

GOOD PRACTICE GUIDE

**Best Practice  
Guidance on the  
Preparation of  
Care Plans for  
People Subject to  
Compulsory Care  
and Treatment**

SEPTEMBER 2015



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## What we do

We are a statutory organisation, accountable to the Scottish Parliament, with a range of duties under mental health and incapacity law.

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

## We do this by

- Checking if individual care and treatment is lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

## Introduction

This document is primarily for Responsible Medical Officers (RMOs), but we hope it will be of interest to other mental health professionals.

In mental health and learning disability services, care plans are a key mechanism by which a person's individual care and treatment can be developed, documented and shared with all those who are involved. Implemented well, and in accordance with the principles of the Mental Health (Care & Treatment) (Scotland) Act 2003 ("the 2003 Act"), care plans and care planning provide a participatory framework for agreeing and reviewing the benefits of a given programme of treatment and care – with an individual – in the context of his or her recovery.

As part of our visiting and monitoring work, Commission practitioners and visitors often look at care plans for individuals. We expect these to give a good overview of what is happening for the individual, and the support, care and treatment that they are receiving. We also look for evidence of participation by the individual themselves, their named person and any other involved relatives or carers. If the individual has made an advance statement, we expect to see that due regard has been given to any wishes regarding treatment contained in it.

In line with the principle of reciprocity, we expect to see good provision of services to support individuals and to promote recovery (both within hospitals and in the community as appropriate).

As part of our statutory duties in promoting best practice in the operation of the 2003 Act, we look at the care plan that the Act requires an individual's Responsible Medical Officer (RMO) to prepare when they are subject to a Compulsory Treatment Order (CTO) or a Compulsion Order (CO). Section 76 requires this to be done when the individual is on a CTO. Part 9 of the Act relates to compulsion orders and requires essentially the same type of care plan to be made (this is known as a "Part 9 care plan").

*During this document we mainly refer to "section 76 care plans". This should be taken to encompass Part 9 care plans, which are essentially the same in practice.*

Our experience is that the quality and content of section 76 care plans varies considerably. We therefore produced the first edition of this good practice guidance on the preparation and review of section 76 care plans in 2009. We hope that this updated version will further assist RMOs to prepare good quality care plans.

We advise that it is good practice for the section 76 care plan to incorporate the individual's main multidisciplinary working care plan, rather than being a stand-alone document. This can avoid unnecessary duplication and confusion.

## Background

The 2003 Act requires the preparation of documented care plans for people who are subject to compulsion. There are various points in time, throughout the life of a CTO or CO, where there is a formal requirement for a care plan to be produced or amended (i.e. updated).

The first care plan is required at the point when an application for a CTO is initiated. At this stage a "proposed care plan" is prepared by the mental health officer (MHO) as part of the application. The second is the production of the section 76 care plan, which has to be completed by the RMO as soon as practicable after the CTO is granted.

## When is the RMO required by the legislation to update the section 76 care plan?

The section 76 care plan is subject to review by the RMO at various points, including:

- When the RMO extends the Order (i.e. for a CTO, when the RMO makes a S86 determination).
- When the RMO undertakes a further mandatory review of the grounds for compulsion.
- If the RMO grants suspension of detention for a period of more than 28 days *and* if the RMO revokes that suspension of detention.
- If the RMO grants suspension of measures other than detention in hospital for a period of more than 28 days *and* if the RMO revokes that suspension of measures.
- When the Mental Health Tribunal for Scotland ("the Tribunal") has varied the CTO.
- When there has been a Tribunal at which the CTO has been extended or a S86 determination made by the RMO confirmed.

The RMO may also update the care plan from time to time as they feel appropriate. It is good practice to do so if there are any significant changes to treatment being given or that it is proposed to give.

## What information should a section 76 care plan contain?

The Mental Health (Content and amendment of care plans) (Scotland) Regulations 2005 (SSI No. 309) set out the information that must be contained in the section 76 care plan, and when the care plan requires to be amended.

Section 76 and the Regulations require that the care plan sets out treatment and care that is proposed, or is being given, to the individual while they are subject to the CTO. This includes care and treatment that they are willing to accept voluntarily.

Where the RMO amends the care plan, they are required to ensure that the amended care plan is included in the individual's medical records.

