Supervised Community Treatment Policy

1. Introduction

This policy sets out the new legal framework for the operation of an order made under Section 17A of the MHA which is known as a ‘Community Treatment Order’ (‘CTO’)

From 3rd November 2008, the Mental Health MHA 1983, as amended by the Mental Health MHA 2007 (‘the MHA’) introduces a new scheme to provide Supervised Community Treatment (‘SCT’) for treatment of mental disorder but not physical disorders which are covered by the Mental Capacity MHA 2005 (‘MCA’).

This policy should be read in conjunction with Chapter 25 of the Code of Practice to the Mental Health MHA (COP) which offers guidance on the operation of the MHA. In particular, the five guiding principles set out in Chapter 1 of the COP should be considered when making decisions about a course of action under the MHA.

2. Scope and Purpose of this Policy

This Future Directions CIC policy sets out procedural requirements where these are explicit in the MHA or COP. It is not a comprehensive explanation of all the implications of SCT and reference will need to be made to other Future Directions CIC policies and procedures in relation to particular aspects of care.

The purpose of this policy is to ensure that there is lawful and appropriate use of SCT and that the legal rights of any service users subject to a CTO are upheld at all stages. There is no lower age limit for SCT.

3. Criteria and Process for Making a CTO

The following criteria must be met in all cases before a CTO can be made by the service users Responsible Clinician (‘RC’):-

- The service user must be currently liable to detention for treatment under Section 3 or an unrestricted section under PART III of the MHA, including a service user currently on Section 17 leave from Hospital. It is not applicable for service users on restriction orders (for a full list of eligible sections see Department of Health [2008] Reference Guide to
the Mental Health MHA 1983 as amended by the Mental Health MHA 2007).

- In the RCs opinion, the service user is suffering from mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment.

- It is necessary for the service users health or safety or the protection of other people that such treatment should be received.

- Such treatment can be provided without the service user continuing to be detained in a Hospital provided the service user is liable to being recalled to Hospital for medical treatment.

- It is necessary that the RC should be able to recall the service user to Hospital (the RC must confirm that he or she has considered risk of deterioration if the service user were not detained in Hospital, with regard to their history of mental disorder and any other relevant factors).

- Taking account of the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the service user

The following conditions are mandatory in all cases:-

- The service user must make him or herself available for examination to determine whether to extend the community treatment period.

- The service user must make him or herself available for examination by a second opinion appointed Doctor when requested.

The decision to implement a CTO must be made by the MDT as part of rehabilitation and discharge planning.

An (AMHP) from the local district must agree in writing that the service user meets the criteria for a CTO, a CTO is appropriate and any conditions made are necessary or appropriate for one or more of the following:-

- To ensure the service user receives medical treatment.

- To prevent risk of harm to service user health or safety, to protect other persons.

If the AMHP does not agree, it is not appropriate for the RC to seek another AMHP for an alternative view.

An order is made by the RC completing Parts 1 and 3 and the AMHP completing Part 2 of Form CTO1.

Although the CTO1 must be given to the Hospital Managers as soon as practicable, there is no statutory form to record receipt of the order. When signed by the RC, the CTO automatically takes effect on the date and time specified for a period up to six months.
As there is no mechanism for retrospectively amending or rectifying a defective Form CTO1 once handed to the Hospital Managers, it is essential that where practicable, the form (or a copy of it) is reviewed by the Trust’s Mental Health MHA Administrator before acting on it.

4. **Treatment and Care Planning and SCT**

A Treatment and Care Plan will be prepared, and subject to the usual considerations of patient confidentiality the following parties should be consulted:

- The nearest relative.
- Any carers.
- An Attorney (authorised by Lasting Power of Attorney – **Personal Welfare**) or Court Appointed Deputy under the Mental Capacity MHA 2005 (where appropriate).
- Members of the Multi Disciplinary Team involved in the patient’s care.
- Current RC
- Prospective RC
- The patient’s GP. Where there is none, encouragement and help should be given to enable the patient to register with a practice.

In common with other CPA arrangements, a local District Care Co-ordinator needs to be identified for service users subject to SCT.

To reflect the development of community based services and ensure best practice, any prospective RC (**identified through transfer of care**) should be involved at an early stage in determining whether SCT is appropriate and specifically in any conditions to be attached to it. This will greatly assist in the delivery of seamless transfer of care from Hospital to community and vice versa although the final decision rests with the current RC.

