Section 117 (Mental Health Act 1983) After-care Procedures

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Introduction

1. This document summarises the legal responsibilities of Health Authorities and Local Social Services Authorities (“the responsible after-care bodies”) under Section 117 of the Mental Health Act 1983 (MHA), and describes the procedures by which South London and Maudsley NHS Foundation Trust (SLAM) exercises those functions on behalf of the responsible after-care bodies.

2. This document should be read in the context of existing s.75 arrangements (under the National Health Service Act 2006 (formerly s.31 of the Health Act 1999) which specifically address partnership working arrangements).

3. As an organisation which provides integrated mental health services, SLAM has been commissioned by its associated Health Authorities, who have also been delegated the health functions of the Local Social Services Authorities, to administer the Section 117 responsibilities of both the health and local social services authorities.

4. References to “Health Authorities” in the MHA refer in current day to day practice to Clinical Commissioning Groups (CCGs) who exercise the functions of providing funding and commissioning responsibilities under s.117 MHA in this area.

5. This document is intended to guide SLAM and LA staff through the process of considering:
   - what is an aftercare service under section 117
   - who is eligible for aftercare services under section 117,
   - how to identify the responsible after care bodies,
   - how to create an after care plan
   - how to review and assess the continuing eligibility to services under section 117,
   - the procedure to cease aftercare services

6. This is an operational document to assist staff in the integrated mental health service. It is not intended to be a comprehensive summary of the law and procedure. It is essential that staff keep up to date with all relevant changes relating to the provision of after-care services, so as to ensure that when exercising functions on behalf of the responsible after-care bodies, the law, and any relevant guidance in operation at the time is complied with.

Section 117 MHA

7. Section 117 MHA 1983, provides:
   
   After Care:

   117. --- (1) This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under
section 37 above, or transferred to a hospital in pursuance of [a hospital direction made under section 45A above or] a transfer direction made under section 47 or 48 above, and then cease to be detained and [(whether or not immediately after so ceasing)] leave hospital.

(2) It shall be the duty of the [Primary Care Trust or] [Local Health Board] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for an person whom this actions applies until such time as the [Primary Care Trust or] [Local Health Board] and the local social services authority are satisfied that the person concerned is no longer in need of such services [; but they shall not be so satisfied in the case of a [community patient while he remains such a patient.

[(2B)] Section 32 above shall apply for the purposes of this section as it applies for the purposes of Part II of this Act.
[(2C)] References in this Act to after-care services provided for a patient under this section include references to services provided for the patient –
 a. in respect of which direct payments are made under regulations under section 57 of the Health and Social Care Act 2001 or section 12A(4) of the National Health Service Act 2006 and
 b. which would be provided under this section apart from the regulations.]

(3) In this [section “the [Primary Care Trust or] [Local Health Board]” means the [Primary Care Trust or] [Local Health Board], and “the local social services authority” means the local social services authority, for the area] in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained.

8. In summary, Section 117 of the MHA requires the responsible after-care bodies, in co-operation with relevant voluntary agencies, to provide after-care for patients detained, transferred, or admitted under sections 3, 37, 45A, 47 or 48 MHA, who then cease to be detained. The duty to provide such services continues until such time as the person is no longer in need of such services.

What are aftercare services

9. After-care services are not defined in the MHA, however the Code of Practice at paragraph 27.5 says this: “After-care is a vital component in a patient’s overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.”

10. The commentary by Richard Jones in his book ‘Mental Health Act Manual’ describes aftercare under s.117 MHA as a service: ‘which is (1) provided in order to meet an assessed need that arises from a person’s mental disorder and (2) aimed at reducing that person’s chance of being re-admitted to hospital for treatment of that disorder.’

11. This formulation was endorsed by Hickinbottom J In R (on the application of Mwanza) v Greenwich LBC [2010] EWCH 1462 (Admin); [2010] M.H.L.R. 226
at para 64, where the Court held that s 117 is not concerned with the provision of support in general, but with a service that is necessary and tailored to meet need arising from a person’s mental disorder. The Judge went on to say at paragraph 65:

The need for work or the need of a roof over one’s head simpliciter are common needs, and do not arise from mental disorder. Section 117 does not impose a general responsibility on the relevant authorities to house or provide an income to a former patient. Of course, a patient’s mental disorder may make it more difficult for him to look for housing or employment on discharge from section 3 – and may therefore give rise to a need for assistance in doing so. But that is a different need and a different issue.

12. The case of Richmond Borough Council v Watson [2000] EWCA Civ 239 provides that aftercare can include residential accommodation which is specifically designed to care for the needs of persons who have been detained under section 3. This however does not mean that as a matter of law ordinary accommodation cannot ever fall within the scope of section 117, but such a situation would be unusual.