The Regulations require that the care plan contains:

- (a) full details of the CTO and the day on which the order was made\*;
- (b) the objectives of the medical treatment which it is proposed to give, and which is being given to the patient;
- (c) details of any community care services or other relevant services and the objectives of those services which it is proposed to give, and which are being given to the patient;
- (d) details of any other treatment, care or service (other than that described in section 76(2)(a) or in paragraph (c) above) and the objectives of that treatment, care or service which it is proposed to give, and which are being given, to the patient;
- (e) the name and other appropriate contact details of the patient's responsible medical officer;
- (f) the name and other appropriate contact details of the patient's mental health officer; and
- (g) details of the two-month period during which the statutory reviews under sections 77(2) or 78(2) are required to take place, and the actual dates on which these reviews took place. For Part 9 care plans there is additional information regarding the date of conviction, the nature of the offence, and any requirements under the Sexual Offences Act 2003.

\*NB this includes details of any recorded matter(s) made by the Tribunal

This represents the minimum requirements and the framework within which the care plan must be constructed. If a care plan contained all this information it would meet the statutory requirements of the 2003 Act. However, even when a care plan "ticks all the boxes" it can still be a somewhat sterile document that says little in terms of recovery objectives for the individual.

We see many care plans which conform to, and go beyond, this basic framework. However, we also see significant numbers which do not meet the basic statutory requirements.

The Code of Practice for the Act gives guidance on the RMO's responsibilities and the required content of section 76 care plans (on pages 104-5 of Volume 2).

## Who should be involved with the RMO in preparing the care plan?

The code of practice emphasises that the MHO and other members of the MDT (multidisciplinary team), including any community care providers, should contribute fully to the preparation of the care plan.

The individual should be involved. So should their named person and other involved individuals as applicable (such as their primary carer, relatives, independent patient advocate).

## Who should have a copy of the care plan?

The care plan should be copied to the MHO, other members of the MDT, the individual themselves and their named person.

## Some characteristics of section 76 care plans we have seen that could be better

We have often seen section 76 care plans that are very brief and "generic" rather than person-centred. These contain insufficient information about the individual's particular needs and the care and treatment they are being provided with to meet their needs.

We have seen care plans with content such as:

- that the individual is receiving a depot antipsychotic (but not what medication this is or how often it is being given);
- that they are seeing a CPN (community psychiatric nurse), but no information about how often they see their CPN, what therapeutic work is being undertaken, or how the CPN is supporting them in the community;
- out-of-date contact information for key involved individuals; and
- inaccurate dates of expiry of authority of detention (due to lack of updating of this part of the care plan from a previous version).

Section 76 care plans such as these are usually stand-alone documents that are filed with the individual's Mental Health Act paperwork. There is usually another care plan, written with the involvement of the individual, which is a working document containing full details of the multidisciplinary care they are receiving under the direction of their RMO.

## General overview of good practice regarding content of section 76 care plans

The care plan should be comprehensive, describe all the person's needs and lead to the provision of an appropriate range of services. It should be person centred, recovery-focused and regularly and meaningfully reviewed.

A good section 76 care plan should reflect the views and participation of the individual. It should include the statutory content as above and detail of:

- the individual's needs;
- current and known views of the individual, their named person (if they have one), and involved family and carers;
- the goals and objectives of their care and treatment;
- the steps that will be taken to meet their needs and achieve the goals;
- the care and treatment they are receiving or that is proposed;
- who will provide care and treatment and what that entails (e.g. what medication they are receiving, frequency of meetings, nature of psychosocial support/psychological interventions, etc);
- how the care and treatment will meet their needs;
- what treatment is being provided on a compulsory basis and what is being provided with the consent of the individual;
- confirmation that T2 and/or T3 form(s) are in place to authorise treatment, and the dates of these;
- actions to be taken to meet any recorded matter(s) and a timetable for these;
- details of non-professional supports including family and carers;
- reference, where applicable, to any advance statement; and
- contact details for key involved individuals (professional and non-professional), including any independent patient advocate.

We have provided some further good practice guidance on care planning procedures below.