5. **Conditions Attached to a CTO**

There are two conditions set out (**see Section 3**) which are mandatory in all cases. An RC may with the agreement of the AMHP, set other conditions which they think are necessary or appropriate to achieve one or more of the goals set out at Section 3.

Advice on setting other conditions is provided by the COP which the RC and AMHP should always consider. It is important that the reason for any conditions is explained to the service user and others, where appropriate and that this is recorded in the service user records. In all cases, there should be a
link between the person’s mental disorder and any condition imposed on a CTO.

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

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

6. **Provision of Information on Making an Order**

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

The Hospital Managers will ensure that the service user is provided with information verbally. This will be recorded on a ‘Rights Form’ which is then copied to the person holding the CTO documentation. An information leaflet will be provided in writing to the service user by the Mental Health Administrator (or equivalent) and to the nearest relative (unless the service user objects).

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

- Appeals to the Mental Health Review Tribunal (‘MHRT’).
- Recall, revocation or discharge by RC.
- Discharge (excluding discharge from recall to Hospital) where permitted, by nearest relative (subject to 72 hours notice requirement), MHRT or Hospital Managers.
- Independent Mental Health Advocacy Services (to be introduced April 2009).
- The role of the Mental Health Act Commission or any subsequent Body.
- Treatment rights while subject to CTO in the community.

The receiving Hospital becomes the responsible Hospital and as such is treated as if it were the detaining authority when the service user was
originally detained in Hospital (and is now subject to recall to) prior to going onto a CTO.

7. Recall from CTO

The decision to recall is the responsibility of the current RC. Where a change of RC on recall is anticipated, best practice requires that they should be made aware of and involved in any of the following actions required of the RC as soon as practicable.

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

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

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

Or

- The service user has broken one of the two mandatory conditions outlined in section 3 above unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered.

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

The RC should ensure that the Hospital to which the service user is recalled is ready to receive him or her and to able to provide appropriate treatment, although this may be given on an out-patient basis, if appropriate. Conveyance to that Hospital should be in the least restrictive manner possible.

The receiving Hospital must complete Form CTO4 recording the date and time of the service users initial recall to Hospital.

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

<table>
<thead>
<tr>
<th>Service user Circumstances</th>
<th>Appropriate Method of Serving Form CTO3</th>
<th>Notice Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user can be</td>
<td>Delivery form by hand</td>
<td>Effective immediately</td>
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</table>
8. **Revocation of CTO or Return to Community**

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

To revoke a CTO, the RC must consider that the service user now needs to be admitted to Hospital for treatment under the MHA. An AMHP, having considered the wider social context for the service user must also agree with the RCs assessment. This need not be an AMHP already involved in the service user’s care and treatment.

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

Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 and 3 and the AMHP completing Part 2 of Form CTO5. The revocation takes effect immediately once signed. The form must be forwarded to the Mental Health MHA Administrator.

The effect of completing Form CTO5 is that the service user reverts to being detained under whichever section of the MHA they were subject to immediately before the CTO was made. However, in all cases they are subject to a new period of detention of up to six months beginning with the day of revocation.
On revocation, Form CTO5 must be copied to the managers of the Hospital to which the service user was recalled, if the service user was transferred during the period of recall.

Transitional arrangements apply to service users who go onto a CTO having transfer on discharge previously been subject to Aftercare Under Supervision (Supervised Discharge Section 25) provisions during the commencement period. Where their SCT is revoked, in spite of having previously been discharged from liability to detention prior to Supervised Discharge, they become liable to detention under Section 3 of the Mental Health Act for a period of up to six months beginning with the day of revocation. It is important to document their new legal status with care as there will be no existing Section 3 papers for such a service user and there may be confusion if they were previously detained under Part III of the Mental Health Act (Department of Health (2008) Mental Health Act MHA 2007: Patients on After-Care under Supervision (ACUS): Transitional Arrangements para. 7.10).

On revocation, the Hospital Manager must refer the service user to the Mental Health Review Tribunal and service user has a right to apply.

9. Extending the Community Treatment Period

A CTO can be extended following examination of the service user by the RC within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met. These mirror the criteria and mandatory conditions described in section 3 with the additional requirement that the RC must also consult one or more other person who has been professional concerned with the service users medical treatment.

