

COMMUNITY TREATMENT ORDER (CTO) POLICY

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Applies to:	All staff involved in the care of patients subject to a Community Treatment Order.

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DOCUMENT CONTROL

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<p>Amendments Updates to information about treatment certification to reflect recent changes in the law, and to clarify requirements during a period of recall. Extra details about conditions attached to CTOs to reflect caselaw from 2017 about authorising deprivations of liberty. Clarification about the legal status of patients on a CTO who accept a voluntary admission to hospital and are not recalled. More explanation about the process of recall and managing AWOLs, including clarification of responsibilities. Also including considerations needed when recall period will fall on a weekend or bank holiday. Inclusion of appendices re: recall/AWOL, obtaining a warrant under s135 (2) and a template form for RCs to complete alongside CTO3 recall forms. Updated to include all relevant changes within the MHA Code of Practice published in 2015- including the removal of all references to 'supervised community treatment', which is a term no longer used in The Code of Practice.</p>			
<p>Document objectives: To inform relevant staff about how to operate a Community Treatment Order (CTO).</p>			
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1. INTRODUCTION

- 1.1 On 3 November 2008, the Mental Health Act 1983, as amended by the Mental Health Act 2007 ('the Act') introduced a new scheme to provide a structure within which treatment for mental disorder may be supported and monitored subsequent to time spent as an inpatient subject to a MHA treatment order. This policy sets out the framework for the operation of such an order made under section 17A of the Act, which is known as a 'Community Treatment Order' ('CTO').
- 1.2 This policy should be read in conjunction with relevant chapters of the Code of Practice to the Mental Health Act ('the Code'- published April 2015), which offers guidance on the operation of the Act. In particular, the five guiding principles set out in Chapter 1 of the Code should be considered when making decisions about a course of action under the Act. Other chapters of particular relevance include: 29, 31 and 32.
- 1.3 A CTO is an order for the patient's discharge from detention in hospital, subject to the possibility of the patient being recalled to hospital for further medical treatment, if necessary. As with any other discharge from detention, the patient does not necessarily have to leave hospital immediately, or may already have done so on leave of absence.
- 1.4 While a CTO is in force, the application for admission for treatment, or the order or direction under part 3, on the basis of which the patient was detained immediately before being made subject to the CTO remains in force, but the hospital managers' authority to detain the patient is suspended.
- 1.5 The authority to detain the patient does not need to be renewed while it is suspended, and so will not expire while the patient remains a CTO patient. An order or direction under part 3 may come to an end for another reason, e.g. if the patient's conviction is quashed on appeal, in which case so too will the CTO.
- 1.6 When a patient's CTO ends the patient will be discharged absolutely both from the CTO and the underlying authority for detention. This does not apply if the reason for the CTO ending is its revocation by the responsible clinician following the patient's recall to hospital. Where the CTO is revoked, the underlying authority for detention is, in effect, revived.
- 1.7 Where the Act refers to patients who are 'detained' or 'liable to be detained' this does not include CTO patients. References in other legislation to patients detained or liable to be detained under the Act do not include CTO patients.

2. PURPOSE & SCOPE

- 2.1 The purpose of this policy is to ensure that there is lawful and appropriate use of CTOs and that the legal rights of any patient subject to a CTO are upheld at all stages. There is no lower age limit for the imposition of a CTO. Where appropriate, reference should be made to other Trust policies.

2.2 This policy applies to all staff involved in the care of patients subject to a Community Treatment Order.

3. DUTIES AND RESPONSIBILITIES

3.1 The **Trust Board** has a duty to care for patients detained by the Trust, which extends to those patients made subject to a CTO.

3.2 The **Director of Strategy and Corporate Affairs** is responsible for this policy covering CTOs, but will delegate authority for the operational implementation and ongoing management of this policy to the Mental Health Act Coordination lead.

3.3 The **Mental Health Act Coordination Lead** is the author of this policy, who will review this policy at least every 3 years or earlier if there is any change to statute or guidance.

3.4 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.

3.5 **All staff** caring for patients subject to a CTO should be familiar with the procedures detailed in the document and other related policies.

3.6 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies.

4. DEFINITIONS

- **RC** – The patient's Responsible Clinician
- **AC**- The approved clinician in charge of a particular area of treatment. This will usually be the same person as the RC, but will not always be.
- **Nearest Relative** – As defined in section 26 of the MHA '83
- **AMHP** – An Approved Mental Health Professional
- **SOAD** – Second Opinion Appointed Doctor, appointed by the Care Quality Commission.
- **CTO** – Community Treatment Order
- **IMHA** – Independent Mental Health Advocate

5. CRITERIA & PROCESS FOR MAKING A CTO:

5.1 In all cases, the following criteria must be met before the patient's Responsible Clinician ('RC') completes a form CTO1 to impose a CTO.

- The patient must be currently liable to detention for treatment under section 3 or an unrestricted section under Part III of the Act, including a patient currently on section 17 leave from hospital. It is not applicable for patients on restriction orders
- In the RC's opinion, the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment

