**S.117 Mental Health After-Care**

**Introduction**

* 1. Section 117 of the MHA places upon Health Authorities and Local Authorities a statutory duty to work together and with independent and voluntary bodies to provide mental health after-care services for all patients who have been detained in hospital under a treatment section of the MHA (i.e. Sections 3, 37, 45A, 47 and 48). This includes all patients subject to a Community Treatment Order (CTO). This duty is not to be interpreted only in *general* terms i.e., through the borough-wide provision of services for mentally ill people in general, but *individually* i.e., the mental health after-care needs of each individual to whom Section 117 applies must be considered and met. Health Authorities now means Integrated Care Boards. Their role in the provision of services may often be delegated to NELFT as the main local provider of mental health services but it should be remembered who has the ultimate responsibility under this section.

**1.2** S117 is an automatic status that starts as soon as someone is detained on a treatment section. It is not necessary for someone to be referred to S117 to have an entitlement to its status.

In practice it is usually through the Care Programme Approach (CPA) that after-care under Section 117 is provided.

Mental Health aftercare under S117 is defined in S117 (6) and again in Section 75(5) of the Care Act 2014. In addition, the following should be noted:

*‘CCGs and local authorities should interpret the definition of after-care services broadly. For example, aftercare can encompass, health, social care and employment services, supported accommodation and services to meet the person’s wider social, cultural and spiritual needs, if these services meet a need that arises directly from and is related to the particular patient’s mental disorder and helps to reduce the risk of a deterioration in the patient’s mental condition.*’ MHA Code of Practice, 33.4.

It should be noted that this extract refers to supported accommodation. Whilst this would be included under S117, as would accommodation provided as part of a Residential or Nursing Home package, S117 would not normally extend to ordinary/mainstream accommodation. This is because accommodation is a basic human need, irrespective of whether someone has a mental disorder. However, it is still arguable that where someone would otherwise be homeless and provision of accommodation is part of their care plan, this forms part of the S117 duty.

**1.3** When the local authority is providing accommodation under S117, as this is part of the patient’s care plan, the Care Act 2014 now specifies that if the patient expresses a preference for a particular placement, this must be respected. This is dependent on the placement:

* Being of the same type as the care plan specifies
* Being suitable to the patient’s needs
* Being available and willing to accept the patient.
* Not being more expensive (though patients or a third party on their behalf can make top-up payments)

**1.4 Charging S117 Services**

A major difference between S117 patients and others is that the statutory duty to provide after care under S117 means it is not lawful to charge the patient for services received as part of an aftercare package. In practice this does not directly affect NHS Trusts, since NHS services are free at the point of use but does make a significant difference to Local Authorities whose services are means tested.

**Scope of S117 Services**

S117 should not be confused with providing for the essentials of life, such as food, clothes, heating etc. These remain the responsibility of the individual except in the very special cases where they are provided as part of a residential placement and even then, there may be arrangements for them to be charged for separately as not being part of the S117 duty. Similarly, S117 does not apply to benefits/money and the DSS does not have responsibilities under S117.

Accommodation is a complex area, and cases should be looked at individually. Where someone has existing accommodation or is able to find their own it would not normally be covered by S117. Where a patient is placed in a care home it is likely this will be covered. In between these two points may be a variety of situations where S117 responsibility must be determined on the facts of the case. Three factors may influence the decision:

1. Is the residence classified as different from independent accommodation such as would be the case with supported accommodation or shared living?
2. has the patient been ‘placed’ there by a care team, sometimes against their will?
3. Would the patient, if left to themselves, be unable or unwilling to find accommodation as a direct result of their mental disorder?

Ultimately, disputed case needs to be decided by the funding body. Where necessary patients can complain to the Local Authority Ombudsman, who have the power to arbitrate and can also fine Local Authorities and reimburse clients wrongly charged.

**UK Citizenship**

The right to S117 aftercare should not be affected by citizenship status. Questions about someone’s right to reside in this country should be resolved between the patient and the appropriate authority. Such patients generally fall into one of three groups:

* + The first is where there has been an application for British Nationality or asylum status has been made but has yet to be decided upon, a process that can take some time and is subject to rights of appeal; S117 should be assumed to apply during this period.
  + The second is where an application has not yet been made but is due to be made; again, S117 should be assumed to apply during this period.
  + The third is where an application for British Nationality or asylum status has been made but refused. This may mean that arrangements will be made for the person’s return to the country they have come from. S117 should be assumed to apply until such return has taken place.

There is nothing in the S117 duty to prevent Trust staff informing the UK Borders Agency or other official bodies of a person who is believed to have no legal right to be in this country.

**1.5**

If either a Mental Health Tribunal or Hospital Managers’ panel discharges a patient on a treatment section, there will be a need for immediate after-care provided under S117.It follows that ideally a S117 aftercare plan should be prepared for a patient in advance of hearings.

