

Towards an Understanding of Supervised Community Treatment

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The reason of a thing is not be enquired after, till you are sure the thing itself be so. We commonly are at *what's the reason of it?* before we are sure of the thing.

John Selden, *Table Talk* (1689)²

Writing in the last issue of this journal, Kris Gledhill gave a broad account of the introduction of supervised community treatment (SCT) to the law of England and Wales as a result of the amending provisions of the *Mental Health Act 2007*³. Gledhill argued that the new SCT status, in which a patient is technically deemed not to be liable to be detained but is liable to recall to hospital, amounts to a less honest re-labelling of existing practice in using long-term s.17 leave of absence from detention in hospital, but left off his account with the observation that “it will come down to how the regime is operated in practice” on its implementation⁴. Some months after Gledhill was writing, we now have Codes of Practice for England and (in draft) Wales⁵, a draft reference guide providing the Department of Health’s interpretation of its legislation⁶, and two very useful and detailed legal commentaries by Phil Fennell⁷ and Paul Bowen⁸. Armed with these documents, it is possible to look in some more detail at how the new legal landscape might be negotiated by practitioners upon its full implementation in November 2008.

I intend here to look at two related areas: first, the actual powers that SCT provides to clinicians, especially in relation to the administration of treatment, and, second, the relationship of SCT with the other community powers of the Act, especially the power under s.17 to allow detained patients leave from hospital. Whether (mindful of the epigraph to this paper) such a focus will enable us to be “sure of the thing” that is SCT is perhaps doubtful, and we obviously cannot resolve the question of how (or indeed if) the SCT regime will be operated in practice across England and Wales, but it may help us to think

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2 This epigraph was borrowed from chapter 5 of Andrew Scull’s *Decarceration* (2nd Edition, 1984, New Jersey: Rutgers University Press).
3 Gledhill, K (2007) *Community Treatment Orders*. JMHL 16: 149-169, Nov 2007, p.169
4 *Ibid.*
5 Department of Health (2008) *Mental Health Act 1983 Code of Practice*, May 2008; Welsh Assembly Government (2007) *Mental Health Act 1983 Code of*

Practice (consultation version), Nov 2007.

6 Department of Health (2008) *Draft Reference Guide to the Mental Health Act 1983 as amended by the Mental Health Act 2007*. Jan 2008.
7 Fennell, P (2008) *Mental Health: The New Law*. Bristol: Jordans. A review of this book is published elsewhere within this issue of the JMHL.
8 Bowen, P (2008) *Blackstone’s Guide to the Mental Health Act 2007*, Oxford University Press. A review of this book is also published elsewhere within this issue of the JMHL.

more clearly about the possibilities and prepare ourselves to untangle some of the knots established in the primary legislation. I will conclude with some comments on the potential numbers of patients involved and whether Scotland's experience of community treatment orders tells us anything about the likely implementation of powers in England and Wales.

The main provisions of supervised community treatment

Supervised community treatment might be thought of as a form of conditional discharge for unrestricted patients. Just as with conditional discharge, the patient ceases to be "liable to be detained" upon leaving hospital, but is subject to a power of recall. The following is a brief outline of the main components of SCT.

Criteria for initiating SCT

Only patients who are detained under s.3 or unrestricted part 3 hospital orders or transfer directions are eligible for SCT. To make a community treatment order (thus initiating SCT), the responsible clinician⁹ and approved mental health practitioner (AMHP)¹⁰ must agree that the statutory criteria are met. These criteria are, in summary, that the patient's mental disorder warrants treatment which is available; that it is necessary for the patient's health or safety or the safety of others that such treatment is given, but that it can be given outside hospital; and that it is necessary that the responsible clinician should be able to exercise a power of recall over the patient¹¹.

Conditions

It is a mandatory condition of SCT that the patient makes him or herself available for examination enabling renewals and second opinion visits¹². The responsible clinician and AMHP also must agree at the point when SCT is initiated any further conditions to which the patient will be subject whilst the SCT is in force¹³. The Act gives a very broad discretion over the nature of those conditions¹⁴. Any condition (which may include, for example, attendance at an outpatient clinic or abstinence from particular conduct) must meet the statutory criteria of being necessary *or* appropriate, either to ensure that the patient receives treatment, or to prevent harm to the patient's health or safety, or to protect other people¹⁵. Once the community treatment order has been made, the responsible clinician can amend or suspend the conditions without reference to the AMHP¹⁶, although the revised Code suggests that "it would not be good practice to vary conditions which had recently been agreed with an AMHP, without discussion with that AMHP"¹⁷.

The powers of recall and revocation

If the patient breaches a mandatory condition of SCT, the responsible clinician can (but does not have to) recall him or her to hospital. Otherwise, the responsible clinician can only recall a patient to hospital

9 This is the revised Act's structural equivalent of a responsible medical officer. The holder will not necessarily be a doctor, but could also be a nurse, social worker, psychologist or occupational therapist.

10 This is the revised Act's structural equivalent of an approved social worker. The holder will not necessarily be a social worker, but could also be a nurse, psychologist or occupational therapist (but not a doctor).

11 For the exact wording of the criteria see MHA 1983 as amended by the MHA 2007, s.17A(5).

12 MHA 1983 as amended by the MHA 2007, s.17B(3).

13 *Ibid.*, s.17B(2).