- It is necessary for the patient's health or safety or the protection of other people that such treatment should be received
 - Such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment
 - It is necessary that the RC should be able to recall the patient to hospital under section 17E(1) (*The RC must confirm that he or she has considered risk of deterioration if the patient were not detained in hospital, with regard to their history of mental disorder and any other relevant factors*)
 - Taking account of the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient.
- 5.2 The decision as to whether a CTO is the right option for any patient is taken by the responsible clinician and requires the agreement of an approved mental health professional (AMHP). The responsible clinician should consider the Code of Practice's principles, in particular the least restrictive option and maximising independence principle. A CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. In particular, the responsible clinician should consider whether the power to recall the patient is necessary and whether the patient can be treated in the community without that power. Consultation at an early stage with the patient and those involved in the patient's care will be important, including family and carers.
- 5.3 In assessing the patient's suitability for a CTO, the responsible clinician must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others, and that appropriate treatment is, or would be, available for the patient in the community.
- 5.4 In making a decision to place the patient on a CTO the responsible clinician must assess what risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.
- 5.5 In assessing that risk the responsible clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.
- 5.6 Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse, the circumstances into which the patient would be discharged, and the

willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

- 5.7 Taken together, all these factors should help the responsible clinician to assess the risk of the patient's condition deteriorating significantly after discharge, and inform the decision as to whether continued detention, a CTO or discharge would be the right option for the patient at that particular time. The responsible clinician should consider the likelihood that a CTO will benefit the patient and take account of the patient's views about the use of a CTO.
- 5.8 A risk that the patient's condition will deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:
- a clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital
 - clear evidence that there is a positive response to medication without an undue burden of side effects
 - evidence that the CTO will promote recovery, and
 - evidence that recall may be necessary (rather than informal admission or reassessment under the Act).
- 5.9 Patients do not have to give formal consent to a CTO. But in practice, patients should be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment. The responsible clinician should inform the patient of the essential legal and factual grounds for the CTO and other information about the CTO both orally and in writing. The patient's care coordinator should ensure this has happened, and should continue to remind the patient.
- 5.10 The responsible clinician's decision to place a patient on a CTO should only ever be made on clinical grounds where the patient meets the criteria in section 17A of the Act.
- 5.11 An AMHP (who could be working in the same team as the RC) must agree in writing (on part 2 of the statutory form CTO1) that the patient meets the criteria for a CTO, a CTO is appropriate and any conditions made are necessary or appropriate for one or more of the following: to ensure the patient receives medical treatment, to prevent risk of harm to patient's health or safety, to protect other persons. If the AMHP does not agree, it is not appropriate for the RC to seek another AMHP for an alternative view. The RC should involve an AMHP as early as possible in the planning process, and it should never be the case that an AMHP is contacted only at the point when their signature on the CTO1 is required.

- 5.12 AMHPs are employed by Somerset County Council and will follow their own policies and procedures.
- 5.13 The RC makes an order by completing Parts 1 & 3 of CTO 1. The AMHP completes Part 2 of the form. The RC may not sign Part 3 before the AMHP has signed Part 2. The forms may be completed electronically, but must be printed prior to being signed (the MHA does not allow electronic signatures on statutory forms). The dates should also be completed only by hand on the paper copy (RiO will sometimes 'auto-update' typed-in dates in saved forms, which leads to confusion).
- 5.14 Although it must be given to the Hospital Managers as soon as practicable, there is no statutory form to record receipt of the order. When signed by the RC, the CTO automatically takes effect on the date and time specified for a period of up to six months.
- 5.15 The RC may specify on the form the date that the CTO is to begin. This may be a short while after the date on which the form is signed. As there is no mechanism for retrospectively amending or rectifying a defective form CTO1 once handed to the Hospital Managers, it is essential that where practicable, the form (or a copy of it) is seen by or discussed with a Mental Health Act Administrator at least two days before the date it is due to begin. The two day period should allow enough time for the administrators to identify and then request the rectification of any errors.
- 5.16 If an error is noticed once the CTO has started the MHA administration team coordinator and/or the MHA Coordination Lead will come to an opinion about whether the error is 'trivial' (requiring no action) or whether it is serious enough to render the CTO potentially invalid. They may seek legal advice when coming to this opinion. See 'Hospital Managers' Scheme of Delegation'.
- 5.17 If the patient has capacity to consent to treatment and is consenting the approved clinician in charge of treatment must complete a CTO12 authorising relevant treatment.
- 5.18 If the patient lacks capacity to consent, or has capacity but is refusing consent, the approved clinician in charge of treatment must make arrangements for a SOAD to visit the patient after one month of treatment. (See section 17 below).

6. CONDITIONS ATTACHED TO A CTO:

- 6.1 A CTO includes conditions with which the patient is required to comply. There are two conditions which must be included in all cases (sometimes called 'the mandatory conditions'). Patients are required to make themselves available for medical examination:
- when needed for consideration of extension of the CTO, and
 - if necessary, to allow a second opinion approved doctor (SOAD) to provide a part 4A certificate authorising treatment.

- 6.2 Responsible clinicians may also, with the AMHP's agreement and following discussions with the patient set other conditions which are identified as being necessary or appropriate to:
- ensure that the patient receives medical treatment for mental disorder
 - prevent a risk of harm to the patient's health or safety as a result of mental disorder, and
 - protect other people from a similar risk of harm.
- 6.3 RCs and AMHPs must remember that breaking a condition (other than a mandatory condition) is not, in itself, grounds for recall to hospital. This must be explained to the patient so that there is no unlawful threat of recall.
- 6.4 The nature of the conditions will depend on the patient's individual circumstances. They should be stated clearly having regard to the least restriction principle. Subject to paragraph 6.2 above, they might cover matters such as:
- where and when the patient is to receive treatment in the community
 - where the patient is to live, and
 - avoidance of known risk factors or high-risk situations relevant to the patient's mental disorder.
- 6.5 The reasons for any condition should be explained to the patient and others, as appropriate, (e.g. the patient's independent mental health advocate (IMHA), family and carers and, in the case of a child or young person, the person(s) with parental responsibility, and recorded in the patient's notes. It will be important, if the CTO is to be successful, that the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply. It is helpful if families can have access to support so they can help the patient to comply. The patient should have a discharge CPA meeting and a copy of the care plan before they are discharged from hospital onto the CTO.
- 6.6 Where there is disagreement between the RC and AMHP about the necessity or appropriateness of a particular condition or conditions, it would not be acceptable for an RC to use his or her right to significantly vary conditions shortly after discharge to overcome a legitimate objection by an AMHP.
- 6.7 The RC may vary the conditions of the CTO (using form CTO2) or suspend any of them where appropriate (e.g. to allow temporary absence of patient) but must record, with reasons, any decision to suspend in the clinical records. In either case, a decision to vary or suspend should be relayed to the Mental Health Act Administrator holding the CTO documentation to enable them to update their records. Any condition no longer required must be removed. It is not necessary to seek the agreement of an AMHP to vary or suspend conditions.
- 6.8 See section 23 below for details about the scope of conditions and deprivations of liberty