We advise that it is good practice for the section 76 care plan to incorporate the individual's main multidisciplinary working care plan, rather than being a stand-alone document. This can avoid unnecessary duplication and confusion. Statutory content that may not have been routinely included in the individual's main care plan can be added.

In some areas, for individuals subject to the care programme approach (CPA), RMOs incorporate the section 76 care plan into the individual's CPA care plan. This avoids duplication, and can work well.

The CPA was developed originally for use at local level in Scotland for people with severe and enduring mental illness in 1996 via Scottish Office Circular SWSG 16/9. Unlike in England, where CPA was mandatory, this circular simply recommended CPA for use in Scotland. The Scottish Government has since directed that the CPA should be used for all restricted patients (see Memorandum of Procedure on Restricted Patients, Scottish Government). We consider that the CPA should be used, as was originally intended, for individuals with a mental illness and complex support needs. This helps to make sure they are getting effective and well co-ordinated ongoing care and support, and are involved as much as possible with their care planning decisions and arrangements.



## The importance of a comprehensive section 76 care plan in Tribunal proceedings

The RMO is required to submit copies of section 76 (or Part 9) care plan(s) when they:

- apply to extend a CO (compulsion order) following first review;
- apply to extend and vary a CTO or CO;
- apply to vary a CTO or CO; and
- make a reference to the Tribunal in respect of a recorded matter.

(The MHO submits a proposed care plan to the Tribunal when an initial application for a CTO is made under section 63.)

The legislation requiring the RMO to submit care plans to the Tribunal with applications is in Regulations. There is some variation in what the Regulations require between different orders and applications. We have provided an overview of this in Appendix 1. In most situations, it is a clear requirement that the RMO must submit an updated care plan to the Tribunal.

We advise that it is best practice for the RMO to submit an updated care plan to the Tribunal with any application to extend and/or vary a CTO or CO (whether or not this is clearly required by the Regulations in the circumstances). The Tribunal expects to receive an updated care plan with all such applications.

Any care plans submitted will form part of the Tribunal papers. The review of the Tribunal papers is an essential part of the Tribunal's preparation for a hearing. Each Tribunal will thoroughly examine the patient's care plan.

The Tribunal requires a good understanding of the patient's needs, the care and treatment they are receiving or that is proposed, and how this will meet their needs (i.e. information contained in a care plan with content as outlined above). They also need to know what treatment it is proposed to provide on a compulsory basis and what the patient is able and willing to consent to receive (i.e. why compulsory measures are considered necessary).

A detailed care plan has particular importance where an application has been made by the RMO to vary, or to extend and vary, the order (i.e. from hospital to community based, or vice-versa). Such a proposed change to the measures authorised in the order merits detailed examination. Accordingly, the Tribunal will wish to identify the various strands of the care plan which address the significant change in circumstances.

A section 76 care plan which is lacking in detail can lead to the need for more oral evidence to be heard, which may result in a longer and more stressful hearing for the patient. In some cases, the hearing may require to be adjourned for the provision of a missing care plan or for a more detailed care plan to be lodged.

The Tribunal is content with advice of the Commission offered in this section.

We have provided some further good practice guidance on care planning procedures below. This is based on our experiences of care plans we have seen on visits, and discussions with service users, carers and professionals about what constitutes a good care plan.

## Good practice in care planning

### Involvement of the person

Involvement of the individual in his or her treatment and care is an important principle underpinning the 2003 Act. Care plans are an ideal vehicle to demonstrate that this is occurring. Our monitoring would suggest that this is not always the case – the individual themselves can sometimes seem to be peripheral to the process. There are many ways of involving the person – even in situations where compulsion is required to ensure treatment is received, or participation appears to be difficult to achieve.

Some pointers to the inclusion of the individual include:

- the use of advance statements and personal statements, and clear regard being given to these by involved professionals;
- the creation of Wellness Recovery Action Plans (or local equivalent); and
- involvement of named persons, primary carers and independent advocacy.

For people who have additional needs, it may be necessary to use varying means of communication to support effective participation. The setting in which the care plan is discussed should take account of the individual's needs – not everyone is comfortable in a large multi-disciplinary meeting. Several smaller meetings may be required.