14 See Fennell, P (2008) *Mental Health: The New Law*, p.212.

15 MHA 1983 as amended by the MHA 2007, s.17B(2).

16 *Ibid.*, s.17B(4),(5).

17 Revised Mental Health Act 1983 Code of Practice, para 25.41

if the patient requires treatment in hospital and there would be a risk to the health or safety of the patient or to other persons if the patient were not recalled for that purpose¹⁸.

Upon recall, the patient can be held for up to 72 hours, by the end of which he or she would have to be released (returning to SCT status in the community) unless during that time SCT status is revoked. Technically patients do not regain the status of being “liable to be detained” (or even of being inpatients) whilst held for up to 72 hours following recall, but to all practical effects it is as if they were so liable: they cannot leave and may have treatment imposed upon them (see under ‘Consent to treatment upon recall or revocation’ below). If the SCT is revoked, the patient’s dormant liability for detention is revived, and he or she will be treated as still subject to the detention powers that he or she had been discharged from (although for the purposes of renewing that detention power, or for rights of application to the MHRT, the detention power is treated as though it had commenced afresh on the day that the SCT had been revoked)¹⁹.

Consent to treatment in the community

The treatment of SCT patients who are in the community with psychiatric medication (or ECT) will be regulated by the new part 4A of the *Mental Health Act*. This provides a reduced scope for the imposition of treatment than that available under part 4 in respect of patients detained in hospital. Most importantly, professionals cannot override the capable refusal of consent to treatment of a community patient who is over 16 years of age (or the refusal of a *Gillick* competent community patient of less than 16 years of age) under the scheme established at part 4A²⁰. As such, the only way to impose medication upon an SCT patient who has capacity and refuses consent whilst in the community is to recall that patient to hospital. It will remain the case that patients who are detained in hospital and subject to part 4 powers can be given medication (but no longer ECT) despite their capable refusal of consent.²¹

In general terms, the revised Act allows treatment to be imposed upon any SCT patient who has not been recalled to hospital and who lacks capacity to give consent, provided that it is unnecessary to use force to administer it.²² However, such force “as is a proportionate response to the patient’s suffering harm, and the seriousness of that harm” may be used on an incapacitated patient where urgent treatment can be justified against criteria equivalent to those set out s.62 of the 1983 Act.²³

A substantial difference between the two schemes of part 4 and part 4A is the role of advance directives and proxy decision-makers provided for incapacitated patients under the *Mental Capacity Act 2005* (i.e. donees, deputies and the Court of Protection). The scheme applicable under part 4A to SCT patients in the community allows that proxy decision-makers may consent or refuse to consent on behalf of an incapacitated community patient, and that valid advance directives must be respected as if they were a contemporaneous refusal of consent.²⁴ By contrast, a Second Opinion Appointed Doctor (SOAD) will, as now, be empowered under part 4 of the Act to certify that medication is appropriate and may be given to a patient detained in hospital, even in the face of a refusal of consent by a proxy-decision maker or through a valid advance directive, and proxy decision-makers may not consent on behalf of such a

18 MHA 1983 as amended by the MHA 2007., s.17E(1).

19 MHA 1983 as amended by the MHA 2007, s.17G.

20 *Ibid.*, s.64B and 64C (adults) and s.64E (children).

21 *Ibid.*, s.58.

22 *Ibid.*, s.64D

23 *Ibid.*, s.64G. The criteria for treatment to be deemed immediately necessary are if (a) it is immediately necessary to save the patient’s life; or (b) if it is

immediately necessary to prevent serious deterioration of the patient’s condition and is not irreversible; or (c) it is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous; or (d) it is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous (s.64G(5)).

24 *Ibid.*, s.64C(2), 64D(6)

patient²⁵. The amended Act *does* allow that (1) a valid and applicable advance decision of refusal in respect of electro-convulsive therapy (ECT) must be respected, and (2) proxy decision-makers under the MCA can refuse (but not consent to) ECT on an incapacitated detained patient's behalf²⁶, *although* such advance decisions and proxy refusals may be overridden in any emergency where the treatment may save life or prevent a serious deterioration of the patient's condition.²⁷

Any ECT treatment of SCT patients who have not been recalled to hospital must be certified by a SOAD, whether the patient consents to ECT or is incapable of consent. The treatment of any SCT patient with medication must, after a certain period, be similarly certified (again, whether the patient consents or is incapable of consent). This period is one month from the commencement of SCT in all cases, although, if the patient was placed upon SCT whilst still subject to the three month rule applicable to detained inpatients, and that three month period has longer than a month to run when they become an SCT patient, then no certificate will be required until the three month period has run its course.

Consent to treatment upon recall to hospital and revocation of SCT

Part 4A only applies to SCT patients when they are in the community. If an SCT patient is recalled to hospital, the powers of part 4 apply (albeit with certain modifications discussed below), even during the period prior to any revocation. The most important consequence of this is that a patient's capable refusal of consent can be overridden upon that patient's recall to hospital. Thus recall powers may be used simply as a short-term holding power allowing for the administration of medication without consent, even if the responsible clinician has no intention of revoking the patient's SCT status (although see under *The example of Scotland* below).

