considers that the patient's mental state is showing signs of deteriorating, for example, by an exacerbation of symptoms, they should alert the Special Medical Officer and the other members of the care team. If following this consultation, the Special Medical Officer also considers **that the patient's mental state is, or is likely to become, such as to give grounds for serious concern as to his or her health or safety, or the safety of others**, he or she may initiate steps to have the patient admitted to and detained in hospital for an assessment period of up to 7 days.

10.5 Before making such arrangements the Special Medical Officer must consult the following people:

- the After Care Officer (whose consent must be obtained);
- the patient's nearest relative (if practical and if the patient does not object, subject to paragraph 5.25); and
- the other people professionally and continuously involved with the patient's medical treatment or local authority after care service; and any other people involved in caring for the patient.

10.6 The consultation with the care team may take place as part of the regular review process.

10.7 The Special Medical Officer should examine the patient and arrange for another medical practitioner to do the same. Reports of these examinations should be made using **Form CCO 9**. If, following these examinations, both medical opinions conclude that the patient's mental disorder is of a nature or degree making it

appropriate for admission to hospital for assessment for a limited period, and that the patient ought to be in hospital for his health or safety or for the protection of others, the Special Medical Officer may, **with the consent of the After Care Officer,** direct the patient to be admitted and detained in a specified hospital. **Form CCO 8** is used for this direction. The Special Medical Officer must send a copy of each medical report and the direction to:-

- the After Care Officer;
- the patient's nearest relative, if they were consulted about the assessment, and informal carer, if different;
- the Mental Welfare Commission for Scotland; and
- the managers of the hospital to which the patient is being admitted.

10.8 The patient may be detained in hospital for assessment for up to 7 days, though that period may be extended if an application for admission to hospital is submitted to the Sheriff in respect of the patient (see paragraph 10.12). While the patient is detained in hospital for assessment, the CCO remains in force but its conditions are suspended. This ensures that the Order will still be in place if the patient is discharged from hospital following an assessment, and that the time spent in hospital for assessment counts as part of the duration of the CCO.

10.9 The period of 7 days should be calculated from midnight at the beginning of the day on which the patient is admitted to hospital for assessment. A patient cannot be re-admitted for a further 7 day period of assessment immediately on the expiry of such a period.

10.10 The Responsible Medical Officer treating the patient in hospital must again examine and report on the patient's condition following admission and arrange for a second medical report. At least one of the doctors preparing these reports must have been approved by the local Health Board under Section 20 of the 1984 Act as qualified to make recommendations for admission to hospital. Where the two doctors giving reports are employed in the same hospital, good practice would suggest that they should not both be involved with the care of the patient or work in the same clinical team. It would also be good practice to ensure that, as soon as practicable within 5 working days of the examination, copies of the medical reports **(using Form CCO 10)** are sent to the Mental Welfare Commission for Scotland.

10.11 Where both medical reports conclude that the conditions for the making of a CCO (see paragraph 5.5) continue to be met, the patient shall be discharged from hospital and again become subject to the conditions of the CCO. It is essential that the After-Care Officer is consulted before any decision to discharge is reached, and that his or her views about the social care elements of the Order are taken into account. It is essential that the After-Care Officer, and the other members of the care team, are advised immediately of any decision to discharge so that the necessary medical treatment and after-care can be in place before the patient leaves hospital.

10.12 If, within 7 days of a patient's admission to hospital for assessment, both medical reports conclude that the patient meets the Section 17(1) criteria for detention in hospital, and an application for admission to and detention in hospital of the patient is made for the approval of the sheriff, then the CCO will cease to have effect and the patient can be detained in hospital for a further period of 21 days from the expiry of the initial 7 day assessment period. (Section 35H(4) of the 1984 Act refers) This 21 day period is to allow the court to deal with the application for admission to hospital. The application for admission must be made in the 7 day period and approved by the sheriff within the further 21 days allowed.

10.13 Where the patient is kept in hospital for 7 days and is not then discharged, or where no application for admission to hospital is then made, or if an application for detention in hospital has been made within the 7 days and the further 21 day period has expired without the approval of the sheriff to that application having been given, then the patient is no longer liable to be detained in hospital for assessment, and the CCO no longer has any effect. In practice the patient is "absolutely discharged" both from hospital and from the Order. (Section 35H(6) of the 1984 Act)

10.14 This places a time-constraint on all those involved in an application under section 18 of the Act if the patient is not to be "absolutely discharged".