13. In Clunis v Camden & Islington Health Authority (1994) the Court provided guidance as to the meaning of after-care services under s117:

“They would normally include social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities.”

14. Psychiatric treatment is also to be added to the above. DoH guidance: Guidance on supervised discharge (after-care under supervision) and related provisions LAC(96)8: HSG (96)11 para 18 advised that services might include ‘appropriate daytime activities, accommodation, treatment, personal and practical support, 24-hour emergency cover and assistance in welfare rights and financial advice’. It also refers to ‘support for informal carers’. Paragraph 27.13 of the Code of Practice identifies these and other factors to be considered as part of a thorough assessment under s.117

15. The type of aftercare services required to meet an individual’s needs will be determined by a thorough assessment. Factors to be included (which are not exhaustive) are set out in Chapter 27.13 of the Code referred to above. With the advent of Personalisation and the proposals in the Care Bill the manner in which we meet an aftercare need may expand.

16. Appendix B outlines the type of wide ranging services which may be provided under s.117 after-care, depending upon the assessed needs of the individual.
Eligibility for aftercare under Section 117

17. The wording of s117 is clear. A person admitted under the relevant sections of the MHA, as referred to above; who then ceases to be detained, is eligible for s117 after-care services.

18. The duty to provide after-care services applies irrespective of a person’s immigration status in the UK. Section 117 is not listed under Schedule 3 of the Nationality, Immigration and Asylum Act 2002 which, together with Section 54 of that Act has the effect of prohibiting Local Authorities from providing specific services listed in the schedule unless certain exceptions apply.

19. Section 117 is a stand alone duty. Unlike some other community care services the responsible aftercare bodies cannot charge a person for after-care services under s117 (as to which, see below). Establishing who the responsible aftercare bodies are for providing after-care to an eligible person is vital given the potential resource commitment. However this should never delay provision of services.

20. Due to the wording of s117 a person is eligible to after care when they are a patient on a Leave of Absence from hospital under Section 17 MHA (confirmed by the Court in R v Richmond LBC ex parte W [1999] M.H.L.R. 149). Any services provided to a patient whilst on leave should be specifically tailored for that purpose. A person subject to supervised community treatment is also eligible for s.117 aftercare (see Chapter 27.2 of the Code of Practice).

Record keeping for eligible patient

21. It is the responsibility of all Health & Adult Social Service professionals to ascertain if a person under their care is subject to Section 117. All new patients placed on sections 3, 37, 45A, 47 and 48 will be placed on s.117 by the epjs system, and this can be checked under the MHA Tab, and on other relevant Local Authority IT systems where applicable. Subsequent to this automatic registration, the responsible aftercare bodies need to be identified.

17. Due to the specific statutory obligation of s.117, the Code of Practice at para 27.11 identifies that it is important that all patients who are subject to Section 117 are identified and that records are kept of them. A list of such patients can be generated from the epjs by the IT Department. All record keeping must be in full compliance with the Data Protection Act 1998. The Code of Practice provides the following guidance:

After-care for all patients admitted to hospital for treatment for mental disorder should be planned within the framework of the Care Programme Approach (or its equivalent), whether or not they are detained or will be entitled to receive after-care under section 117 of the Act. But because of the specific statutory obligation it is important that all patients who are entitled to after-care under
section 117 are identified and that records kept of what after-care is provided to them under that section.

How to identify the responsible Aftercare Bodies (and Commissioners)

18. Deciding which Health and Local Social Service Authorities are responsible for commissioning after-care services under s117 for a person is the vital first step of the planning process, but any dispute as to responsibility for providing such services should never delay the provision of required services, nor prejudice a patient/service user.

19. Staff in integrated mental health service must also remember there is a possibility that the joint duty to provide after-care services may rest with Health and Local Social Services Authorities from different areas.

20. In the case of *R v Mental Health Review Tribunal ex parte Hall* (1999), the Court confirmed that:

- The relevant aftercare bodies are those for the area where the patient was “resident” at the time s/he was detained in hospital, even if the person does not return to that area on discharge;
- If no such residence can be established, the duty falls on the authority where the person is sent on discharge from hospital. Detailed guidance provided by DOH is referred to below.

21. Following the judgment in *Hall*, the Department of Health issued guidance (HSC 2000/003: LAC (2000) 3 which considered the implications of the judgment. Paragraph 7 of the guidance states:

“A patient who was resident in an area before admission to hospital does not cease to be resident there because of his/her detention under the Act. If a patient with ordinary residence in one area is sent to another area on discharge, it is the responsibility of the health and social services authorities in the area where the patient was resident before admission to make the necessary arrangements under section 117. However, where a patient does not have a current residence, the responsibility for providing after-care under section 117 falls to the health and social services authorities covering the area to which the person is sent on discharge. When a patient is conditionally discharged, the Tribunal may send the patient to an area by imposing a residence condition.”