The consent to treatment rules regarding recall and revocation appear to be unnecessarily complex, and although the following is an attempt to explain them with some clarity, it is unavoidably hard work to comprehend them.

The revised Act states that a recalled SCT patient is subject to part 4 consent to treatment provisions²⁸, although s.62A makes certain special provisions that slightly alter the way in which part 4 works in their case. For example, s.62A(2) provides that a patient who is recalled from SCT (or has SCT status revoked) is treated "as if he had remained liable to be detained since the making of the community treatment order" for the purposes of determining the three-month period during which medication need not be certified under part 4²⁹. The obvious (and clearly intended) effect of this provision is to ensure that the three-month period does not start afresh when an SCT patient is recalled to hospital. If, however, a patient is subject to his or her original three-month period when recalled to hospital from SCT, or when his or her SCT status is revoked, there is no requirement that treatment with medication be certified until *that* three-month period has expired, and consent of the patient "is not required" for such treatment given by or under the direction of the approved clinician who is in charge of it³⁰. The same principle, with rather less justification, applies to any patient who is recalled within the first month of being discharged onto SCT: the one-month period where certification is not required follows the patient back to hospital, so that there is no need for certification of treatment whilst it runs its course³¹.

25 *i.e.* under MHA 1983 s.58(3)(b).

26 MHA 1983 as amended by the MHA 2007, s.58A(5)(c)(ii)

27 *Ibid.*, s.62(1A)

28 *Ibid.*, s.56(4)

29 For this 'three-month period' see MHA 1983 s.58(1)(b)

30 MHA 1983 as amended by the MHA 2007, s.63

31 *ibid.*, s.62A(3)(b)

Another consequence of sections 56(4) and 62A(2) appears to be that any certificate that had authorised treatment prior to the patient's discharge onto SCT regains technical validity upon his or her recall to hospital. It is not clear that this consequence was anticipated in the drafting of the Act: the Department of Health appears to have the role of the surprised women in this particular resurrection story³². In the only reference to this revival of old certificates that I have found in the official literature, the revised Code of Practice for England advises that

*it is not good practice to use a certificate issued to a patient when detained and who has since been discharged onto SCT to authorise treatment if the patient is then recalled to hospital, even if the certificate remains technically valid.*³³

In my view this statement correctly identifies as “not good practice” the fact that an authority for treatment dating back to when a patient was detained regains validity upon their recall from SCT. It might be argued, however, that the “not good” practice was evident in the legislation's drafting, and that it is a bit late now to try to make amends with advice upon its implementation. Nevertheless, it is obvious that any certification of a patient's consent to treatment (i.e. on what is now Form 38) should not be relied upon after the patient has been discharged from hospital onto SCT and then recalled under duress: it is likely that the consent so certified is no longer being given, and at the very least the consent should be reaffirmed by the treating clinician. Neither, in my view, should any certification that treatment in the absence of consent was appropriate before the patient was discharged onto SCT be taken as reliable authority that it is still appropriate after a patient has been so discharged and recalled. Firstly, this is because such a certificate may well be rather old by this time. Secondly, it is because a SOAD system that provides *any* protection for patients should certify only that which is appropriate given the patient's specific circumstances and the prognosis of the case at the time of the SOAD visit. In my view, discharge into the community and recall to hospital are significant events in a patient's treatment that should be taken into account when deciding what imposition of treatment is appropriate.

It may be questionable whether the Code of Practice has the legal authority to tell practitioners to disregard otherwise valid statutory forms authorising treatment, or indeed to require them to do so, on the basis of “good practice”³⁴. But if the Code cannot protect patients against the revival of long-dormant certificates authorising treatment without consent, then it may be possible to encourage SOADs to provide such protection themselves by adding, as a condition to any certificate authorising such treatment whilst a patient is detained in hospital, that the certificate expires upon the patient's discharge onto SCT.

The revised Act also allows that a SOAD authorising treatment for an SCT patient in the community may, at the same time, authorise such treatment as he or she feels would be appropriate upon the patient's recall to hospital. Such a certificate (although technically made under part 4A), provides authority for the treatment to be given when the patient is recalled, even trumping any old part 4 authorities revived as a consequence of the recall³⁵. The SOAD would have to expressly state on the part 4A certificate that it authorises the particular treatment upon recall to hospital, and will be empowered to also specify any conditions attached to such authority. The revised Code of Practice for England provides the banal-sounding advice that this power to specify future treatment upon recall should only be exercised where

32 *cf.* Luke 24:1-4.

33 Revised Mental Health Act 1983 Code of Practice, para 24.81

34 On the question of “good practice” setting aside of valid legal forms generally, see Jones R (2006) *Mental Health Act Manual*, (2006) (10th ed) (Sweet & Maxwell), para

1-721 under the note to ‘certified’, where the current Code of Practice's guidance that Forms 38 should be considered to ‘lapse’ when there is a change in responsible medical officer, is disputed.

35 MHA 1983 as amended by the MHA 2007, s.62A(3) & (5).

SOADs “believe they have sufficient information on which properly to make such a judgment”³⁶. The Code is here treading lightly upon what may turn out to be very thin ice.