7. CARE PLANNING, MONITORING AND CTOs:

- 7.1 A care plan should be prepared in a language or format which the patient can easily understand and subject to the usual considerations of patient confidentiality the following parties should be consulted:
- The nearest relative
 - Any carers
 - An Attorney (authorised by Lasting Power of Attorney – Personal Welfare) or Court Appointed Deputy under the Mental Capacity Act 2005
 - Members of the multi-disciplinary team involved in the patient's care
 - The patient's GP. Where there is none, encouragement and help should be given to enable the patient to register with a practice.
- 7.2 A care plan must be prepared prior to the implementation of a CTO describing in detail how the CTO will be managed. This should include details of how the patient's compliance with any conditions will be monitored, and what support will be offered.
- 7.3 The care plan should consider what appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder or withdraws consent to treatment (or begins to object to it). The responsible clinician should consider, with the patient (and others where appropriate), the reasons for this and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow the patient to continue safely on a CTO and which the patient would accept, the responsible clinician should consider such treatment if this can be offered. If so, the treatment plan, and if necessary the conditions of the CTO, should be varied accordingly (note that a revised part 4A certificate may be required).
- 7.4 In common with other CPA arrangements, a care coordinator needs to be identified for patients subject to a CTO. Where appropriate, this could be the RC although this may be an exceptional arrangement.
- 7.5 Any prospective RC should be involved at an early stage in determining whether a CTO is appropriate and specifically in any conditions to be attached to it. This will greatly assist in the delivery of seamless transfer of care from hospital to community and vice versa although the final decision rests with the current RC. This process is particularly important when the patient will be living in a different county whilst subject to a CTO.
- 7.6 When the identity of a patient's RC is going to change on discharge from hospital on a CTO the RC should agree this formally with the 'new' RC and should complete the Trust's form recording the change of RC. The patient should be informed of the change of RC, and a copy of the form should be sent to the MHA administrators. In the absence of an

agreement about a change of RC, the RC who imposed the CTO will remain the RC until an agreed transfer of RC happens.

8. PROVISION OF INFORMATION UNDER SECTIONS 133 and 132A:

8.1 As soon as the decision is made to discharge a patient onto a CTO, two separate responsibilities apply.

8.2 **Firstly:** Hospital managers have a duty under section 133 to take whatever steps are practicable to inform the person they think is the nearest relative that a detained patient is to be discharged from hospital, unless the patient or the relative has asked that such information should not be given, or there is no nearest relative. This duty applies equally where patients are to be discharged from hospital by means of a CTO. If practicable, the information should be given at least seven days before the date of discharge. The RC or the care coordinator has the delegated authority to carry out this responsibility on behalf of the hospital managers (see point 35A in the Trust's 'Scheme of Delegation of Hospital Managers' functions). The MHA administration team can help the RC and care coordinator only if requested to do so (without such a request the team will have no way of knowing that their assistance is required)

8.3 **Secondly:** Section 132A requires the managers of the responsible hospital to take whatever steps are practicable to ensure that CTO patients understand:

- the effect of the provisions of the Act which apply to them as CTO patients, and
- their rights to apply to the Tribunal.

This action must be taken as soon as practicable after the patient becomes a CTO patient, and must include providing the necessary information both orally and in writing.

8.4 The hospital managers must also take whatever steps are practicable to give or send a copy of the written information to the person they think is the patient's nearest relative, unless the patient requests otherwise, or does not have a nearest relative. This must be done either at the same time, or within a reasonable time afterwards.

8.5 The responsible clinician is responsible for ensuring the patient understands the effect of the provisions of The Mental Health Act applying to community patients (see 8.8 below). The RC or the care coordinator is responsible for ensuring that the patient and others consulted of the decision, are informed of the conditions to be applied to the CTO, and the services which will be available for the patient in the community, including the continuing right to an IMHA. This will normally include making a copy of the CTO documentation available to the patient and any professional consulted as part of the process. As patients, relatives and carers have differing languages and communication needs, this may necessitate the use of a professional interpreter or translator to ensure the patient fully understands what is being said. This includes the provision of written

material and correspondence in a language or format which the patient can easily understand.

- 8.6 If the patient lacks the capacity to understand any relevant information the responsible clinician must ensure that their assessment of the patient's capacity is recorded, and what measures were taken, without success, to help the patient understand.
- 8.7 The patient's care coordinator has the responsibility of ensuring that the patient is reminded of this information as often as they deem necessary. Different patients will require reminders at different timescales depending on their level of understanding/individual circumstances. This should be considered as part of the care plan. At the very least, attempts must be made to remind patients of relevant information (see 8.4 below) when the CTO is renewed, recalled or revoked. The Mental Health Act Administration team will provide an Information leaflet to the patient and to the nearest relative (unless the patient objects) when the CTO is imposed, and will record that they have done so in line with S132A MHA).
- 8.8 Information in writing given to the patient (and where copied to the nearest relative) will include reference to their rights and the following matters:
- Appeals to the First tier Tribunal (Mental Health) (FTT)
 - Appeals to the Hospital Managers
 - Recall, Revocation or Discharge by RC
 - Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours notice requirement), FTT or Hospital Managers
 - Independent Mental Health Advocacy Services
 - The Role of the Care Quality Commission
 - Treatment rights while subject to CTO in the community, and during a period of recall to hospital.
- 8.9 It is especially important that care coordinators ensure that all CTO patients are offered the services or an IMHA. Unless the patient requests otherwise, or does not have a nearest relative, the care coordinator (who may request the assistance of the MHA administration team) must also take whatever steps are practicable to give this information to the person they think is the patient's nearest relative.