22. The term ‘resident’ is not defined in the MHA and must be given its ordinary and natural meaning (see paragraph 187 of the Department of Health guidance ‘Ordinary Residence: Guidance on the Identification of the Ordinary Residence of People in Need of Community Care Services, England,’ (March 2010, revised in April 2011). This guidance also makes it clear that the term ‘resident’ in s 117 MHA does not have the same meaning as the term ‘ordinarily resident’ in the National Assistance Act 1948. This has been confirmed by the Court of Appeal in *R (on the application of M v Hammersmith and Fulham LBC* [2011] EWCA Civ 77.
23. For the relevant NHS Guidance which supports how to identify the responsible NHS aftercare body for s.117 refer to The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and NHS England’s Rules and Guidance for CCGs on Who Pays published in August 2013, which reflects earlier DH Guidance.

24. Staffs are encouraged to seek clarification on responsible authorities from lead mental health social workers or mental health commissioners from the local CCG.

**Persons Who Move to Other Areas**

17. In the event that a person who is subject to s.117 moves to another area, the care co-ordinator must inform the local integrated mental health service (local health and social services providers) of the person’s presence in the new area. The care coordinator must forward a copy of the relevant assessment.

18. The responsibility for providing after-care remains with the originally identified responsible after care bodies, notwithstanding that the person may have moved outside of their area. The aftercare duty will continue until such time as one of the events that may lawfully bring about the current aftercare body’s responsibility to an end has occurred, and as referred to elsewhere in this document.

19. There is no statutory mechanism for transfer of s117 duty. Any transfer of responsibility is a matter for agreement between each health and social services authority on a case by case basis, and all employees should speak to a social Care lead about any issues to do with s.117 responsibility.

20. Where a person who is entitled to s.117 MHA aftercare was ‘resident’ in an area prior to admission but is to be discharged from hospital to an area different from that where s/he was resident at the time of admission, the responsible after-care bodies will be those where s/he was ‘resident’ prior to admission. The responsible after-care bodies may need to purchase services in the new area. They should inform the health and social services authorities in the person’s new area of the arrangements made for the person’s after-care.

21. The responsibility for purchasing after-care services in the new area where the person has moved to will remain with the responsible after-care bodies until such time as one of the events occur that bring the s117 duty to an end. Further guidance regarding when the s.117 duty ends is set out in this document below.

22. The above does not preclude the responsible after care bodies agreeing to contract the care package out to local providers in advance of formal transfer. Any such action should be discussed with the person, and with the person’s wishes, and that of any carer, taken into account. Care must be taken to ensure that any newly commissioned services meet the person’s assessed needs.
Persons on s117 who move into area

23. If any member of staff working in the integrated adult mental health services receives a request to accept the transfer of a s.117 eligible patient they should discuss this with the Head of Social Care for their Borough.

Section 117 After-care Planning Process

24. There is a need for good practice in all after-care planning. The Code of Practice at section 27 provides helpful guidance in relation to the responsible after-care bodies obligations when delivering after-care services.

25. The Code of Practice makes it clear that while the duty to provide after-care services begins when the patient leave hospital, good practice requires the planning of after-care services to begin as soon as the patient is admitted to hospital (paragraph 27.8). Staff in integrated mental health service, acting on behalf of the responsible after-care bodies should therefore identify appropriate after-care services for the patient as soon as possible.

26. As to the timing of when an assessment and care plan should actually be drawn up, much will depend on whether or not the discharge is disputed or not. If not disputed, it would be appropriate to have a more detailed care plan in place prior to any tribunal hearing or managers meeting at which discharge is being determined.

27. In the matter of a contested discharge, the case of R (on the application of W) v Doncaster MBC [2004] EWCA Civ 378 approved the idea that care plans should be in place in some “embryonic” form prior to a tribunal sitting. This very much echoes what the Code of Practice (2008) says at paragraph 27.9:

‘Where a Tribunal or hospital managers’ hearing has been arranged for a patient who might be entitled to after-care under section 117 of the Act, the hospital managers should ensure that the relevant PCT and LSSA have been informed. The PCT and LSSA should consider putting practical preparations in hand for after-care in every case, but should in particular consider doing so where there is strong possibility that the patient will be discharged if appropriate after-care can be arranged.

28. This planning would also be required for an Associate Hospital Manager’s Hearing.

29. All patients detained under one of the qualifying sections of the MHA should be allocated a care co-ordinator as soon as possible to ensure adequate care planning for discharge. The patient’s responsible consultant psychiatrist and the ward manager should notify the relevant Community Mental Health Team (CMHT) that the patient is likely to be discharged and specify when the discharge is likely to take place.
30. CPA discharge planning, and S117 aftercare meetings will be arranged to facilitate the attendance and participation of all relevant and interested parties. The allocated Care Co-ordinator / Local Authority Care Manager will be responsible for arranging the CPA / Local Authority review meetings.