The draft revised Code was more explicit in stating how this power to authorise future treatment might be exercised, with its advice that “the SOAD can specify, if appropriate, that an antipsychotic can be given to the patient on recall without the patient’s consent”³⁷. For some reason this statement has been excised from the version of the Code that was placed before Parliament. It may be that the drafters of the Code realised that it raised difficult questions, such as what would be deemed “appropriate”? The domestic courts have already determined, in response to a challenge that the imposition of treatment to a refusing patient under the current provisions of the Act breached Articles 3 and 8 of the Convention, that to be “in accordance with law” such imposition must not only meet the criteria established within the Act itself, but must also be justifiable as being in the best interests of that patient in accordance with the common law test³⁸. There are inherent difficulties in providing such justification in advance of the circumstances in which it might apply. On this basis, Lord Patel of Bradford, the chairman of the Mental Health Act Commission (MHAC), is on record as saying that “the MHAC will be likely to advise SOADs to be extremely cautious when considering whether or not to authorise treatments to be given in an unforeseeable situation at an unidentified point in the future.”³⁹

If the Code of Practice discourages reliance on old but revived certificates of authority left over from detention, and the MHAC discourages SOADs from advance certification when they see the patients in the community, where will the authority to treat SCT patients who are recalled to hospital come from? It seems most likely that clinicians will rely upon the “urgent treatment” provisions in the Act. Being subject to part 4 of the Act, recalled SCT patients may have treatment imposed upon them that meets the criteria for urgent treatment set out at s.62(1). A provision mirroring s.62(2) is also applicable to SCT patients on recall, allowing the continuance without certification of any treatment underway at the time of recall (but only pending a SOAD visit) if discontinuance is deemed to be likely to cause serious suffering to the patient concerned⁴⁰.

These are broad powers, but not without some problems. It is easy to imagine, for example, clinicians being reluctant to use either of these powers in preference to authority that might be claimed from a “technically valid” revived SOAD authority dating back to the patient’s detention. Indeed, the lawful basis of doing so might be questioned. Furthermore, the draft Code may provide a disincentive to using s.62, by requiring the recording and monitoring of the justification for its use, with the clear implication that hospital managers should be on guard against excessive usage⁴¹. Clinicians may also struggle with the expectation that the use of urgent treatment powers should trigger a SOAD visit (or in the case of s.62A(4), that such use is only valid whilst such a visit is being arranged – “pending compliance with s.58”⁴²). If the clinician’s intention is simply to pull a patient into hospital to administer a depot injection of antipsychotic drugs, it may also be intended that the patient is returned to the community long before any such visit might be arranged. In such cases, it may well be appropriate to arrange for a SOAD to visit the patient in the community, but such a visit would be for the purposes of part 4A rather than part 4. Could a patient challenge the use of s.62A(4) on the grounds that “compliance with section 58” was, in such circumstances, never realistically possible?

36 *Revised Mental Health Act 1983 Code of Practice*, para 24.30.

37 *Department of Health (2007) Draft Mental Health Act 1983 Code of Practice*, Oct 2007, para 26.7

38 *R (on the application of PS) v (1) Dr G and (2) Dr W* [2003] EWHC 2335 (Admin)

39 *Hansard (Lords)* 26 Feb 2007, Col 1451

40 *MHA 1983 as amended by the MHA 2007*, s.62A(4)

41 *Revised Mental Health Act 1983 Code of Practice*, para 24.37.

42 *Ibid.*, para 24.31

These thickets of consent to treatment provisions may discourage practitioners from exploring the statutory landscape of SCT, perhaps especially because of the relative simplicity of the law relating to consent to treatment for patients given long-term s.17 leave, where part 4 certificates simply follow the patient out into the community. With this in mind, we now turn to the relationship between SCT and existing community powers.

The relationship of SCT with other community powers

Prior to the 2007 Act amendments, the *Mental Health Act 1983* already contained a number of potentially coercive powers over patients in the community, notably: leave of absence (s.17); supervised discharge (s.25A-J); guardianship (ss.7 or 37); and, in the case of restricted patients, conditional discharge (ss.42,73).

Conditional Discharge

The introduction of SCT has no effect on the provisions of conditional discharge. SCT and conditional discharge provide essentially the same power over patients (i.e. discharge from liability to detention with a fast-track power of recall), and the choice between the two regimes is simply determined by whether or not the patient concerned has a restricted status. Only unrestricted patients are eligible for SCT, and only restricted patients can be conditionally discharged.

Guardianship

There is a less clear-cut division between patients for whom SCT or guardianship might be considered. An important and very real distinction between the two regimes is that a patient must be detained under s.3 or its part 3 equivalents to be eligible for SCT, but there is no comparable threshold for imposing guardianship⁴³ (although it is the case that a patient who is detained in hospital under the 1983 Act can be transferred to guardianship with minimum formality⁴⁴). Government guidance in the revised Code of Practice for England would seek to make a further distinction: that SCT is intended as a power enabling quick recall to hospital for treatment, whereas guardianship is a community power intended to focus on “patient’s general welfare, rather than specifically on medical treatment”⁴⁵. There is clearly a role for guardianship in protecting patients from exploitation and neglect, but the Department’s distinction is far from self-evident. Guardianship also can provide a route to detention under s.3 of the Act and subsequent treatment powers should these be required⁴⁶, and has been used to encourage if not enforce treatment compliance⁴⁷. Indeed, in previous debates about community treatment powers, the MHAC has suggested that guardianship provisions could address the needs of the majority of the patient groups targeted⁴⁸. The Code further suggests that the choice between SCT and guardianship may rest on whether the primary agency responsible for the patient’s care package is characterised as health or social services (with guardianship being the preserve of the latter)⁴⁹. Such a distinction may seem anachronistic to combined services.