9. RESPONDING TO CONCERNS RAISED BY RELATIVES OR CARERS

- 9.1 Particular attention should be paid to carers and relatives when they raise a concern that the patient is not complying with the conditions of their Order, or that the patient's mental health appears to be deteriorating.
- 9.2 Where it has been possible to involve relatives and/or carers in the planning process, the RC should ensure the relatives/carers know how to raise any concerns with the RC: either directly or via any member of the care team. The RC should ensure that relevant addresses and phone

numbers are provided in writing. The details should also be included in the patient's care plan.

- 9.3 When the RC is made aware of concerns raised by a relative or carer, he or she should respond as quickly as is practicable to let the relative or carer know that their information has been received, and how the RC intends to respond.
- 9.4 To respond appropriately, the RC may choose to:
- Vary, or temporarily suspend, the non-mandatory conditions of the Order (see section 10 below)
 - Recall the patient to hospital if they need medical treatment in a hospital and there would be a risk of harm to the health or safety of others if they were not recalled
 - Recall the patient to hospital if they need medical treatment in a hospital and there would be a risk of harm to the health or safety of others if they were not recalled
 - Revoke the patient's CTO once recalled, and subject to the agreement of the AMHP
 - It may, of course, be possible to resolve any concerns without resort to any of the above options.

10. VARYING AND SUSPENDING CONDITIONS

- 10.1 The responsible clinician has the power to vary the conditions of the patient's CTO, or to suspend any of them. The responsible clinician does not need to agree any variation or suspension with the AMHP. However, it would not be good practice to vary conditions which had recently been agreed with an AMHP without discussion with that AMHP. The responsible clinician should record the reasons for varying conditions in the patient's notes. A copy should also be placed with the care plan. Any variation in the conditions must be recorded on the relevant statutory form (CTO2), which must be sent to the MHA Administration team
- 10.2 Suspension of one or more of the conditions may be appropriate to allow for a temporary change in circumstances, e.g. the patient's temporary absence or a change in treatment regime. Suspending conditions may be a useful way to test whether they are still needed and could be part of a planned reduction of conditions leading to the patient's possible discharge from the CTO. The responsible clinician should record any decision to suspend conditions in the patient's notes, with reasons.
- 10.3 It will be important to discuss any proposed changes to the conditions with the patient and ensure that the patient, and anyone else affected by the changes such as their family and carers (where appropriate, and subject to the patient's right to confidentiality) knows that they are being consulted and why. As when the conditions were first set, the patient's views about the changes should be sought and considered before a change is made; and the responsible clinician should discuss with the patient whether they will be able to keep to any new or varied conditions. The patient and their nearest relative (where appropriate) should be informed of any changes to

the conditions. Any help the patient needs to comply with them should be made available. Families and/or carers should be supported to help the patient.

11 RECALL FROM CTO (See Appendices A and B):

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

11.2 Where a patient breaches a condition of their CTO, refuses necessary treatment, or engages in high-risk behaviour as a result of mental disorder, the RC may review the conditions of the CTO. Having done so, if he or she believes that the criteria described in 11.3 below apply, the RC may recall the patient to hospital. Responsibility for coordinating the recall process rests with the RC, but could be implemented by the patient's care coordinator.

11.3 It must be remembered that a breach of any non-mandatory condition is not enough, by itself, to justify the need for recall. Recall is possible only if:

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

OR

- The patient has broken one of the two mandatory conditions outlined at 5.2 above unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered.

11.4 The RC must complete a written notice of recall to hospital (form CTO3), which is effective only when served on the patient. Where possible, this notice should be handed to the patient personally, or otherwise be sent by first-class post or delivered by hand to the patient's usual or last known address. Table 1 below summarises the reasons for and effect of each method of serving a notice of recall.

11.5 As well as the statutory notice of recall (CTO3) the RC should complete the form in Appendix B informing the patient when they should present themselves at hospital, and when exactly they would be considered to be absent without leave (AWOL). If the patient becomes AWOL, consideration should be given to obtaining a warrant under section 135(2) of the Act (see section 20 below and the Trust's AWOL policy for details).

11.6 The RC should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide treatment, although this may be given on an outpatient basis, if appropriate. The RC must give careful consideration to this when the period of recall will include a weekend or bank holiday to ensure that the actions in 11.10 below are carried out. Conveyance to that hospital should be in the least restrictive manner possible.

- 11.7 If the hospital is under the management of the same organisation as the patient's detaining hospital immediately before making the CTO, a copy of the completed form CTO3 will provide authority for detention. Form CTO6 is not required for transfers within the same organisation but the receiving hospital must complete form CTO4 recording the date and time of the patient's initial recall to hospital.

Appropriate Method by which to Serve a Notice of Recall

Patient's Circumstances	Appropriate Method of Serving form CTO3	Notice effective
Patient can be approached in person and may be at or in hospital already	Deliver form by hand personally	Effective Immediately
Patient not available in person e.g. has failed to attend requested appointment to see Second Opinion Appointed Doctor but situation is not urgent	Deliver form by 1 st class mail to address where patient is believed to be	Served on the 2 nd <u>working</u> day after posting (e.g. posted Friday effective from Tuesday)
Need for recall is urgent but not possible to hand notice to patient personally as their whereabouts are unknown, patient is unavailable or refuses to accept the notice	Deliver form by hand to patient's usual or last known address <u>If appropriate, consider whether s135(2) warrant should be sought</u>	Notice deemed to be served after midnight on the day it was delivered. It does not matter whether it is a working day, a weekend or a holiday. It does not matter whether it is actually received by the patient or not

If the need to recall the patient is believed to be urgent, and it has not been possible to serve a notice of recall in a way which is quick enough to avoid potential harm, then it would be possible (if the patient's whereabouts are known) for an AMHP to apply for a warrant under S135 (1) in order to gain entry and bring the patient to a place of safety. At the place of safety the RC should examine the patient and could issue a notice of recall by hand which would become effective immediately.