31. Putting in place suitable aftercare services is an essential component of discharge from hospital. The Code of Practice to MHA at para 27.12 sets out details of the persons, in addition to the patient, who may need to be involved in such a process, to ensure that the aftercare plan reflects the needs of the patient. This may include:

a. The patient’s responsible clinician;
b. Nurses and other professionals involved in caring for the patient in hospital;
c. A clinical psychologist, community mental health nurse and other members of the community team;
d. The patient’s GP and primary care team;
e. Subject to the patient’s views, any carer who will be involved in looking after them outside hospital, the patient’s nearest relative other family members;
f. A representative of any relevant voluntary organisations;
g. In the case of a restricted patient, the probation service;
h. A representative of housing authorities, if accommodation is an issue;
i. An employment expert, if employment is an issue;
j. An independent mental health advocate, if the patient has one;
k. An independent mental capacity advocate, if the patient has one;
l. The patient’s attorney or deputy, if the patient has one; and
m. Any other representative nominated by the patient.

32. It must be made clear to those in attendance that the CPA meeting has been convened specifically to consider the after-care plan within the context of S117 of MHA. The meeting must explicitly consider the fact that the patient is subject to S117 after-care and both Health and Social Services staff are jointly responsible for providing any after-care services.

33. The allocated care co-ordinator will take responsibility for co-ordinating a health and social care needs assessment for after-care services under S117 duties. The care co-ordinator will take into account the assessment of the responsible consultant psychiatrist and any other relevant information provided by multi-disciplinary team colleagues to determine what, if any, services are called for under S117 and/or any other statutory duties. The Code of Practice to MHA at para 27.13 indicates what a thorough assessment would be likely to include consideration of, and is reproduced in Appendix B. Paragraph 27.11 of the Code provides that aftercare should be planned within the framework of the Care Programme Approach (or its equivalent).

34. Section 130A of the MHA requires the Secretary of State to make arrangements for independent mental health advocates to provide assistance to those who are eligible for aftercare services to provide them information about this. The care co-ordinator should ensure that such assistance has been offered to the patient in advance of the finalising of any care plan.
35. In addition for those patients who lack capacity to make decisions about their residence, the Mental Capacity Act requires certain patients to be provided with an Independent Mental Capacity Advocate (IMCA) where a change in the patient’s accommodation to another hospital or care home is being considered and there is no person with whom it would be appropriate to consult with in the patient’s best interests (see section 38). Care co-ordinators should be aware of this and ensure that an IMCA is appointed and consulted prior to the implementation of any aftercare plan in which a change in the patient’s residence is involved.

36. Consideration should be given by the care co-ordinator as to whether the patient has the capacity to reject or accept after-care services. In the event that a patient is deemed to lack capacity in this regard and is non-compliant with the proposed care plans, consideration will need to be given as to:

   a. whether the care plan can be delivered in the person’s best interests pursuant to the Mental Capacity Act;
   b. whether a person is resident in a care home consideration should be given as to whether the care plan may amount to a deprivation of the patient’s liberty requiring a request to be made to the Supervising Authority for the requisite assessments to be carried out with a view to granting an Urgent or Standard DOLs Authorisation; or
   c. in other care and support settings, whether the matter needs to be brought before the court to obtain lawful authority to impose the care plan.

37. The focus of the after-care plan will be to provide such support for a period, to equip the patient to cope with life outside hospital and to assist them to progress to the stage where they will no longer be in need of such services, and to prevent the need for re-admission in order to receive treatment.

38. The case of Clunis makes it clear that the relevant aftercare authorities have a discretion (described as ‘wide’ in Muwanzal) as to what if any services are required to meet the assessed needs. Lord Phillips at paragraph 29 of that case stated that this discretion must be exercised with regard to the other demands in the relevant public body’s budgets.

39. The Code of Practice to MHA requires that the after-care plan is recorded in writing. Once the plan is agreed it is essential that any changes are discussed both with the patient and others involved with the patient before it is implemented. All services provided on discharge will be recorded in the person’s discharge plan, as well as in the assessment and care plan.

40. The Community Care, Services for Carers and Children’s Services (Direct Payment) (England) Regulations 2009 require local social services authorities to offer direct payments to patients for the provision of their aftercare services. This can be achieved even where the patient lacks the capacity to manage the direct payments themselves by appointing a suitable person to manage them on the patient’s behalf. There is also a power to offer direct payments to those on a conditional discharge.
**Complying with Tribunal Conditions**

41. The Court of Appeal summarised the obligations on aftercare bodies to comply with conditions for aftercare services provided by Tribunals in the case of *W v Doncaster MBC* [2004] EWCA Civ 378 at paragraph 73 as follows:

> If such treatment is an essential pre-requisite of discharge (as it was in *IH*), but it proves impossible to provide, then continuing detention is lawful, although the impossibility of providing the treatment envisaged by the Tribunal means that the matter will have to return to the Tribunal for reconsideration: [2003] UKHL 59, paragraph 27. If such treatment is not an essential pre-requisite to discharge, then, although discharge may be delayed for a period while efforts are made to arrange the expected treatment, discharge cannot be unreasonably delayed, even if it proves impossible to arrange it: see Johnson v. UK (1997) 27 EHRR 296.