### Best practice points:

- *Involve the person from the beginning*, e.g. make sure that the personal details and the history are accurate. If there is information from previous care plans, or other documents, make sure it is still accurate and relevant. People's lives and circumstances change and sometimes details are recorded or transcribed inaccurately.
- *Check out the individual's communication style/needs*, e.g. make sure that the person has and uses any necessary hearing aid.
- *Check out person's understanding of any discussion*: do not assume that people understand, just because they do not ask questions.
- *Ask about an advance statement*: if no advance statement exists then encourage the person to consider making one in the future and suggest sources of support for this.
- *Involve the named person/independent advocate/carer*: he or she may have useful and relevant additional information and may also be involved in the delivery of care.
  - *If the individual has a welfare proxy appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), involve and consult them appropriately* (a welfare proxy is either a welfare power of attorney previously appointed by the individual, or a welfare guardian).
  - *Assess and document the individual's capacity to consent to treatment and keep this under review*. Possible need for authorisation of treatment for physical conditions under section 47 of the AWI Act should be considered.
  - *Document the person's views, including his or her needs (met and unmet) and aspirations*: finding out what people want out of life may influence the proposed treatment plan and help recovery.

- *Ensure equality and non-discrimination.*

### **Best practice example:**

From our themed visits to adult acute wards in 2012:

*"I am fully involved through my Staying Well plan and I have an advance statement."*

An individual, Royal Edinburgh Hospital, Balcarres Ward.

### **Accessibility**

Our visits indicate that there are varying degrees of understanding among service-users about what their care plans say. For some it is about the language, for others it is simply the fact they have limited literacy skills and therefore cannot read what is written. In some cases people do not know who to ask about their care plan, or where it is kept. The care plan should be recorded in a manner that is accessible for the individual. In some circumstances this may require two versions of the care plan, one for the formal record and another that is tailored for the individual's own use. There is not much point in being involved in the preparation of your own care plan if you cannot read or remember what you agreed. Mental illness, learning disability and related conditions can and do impact on people's ability to retain and/or understand information. It is therefore crucial that there is an accessible record of what has been agreed. We have seen very good examples of care plans for people with learning disability which involve the use of pictures and drawings.

### **Best practice points:**

- *The care plan is also available in a format that is meaningful to the person, e.g. use pictures where these would help understanding, or increase size of font for those with poor vision.*
- *The person has a copy of his or her care plan, or knows where it is kept and can access it.*
- *The language used is easy to understand, e.g. plain English.*
- *The care plan contains up-to-date contact details for all involved, including telephone numbers.*

### **Best practice example:**

RMOs in the NHS Lothian Rehabilitation service incorporate section 76 care plans into the Integrated Care Plans for inpatients. For individuals in the community, the section 76 care plan is incorporated into their MDT care plan, whether they are subject to CPA or standard review. The individual has a copy of their care plan.

In the Fife Learning Disability Forensic Service, the Section 76 care plan is incorporated into CPA documents for individuals.

A service-user-accessible guide to the CPA process has been compiled. Individuals complete easy read preparation documents with their key workers prior to CPA meetings, and have an easy read, accessible version of their care plan – "My CPA Action Plan".

## Provision of appropriate services that are of benefit

The principle that a person who is required by law to accept care and treatment against his or her will should be provided with appropriate care and treatment is not set out in absolute terms in the 2003 Act. However, the legislation does require that persons who are discharging functions under the Act “shall have regard to” the importance of providing appropriate services to patients subject to emergency and short-term certificates and to patients on compulsory treatment and compulsion orders. This principle also applies to persons no longer subject to a certificate or order. In addition, the Mental Health Tribunal can specify as a “recorded matter” a medical treatment, community care services, or other relevant services, that must be provided to the person. Care plans must make clear what is being provided on a compulsory basis and what matters have been recorded by the Mental Health Tribunal. Services that are provided or commissioned by the local authority should be included.

### Best practice points:

- *The proposed treatments and services are available to the person*, e.g. if the provision of appropriate rehabilitation periods away from a ward is proposed, then they should be available within a reasonable timescale. This should include services provided by or commissioned by the local authority.
- *If there are unmet needs these are recorded and proposals to remedy them documented, if appropriate*, e.g. if the person requires an adaptation to their house, or a specialist psychological assessment.
- *The plan clearly identifies those elements that are to be provided on a compulsory basis and those with the consent of the person*, e.g. the person may be unwilling to comply with inpatient treatment and require compulsory measures to ensure this, but be willing to engage in attendance at therapeutic groups.
- *Any recorded matters are clearly identified and the actions required clearly timetabled*: This includes notification to the Mental Health Tribunal if recorded matters are not addressed.