As when making the original CTO order, the RC must obtain the written agreement of an AMHP that the conditions for extending SCT are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1 but where the RC is not a registered medical practitioner, they should consult a doctor. Although this is not an explicit requirement of the MHA currently, this is a safeguard against potential future challenges to the validity of ‘medical evidence’.

The RC completes and signs Parts 1 & 3, the AMHP completes Part 2 of form CT07 addressing the report to the relevant Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital’s internal mail system. It is then received by a Mental Health Act Administrator (or other authorised person) who completes part 4.

Once received, the Managers must undertake review of the report provided on form CT07 which may vary in uncontested cases. Where practicable, this should be done before the new period of extension takes effect but the completed form CT07 itself provides lawful authority for the service users continued SCT. Such reports will be dealt with in the same way as reports made to renew detention under the Mental Health Act although it may be appropriate to arrange the Managers’ review at a more convenient location.
The COP sets out questions that a Panel of Managers should address the following criteria in the order given whenever they review a report made using form CT07:-

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

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

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

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

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

Special provisions for extending the community treatment period apply to service user who have been unlawfully at large (‘absent without leave’) which are set out in Sections 21A & 21B of the Mental Health Act. After an absence of more than 28 days, form CT08 must be completed to extend the CTO period.

Where the criteria for extending SCT are not met and consequently, the RC does not plan to make a report to the Managers using form CT07 (or where applicable, form CT08) the service user should be discharged by the RC rather than waiting for the current CTO to expire. This does not apply to a case where an AMHP does not agree to extension. In such a case, the RC may choose to exercise his or her right of discharge or may allow the CTO to lapse.

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

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

The RC can discharge a service user from SCT at any time in writing by completing the local discharge from liability to detention form under Section 23 or the Mental Health Act and providing it to the Managers of the responsible hospital. There is no statutory form for this purpose nor statutory requirement to consult with any other person.

A Part II Mental Health Act SCT service users nearest relative (there is no available power in relation to Part III SCT service user) can order their discharge in the same way as they can for Section 2 or 3 service user. An order must be put in writing giving at least 72 hours notice. There is no statutory form but Future Directions CIC will provide a standard letter to assist this process (paragraph 29.23 of the COP).

Within the permitted 72 hours, the RC may sign a report barring discharge under Section 25 of the Mental Health Act. In doing so he or she has concluded that ‘service user’, if discharged would be likely to act in a manner that is dangerous to other people or to him or herself. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness. Where a report is made, the nearest relative must be advised of their right to apply to the MHRT.

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

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

The MHRT can discharge an SCT service user other than during the 72 hour period of recall. If following recall, a service user CTO is revoked, the Mental Health Act Administrator must refer the service user’s case to the MHRT as soon as possible. All circumstances where there is a duty to refer a case to the MHRT are set out in Section 68 of the Mental Health Act.

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

It may be appropriate for the MHRT hearing to be held in an alternative setting such as a community facility by prior discussion and agreement if there are practical reasons for doing so.

If a service user is detailed in another hospital under Section 3 or equivalent, other than by their CTO being revoked, this will automatically discharge the existing CTO and its underlying section. SCT can only be recommenced by starting a fresh assessment again. Detention under Section 2 will not affect a current CTO. Detention in prison or elsewhere of less than six months' duration will allow a CTO to continue or to be extended in accordance with the provisions set out in section 9. Detention in custody for a period of more than six months will automatically bring the CTO to an end.

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

11. Transfer between Hospitals and Jurisdictions

Recall from hospital section above describe the process for the physical transfer of a service user between hospitals following recall which requires the completion of form CT06 where the hospitals are managed by different organisations. It does not necessarily mean that there is a transfer of the service user’s responsible hospital.

The responsible hospital for a service user subject to a CTO in the community (who may have been recalled to hospital) may be assigned to another hospital managed by a different organisation, with their agreement on completion of form CTO10. It is referred to as an ‘assignment of responsibility for community service users’.

Assignment of responsibility for community service users between hospitals within the same organisation requires no statutory paperwork but the Managers of the receiving hospital must write to the service user informing him or her of the assignment either before or soon after it takes place and must give their name and address even if part of the same organisation.