42. This echoes what the Code of Practice says at paragraph 27.9:

> Where the Tribunal has provisionally decided to give a restricted patient a conditional discharge, the PCT and LSSA must do their best to put after-care in place which would allow that discharge to take place.

**Voluntary Sector Involvement**

43. Section 117 refers to the duty to provide after-care services in co-operation with relevant voluntary agencies.

44. When the care co-ordinator is arranging the CPA meetings, including the review of after-care services, they should also liaise with any voluntary agencies who may be involved in providing the after-care, and any advocates working with the patient.

**Charging**

45. In the case of *Stennett*, the House of Lords confirmed that there is no power to charge for services provided under s 117, with the effect that persons cannot be charged for services provided under it, which must be provided free of charge.

46. It should be noted that Department of Health guidance states:

> “Occasionally, there may be other non-residential community care services which are not part of the Section 117 MHA 1983 After-Care Plan. These may relate to physical disabilities or illnesses, which have no direct bearing on the person’s mental health. Such services will generally fall outside Section 117 MHA 1983 After-Care.”

47. The completion of a detailed assessment is therefore very important in identifying any needs and what services are required to meet those needs, and informing the after care plan so it is explicit as to what services are required under s117 in the after-care plan, and those services that are outside of it, which
the local social services authority may be required to charge for. Such decisions would need to be discussed with the service manager from the responsible local social services authority team and be well documented.

48. Consideration within the detailed assessment should also be given in appropriate cases to whether or not the patient meets the criteria for continuing healthcare funding.

49. Staff in the integrated mental health service, are therefore required to complete relevant assessments in a timely and thorough manner, and in accordance with any published guidance.

50. When services are being provided under s117, which if they were not included on the after-care plan they would otherwise be charged for by the local authority, the person (as well as relatives and/or carers where appropriate) must be made aware of the implications as to how the position will change should there be a subsequent review decision that the service will no longer be provided under s117.

Third party top ups

51. The court (Coombs v Dorset NHS Primary Care Trust [2012] EWHC 521 (QB) has held that it is not contrary to public policy to allow a patient who has been detailed pursuant to the MHA to pay for (but not decide) their own treatment (either by allowing them to pay for a particular treatment or a placement at a particular hospital that the detaining authority would not pay for). This case is awaiting appeal to the Court of Appeal.

52. There is therefore some authority to suggest that patients can pay for (as opposed to being charged for) their own aftercare services. This is however a complex and novel area of law and staff are advised to seek legal advice if this issue arises.

53. Further, if accommodation is being provided as part of the aftercare plan and the patient wishes to reside in alternative more expensive accommodation, it is possible for top up payments to be made directly to the service provider, but only if the service provider is willing to enter into a direct contractual agreement either with the patient or a third party.

Information to be provided to Persons and Carers

54. Persons subject to S117 must be provided with information in relation to any aftercare services and any changes to such services.

55. The person needs to be informed in writing of the purposes of the review procedures for s.117. As part of this it is essential that the person is informed that upon discharge from s.117 they may become liable for charges for certain elements of the social care package (see template letter for nearest relative below) see also paragraphs above for further information on charging.
56. The Code of Practice to MHA at 2.39 to 2.42 provides detailed guidance on the involvement of carers. The Code of Practice makes clear the importance of involving carers in the process.

57. Staff should also be aware that carers may have a right of their own to an assessment of their needs as carers. It is important that carers are advised of their right to have a carer’s assessment completed, in appropriate cases.

**Monitoring of Patients Subject to Section 117**

58. It is the responsibility of all Health & Social Service professionals to ascertain if a patient under their care is subject to Section 117.

59. Due to specific statutory obligation, it is important that SLAM in exercising the responsible after-care bodies’ functions under s117, ensures that all patients who are subject to s 117 are identified and that up to date records are kept of them.

60. A Register of s.117 patients will be extracted from the ePJS. This will mean that the Mental Health Minimum Dataset for CPA will always identify whether a patient is subject to s.117.

61. The person’s need for aftercare services would usually change over time. The fact that the services that are currently being provided differ from those which were provided at the time of the person’s discharge does not have the effect of extinguishing the duty to provide after-care services under this section.’.