In reality most hearings do not result in discharge, and it is reasonable for the care team to bear this in mind. This has been recognised by the Courts (R v Mental Health Review Tribunal ex p Hall, 1999). However, the same Court also recognised that, whilst this is the case, a care plan ‘at least in embryo’ should be available before an appeal/review hearing takes place.

If a patient with immediate after care needs is felt by the Tribunal/Hospital Managers not to meet the criteria for detention, the case should be made for a deferred discharge to allow a care plan to be put in place.

In the event of an immediate discharge, S117 still applies, and other options should be considered such as persuading the patient to stay informally until a care plan is prepared, initiating an emergency care plan.

**Discharge from S117**

**1.6** Once the person is no longer in need of any aftercare services, they should be discharged from S117 and their exemption from charges will therefore cease to apply.

Neither subsequent admissions informally nor admission on another section not covered by S117 have the effect of discharging someone from S117.

Discharge from S117 is therefore of key importance. The decision to discharge will normally be made by the full multi-disciplinary team.

Although decisions will be individually based, the following are agreed as suitable to inform decision-making.

* If the patient is no longer in need of treatment for mental disorder it should always follow that they are also discharged from S.117 since they no longer need mental health aftercare.

However, the following important points must be noted: -

* A patient (who is not subject to a CTO) who is refusing treatment may be discharged from NELFT but still be covered by S117 i.e. any unwillingness to receive after care should not be equated with the absence of need for after care; therefore, S117 remains applicable.
* A patient discharged to a care home may still receive input from NELFT. In such cases they will remain on the Trust’s ‘books. Where there is no input from the Trust, however, if the care home placement still constitutes after-care it must be covered under S117.
* When a patient is eligible for S117, services should be provided under S117 not under NHS Continuing Healthcare. There are no powers to charge for services under S117, regardless of whether they are provided by the NHS or SSD. Therefore it is not usually necessary to assess for NHS Continuing Healthcare.
* A non-S117 service e.g., relating to physical health care may be provided under NHS continuing health care even though the patents mental health aftercare needs are met under S117.
* Patients may continue to receive services from NELFT but because of a substantial improvement and stabilisation may nevertheless be discharged from S117. Examples of such patients are those where all of the following apply: -
  + The patient has settled into the community, even though they continue to receive an agreed level of support from the Trust.
  + This has continued for a reasonable period of time.
  + There is no foreseeable need for readmission bearing in mind the reasons for the original admission to hospital.
  + Continuing services such as oral medication/periodic attendance at outpatients have ceased to be after-care as such i.e., in that the service has become continuing community care without reference to the need for readmission to hospital.

Any decision to discharge a patient from S117 must be: -

* Discussed fully with the patient (where possible) so that their views are taken into account.
* Agreed by the multi-disciplinary team including both health and social services.
* Recorded on RIO/System One
* Communicated in writing and if possible, verbally to the patient.
* Followed up with information about how it will affect the patient’s right to care/benefits.
* Someone discharged from S117 will only come back under its provisions if they are re-admitted to hospital under a treatment section of the MHA.
* No one can be discharged from S117 if they are still subject to a CTO or are still subject to conditional discharge under part 3 of the MHA or are subject to Section 7 (Guardianship) or are on S17 Leave.

**1.7**  S.117 status will be recorded on RiO/System One by the MHA Office as part of the total MHA record.

Queries about whether a patient is covered by S117 should normally be directed to the MH Legislation Office

**1.8** The **Care Act 2014**

The Care Act 2014 has meant that the rules of ‘ordinary residence’ now apply to S117. This means that the local authority responsible for a patient is the one for the area where the patient wis ordinarily resident before being detained in hospital.

When determining ordinary residence, it is useful to bear in mind the following:

‘… *the place he has adopted voluntarily and for settled purposes – whether of short or of long duration*. ‘Ex p Shah [1983] Z Al 309.

Also: ‘*In the case of adults lacking capacity to decide where to live, the question of ordinary residence will turn on the facts* ‘R (Cornwall Council) v S of S for Health [2014] EWCA

If a patient is discharged to another local authority area, the local authority where they are ordinarily resident will be the one that is funding any placement (Care Act 2014, Section 39 (4).

Disputes about ordinary residence or S117 responsibilities can now be referred to the Secretary of State for Health (i.e., rather than the courts as pre the Care Act).

If S117 responsibility is in dispute the first rule is that it sits with the ICB under which the GP, the patient is registered; and local authority where the patient was ordinarily resident before admission. If the patient is not registered with a GP, their ICB should be determined by their address. If their residence cannot be determined, e.g., the person is NFA it is the area where the patient was ‘present’ when they were detained.

The Care Act has reversed the position established by what was known as the Hammersmith case (*R on the application of M v London Borough of Hammersmith and Fulham and Another*) whereby S117 responsibility changed if someone was placed on a fresh S3 in a different area. The position now is that if a patient is the S117 responsibility of area A and is placed in area B and placed on a fresh section 3 in area B, it is area A that is still responsible for S.117 aftercare. Note that this applies only to funded placements. If a person is living independently and of their own volition in area B as in the above example, the S117 responsibility would change to area B.