Re-admission to hospital or imprisonment

10.15 The proactive reassessment power of section 35G is the preferred route for a CCO patient to be returned to hospital. However, if the care team believe at any time that the patient's condition warrants his or her **urgent** re-admission to hospital they should make the necessary emergency arrangements by way of section 24 of the 1984 Act.

10.16 The new provisions do not provide for the effect of voluntary admission to hospital for a patient on a CCO. Nothing prevents the patient entering hospital voluntarily. The Special Medical Officer will have to consider whether to revoke the CCO under section 35I (see paragraph 13.1) when a patient decides to go voluntarily in to hospital. If the period of voluntary stay in hospital is relatively short, it is suggested that the CCO continues to run, while the conditions are temporarily suspended.

10.17 Patients admitted to hospital under section 35G are covered by the Consent to Treatment provisions of Part X of the 1984 Act. Voluntary patients will **not** be covered by the consent to treatment provisions of Part X of the 1984 Act.

10.18 An emergency admission under section 24 followed by short term detention under section 26 or 26A of the Act does not terminate the CCO. The CCO continues to run but the conditions of the Order are suspended. If the CCO were to expire during the period of detention, it is extended for a further period of 28 days beginning with the day on which it would have expired. During that extended period the CCO may be renewed, and will take effect on the day after the expiry date of the original period.

10.19 A CCO should be regarded as terminated if a patient is readmitted and made liable to detention in hospital for treatment under section 18 of the 1984 Act, is received into guardianship, or is detained in custody for more than six months.

10.20 When a patient subject to a CCO is imprisoned for six months or less, the CCO will continue to run, but its conditions will be suspended until the patient's release. If the CCO would have lapsed whilst the patient was detained in custody or in hospital, it will be deemed to have been extended for 28 days after his or her release or discharge. Where a CCO is renewed in this way the date of renewal will be backdated and will be taken from the day after which the Order would normally have expired. (See section 35J of the 1984 Act)

10.21 If the team concludes that the CCO is no longer appropriate and that the patient does not need to be re-admitted to hospital the Special Medical Officer should terminate the order. This is explained more fully in part 13 of this guidance.

11. RENEWAL OF A COMMUNITY CARE ORDER (Section 35C)

11.1 A CCO applies initially for a period of up to six months and can thereafter be renewed for a further six months and then for periods of up to a year at a time (see Section 35C). The Special Medical Officer must examine the patient in the two months preceding the CCO's expiry date. It would be good practice for the Special Medical Officer to obtain the After-Care Officer's agreement to the Order being renewed.

11.2 A CCO can be extended during a period of imprisonment or emergency detention in hospital - see paragraphs 10.18-10.20.

11.3 The Special Medical Officer must also ensure that the following are consulted and their views taken into account:

- the After-Care Officer;
- the patient;
- those professionally concerned with the patient's medical treatment and after-care;
- any informal carer;
- the patient's nearest relative (if practicable and the patient doesn't object, subject to what is said in paragraph 5.25).

11.4 Consultation with the care team will normally take place as part of the regular review process (see part 9 of this guidance).

11.5 If, following the examination and consultation the Special Medical Officer decides that the CCO is to be renewed, he or she must submit a renewal report (using **Form CCO 4**) to the Mental Welfare Commission for Scotland. This report must state that the patient still meets the criteria for a CCO (set out in paragraph 5.5) and specifying the date from which the renewal is effective. All of these actions must have been completed before the expiry of the CCO for it to be successfully renewed. To avoid uncertainty it will be best to ensure the Mental Welfare Commission for Scotland has a copy of Form CCO 4 by post or Fax before the expiry date of the CCO.

11.6 The Special Medical Officer must inform the following people that the CCO has been renewed and the period of that renewal:

- the patient, orally and in writing. The implications of renewal for the patient must be made clear to him or her - in particular, his or her right to appeal to the sheriff (see paragraph 12.1);
- the After-Care Officer;

- the nearest relative, in writing (if practicable and unless the patient objects, subject to what is said in paragraph 5.25) and the informal carer if different.

11.7 The Special Medical Officer must explain to the patient both orally and in writing the effect of the renewal and their right to make representations to the Mental Welfare Commission and their right to appeal to the Sheriff for revocation of the order (under section 35F). A copy of the written explanation should be sent to the nearest relative (if consulted) and to the informal carer if different. It would be good practice to ensure that others involved in the care of the patient, including the patient's GP, are informed of the renewal of the CCO.