62. A person will only be removed from the s.117 register after a thorough and lawful reassessment which determines that s/he is no longer eligible for s.117 MHA aftercare services. In such circumstances, clear records relating to the services that the person is entitled to must be kept up to date in the usual way.

63. Audits of CPA documentation will be carried out on a regular basis. This will include whether s 117 status is recorded appropriately and that the care plan clearly shows which services are provided under s 117 and which are not. This should be built into the Trust’s Clinical Audit regime.

**Review of Persons Subject to Section 117**

SLAM and LA staff members working for the responsible aftercare bodies are responsible for re-assessing the person’s s.117 status at regular intervals, and in response to any change in needs.

64. For review of aftercare plans the Code of Practice suggests, ‘The aftercare plan should be regularly reviewed. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed that it is no longer necessary.’

65. The after-care plan, within the CPA, will be monitored and reviewed by the care co-ordinator and responsible consultant psychiatrist. The aim will be to ensure that the after-care plan objectives are followed and to ensure that the services
provided remain relevant to the objective of equipping the person for life outside hospital and reducing the need for the person to be re-admitted to hospital for the provision of treatment, and to ensure that eligible needs arising from the person’s mental disorder are met.

66. The review of those subject to s117 will form part of the Care Programme Approach (CPA) Policy. After-care plan reviews should be held at least six monthly. However, it is essential that any needs be reviewed at appropriate times, in response to any developments and needs of the person and any carer(s).

67. The patient, carer/s or any member of the patient’s care team may request an earlier review, and it is essential that staff are aware of the patient’s and carer’s changing needs, and to respond to the same to reflect any change in services that may be required.

68. If possible the person, their carer/s, and any advocate if requested, as well as any other organisations or persons concerned should be present at a review meeting. The after-care review meeting must always consider the following elements;

- What after-care needs the person has relating to his/her mental disorder that require a service;
- What community care services the person still requires relating to their mental disorder, and identify/review any new community care or health needs unrelated to that disorder which may nonetheless call for the provision of services;
- The services needed to meet any identified needs and their purpose (including the differentiation between those services being provided under Section 117 and those provided under alternative Community Care legislation and what if any services are subject to charging provisions);
- The person may still require support/care but not for their mental disorder. This situation would require an assessment of needs and application of the FACS criteria to determine eligibility for community care services from the relevant social services department of the responsible local authority, or any health related needs from the health authority. Staff must be aware that people who have a mental disorder may be entitled to the full range of other community care services, including accommodation under the National Assistance Act 1948, as well as the wide ranging non-accommodation services under s.29 National Assistance Act 1948, s.2 Chronically Sick and Disabled Persons Act 1970, and the NHS Act 2006. Services may also be required under the Children Act 1989.

69. Each of the respective Social Services authorities has policies regarding the review of residential care placements within a specific timeframe of the placement commencing. That time frame must be recorded in each CPA aftercare plan.

70. At the conclusion of the after-care review meeting recommendations may be made by the consultant in conjunction with the relevant team members and
taking into account the views of the patient, family members, any carers, and any other persons concerned as to whether:

- the s.117 after-care plan needs to continue, or
- the s.117 after-care plan needs to be modified in response to changing needs, or
- the need for a s.117 after-care plan has come to an end.

71. If the service user or their carer is unhappy with the recommendation decision they have recourse to SLAM and/or the Local Authority’s complaints procedure. Staff should notify the Local Authority and SLAM Legal Departments of any potential challenges to s.117 entitlement.

**Discharge from Section 117 and Authorisation**

72. Section 117 requires both of the responsible after care bodies to be satisfied that the person no longer requires after care services in order for s117 MHA duty to be lawfully brought to an end, and any such decision may only be taken after a thorough and lawful multi-disciplinary reassessment of the person’s needs.

73. As indicated above, the duty to provide after-care services continues until the responsible after-care bodies are satisfied that the person no longer needs any after-care service for his or her mental health disorder.

74. To lawfully discharge a person from s117 the responsible after-care bodies must have undertaken a thorough multi-disciplinary assessment and be satisfied that the person is no longer in need of such services. Further information regarding the assessment procedure is set out below.

75. An exception to the above is where a person is subsequently once more detained in hospital under section 3, 37, 47, 48, or 45A MHA 1983. In these circumstances any existing after care duty owed to that person ceases, but a new entitlement would start when discharged from hospital following the new period of detention. The process of identifying the responsible after care bodies and making an aftercare plan would start over. SLAM and LA staff must check upon each admission under these sections of MHA where the actual residence of the patient was prior to admission to determine the responsible after care bodies on each occasion. In circumstances where a person was resident in another area prior to being compulsorily detained under any of the provisions that give rise to after care duties under s.117 MHA 1983, may have changed ‘residence’ within the meaning of the MHA consequently the responsible after care bodies may have changed.