- 11.8 Transfer after recall, to a hospital managed by different hospital managers (i.e. a different Trust or a private hospital) requires that arrangements for the transfer are properly in place and that form CTO6 is completed to provide authority to transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to. The MHA administrators must be informed as soon as

possible about any transfer. They can: liaise with the receiving hospital's administrators, assist with the necessary paperwork and ensure that RiO is updated as required.

- 11.9 As soon as practicable, the nurse in charge should ensure the patient is given information, verbally and in writing, about their rights following recall and the impact, if any on their treatment rights which are set out in a separate section below. The provision of information about the CTO must be recorded in the same manner used for other detained patients.
- 11.10 Following recall, the RC and clinical team will consider the circumstances of the recall and in particular, whether a CTO remains the right option for the patient. They must consult the patient and (subject to usual considerations about involving a nearest relative) any other carer, to decide whether a variation in the conditions or change in the care plan – or both – is appropriate.
- 11.11 The RC may not allow the patient to go on leave outside the hospital at any time during the 72-hour recall period. This is due to Section 17 D (2) (b) which excludes patients subject to a CTO from being defined as 'liable to be detained' or 'detained'.
- 11.12 The responsible clinician may release a recalled patient from detention at any time before the end of the 72 hour period. There is no form to record this decision. The RC must: inform the patient in a way the patient understands, record the decision clearly in the patient's notes and inform the MHA administration team.
- 11.13 On release, the patient continues to be a CTO patient and so remains subject to the CTO and its conditions as before, unless those conditions have been varied (or suspended) in the normal way while the patient was recalled to hospital
- 11.14 If recall is not appropriate or necessary because a patient with capacity agrees to come into hospital on an informal basis or to attend for treatment in a community setting, there is no statutory reason why that should not happen. Recall is permissible in relation to an existing inpatient. To avoid confusion or failure to adhere to the intended statutory scheme, it is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in the clinical records.
- 11.15 It is not lawful to use section 5(2) or 5(4) (doctors' and nurses' holding powers) to prevent a CTO patient from leaving a hospital if they are in hospital on a voluntary or informal basis. Whenever such a patient is admitted the RC and the clinical team should consider how a notice of recall could be delivered to the patient quickly if it becomes necessary. These plans should consider especially how such a notice could be provided at weekends or outside daytime working hours.

12. REVOCATION OF CTO OR RETURN TO THE COMMUNITY:

- 12.1 A CTO may only be revoked while the patient is detained in hospital as a result of being recalled
- 12.2 If in-patient treatment is required for longer than 72 hours from arrival in hospital, the RC must consider revoking the CTO. Although not specifically covered by the legislative scheme or the Code, there is no impediment to a patient agreeing to remain in hospital on a voluntary basis where they have the capacity to choose to do so for a brief period. Such a decision will require the RC to reconsider the appropriateness of the CTO and document that they have done so.
- 12.3 To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. An AMHP, having considered the wider social context for the patient, must also agree with the RC's assessment. This need not be an AMHP already involved in the patient's care and treatment, although whenever possible it should be the AMHP involved in the initial application, who should have remained involved in the patient's care and treatment (see 5.4).
- 12.4 Having decided to revoke the CTO, the RC should ensure the prompt attendance of an AMHP within the 72 hours allowed. The RC should be mindful of the time it may take for an AMHP to assess the patient, especially if the request for an assessment has to involve an AMHP from Social Services Emergency Duty Team, and ensure the AMHP has sufficient notice to enable them to complete part 2 of form CTO5 within the 72-hours.
- 12.5 If the AMHP does not agree that the CTO should be revoked, their decision and the reasons for it must be fully documented in the clinical records. It is not appropriate for an RC to approach another AMHP for an alternative view. The patient must be allowed to leave hospital at the end of the 72 hours and the CTO continues. There is no power to use Ss 5(2) or 5(4) of the Act to further detain the patient in hospital beyond the 72-hour period (see 10.11).
- 12.6 Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 & 3 and the AMHP completing Part 2 of form CTO5. The RC may not sign Part 3 until the AMHP has signed part 2. The revocation takes effect immediately once signed. The form must be forwarded to the Mental Health Act Administrator or equivalent as soon as practicable.
- 12.7 The effect of completing form CTO5 is that the patient reverts to being detained under whichever section of the Act they were subject to immediately before the CTO was made. However, in all cases they are subject to a new period of detention of up to six months beginning with the day of revocation (see also, paragraph 11.7). The MHA administrators will carry out the responsibility of the hospital managers and will refer the patient's case to the First Tier Tribunal (Mental Health) (see 13.7 below).

12.8 On revocation, form CTO5 must be copied to the managers of the hospital to which the patient was recalled, if the patient was transferred during the period of recall.

13. EXPIRY AND EXTENSION OF A COMMUNITY TREATMENT ORDER:

13.1 Unless extended, a CTO expires at the end of the six months starting with the day on which it is made. So, if it is made on 1 January, it expires at the end of 30 June. If it is not extended and the CTO expires, the underlying authority for detention (whether it is an application for admission for treatment under part 2 or an order or direction under part 3) also ceases to have effect.

13.2 A CTO can be extended for a further six months, and then for a year at a time.

13.3 At some point during the final two months of the first and each subsequent period for which the CTO is in force, the responsible clinician must examine the patient in order to decide whether the patient meets the conditions for extension. Following this examination the RC can extend the CTO. RCs should not leave the decision to renew the Order until close to the expiry date, because doing so places unnecessary pressure on the completion of the actions described below (13.5-7). The RC must determine that the conditions for extension are met:

- the patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment
- it is necessary for the patient's health or safety or for the protection of other persons that the patient should receive such treatment
- subject to the patient continuing to be liable to be recalled as mentioned below, such treatment can be provided without the patient being detained in a hospital
- it is necessary that the responsible clinician should continue to be able to exercise the power of recall under section 17E(1) to recall the patient to hospital, and
- appropriate medical treatment is available for the patient.