12. APPEALS AGAINST RENEWAL OF A CCO (Section 35F)

12.1 A patient whose CCO has been renewed has a right to appeal to the sheriff to have the CCO revoked at any time while it is in force (see section 35F). This right of appeal cannot be exercised where an order has not yet been renewed for the first time as the patient will have had the right to have been heard and lead evidence when the CCO was made.

12.2 A sheriff considering an appeal will have to decide whether the patient continues to require to be subject to a CCO with a view to ensuring that he or she receives medical treatment and after-care services, and that the order is necessary for the patient's own health or safety or for the protection of others. As for appeals against renewal of detention it is expected that the sheriff will request appropriate evidence by way of medical reports and after-care reports.

12.3 If the sheriff is satisfied that the patient continues to meet the specified criteria, the appeal must be refused and the CCO affirmed, either with or without such amendment or variation as the sheriff considers appropriate.

12.4 If the sheriff is not so satisfied, the CCO must be revoked. Where a CCO is revoked on appeal, the sheriff may specify whether the order should end immediately or at another date within the next 28 days.

12.5 The Special Medical Officer must advise the After-Care Officer of any variation or revocation of the Order. It would be good practice for the After-Care Officer then to advise others involved in the patient's care of any variation or revocation of the Order.

12.6 A patient subject to a CCO may make representations to the Mental Welfare Commission for Scotland at any time.

13. TERMINATION OF A COMMUNITY CARE ORDER (Section 35I)

13.1 In conjunction with the After-Care Officer, the Special Medical Officer should keep the patient's need for a CCO under constant review. The Special Medical Officer may revoke the CCO, if after this consultation he considers that the patient does not require to be subject to a CCO (section 35I). In considering whether to terminate a patient's CCO, the Special Medical Officer must consult with the patient and the people who would have had to be consulted if a renewal application were being made (see paragraph 11.3). For instance, the care team may decide that the patient has proved he is capable of complying (and willing to comply) with the conditions of treatment and after-care on a voluntary basis.

13.2 When a patient ceases to be subject to a CCO the Special Medical Officer must notify:

1) the patient;

2) the patient's nearest relative (if practicable);

3) the After-Care Officer;

4) the Mental Welfare Commission for Scotland;

5) any informal carer; and

6) other persons concerned with the patient's medical background.

The Special Medical Officer may use **Form CCO 11** for this notification.

13.3 The Mental Welfare Commission for Scotland should also revoke a CCO if they consider that it is no longer required. If the Commission revoke an Order they must inform the Special Medical Officer and the people listed at 1 to 5 in paragraph 13.2 (using **Form CCO 12**). It would be good practice to ensure that others involved in the care of the patient, including the patient's GP, are informed of the termination of the CCO.

13.4 The duties on the Health Service to provide treatment and on the local authority to provide after-care services do not end simply because the CCO has been terminated. Their duty under section 8 of the 1984 Act continues until these authorities are satisfied that the patient no longer requires after-care services.

14. PATIENTS MOVING WITHIN SCOTLAND

14.1 If a patient subject to a CCO wishes to move to an area in Scotland covered by a different health board and possibly a different local authority, such a move will clearly entail modification of the care plan, a change of Special Medical Officer and After-Care Officer, and is likely to require variation of the conditions of the patient's CCO. The After-Care Officer and the Special Medical Officer will need to take the lead in contacting the professionals who will be responsible for after-care services and medical treatment in the new area, and in ensuring the close liaison between the current and proposed care teams necessary to effect such a move.

15. PATIENTS MOVING TO OR FROM ENGLAND AND WALES

15.1 If a CCO patient wishes to **move to live in England or Wales** an application for supervised discharge (the English and Welsh equivalent of a CCO) may be made under the Mental Health Act 1983. In these cases while the application will normally be made by the prospective Community Responsible Medical Officer (CRMO - the equivalent of the Special Medical Officer) in England or Wales, in practice initial enquiries must be made by the care team in Scotland. While the CRMO is responsible for consulting members of the care team, any informal carer and the nearest relative (subject to paragraph 5.25) in Scotland (as well as members of the prospective care team in England or Wales), good practice would suggest that their Scottish equivalents should provide them with the necessary supporting reports.