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

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

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

Where a community service user under broadly equivalent legislation in Scotland, the Isle of Man or any of the Channel Islands is removed to England, their arrival in England is recorded using form M1 (date of reception of a patient in England) and where they are to be treated as if they were subject to a CTO, form CT09 is completed by the RC (Part 1) and an AMHP (Part 2). As when making a new CTO, any conditions must be specified on form CT09 and have the written agreement of an AMHP.

12. Decision to Use SCT or Section 17 Leave

Section 17 (relating to leave of absence from hospital) of the MHA is amended so that when considering granting longer term leave, an RC must consider whether SCT is the more appropriate way of managing the service user in the community. This applies to Section 17 leave for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).

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

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

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<thead>
<tr>
<th>Factors suggesting longer-term leave</th>
<th>Factors suggesting SCT</th>
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<tbody>
<tr>
<td>• Discharge from hospital is for a specific purpose or a fixed period</td>
<td>• There is confidence that the patient is ready for discharge from hospital on an indefinite basis</td>
</tr>
<tr>
<td>• The service user discharge from hospital is deliberately on a ‘trial’ basis</td>
<td>• There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given</td>
</tr>
<tr>
<td>• The service user is likely to need</td>
<td>• The service user appears prepared</td>
</tr>
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further in-patient treatment without their consent or compliance  
- There is a serious risk of arrangements in the community breaking down or being unsatisfactory - more so than for SCT  
- The risk of arrangements in the community breaking down or of the service user needing to be recalled to hospital for treatment, is sufficiently serious to justify SCT, but not to the extent that it is very likely to happen

Table 2: SCT or longer-term leave of absence: relevant factors to consider

13. Treatment on Recall (Part IV of the MHA)

When a service user on SCT is recalled, they will become subject to the provisions of those Sections of the Mental Health Act governing treatment for detained service user(see Procedure 20.5 Consent to Treatment Part IV MHA 1983). If treatment does not include psychotropic medication or Electroconvulsive Therapy (ECT) and a patient with capacity consents to it, it may be given under the direction of the RC.

If a Second Opinion Appointed Doctor (‘SOAD’) has approved any treatment (on form CT011) in the event of the service users recall to Hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the SOAD has indicated otherwise, the certificate will authorise treatment (other than ECT) whether the service user has or does not have capacity to refuse it.

On recall, treatment that was already being given as described on form CT011, may continue to be given if the approved clinician in charge of the treatment considers that stopping it would cause the service user serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

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

14. Treatment while in the Community (Part 4a of the MHA)

The treatment of SCT service users who have not been recalled to Hospital, including service users who are in hospital on a voluntary basis not having been recalled, is dealt with under Part 4A of the Mental Health Act. The COP refers to them for convenience as ‘Part 4A patients’ and provides detailed guidance on their treatment in Chapters 23 and 24.
There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the service user meets the criteria set out at 7.3 above.

The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act (MCA) 2005, Procedure No. 20.13 including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a Court appointed deputy. It should be noted that the MCA may not generally be used to give SCT service user any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for an SCT service user.

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

If physical force needs to be used to administer treatment to a service user of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in MHA Section 64G which reflect the similar scheme in the MCA. The alternative mechanism is via recall to Hospital but the recall criteria set out in section 7 apply equally to service users lacking capacity.

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

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

For ECT (or medication administered as part of ECT), only the first two categories apply.
In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the service user’s behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting SCT service user without first recalling them to hospital.

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

After the first month, a SOAD must certify that such treatment is appropriate on a Part 4A certificate \textit{(Form CT011)}. The SOAD certifies the appropriateness of treatment and any conditions attached to it, not whether a service user has or lacks capacity or is refusing, e.g. temporary loss of capacity.

The SOAD will consider what \textit{(if any)} treatments to approve in the event that the service user is recalled to hospital and to specify any conditions that will apply. See paragraph 13.3 above.

Form CTO11 should be kept with the original SCT and detention papers but a copy must be kept in the clinical notes which might include a scanned copy where the primary record is electronic.

The arrangements surrounding the SOAD’s examination will be complicated by the fact that the service user is in the community so an appropriate person should be asked to confirm arrangements with the SOAD and co-ordinate the process. This may be care co-coordinator.

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