13.4 The responsible clinician may recall the patient to hospital for this purpose, because being available for this examination is one of the mandatory conditions to be included in all CTOs

13.5 As when making the original CTO order, the RC must obtain the written agreement of an AMHP that the conditions for extending the CTO are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1. Where the RC is not a registered medical practitioner, they should consult a doctor.

13.6 The RC completes and signs Parts 1 & 3, and the AMHP completes Part 2 of form CTO7. The RC may not sign Part 3 until the AMHP has signed Part 2. The completed report will be effective once it has been sent or delivered to the Managers (the MHA administration team, for this purpose)

or put into the hospital's internal mail system. A Mental Health Act administrator will complete Part 4 on behalf of the Hospital Managers.

- 13.7 The hospital managers must arrange for the patient to be told about the extension. See section 8 above for details.
- 13.8 Once the CTO7 is received, the MHA administrators will arrange for a hospital managers' panel to undertake a review of the report provided on form CTO7 based on written reports provided by (or on behalf of) the RC and a social circumstances report (written by the person best placed to write it, who may be a care coordinator employed by The Trust, or a social worker employed by the Local Authority) This may be a 'paper based' review if the patient is not contesting the renewal. Where practicable, this should be done before the new period of extension takes effect but the completed form CTO7 itself provides lawful authority for the patient's continued CTO. Such reports will be dealt with in the same way as reports made to renew detention under the Act although it may be appropriate to arrange the Managers' review at a more convenient location than the hospital in which the patient was originally detained. (See 14.9 below)
- 13.9 The Code sets out questions that a Panel of Managers should address in the order given whenever they review a report made using form CTO7:
- Is the patient still suffering from mental disorder?
 - If so, is the disorder of a nature or degree making it appropriate for the patient to receive medical treatment?
 - If so, is it necessary in the interest of the patient's health or safety or the protection of other people that the patient should receive such treatment?
 - Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
- 13.10 If three or more members of the panel (being a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is "no", the patient should be discharged.
- 13.11 Where the answer to all these questions is "yes", but the RC has made a report under section 25 barring discharge by the nearest relative (discussed further below) the following question must then be addressed:
- Would the patient, if discharged, be likely to act in a manner that is dangerous to other people or to him or herself?
- 13.12 Where three or more members of the panel (being a majority) disagree with the RC and conclude that the answer is "no", they should usually discharge the patient. However, they retain a residual discretion not to discharge in such cases, so should always go on to consider whether there are exceptional reasons why the patient should not be discharged.
- 13.13 Special provisions for extending the community treatment period apply to patients who have been unlawfully at large ('absent without leave') which are set out in sections 21A & 21B of the Act. After an absence of more than 28 days, form CTO8 must be completed to extend the CTO period.

- 13.14 Where the criteria for extending the CTO are not met and, consequently, the RC does not plan to make a report to the Managers using form CTO7 (or where applicable, form CTO8) the patient should be discharged by the RC rather than waiting for the current CTO to expire. This does not apply to a case where an AMHP does not agree to extension. In such a case, the RC may choose to exercise his or her right of discharge or may allow the CTO to lapse.
- 13.15 Extension periods for CTOs mirror the renewal scheme for section 3 patients: the initial CTO lasts for up to six months, if extended lasts for a further six months and thereafter, up to one year on each extension. The new period of a CTO is calculated from the day after the date on which the current order would have otherwise come to an end if it had lapsed.

14. DISCHARGE FROM a CTO:

- 14.1 'Discharge' for a CTO patient, regardless of who orders it, means complete release from liability to detention or compulsion under the Act in hospital or in the community. It is not the same as 'recall' or 'revocation' which are described at 11 and 12 above nor the process of 'discharge subject to...being liable to recall' which follows the making of a CTO order.
- 14.2 The RC can discharge a patient from a CTO at any time in writing by completing the local discharge from liability to detention form under section 23 of the Act and providing it to the MHA administration team. This order must be sent to MHA administration team as soon as practicable after it is made, but it is effective even before it is submitted. There is no statutory form for this purpose, or a statutory requirement to consult with any other person.
- 14.3 A Part II CTO patient's nearest relative (there is no available power in relation to Part III CTO patients) can order their discharge in the same way as they can for section 2 or 3 patients. An order must be put in writing giving at least 72 hours notice but need not be in any specific form. To assist this process, a standard letter will be made available where required. Contact the MHA administrators for a copy, or print out the copy in APPENDIX C). Nearest relatives may also be directed to the illustrative example in paragraph 32.25 of the Code of Practice.
- 14.4 Within the permitted 72 hours (which start when the order is first received by either the ward manager or the MH Administrators (whichever is earlier)), the RC may sign a report (form M2) barring discharge under s25 of the Act. In doing so he or she has concluded that 'the patient, if discharged, would be likely to act in a manner that is dangerous to other people or to him or herself'. The M2 form vetoes the nearest relative's decision to discharge the patient. It also prevents the nearest relative from discharging the patient from the CTO at any time in the six months following the date of the report. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness. Where a report is made, the nearest relative must be

informed in writing without delay (this to be coordinated by the RC), and be advised of their right to apply to the FTT.