76. A patient subject to section 17A aftercare under supervision, or a patient who is conditionally discharged or a patient on section 17 leave cannot be discharged from section 117 aftercare services.
The assessment

77. SLAM and LA staff are required to conduct multi-disciplinary assessments to inform the decision as to whether or not a person may be discharged from s117.

78. The assessment recommending discharge from after-care services which will be based upon a multi-disciplinary assessment/meeting must be signed by both the person’s care co-ordinator and the responsible consultant psychiatrist. If they are not in agreement the client cannot be discharged from s.117 aftercare until they do reach agreement. This is to ensure that all relevant factors have been considered and to ensure that both the health body and local social services authority are satisfied that the person is no longer in need of such services.

79. Details of the circumstances in which the duty under Section 117 may end are set out below. At all times those operating and using the policy on a day to day basis, will be expected to do so in accordance with the current law and guidance at any given time.

80. The person subject to s117 and their carer/s (where the person consents) should be fully consulted throughout the whole process, as should any other member of the multi-disciplinary team concerned with the person’s care.

81. The responsible after-care bodies can not be satisfied that the patient no longer needs after care services for his or her mental health needs just because a patient is still a community patient i.e. a patient subject to a Community Treatment Order pursuant to s17A MHA 1983.

82. Both the responsible after-care bodies can only be “satisfied” that services under s.117 are no longer required after a lawful multi-disciplinary reassessment has been conducted which concludes that the person no longer requires any section 117 services.

83. Paragraphs 27.19 to 27.20 of the Code of Practice to MHA, provides guidance as to the circumstances in which s.117 MHA after care may lawfully be brought to an end. It states:

27.19 The duty to provide after-care services exists until both the PCT and the LSSA are satisfied that the patient no longer requires them. The circumstances in which it is appropriate to end section 117 after-care will vary from person to person and according to the nature of the services being provided. The most clear-cut circumstances in which after-care will end is where the person’s mental health has improved to a point where they no longer need services because of their mental disorder. But if these services include, for example, care in a specialist residential setting, the arrangements for their move to more appropriate accommodation will need to be in place before support under section 117 is finally withdrawn. Fully involving the patient in the decision-making process will play an important part in the successful ending of after-care.

27.20 After-care services under section 117 should not be withdrawn solely on the grounds that:
• the patient has been discharged from the care of specialist mental health services;
• an arbitrary period has passed since the care was first provided;
• the patient is deprived of their liberty under the Mental Capacity Act 2005;
• the patient may return to hospital informally or under section 2; or
• the patient is no longer on SCT or section 17 leave.

27.21 Even when the provision of after-care has been successful in that the patient is now well settled in the community, the patient may still continue to need after-services, for example to prevent a relapse or further deterioration in their condition.

27.22 Patients are under no obligation to accept the after-care services they are offered, but any decisions they may make to decline them should be fully informed. An unwillingness to accept services does not mean that the patients have no need to receive services, nor should it preclude them from receiving them under section 117 should they change their minds.

84. The following matters should be considered on assessment:

a. What the patient’s current assessed mental health needs are and what services are required to meet those needs. This should include consideration of the patient’s medication needs and the need for ongoing care under the supervision of a psychiatrist or specialist mental health services.

b. Whether the patient’s needs have changed since discharge from hospital pursuant to section 117.

c. What the risks of a return to hospital/relapse are.

d. How successful the aftercare services have been in reducing the risk of relapse/return to hospital.

The Authorisation

85. If, following the completion of an assessment of the person’s needs both the decision-makers for the responsible Heath authority/PCT and Social Services authority are satisfied that the person is no longer in need of s.117 aftercare services, a decision may be taken that such services be brought to an end.

86. As noted above, there may be situations where a person no longer requires after-care for their mental illness but does require social services provision for other needs, for example, due to a physical disability. In such cases care must be taken before deciding to discharge a patient from s117. A community care assessment (under s.47 National Health Service and Community Care Act 1990) will be required to properly determine what community care needs the person has and what duty the local authority may owe them.

87. In summary the procedure to discharge a person from s117 which must be followed is summarised in Appendix C Flowchart
Resumption of Section 117 Status

88. A patient who has previously been subject to s 117 but was discharged (in accordance with the correct procedure) is not entitled to further cost free care, except where these are services free at the point of delivery, provided to meet an assessed need.

89. If the responsible after care bodies lawfully discharge their s117 responsibility to a person, but the person’s mental health deteriorates again and they are detained under Section 3, 37, 47, 48, 45A a new entitlement to s117 after-care will arise. As indicated above, staff must conduct necessary checks to establish who the responsible after care bodies are on each occasion.

Supervised Community Treatment and After-Care

90. Section 117 entitlement applies when a patient is subject to a Community Treatment Order (CTO) under section 17A of the Act. A CTO constitutes part of a patient’s s.117 aftercare arrangements. Only unrestricted Part III patients (s37, 47, 48 and 45A) are eligible for CTOs. CTO patients should be eligible for a personal budget.