In general the Care Act’s changes to S117 mean that ‘The *current authority’* (for S.117) ‘will *remain responsible for commissioning those services for as long as the person concerned continues to need them*’( Explanatory Notes to Care Act 2014, para 454)’. The only way that S117 responsibilities will normally change is for a) the patient to live independently in a new area and subsequently to be placed on a fresh treatment section; or b) to be discharged from S117 and subsequently to be placed on a fresh treatment section.

**1.9 Who Pays? Determining responsibility for payments to providers** **NHS England Guidance, Who Pays?**

This guidance was revised in April 2016 and again in 2020 specifically in relation to S.117.

The new guidance does not have retrospective effect and only applies to those patients where the S.117 duty has arisen after 01.01.2016.

This means that there are now three possible positions depending on the date the patent was discharged and became entitled to S117 aftercare.

**Those discharged pre-01.01.2013**.

These patents come under the pre-August 2013 PCT Who Pays Guidance. This means that the originating ICB continues to be responsible for S117 subsequent aftercare despite subsequent admission under a treatment section of the MHA, or a move to another area, or registration with a GP in another area.

**Patients discharged between 01.04.2013 and 31.03.2016.**

The responsible commissioner should be established by the location of where a patient has been registered with a GP practice, or if not registered, where the patient is ‘usually resident’. If a patient who is resident in one area (ICB A) and discharged to another (ICB B) and registers with a GP there, it is then that ICB’s responsibility to fund their S117 aftercare.

The responsible local authority would be determined by the ‘usual residence’ rules and might be a different area from the ICB.

**Patients discharged between after 31.03.2016.**

This changed the position so that if a patient who is resident in ICB A area is discharged to ICB B’s area, ICB A will retain responsibly for the patents S117 aftercare.

It also means that:

* + ICB A will continue to be responsible for S117 aftercare even when the patient is subsequently readmitted to hospital under a treatment section of the MHA.
  + ICB A would remain responsible for the S117 aftercare where the patient changes their GP (and associated ICB)

**1.10 Local Authority Responsibilities**

Local Authorities are jointly responsible with ICBs for aftercare services under S117.

They therefore need to ensure that social workers, housing officers and others are willing to participate in S117 meetings.

Local Authorities also need to ensure that services identified as necessary for a particular patient are provided when it is within their responsibility.

Local Authorities need to provide an adequate mechanism so that patients subject to S117 are not charged under S117.

Decisions to end the S117 status of a patient are joint Health/Social Service decisions.

**1.11 Voluntary Sector Responsibilities**

The MHA specifies that Health Authorities and Local Authorities may provide after care under S117 ‘*in co-operation with relevant voluntary agencies*.

Services for which the ICB or Local Authority has responsibility may be contracted for with a voluntary organisation. These services could therefore be provided under S117 by the Voluntary Sector.

The Voluntary Sector may often be responsible for advocacy which qualifies as a S117 eligible service.

**1.12 Section 117 and Section 17 Leave**

Patients on S17 leave may be covered by S117. For any lengthy periods of leave therefore there should be a S117 care plan to cover the period of leave and providing as necessary for: -

* Arrangements for administration of medication
* Emergency contact
* Any necessary support
* Leave address and any necessary care arrangements.

This is now particularly important since the Courts have signalled their acceptance that S.17 leave can form part of inpatient treatment lasting for months and continuing even when contact with a hospital has become minimal.

**1.13 Section 117 and Care Programme Approach (CPA)**

Responsibilities under S117 can be met through the correct application of the CPA.

S117 discharge planning meetings will therefore be combined with CPA care planning meetings.

S117 care plans will be standard CPA Care Plans though the S117 status of the patient will be stated.

Review of S117 will be carried out at CPA Reviews.

Decisions to discharge patients from S117 will where possible be made at CPA Review meetings.

**1.14 Section 117 Information to Patients**

It is essential that patients are made aware of their S117 Status and their right to mental health aftercare. This will be communicated to them after the application for S3 is made and discussed at ward reviews and discharge meetings.

There is a Trust leaflet, which will be given to patients to inform them of their rights under S.117 by the MHA Office.

**1.14 Section 117 and Advocacy**

S117 patients have a statutory entitlement to advocacy representation from an independent Mental Health Advocate (IMHA). This is particularly important at S117 care planning meetings; including anywhere a decision to discharge a patient is due to be made.

**1.15 Section 117 and Community Treatment Orders**

All patients on a CTO are covered by S117.

Patients cannot be discharged from S117 whilst still subject to a CTO since by definition the need for aftercare still applies.

Patients discharged from a CTO may still be subject to S117 i.e. some form of treatment and care that amounts to continuing aftercare may still apply.