## Recovery-focused and responsive to change

The emphasis on treating the person as an individual and not merely as a collection of symptoms is an inherent part of the recovery focus that drives mental health care today. Care plans are a crucial part of supporting and helping the process of recovery.

The Scottish Recovery Network describes recovery as follows:

*“Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.”*

The process of care planning should enable people to take more control of their lives and ensure that the person’s perceived needs and aspirations have been taken into account. A good care plan will have the individual, not just his or her symptoms, at the heart of it.

Care plans should be evolving documents and an integral part of the recovery journey. Care planning – and the production of required care plans at specific points in the journey – should not be a separate process from the day-to-day provision of care, support and treatment, and the recording of treatment and progress. Section 76/Part 9 care plans should be the distillation and recording of all relevant information and the statements and information contained in them should be backed up by further information in case notes.

Acceptance of a recovery focus for an individual, even where full recovery is unlikely such as in dementia or learning disability, will ensure that the care plan is reviewed on a regular basis and able to respond to changes in individual needs and circumstances. The concept of the care plan as a dynamic document will further enhance the relevance of it to individual circumstances.

### **Best practice points:**

- *Clearly identified timescales for review and evidence of this occurring, e.g. the date of the next review is recorded in the notes of the current review.*
- *Evidence that outcomes are monitored and care and treatment are adjusted accordingly, e.g. mental state is assessed regularly and any drug or other treatments amended as appropriate.*
- *Changes are documented and a system is in place to ensure that the most up to date care plan is available to the care team and to the person themselves, e.g. each change is dated. If care plans are stored electronically, there is clarity over which is the present care plan and access to the information is facilitated for staff and the person concerned.*
- *Risk assessments and risk management plans are regularly reviewed and updated.*
- *Crisis plans, or out of hours contact arrangements, are clearly documented.*

### **Best practice examples:**

From our themed visits to adult acute wards in 2012:

Comment made by an individual during our visits to individuals who have had contact with Intensive Home Treatment Services (IHTT), 2012:

*"Relapse plan clear and shared with all services and I knew exactly what to do should I relapse in the future. I am better prepared now."*

*"The introduction of the IHTT is so good. Before discharge I will have gone through my crisis plan with my CPN and my nurse here"* (Comment made by an individual, Dykebar North Ward).

## Person-centred and holistic

People with mental illness, learning disability and related conditions who are subject to compulsion, and those who are not, are frequently defined by their condition and their lives are viewed through this lens. This may lead to a narrow focus of care planning which ignores essential aspects of an individual's life. Treatment of mental illness, learning disability and related conditions is not just about the nursing care and medical treatment which is proposed. An individual's physical health, social and recreational, spiritual and financial needs may all have a bearing on their recovery. This is not to say that the care plan should cover all these aspects of an individual's life on all occasions, but there should be evidence that a broad approach has been taken to the creation of the care plan. The focus should be on the person and not just on their condition.

For many people finding employment can be a key theme of recovery. Care plans should cover employment and other meaningful occupation.

### Best practice points:

- *The care plan makes reference to social, recreational, occupational and spiritual needs as well as to treatment and community care needs, e.g. regular attendance at church may be very important to the individual and, if so, should be facilitated where possible.*
- *Wider issues relating to disability and health needs, including physical healthcare needs, are addressed. These should be included in the care plan where appropriate, e.g. regular physical health checks and screening are important for a person at risk of heart disease. When the individual is receiving longer term care and treatment, health checks should be regular and not only based on their mental illness, learning disability or related condition.*
- *Indications for use of legislative measures other than the 2003 Act to authorise treatment, care and support for the individual have been considered, e.g.*
  - Authorisation of medical treatment under section 47 of the AWI Act
  - DWP (Department of Work and Pensions) appointeeship for management of benefits
  - Management of funds under Part 3 or Part 4 of the AWI Act
  - Application for welfare and/or financial guardianship
- *Named persons/carers/independent advocates/any welfare proxies and others, as well as professionals, have been involved in the preparation of the care plan.*
- *Evidence of the issues that are important to the individual being taken into account, e.g. advance planning and documentation of arrangements the individual would like made if they were unwell and unable to do things they would normally, e.g. providing care and support for relatives, looking after pets.*