15.2 It is essential that, before making the application, the Special Medical Officer ensures that the health authority and the local authority in England or Wales agree to provide medical care and "section 117 after-care" respectively for the patient.

15.3 While in England and Wales after-care under section 117 of the Mental Health Act 1983 is only available to people detained in hospital for at least 6 months, Section 25J(2) of the 1983 Act (as amended by the Mental Health (Patients in the Community) Act 1995) also applies this section to any patient to whom a supervision application is made or is being made.

15.4 There are to be similar arrangements for patients subject to supervised discharge in England and Wales moving to **Scotland.** In that event the prospective Special Medical Officer in Scotland will be contacted by the English or Welsh care team to discuss the proposed move and to agree the basis of a community care order application. The Special Medical Officer, as applicant, will be responsible for consulting members of the care team in England, any informal carer and the nearest relative (subject to paragraph 5.25 above), as well as members of the proposed care team in Scotland. It is essential before making the application to ensure that the health service and the local authority in Scotland agree to provide the necessary medical care and after-care services respectively for the patient. The application must be supported by two medical reports and a report from the After-Care Officer.

16. THE MENTAL WELFARE COMMISSION FOR SCOTLAND

16.1 The Mental Welfare Commission for Scotland has a statutory duty to protect persons who may, by reason of mental disorder, be incapable of adequately protecting themselves or their interests. This duty extends to all mentally disordered persons in Scotland whether they are in hospital; local authority, voluntary or privately-run accommodation; or in their own homes. In appropriate cases, the Commission's powers include the discharge of patients from liability to detention or guardianship.

16.2 The duties of the Commission were extended by the provisions to include persons subject to a CCO; the Commission's powers now include the discharge of persons on CCOs. The care team and their employing authority should co-operate fully with the Commission in carrying out their protective functions in respect of these patients. The new provisions also require local authorities providing after-care services to CCO patients to co-operate with the Commission in carrying out these extended duties.

16.3 There are a number of points during the setting up and renewal of a CCO when the Commission must be provided with appropriate information (either forms or reports). For ease of reference these are listed at Annex C.

16.4 Where there is a requirement to submit a report to the Commission, good practice suggests that this should be done within 5 working days.

17. ABSENCE WITHOUT LEAVE (SECTION 31)

17.1 The new provisions extended the period (previously 28 days) set out in section 28 of the 1984 Act during which patients detained in hospital (except those subject to special restrictions) or subject to guardianship, who absent themselves without leave, may be taken into custody and returned. A patient who goes absent without leave may now be returned at any time up to 6 months from the date on which they absconded or, if later, until the expiry of the current authority for his or her detention in hospital or guardianship. These provisions do not apply to detentions under sections 24, 25 or 26. If, at the time the patient goes absent, the authority for detention or guardianship has been renewed in accordance with the provisions of sections 30 and 47 of the Act, but the new period has yet to begin, the renewal is ignored and the six month time limit for returning the patient applies.

17.2 The new time limits **do not apply** to patients subject to special restrictions who are absent without leave. Restricted patients continue to be liable to be returned at any time.

Patients Returning within 28 days

17.3 Where a patient returns within 28 days of going absent, and the current authority for detention or guardianship has not expired, that authority remains in force until its original expiry date. If the authority has expired, or has less than 7 days to run, the new provisions extend the authority by up to a week from the date of patient's return to enable the appropriate medical officer to examine the patient and make a renewal report under section 30(3) or 47(3). The new authority for detention or guardianship (if granted) will then run from the expiry of the previous authority.

Patients returning after 28 days

17.4 Where a patient returns after an absence of more than 28 days (but within six months or the period of the current authority - see paragraph 17.1), the Responsible Medical Officer **must** examine the patient within one week of his or her return to hospital or obtain a report from another doctor. The Responsible Medical Officer also has to consult others principally concerned with the patient's medical treatment **and** a Mental Health Officer and review the authority for the patient's detention in accordance with the criteria in section 17(1) of the 1984 Act (or section 36 for guardianship).

17.5 The Responsible Medical Officer must decide whether the criteria for detention or guardianship are met.

- If the criteria for **detention** continue to be met, the Responsible Medical Officer's report will effect a renewal of the authority and the Responsible Medical Officer must furnish the report to the managers of the hospital and the Mental Welfare Commission for Scotland in the usual way. The hospital managers must, in turn, advise the patient and his or her nearest relative of this decision.