43 *The criteria for guardianship, as amended by the 2007 Act, will be that the patient is suffering from mental disorder of a nature or degree which makes it appropriate; and it is necessary in the interests of the welfare of the patient or for the protection of other persons (s.7(2)).*

44 *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 7.*

45 *Revised Mental Health Act 1983 Code of Practice, para 28.6.*

46 *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, reg. 8(3).*

47 *See Jones R (2006) op cit, para 1-086.*

48 *Ibid., para 1-280*

49 *Revised Mental Health Act 1983 Code of Practice, para 28.3*

Guardianship is used patchily⁵⁰. It is unfortunate that certain patients with learning disability are still to be excluded from guardianship provisions (as they are excluded from detention and will be excluded from SCT) unless they exhibit abnormally aggressive or seriously irresponsible conduct⁵¹. Guardianship will therefore probably continue to be used mostly as a framework for arranging the care of people with mental illnesses, predominantly the elderly. It seems likely that those few services who have had cause to discharge patients from detention under the Act into guardianship (an arrangement that probably accounts for only a small proportion of guardianship cases) will find reasons to continue to do so in similar circumstances.

Supervised Discharge

The implementation of SCT powers will coincide with the repeal of supervised discharge (“aftercare under supervision”), which was inserted into the 1983 Act’s framework by the previous administration⁵². About 600 patients are made subject to supervised discharge every year, although no statistics are available on the total number of patients so subject at any one time⁵³. The transitional mechanism for the introduction of the new powers will allow that patients subject to supervised discharge upon its demise *could* be transferred to SCT status, although there will be no automatic transfer and such patients who meet other criteria (i.e. for guardianship, detention in hospital or absolute discharge) may be dealt with accordingly⁵⁴.

Leave of Absence

The relationship between SCT and leave of absence is more complex. Gledhill has described how the courts have gradually allowed s.17 leave to be extended in duration so that it now provides authority for long-term community treatment⁵⁵. The revised Act now includes a definition of such “longer-term leave”, which is deemed to be any leave under s.17 that is either authorised without specified limit of time, or is authorised (whether in the initial authorisation of leave or in subsequent extensions of the period initially granted) for a specified limit of time that exceeds seven consecutive days⁵⁶. It will be a requirement of s.17(2A) that longer-term leave of absence under s.17 may not be granted to a patient unless the responsible clinician “first considers” whether the patient should be dealt with under supervised community treatment instead⁵⁷. It seems likely that the policy intention behind this is to ensure that practitioners do not use longer-term leave when SCT might otherwise be applied, and thus anticipates resistance from practitioners to the new SCT powers. Whether the statutory construction achieves that intention is open to question.

50 See Information Centre (2007) *Guardianship under the Mental Health Act 1983, England 2007*, p.3: 16 (12%) of 133 local authorities accounted for 402 (44%) out of 926 guardianship cases open at March 31 2007. Similar proportions are reported in previous years.

51 MHA 1983 as amended by the MHA 2007, s.1(2A) and 1(2B). See Bartlett P & Sandland R (2007) *Mental Health Law Policy and Practice*, third edition, p. 489-490 on the exclusion of LD patients from guardianship.

52 MHA 1983 as amended by the Mental Health (Patients in the Community) Act 1995, s.25A – 25J (repealed under the Mental Health Act 2007 from November 2008)

53 Department of Health (2007a) *Mental Health Act 2007*

Secondary Legislation Consultation, p. 167. See Information Centre (2007) *In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, NHS Trusts, Care Trusts, Primary Care Trusts and Independent Hospitals, England; 1995-96 to 2005-06*, table 7, p.21 for data.

54 See Mental Health Act 2007 (Commencement No.6 and After-care under Supervision: Savings, Modifications and Transitional Provisions) Order 2008 (No. 1210).

55 Gledhill, K (2007) *op cit*.

56 MHA 1983 as amended by the MHA 2007, s.17(2B)

57 *The Revised Mental Health Act 1983 Code of Practice* restates this requirement, keeping carefully to the language used in the Act itself, at para 21.9.

Indeed, there is a whiff of absurdity in this provision of the law, in that it appears at first sight to be very prescriptive and yet, as if by some failure of nerve, its actual requirement remains rather vague. What does it mean, after all, to “consider” something? From one point of view, “consider” is an ordinary word of the English language and nothing may be inferred from it beyond its ordinary use⁵⁸. As such, the legal requirement upon responsible clinicians when they are minded to let a detained patient leave hospital for more than seven days without granting an absolute discharge may be viewed as nothing more than that they contemplate mentally and weigh the merits of using either s.17 leave or SCT⁵⁹.

However, it has been argued by Bowen that SCT provides better patient safeguards and raises fewer human rights implications than longer-term s.17 leave⁶⁰. If this is correct, then the mental scales upon which a responsible clinician is required to weigh the merits of either regime should tip strongly in favour of SCT.