- 14.5 If the RC does not sign such a report, discharge by the nearest relative takes effect after 72 hours or at a point shortly after that which they have specified. Where a patient has been recalled to hospital, only the RC can discharge him/her during the period of 72 hours following recall. During the same period, there is no power of discharge available to the nearest relative, Hospital Managers or FTT.
- 14.6 The Hospital Managers have the power to discharge a CTO patient exercisable by 3 or more members of a panel (being a majority) on agreement that one of the criteria for a CTO or its extension is no longer met and, consequently, a CTO is no longer appropriate or necessary. Where a patient's CTO has been revoked, the review will be essentially the same as that for any patient liable to detention under the Act.
- 14.7 The FTT can discharge a CTO patient other than during the 72-hour period of recall of such a patient. If, following recall, a patient's CTO is revoked; the Mental Health Act Administrator must refer the patient's case to the FTT as soon as possible. All circumstances where there is a duty to refer a case to the FTT are set out in section 68 of the Act.
- 14.8 The patient can make an application for discharge to the FTT once during any period of their CTO. Any withdrawn application is disregarded and does not interfere with this right. The FTT cannot vary the conditions of a CTO imposed by the RC and although it can make a recommendation, cannot oblige an RC to make a CTO for a detained patient. The FTT application rights of both patients and their nearest relatives are set out in section 66 of the Act.
- 14.9 It may be appropriate for the FTT hearing to be held in an alternative setting such as a community facility by prior discussion and agreement if there are practical reasons for doing so.
- 14.10 If a patient is detained in another hospital under section 3 or equivalent, other than by their CTO being revoked, this will automatically discharge the existing CTO and its underlying section. There must be a fresh assessment process before a new CTO could be imposed. Detention under section 2 will not affect a current CTO. (See sections 21 and 22 below)
- 14.11 Special rules apply to CTO patients who are imprisoned, remanded or otherwise detained in custody by any court in the UK. These are similar to those for part 2 detained patients.
- 14.12 Such patients automatically cease to be CTO patients if they remain in custody for longer than six months in total.
- 14.13 Until then, they formally remain CTO patients, unless discharged from their CTO in the interim. If they are released from custody during that six month period, they are treated as if they had gone AWOL on the day of their release.

- 14.14 Because patients in this situation are treated as being AWOL, if such a patient's CTO would otherwise have expired, or is about to expire, it will not in fact expire until the end of the week starting with the day of the patient's return to hospital (if the patient had already been recalled to hospital when first imprisoned) or (if not) the date of the patient's release from custody.
- 14.15 The effect of this is that; if the patient's CTO is otherwise due to expire, responsible clinicians will always have at least a week in which to examine the patient and submit a report extending the CTO, if appropriate, under section 20A.
- 14.16 Although CTO patients released from custody after less than six months are treated as having gone AWOL, they may only automatically be taken into custody and returned to a hospital if they had already been recalled to that hospital when they were first imprisoned. Even then, that can only be done during the 28 day period starting with the date of their release.
- 14.17 The normal rules about recalling patients to hospital apply to patients released from custody during whatever period remains of their CTO (including the one week extension, where relevant). They can, if necessary, be recalled to hospital in order to be examined with a view to making a report extending their CTOs (see section 13 above). If they failed to attend, they would be considered AWOL in the normal way, and could therefore be taken into custody at any time during the six months starting with the day they failed to attend, as described in section 20 below.

15. TRANSFER BETWEEN HOSPITALS AND JURISDICTIONS

- 15.1 Paragraph 11.8 above describes the process for the physical transfer of a patient between hospitals following recall, which requires the completion of form CTO6 where the hospitals are managed by different managers (organisations). It does not necessarily mean that there is a transfer of the patient's responsible hospital.
- 15.2 The responsible hospital for a patient subject to a CTO in the community (who may have been recalled to hospital) may be assigned to another hospital managed by a different organisation, with their agreement on completion of form CTO10. This process does not include the physical transfer of a patient, which is dealt with above. It is referred to as an 'assignment of responsibility for community patients'.
- 15.3 Assignment of responsibility for community patients between hospitals within the same organisation requires no statutory paperwork but the managers of the receiving hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give their name and address even if part of the same organisation.
- 15.4 In any case, the new hospital becomes the responsible hospital and as such is treated as if it were the detaining authority when the patient was

originally detained in hospital (and is now subject to recall to) prior to going onto a CTO.

- 15.5 In the case of any transfer or reassignment of responsibility, the Code requires that the needs and interests of the patient are considered to ensure compatibility with the patient's rights to privacy and family life under Article 8 of the European Convention on Human Rights.
- 15.6 Once a CTO has been revoked, transfer between hospitals under different managers is the same as for any other patient who is currently liable to detention using form H4.
- 15.7 Where a community patient under broadly equivalent legislation in Scotland, the Isle of Man or any of the Channel Islands is removed to England, their arrival in England is recorded using form M1 (date of reception of a patient in England) and where they are to be treated as if they were subject to a CTO, form CTO9 is completed by the RC (Part 1) and an AMHP (Part 2). As when making a new CTO, any conditions must be specified on form CTO9 and have the written agreement of an AMHP.

16 DECISION TO USE A CTO OR SECTION 17 LEAVE:

- 16.1 Section 17 (relating to leave of absence from hospital) states that when consideration is given to granting long-term leave, an RC must also consider whether a CTO is the more appropriate way of managing the patient in the community. This applies to s17 leave for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).
- 16.2 These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for a CTO. An RC may still legitimately authorise longer-term leave where it is the more suitable option but must demonstrate that he/she has considered whether a CTO is more appropriate.
- 16.3 The RC must record in the clinical records that he/she has considered whether longer-term leave or a CTO is appropriate with reasons when authorising or reviewing such leave. This question should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, s17 leave forms will carry a statement to the effect that a CTO has been considered where appropriate.
- 16.4 The Code of Practice has a whole chapter (chapter 31) devoted to "Guardianship, leave of absence or CTO?", and it contains a table of pointers for CTO, or longer-term leave of absence, which may be of assistance to RCs and is replicated below. (A further table contrasting CTO and guardianship can also be found in the Code at Para. 31.7)