- If the criteria for **guardianship** continue to be met, the Responsible Medical Officer's report must be furnished to the MHO who must consider if the grounds set out in section 36(b)* of the 1984 Act continue to apply. If they do, the MHO must furnish a report to the local authority and the Mental Welfare Commission for Scotland. The local authority must, in turn, advise the patient, the nearest relative and the guardian of this decision

17.6 If these reports are not made, the liability to detention, or guardianship, will end (even if the original expiry date has not been reached).

*Note: In spite of the reference in new section 48B(2)(b) to "section 36(a)" it is suggested that the MHO should have regard to "section 36(b)"

The effect of the reports

17.7 Where the above reports are made **before the date when the original authority expires**, the effect is to continue the authority, which then runs until the original expiry date. However if the original authority has less than 2 months to run the reports shall have the effect of a renewal report under section 30, or for guardianship under section 47(3) . The authority for detention or guardianship is then renewed for the appropriate period of up to 6 or 12 months.

17.8 If the report is made **after the date of expiry of the original authority**, it has the effect of a section 30 renewal report. The new authority (whether for up to 6 or 12 months) is then deemed to run from the day the original authority ended.

Special Provision for Patients sent to Prison for 6 months or less

17.9 Where a patient has been in prison for 6 months or less and is then returned to hospital (or guardianship) and the authority for his or her detention (or guardianship) has expired, the authority is extended by virtue of section 32(2) or 49(2), and the patient is then treated as if he or she were absent without leave. There is a continuing authority for detention or guardianship for a further 28 days from the date of his or her release from prison, during which period a renewal of authority under section 30 or 47 of the Act is required.

17.10 Extension by virtue of section 32(2) or 49(2) means that the authority which has expired prior to release from prison continues until the end of the day of release.

Patient Rights

17.11 A patient who has the authority for his or her detention or guardianship renewed after being absent without leave has the right to appeal against such a renewal. There is no right of appeal if the authority is simply continued under section 31 or section 48.

"Hospital Order" patients taken into custody abroad

17.12 Section 60 of the 1984 Act has also been amended to make provision for Hospital Order patients who are taken into custody abroad, and for whom a warrant to arrest has been issued under section 121A of the 1984 Act (formerly section 13 of the

Criminal Procedure (Scotland) Act 1975). He or she shall be treated as being taken into custody under section 28 on first so being held under the warrant.

18. LEAVE OF ABSENCE

18.1 The new provisions amend section 27 of the 1984 Act by fixing at one year the total of consecutive periods of leave of absence from hospital which may be granted to patients detained in hospital under the 1984 Act. These new provisions should be read in conjunction with the new sections providing for Community Care Orders. Any formalised community-based care and treatment beyond the maximum 12 month period now requires to be a Community Care Order or guardianship.

18.2 If a patient's leave of absence expires while an application for a CCO is pending, or where an Order has been made but is not yet in force, the new provisions extend the total period of leave of absence until the Order comes into force or the application is refused.

18.3 If a patient returns, or is returned, to formal detention in hospital, the duration of any future period of leave of absence will not be restricted by leave of absence already received.

18.4 These amendments to section 27 do not apply to patients to whom special restrictions apply. Such patients' leave of absence is restricted to specified occasions and only with approval of the Secretary of State. (See Part II to Schedule 2 of the 1984 Act).

18.5 A transitional provision provided that all patients who had been on leave of absence for more than 6 months on 1 April 1996 might have their leave of absence renewed for one further period of up to six months from the expiry of the current leave of absence period. For example, if on 1 April 1996 a patient had been on leave of absence for 16 months (that is continuously from 1 December 1994) his current 6 month period of leave of absence would have commenced on 1 January 1996 and expired on 30 June 1996. That patient might have been granted a further period (maximum 6 months) of leave of absence from 30 June, i.e. up to 31 December 1996. This provision expired on 1 October 1996.

The Scottish Executive Health Department
Public Health Policy Unit
December 1999

ANNEX A

THE MENTAL HEALTH (SCOTLAND) ACT 1984 AS AMENDED BY THE MENTAL HEALTH (PATIENTS IN THE COMMUNITY) ACT 1995

JOINT PROTOCOLS ON COMMUNITY CARE ORDERS: ISSUES FOR LOCAL INTER-AGENCY AGREEMENT

Shared understanding needed on:

- Consultation between Health Board, provider unit and local authority on consideration of need for a Community Care Order, and on facilitating completion of the documentation necessary to submit an application, or vary or terminate an Order.
- Role of key worker and links to the After-Care Officer and Special Medical Officer.
- Risk assessment procedure.
- Problem resolution.
- Reviewing and monitoring.
- Appeals and complaints.