Bowen’s contention is echoed, at least in part, by the Code of Practice, which describes SCT as “a more structured system than leave of absence” with “more safeguards for patients”⁶¹. The Code, as a document drafted by officials of the Department of Health, understandably is rather coy in pointing out the lack that is highlighted in s.17 by the requirements and procedures of SCT. Not so Mr Bowen. He suggests the following contrasts between the two regimes:

1. That a responsible clinician and AMHP must be satisfied that the criteria for SCT are met, whereas the decision to grant long-term s.17 leave is taken by the responsible clinician alone, without any applicable criteria at all⁶².
2. SCT is subject to provisions for expiry, renewal and discharge, and the patient has the right to apply to the MHRT to be discharged, “whereas s.17 contains no such safeguards beyond those that apply to the underlying application for admission for treatment”⁶³.
3. The criteria for recall “are more stringent (if not by a significant degree) than those that apply to s.17 leave”⁶⁴.
4. SCT patients are, whilst in the community, treated under the new consent to treatment provisions of part 4A, which do not permit the compulsory treatment of a competent patient, whereas patients on s.17 leave are subject to the provisions of part 4, which do permit the overriding of a competent refusal of consent and forcible treatment.⁶⁵

Further to this, Bowen suggests that SCT is “probably less likely” to violate the European Convention on Human Rights (ECHR) than does the long-term use of s.17, for the following reasons:

5. The lack of criteria and procedure noted at (1) above result in s.17 powers that are “arguably” too vague to meet the requirement that any interference with rights protected by Article 8 (private and family life) be “in accordance with the law”⁶⁶; and

58 A version of this argument was suggested from the floor by Richard Jones at the Cardiff University Law School conference (‘the Mental Health Act 2007’) of the 15 February 2008.

59 See Concise Oxford Dictionary: “Consider v.t.: contemplate mentally; weigh merits of (course of action...etc)...”

60 Bowen, P (2008) *op cit.*, paras 5.09-11, 5.89-93

61 Revised Mental Health Act 1983 Code of Practice, para 28.5.

62 Bowen, P (2008) *op cit.*, para 5.10

63 *Ibid.*

64 *Ibid.* The criteria for recall from s.17 are that this is necessary for the patient’s health or safety or for the protection of other persons: see MHA s.17(4).

65 *Ibid.*

66 *Ibid.*, para 5.90

6. The lack of stringent criteria for recall to hospital from s.17 noted at (3) above potentially allows for recall where the *Winterwerp* criteria (justifying detention upon the basis of up to date medical evidence of unsoundness of mind) are not met⁶⁷.

Some of these complaints against s.17 leave appear to have a rather speculative basis: and Bowen acknowledges as much in relation to the “human rights implications”⁶⁸ listed at points 5 and 6. An implication is not a violation, and even such a skilful and tenacious advocate⁶⁹ as Mr Bowen might run into difficulties in arguing, as he appears to do at points 3 and 6, that legal consequences arise from an *insignificant* difference in the degree of stringency between two sets of criteria. It would seem to me self-evident that, if the criteria are essentially the same, they must either stand or fall together. Similarly, it is not clear to me what practical consequences emerge from the fact, set out at point 2, that the expiry, renewal and discharge mechanisms for s.17 patients are those that apply to the underlying application for admission for treatment, whereas such mechanisms for SCT patients are contained within the provisions of the Act that establish SCT and its administration. It may be that there is a significant difference of entitlement between the practical effects of such mechanisms, but if so I have not seen it. It is also unclear how the relatively broad discretion given to a responsible clinician to grant s.17 leave (point 1) fails any specific requirement of law, given that the patient given leave under these circumstances must still meet the criteria to remain liable to be detained, and that renewal of such liability will require the agreement of another professional to the responsible clinician.

This leaves the differences in consent to treatment provisions between the two regimes raised at Bowen’s point 4. Some of these differences are undeniably significant: in particular the ability to enforce treatment, at least in principle, on a capably refusing s.17 leave patient whilst that patient remains in the community, which is not replicated in SCT provisions. Faced with this difference, alongside the SCT regime’s complex arrangements for additional SOAD visits and the Code of Practice’s explicit statement that SCT has more safeguards for patients, a court (or for that matter an MHRT panel) might be easily persuaded that a patient subject to long-term s.17 leave who appears otherwise eligible for SCT is getting a raw deal.

As such, it is quite possible that the contention that SCT has better patient safeguards than s.17 could have some influence over responsible clinicians’ choice between the two regimes. But if the gravitational pull of SCT is thus increased, so might be the resistance to it by responsible clinicians who perceive it as bureaucratic or as a curtailment of their power. Such clinicians may find some assistance in the chapter of the Code of Practice dealing with the choice between community powers.

In the Mental Health Bill debates, the Secretary of State for Health (Patricia Hewitt) stated that SCT was

*“designed particularly for the so-called “revolving door patients”—people who are hospitalised, whether under compulsion or voluntarily, who respond to treatment, who are released, and who then fail to maintain their treatment, producing another crisis and yet another hospitalisation.”*⁷⁰

The revised Code of Practice for England, at chapter 28, suggests some “pointers” for clinicians deciding between leave of absence and SCT, including a table essentially similar⁷¹ to that reproduced at Table 1. In this schema, patients for whom community arrangements are likely to break down, and who are likely

67 *Ibid.*, para 5.91

68 *Ibid.*, paras 5.89 – 91.