91. The Code of Practice sets out, at Chapter 25, the procedure to be followed where a patient is discharged under section 17A. It should be noted that where a patient is formally recalled to hospital, and the patient arrives at hospital after the recall, the patient may be detained in hospital for a maximum of 72 hours after the recall to allow the responsible clinician to determine what should happen next. During this period the patient remains a Supervised Community Treatment (SCT) patient, even if they remain in hospital for one or more nights. Should the responsible clinician and the AMHP agree that the CTO should be revoked, upon legal revocation of the CTO, the patient is then detained again under the powers of the Act exactly as before going onto the SCT, except that a new detention period of six months begins for the purpose of review and applications to the Tribunal.

Interfacing Policies and Guidance

92. This policy applies to all staff involved in the compilation and maintenance of the Section 117 Register. Staff should be keep up to date, with relevant polices.
Appendix A. Clinical Commissioning Groups (CCG’s)

Southwark CCG
Rabia Alexander - Mental Health Commissioner
Southwark CCG
Tooley Street
London SE1 5LX
Tel: 020 7525 3176
Email: rabiaalexander@nhs.net

Lambeth CCG
Dennis O’Rourke, Mental Health Commissioner
Lambeth CCG
1 Lower Marsh
Waterloo
London SE1 7NT
Tel: 020 7716 7000
Email: denisorourke@nhs.net

Lewisham CCG
Dee Carlin, Mental Health Commissioner
Lewisham CCG
Cantilever House
Eltham Road
Lee
London SE12 8RN
020 7206 3200
Email: dee.carlin@nhs.net

Croydon CCG
Patrice Beveney, Mental Health & Substance Misuse Commissioner
Croydon CCG
Leon House
233 High Street
Croydon
Surrey CR0 9XT
020 8274 6000
020 8680 2418
Email: Patrice.Beveney@nhs.net
Appendix B. Examples of Aftercare Services

The type of after-care services that may be provided under s.117 MHA are very wide and must be tailored to meet the patient’s needs.

After-care services are not defined in the Mental Health Act 1983, but as indicated in the case of Clunis v Camden & Islington Health Authority (1984): *They would normally include social work, supporting health in the ex-patient with employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities. Psychiatric treatment is also included.*

The Code of Practice provides assistance in the type of after-care services that *may* be appropriate. It is essential that staff are fully familiar with the Code of Practice. In particular, paragraph 27.13 of the Code confirms that a thorough assessment is likely to involve consideration of:

- Continuing mental health care, whether in the After-care community or on an out-patient basis;
- A psychological need for the patient and, where appropriate, of their family and carers;
- Physical healthcare;
- Daytime activities or employment;
- Appropriate accommodation;
- Identified risks and safety issues;
- Any specific needs arising from, for example, a co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder;
- Any specific needs arising from drug, alcohol or substance misuse (if relevant);
- Any parenting or caring needs;
- Social, cultural or spiritual needs;
- Counselling and personal support;
- Assistance in welfare rights and managing finances;
- Involvement of authorities and agencies in a different area, if the patient is going to live locally;
- Involvement of other agencies, for example the Probation Service or voluntary organisations;
For a restricted patient, the conditions of which the Secretary of State for Justice or the Tribunal has imposed or is likely to impose on their conditional discharge; and

Contingency plans, should the patient’s mental health deteriorate (and crisis contact details).

In future these needs are likely to be met through the mechanism of a personal budget.

This list is not exhaustive but is meant to act as a guide to staff when considering if a person is still in need of aftercare services

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2 Code of Practice, 2008 paragraphs 27.5
4 Code of Practice, 2008 paragraphs 27.5 to 27.18, especially 27.12
5 Code of Practice, 2008 paragraph 27.11
7 Code of Practice, 2008 paragraph 27.19
8 Jones, 13th Edition, 2010 paragraph 1-1069 page 476 and 1-1074 page 480
10 Jones, 13th Edition, 2010 paragraph 1-1185 page 520
12 Code of Practice, 2008 paragraphs 27.7 to 27.18
13 W –v- Doncaster MBC [2004] EWCA C iv page 378
14 Code of Practice, 2008 paragraph 27.9
15 R. v Manchester City Council ex parte Stennett 2002
16 Department of Health, 2000 Health Service Circular 2000/003 paragraph 2 page 4
17 R. v Richmond LBC ex parte Watson 1999
18 R v Mental Health Review Tribunal ex parte Russell Hall [1999] 3ALL ER 132
19 Department of Health, 2000 Health Service Circular 2000/003 paragraph 7 page 4
20 Department of Health, 2000 Health Service Circular 2000/003 paragraph 9 page 5
22 Code of Practice, 2008 Chapter 25