Making the procedures work

- How best to integrate Care Programme Approach and care management assessments and policies with Community Care Order procedures.
- What joint procedures to use if the patient does not comply with the terms of the Order.
- Involvement of users and carers.
- How to provide advocacy and representation.

Implementation planning

- Joint training for Responsible Medical Officers, Special Medical Officers, After-Care Officers and other professionals.
- Joint discussion of arrangements with GPs, housing, criminal justice, social workers and police.

ANNEX B

LIST OF PRESCRIBED FORMS

Form Name	Form Title	Form Number.*
CCO1	Community Care Order application	Form 18
CCO2	Medical Recommendation for Community Care Order	Form 19
CCO3	After-care report for Community Care Order	Form 20
CCO4	Renewal of Community Care Order - Report by Special Medical Officer	Form 21
CCO5	Variation of conditions of community care order	Form 22
CCO5A	Notification to patient of right to object to proposed variation of conditions of community care order	
CCO6	Notification of change of Special Medical Officer under community care order	Form 23
CCO7	Notification of change of After-Care Officer under community care order	Form 24
CCO8	Direction for community care order patient to be admitted to hospital	Form 25
CCO9	Medical report to accompany admission to hospital for assessment	Form 26
CCO10	Medical report for community care order patient following an admission to hospital for assessment	Form 27
CCO11	Notification of Termination of Community Care Order (to MWC)	Non-prescribed
CCO12	Notification of Termination of Community Care Order (to SMO by MWC)	Non-prescribed

*Form Number refers to the Form Number as set out in the Mental Health (Prescribed Forms) (Scotland) Regulations 1996. This is available from Stationery Office - (ISBN 9 780110 553276)

ANNEX C

POINTS AT WHICH INFORMATION ABOUT A CCO SHOULD BE PROVIDED TO THE MENTAL WELFARE COMMISSION FOR SCOTLAND

Section	Information to be provided to MWC	Paragraph in guidance	Form Name
35A(9)(b)	Copy of CCO	7.4	CCO 1
35C(5)	Reports on Renewal of CCO	11.5, 17.5	CCO 4
35D(6)(b)	Copy of variation of CCO	9.7	CCO 5
35E(6)(b)	Change of SMO/ACO	8.13	CCO 6/CCO 7
35G(7)(c)	Direction for community care order patient to be admitted to hospital/ Medical Reports to accompany admission for reassessment	10.7	CCO 8/CCO 9
35H(5)	Medical report following reassessment in hospital	10.10	CCO 10
35I(1)(b)	Revocation of CCO	13.2	CCO 11

NOTIFICATION BY MENTAL WELFARE COMMISSION FOR SCOTLAND

35I(4)	MWC power to revoke CCO – notification to SMO	13.3	CCO 12

Code of Practice	The Code of Practice relating to the 1984 Act for the guidance of medical practitioners, managers and staff of hospitals and MHOs in relation to detention and discharge of patients in and from hospital under the Act and for the guidance of medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder. The Code is available from the Stationery Office.
Community Care Order	Order under section 35A of the 1984 Act which provides that, instead of continuing to be liable to be detained, a patient who was previously liable to be detained in hospital should be subject to conditions specified in the order with a view to ensuring he receives medical treatment and after-care services in the community.
Emergency procedures	Procedures under Section 24 of the 1984 Act which enable a patient to be admitted and detained in hospital for up to 72 hours on the recommendation of a medical practitioner.
Guardianship	If a person is suffering from mental disorder they can be made subject to guardianship. The guardian (a local authority or an individual) has the power to require the person to reside at a particular place, the power to require the person to attend at particular places and times for medical treatment, occupation, education or training, and the power to require access to the person to be given to specified medical practitioners, mental health officers and others. Applications for guardianship are made to the Court and approved by the Sheriff (section 36 etc. of the 1984 Act)
Hospital order	The High Court or the Sheriff Court may order a person who has been convicted of an offence to be detained in hospital if it is satisfied that he is suffering from a mental disorder which makes it appropriate for him to receive medical treatment as a detained patient and if it is of the opinion that this is the most suitable method of disposing of his case. (Broadly the court may also have to make such an order if the person is found to be insane in bar of trial or acquitted on account of insanity.) The order is made under section 57 of the Criminal Procedure (Scotland) Act 1995.
Hospital Order Patient	A patient on whom a hospital order under section 57 of the Criminal Procedure (Scotland) Act 1995 has been made, restricting the decision on his/her discharge from hospital to their Responsible Medical Officer or the sheriff on appeal.
Informal carer	See 'Carer'

GLOSSARY

Note: the Mental Health (Scotland) Act 1984 is referred to as the '1984 Act'.