69 *Ibid.*, p.vii: the description is that of Sir James Munby (High Court Judge).

70 *Hansard (Commons)* 16 April 2007, Col 56.

71 Although I have slightly condensed the phrases and included two statements (shown in quotation marks) from the text of that chapter.

to require future hospitalisation without consent, are deemed appropriate for longer-term s.17. Patients for whom the likelihood of community arrangements breaking down is serious but not high, and who are unlikely to require future hospitalisation without consent, are marked out for SCT. As such, the attributes of a “revolving door” patient (or any patient for whom there is deemed to be a risk of relapse) can as easily, if not more easily, be ascribed to the description of patients for whom the Code recommends longer-term s.17 leave than SCT. Whilst the Code is careful not to appear prescriptive in its guidance over which power to use, that guidance could be used as an excuse by clinicians who are reluctant to engage with the new powers.

Section 17 leave	Supervised Community Treatment
<ul style="list-style-type: none"> Discharge from hospital for specific purpose or fixed period: “may be useful where the clinical team wishes to see how a patient copes outside hospital before making a decision to discharge”. 	<ul style="list-style-type: none"> Confidence that patient is ready for discharge on more than a trial basis: “focus on ensuring patient continues to receive medical treatment without having to be detained again”.
<ul style="list-style-type: none"> Patient is likely to need further inpatient treatment without compliance or consent. 	<ul style="list-style-type: none"> Good reason to expect that patient will not need to be detained for the treatment they need.
<ul style="list-style-type: none"> Risk of arrangements in the community breaking down or being unsatisfactory is high. 	<ul style="list-style-type: none"> Risk of arrangements in the community breaking down or patient needing to be recalled to hospital for treatment is sufficiently serious to justify SCT, but not so high that it is very likely to happen.

Table 1 – Pointers to the use of leave of absence or SCT, from the MHA Code of Practice (England), chapter 28

Estimating the likely implementation of SCT

The above discussion has not established any very solid ground upon which to base estimations of the likely impact of SCT. Indeed, such an estimate must range from anticipating almost no effect upon implementation (if practitioners ignore the new SCT powers, as they have largely ignored the powers of supervised discharge, and continue to use leave of absence powers as a community-based power) to expecting a significant shift in the means by which patients released from detention in hospital remain subject to compulsion under the Act (if practitioners largely abandon longer-term s.17 leave in favour of SCT, and/or use SCT as a standard discharge package for s.3 detainees). However, we can identify the pool of patients whose legal status (if not necessarily individual circumstance) makes them eligible for SCT, and we can look to the example of Scotland where community treatment orders, although not identical to SCT, have been in effect from October 2005.

The number of patients eligible for SCT in England and Wales

The *Count Me In* census recorded a population of 8,223 detained patients who were subject to s.3 (or a relevant part 3 order) in England⁷², and 1,501 in Wales⁷³ on the 31 March 2006. As such we might assume a likely 'pool' of roughly 10,000 patients who will be broadly eligible for SCT upon its implementation in England and Wales. Counted over the course of a whole year, that pool may be almost four times larger. Section 3 powers were applied to 37,777 patients in England in the financial year 2006/07, and at least 470 patients were made subject to relevant part 3 sections⁷⁴. Of course, not everyone who is detained under a relevant section of the Act will be a suitable patient to be discharged onto SCT, whether this is because their recovery is more complete than would justify continuing powers; or because they never become compliant with a care package; or for any number of other reasons. The Department of Health has estimated that 2% of such potentially eligible patients will be made subject to SCT in the first year of implementation, rising to 10% within 5 years⁷⁵: this implies a starting population of 200 SCT patients, rising to approximately 4,000 initiations of SCT each year.

The example of Scotland

The number of people made subject to community treatment orders in Scotland has shown a steady rise from their introduction in October 2005⁷⁶. In January 2006 there were 65 patients on community orders (about 4% of all patients subject to compulsory treatment orders overall), rising to 280 patients (18% of all patients on treatment orders) at the end of April 2007⁷⁷. Statistics were not available to show the rate at which people are discharged from community orders, although in the financial year 2006/07, 90 orders either lapsed or were revoked, whereas 371 new orders were made⁷⁸.

There are significant differences between the Scottish legislation and that being introduced to England and Wales, which clearly limit the extent to which the Scottish experience can act as a model to predict the impact of SCT. Most notably, in Scotland the community order is free-standing and not necessarily a power of discharge from detention, although over half (197) of all new Scottish community orders in 2006/07 were effectively discharge from detention in hospital⁷⁹ (thus suggesting that community treatment orders upon discharge from hospital account for approximately 9% of all hospital and community orders made in the second year of implementation). This might suggest that the Department of Health has underestimated the rate of use for SCT.

There may be lessons from the Scottish experience in *how* SCT powers will be used. In particular, it may be instructive to look at how or why patients are recalled to hospital from community treatment orders in Scotland. The Scottish Act differs markedly from the SCT regime in that the former provides a specific power in relation to CTO patients who fail their requirement to attend places of treatment, so that such patients can be taken, conveyed and held for up to six hours at such places for the treatment to be

72 http://www.healthcarecommission.org.uk/_db/downloads/xtabEngland_mh.xls

73 http://www.healthcarecommission.org.uk/_db/downloads/xtabWales_mh.xls

74 Information Centre (2007) *op cit* (n.52 above), table 4, p.7, table 1, p.15, & table 7, p.21.

75 Department of Health (2006) *Mental Health Bill: Regulatory Impact Assessment*. November 2006, p.55.

76 *Mental Welfare Commission for Scotland (2007) Community Based Compulsory Treatment Orders under the Mental Health (Care and Treatment) (Scotland) Act 2003*. www.mwscot.org.uk

77 *Ibid.*, page 3.