## **Best practice examples:**

From our themed visits to adult acute wards in 2012:

*"She spoke very positively about her relapse prevention plan that she developed with her CPN, her husband and son. She described feeling that her mental health was a shared responsibility and when she was becoming unwell it was an open topic of conversation."*

(Written comment from Commission visitor to Parkhead Hospital).

## **Conclusion**

Although this guidance is focused on the requirements of the Mental Health Act, we hope it will also prove useful in the wider context of care planning in all settings. With this in mind, we have decided not to provide a pro-forma for a standard care plan in this guidance. Our perspective is that care plans should be driven by the individual and therefore personal to them, while being sensitive to the needs of the professionals who may need to use them. Many services have already devised suitable documents to comply with the requirements of the Act and which give a sense of the person being at the heart of the care plan. We support this approach.

## Appendix 1

### Care plans that the RMO is required by the Regulations to submit with applications to the Tribunal

Regulations require the RMO to submit care plans with applications to the Tribunal. We have referred to this in the above section “**The importance of a comprehensive section 76 care plan in Tribunal proceedings.**”

The Regulations regarding this are complex, and there is variation in what they require in different situations. Table 1 shows details of this.

We advise that it is best practice for the RMO to submit an updated care plan to the Tribunal with any application to extend and/or vary a CTO or CO (whether or not this is clearly required by the Regulations in the circumstances). Where the Regulations do not clearly specify this, we have made a best practice comment to this effect in Table 1.

It is relevant also to refer to section 76(3) of the 2003 Act. This determines that the RMO may amend the patient’s care plan at times when this is not specifically required by the Regulations. It is good practice for the RMO to update the care plan at any time when it no longer contains full details of current and proposed treatment.

The relevant Regulations are:

Mental Health (Compulsory treatment orders – documents and reports to be submitted to the Tribunal) (Scotland) Regulations 2005. SSI 2005/366

<http://www.legislation.gov.uk/ssi/2005/366/contents/made>

Mental Health (Compulsion orders – documents and reports to be submitted to the Tribunal) (Scotland) Regulations 2005. SSI 2005/365

<http://www.legislation.gov.uk/ssi/2005/365/contents/made>



**Table 1 – Care plans that the RMO is required by the Regulations to submit with applications to the Tribunal**

Type of application made by RMO	What the legislation requires the RMO to submit to the Tribunal		Best practice comment
Application to extend and vary a CTO (s92)	A copy of the original s76 care plan.	The RMO must amend the care plan after the mandatory review. A copy of this must also be submitted.	
Application to vary a CTO (s95)	A copy of the original s76 care plan.	A copy of any amended care plan.	If the last amended care plan does not contain full details of current and proposed treatment, update it and submit the updated version.
A reference in respect of a recorded matter (s96)	A copy of the original s76 care plan.	A copy of any amended care plan.	If the last amended care plan does not contain full details of current and proposed treatment, update it and submit the updated version.
Application to extend a CO following first review (s149)	A copy of the original Part 9 care plan.	The RMO must amend the care plan after the mandatory review. A copy of this must also be submitted.	
Application to extend and vary a CO following first review (s158)	A copy of the original Part 9 care plan.	The RMO must amend the care plan after the mandatory review. A copy of this must also be submitted.	
Application to extend and vary a CO other than following the first review i.e. later (s158)		The RMO must amend the care plan after the mandatory review. A copy of this must be submitted.	Submit a copy of the original Part 9 care plan as well.
Application to vary a CO in the first 6 months (s161)	A copy of the original Part 9 care plan.	An amended Part 9 care plan.	If the last amended care plan does not contain full details of current and proposed treatment, update it and submit the updated version.
Application to vary a CO after it has been extended (s161)		A copy of the amended Part 9 care plan.	If the last amended care plan does not contain full details of current and proposed treatment, update it and submit the updated version.







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