Term	Description
Absence without leave (AWOL)	A detained patient who, without formal permission, absents himself from the hospital or other place where he is required to reside, is considered to be absent without leave; he may be taken into custody and returned to hospital (section 28 of the 1984 Act)
After-Care Officer (ACO)	The person whose role it is to co-ordinate the provision of the after-care services to be provided for the patient under section 8 of the 1984 Act. The After-Care Officer must be a Mental Health Officer - i.e. a social worker experienced in mental health, in accordance with section 9 of the 1984 Act.
Care plan	The care plan for a patient should be drawn up by the key worker following a multi-agency , multi-disciplinary meeting of the relevant professionals and involving the user and carer as appropriate. The care plan should set out the objectives of the care and the nature and range of treatment and services (including accommodation and primary care) to be provided. Further guidance on the care plan is available in the CPA circular No: SWSG 16/96.
Carer/Informal Carer	This term is used to describe any person who the Responsible Medical Officer believes will play a substantial part in the care of the patient after the order comes into force but who will not be professionally concerned with the after-care services. Such a person may be the nearest relative or another close relative but may be a friend or other person who assists the person in their daily routine. It would be good practice to ensure that both the patient and the carer are content that the carer is so named.
Care Programme Approach	The Care Programme Approach is a crucial element in the Government's policy for people with mental illness and dementia. Its aim is to ensure that properly designed and managed individual packages of care are arranged for people with severe and enduring mental illness, including dementia, who require health and social care in appropriate accommodation in the community.

	expressed during consultation with a range of people specified by the Act.
Supervised discharge	Supervised discharge is the equivalent provision to Community Care Order in England and Wales. A Community Care Order application may be made on behalf of a patient who is subject to supervised discharge in England or Wales under the Mental Health Act 1983 and who wishes to live in Scotland (see paragraph 15.4).
Voluntary patient	A patient who enters hospital voluntarily for treatment. See paras 10.16 and 10.17 for the effect of this on a CCO.

Key Worker	Key worker is person, usually a mental health professional, whose main responsibility is to co-ordinate an individual's care programme in close collaboration with the individual, their carer and other members of the care team including the Special Medical Officer and the After-Care Officer. The key worker should have authority to trigger the required multi-agency review of the individual's case.
Leave of absence (LOA)	A patient who is detained in hospital, or who remains liable to be so detained, may be granted leave to be absent from the hospital for a period of up to 6 months, which can be extended for a further 6 months to a total of 12 months, if his Responsible Medical Officer considers that this course of action would be in the patient's best interests rather than that he should be discharged from hospital. A patient who is on leave of absence is still liable to be detained and is, in effect, still under medical treatment.
Multi-disciplinary team	Team of professionals from various disciplines involved in caring for a person in the community.
Nearest relative	Nearest relative as defined in section 53 of the Mental Health (Scotland) Act 1984. The nearest relative must be the first mentioned in the list who is caring for the person.
Order	Short term for Community Care Orders. The CCO application form, if approved, constitutes the Order.
Responsible Medical Officer (RMO)	The medical practitioner who is responsible for the patient's care and treatment while the patient is liable to be detained in hospital. Only the Responsible Medical Officer may authorise leave of absence for detained patients.
Short term detention	Detention under section 26 of the Mental Health (Scotland) Act 1984. There is a limit of 28 days on this detention.
Special Medical Officer (SMO)	This refers to the medical practitioner who is to be principally concerned with the patient's medical treatment while the order is in force. The Special Medical Officer should be a practitioner approved for the purposes of section 20 of the 1984 Act by a Health Board as someone having special experience in the diagnosis and treatment of mental disorder. The Special Medical Officer will take over from the Responsible Medical Officer while the person is in the community and subject to a CCO. (In practice the Special Medical Officer and the Responsible Medical Officer may be the same person.) The Special Medical Officer has powers to renew and terminate the CCO, taking into account views