78 *Mental Welfare Commission for Scotland (2008) Our overview of mental welfare in Scotland 2006-07*, p.46.

79 *Ibid.*

administered⁸⁰. This is in addition to powers of recall which allow that a patient who has failed to comply with the requirements of any order may be retaken to hospital and detained there for up to 72 hours in the first instance⁸¹, extendable to 28 days⁸², if the responsible medical officer has tried to contact the patient, given the patient the chance to comply, and believes that it is reasonably likely that further non-compliance would lead to significant deterioration in the patient's mental health.

Table 2 shows the use of these powers as reported in Scotland. By the end of April 2007, only nine people were known to have been made subject to the six-hour holding power for enforced treatment (s.112), although one patient had been so subject four times, whereas 64 patients accounted for a total of 71 recalls to hospital under the initial 72-hour holding power (s.113), with 54 such recalls leading to a further 28-day detention (s.114)⁸³. Nineteen further community patients were directly readmitted to hospital under emergency or short-term detention powers during this period⁸⁴.

Compulsory measure used	No. of occasions	No. of people	No. of people as % of all on community treatment orders
s.112 (six hour treatment power)	12	9	3
s.113 (recall for up to 72 hours)	71	64	23
s.114 (recall for up to 28 days)	54	50	18
s.36 (emergency detention – up to 72 hours)	3	3	1
s.44 (short-term detention – up to 28 days)	16	16	6

Table 2 – Recall of community patients in Scotland, 5 October 2005 to 26 April 2007

The apparently scarce use of the six-hour treatment power in Scotland (if it is not simply a reflection of failure to report its use to the Mental Welfare Commission) may indicate something quite significant about the use of community powers in general. Although specifically empowered to do so in Scotland, it appears that professionals may be reluctant to pull patients into hospital under compulsion solely for the purpose of administering medication by force. There is no direct equivalent of the six-hour treatment power in the amended Act for England and Wales, but it has been a long-standing assumption that patients who are made subject to the 72-hour recall power might be held only for so long as is required for the safe administration of medication without consent before being released back into the community, and in this sense the recall power encompasses the powers created separately in the Scottish legislation.

80 *Mental Health (Care and Treatment) (Scotland) Act 2003, s.112*

81 *Ibid., s.113*

82 *Ibid., s.114*

83 *Ibid, pages 4 – 5 (see table 2)*

84 *Ibid, page 5, table 2*

In particular, as we have seen, the consent to treatment provisions for recalled SCT patients explicitly provide that treatment powers should be available to clinicians immediately upon the patient's recall⁸⁵.

There is, no doubt, much that we have yet to understand about the patterns of CTO use in Scotland, but the rarity of use of the six-hour treatment power may suggest that the powers given over patients are being used with more caution, or just with more humanity, than many may have feared. It may be, for instance, that clinicians who decide to recall community patients to hospital view such action as being such a serious intervention, or as highlighting such a serious level of concern over a patient's ability to manage in the community, that to keep the patient for only so long as it takes to administer an injection does not seem to be an adequate response. In such cases, practitioners may choose to bring a patient in for assessment rather than a single forcible treatment. The power to recall for treatment over a maximum of six hours may also be regarded as too nakedly coercive by clinicians who are concerned to maintain a therapeutic relationship with their patients. Perhaps such relationships are less damaged by the softer coercion of persuasion (albeit persuasion against the option of remaining in hospital under detention following recall from SCT), and as such the powers to impose medication will not, after all, be at the centre of decisions to recall SCT patients to hospital. It is important to remember that, from a practical point of view, the continuation of SCT after a patient has been recalled will often rely on regaining that patient's compliance with treatment. A patient who continues to refuse to consent to or comply with treatment upon recall from SCT, even after that treatment is imposed by force, is unlikely to be considered fit to be discharged back into the community on SCT status.

There would be no small irony if the hard-won and controversial legal power to impose treatment upon a patient recalled from a community placement turns out, in practice, to much less of a great clunking fist than was feared by its detractors, or indeed implied by its supporters⁸⁶. The power to recall, and to impose treatment upon recall, may turn out to be only marginally different in effect to the power under supervised discharge or guardianship to convey community patients to places of treatment and there persuade them (by fair or not so fair means) into compliance.

85 See, for example, Hansard (Commons) 18 Jun 2007: Col 1199, where the relevant Minister (Rosie Winterton) objected to amendments requiring SOAD authorisation of treatment upon recall because that "would, in practice, prevent a patient from being treated without delay on recall to hospital, and would thus render recall useless".

86 See, for example, Boateng P (1998) *Mental Health Act Review – Speech to the Midhurst Seminar (First Meeting of the Richardson Scoping Study Review Team)*: "Non-compliance can no longer be an option ... I have made it clear to the field that this is not negotiable"