CTO or longer-term leave of absence: relevant factors to consider

Factors suggesting longer-term leave	Factors suggesting a CTO
<ul style="list-style-type: none"> • Discharge from hospital is for a specific purpose or a fixed period. • The patient’s discharge from hospital is deliberately on a “trial” basis. • The patient is likely to need further in-patient treatment without their consent or compliance. • There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a CTO. 	<ul style="list-style-type: none"> • There is confidence that the patient is ready for discharge from hospital on an indefinite basis. • There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given. • The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary. • The risk of arrangements in the community breaking down or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify a CTO, but not to the extent that it is very likely to happen

17. TREATMENT WHILE IN THE COMMUNITY, OR IN HOSPITAL WHILST NOT RECALLED (PART 4A OF THE ACT):

17.1 Compulsory treatment cannot be given to a patient on a CTO who has not been recalled (referred to in this section as a ‘part 4A patient’) and who has capacity (or competence, for patients under 16) to consent to or refuse a treatment, and who refuses the treatment (unless it is immediately necessary and being given under section 64G- Emergency treatment for patients lacking capacity or competence). Refusal to consent to treatment in itself does not justify a recall to hospital and fuller consideration of the patient’s presentation and circumstances is required when considering whether a recall to hospital is warranted (see section 11 above)

17.2 There are specific rules regarding the certification of certain treatment given to part 4A patients:

- ‘section 58 type treatment’ – treatment to which section 58 would apply if the patient were detained. I.e. medication after an initial three-month period, and
- ‘section 58A type treatment’ – ECT and other types of treatment to which section 58A applies.

17.3 In the case of a part 4A patient who lacks capacity (or competence, if under 16) to consent to treatment, a SOAD must certify that the treatment is appropriate (a part 4A certificate- CTO11) after the first month of

treatment under a CTO. The approved clinician in charge of the patient's treatment must make requests for a SOAD via CQC's 'provider portal'. This is accessed here:

<http://www.cqc.org.uk/organisations-we-regulate/mental-health-services/mental-health-act-guidance/second-opinion-appointed>

- 17.4 If a patient with the capacity to do so is refusing medication the approved clinician in charge of treatment may still request a SOAD visit, and ask the SOAD to certify what treatment would be appropriate should the patient's status change. The outcome of such visits will be entirely a matter for the SOADs concerned, who act independently of the Care Quality Commission and of any other body. Certificates given in these circumstances provide no legal authority to give treatment to patients in the community if they refuse to consent to it.

Furthermore, a certificate issued when a patient with capacity is refusing consent could not be used to fulfil the certification requirement if the patient subsequently consents to treatment. In these circumstances, the approved clinician in charge of treatment would need to complete form CTO12 (see paragraph 17.7 below)

- 17.5 The arrangements surrounding the SOAD's examination will be complicated by the fact that the patient is in the community, so the care coordinator and/or the RC should discuss and agree arrangements for the SOAD visit with the patient, prior to the patient being made subject to a CTO. The care coordinator and/or the RC, together with the Mental Health Act Administrator, should confirm arrangements with the SOAD and coordinate the process.
- 17.6 Other than in exceptional circumstances, SOAD examinations should be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit an SCT patient in a hostel or home, an appropriate member of the care team must always accompany the SOAD.
- 17.7 In the case of a part 4A patient who has capacity (or, if under 16, is competent) to consent to the treatment and has consented, the approved clinician in charge of the patient's treatment must certify that the patient has capacity/competence and has consented (a part 4A consent certificate- CTO12). This form should usually be completed by the AC in charge of the patient's treatment whilst in the community. If it is completed by the AC in charge of inpatients, then a new form should be completed as soon as possible by the AC in charge of the patient's treatment in the community. Likewise, if the identity of the patient's AC changes permanently (i.e. not just during periods of an AC's leave or other temporary absence) for any other reason, the new AC should complete a new form.
- 17.8 In the case of patients aged under 18, regardless of capacity to consent, ECT can only be authorised by a part 4A certificate, CTO11 (i.e. not by a part 4A consent certificate, CTO12).

- 17.9 Neither a part 4A certificate, CTO11 nor a part 4A consent certificate, CTO12 is required for section 58 type treatment (requiring consent or a second opinion) to be given:
- where less than three months have passed since the patient was first given the treatment during an unbroken period of detention and discharge onto a CTO (or an unbroken succession of periods of detention and CTO), or
 - during the first month following a patient's discharge from detention onto a CTO (even if the three-month period referred to in section 58 has already expired or expires during that first month)
 - if the criteria under section 64G are met for emergency treatment in the community of patients lacking capacity or competence, or
 - it is immediately necessary and the patient has capacity to consent to it and has consented, or their donee or deputy or the Court of Protection has consented on the patient's behalf.
- 17.10 When giving part 4A certificates, SOADs do not have to certify whether a patient has, or lacks, capacity to consent to the treatments in question, nor whether a patient with capacity is consenting or refusing. They may make it a condition of their approval that particular treatments are given only in certain circumstances. For example, they might specify that a particular treatment is to be given only with the patient's consent. Similarly, they might specify that a medication may be given up to a certain dosage if the patient lacks capacity to consent, but that a higher dosage may be given with the patient's consent. Any member of staff administering medication to a CTO patient must ensure that they are familiar with any such conditions.
- 17.11 The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 ('MCA') including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give CTO patients any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient.
- 17.12 The MCA does not normally apply to a child under the age of sixteen. Decisions about capacity, in relation to medical treatment, are made by determining whether a child is 'Gillick competent'; in accordance with a landmark ruling of the House of Lords. This is, in some circumstances, sometimes referred to as 'Fraser competency' acknowledging the Law Lord who set out the principles to be applied in determining such competency.
- 17.13 Part 4A patients, over the age of sixteen and who lack capacity, may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient's behalf. If the patient is over eighteen, treatment cannot be

authorised if it would contravene a valid and applicable advance decision made under MCA.

- 17.14 If physical force needs to be used to administer treatment to a patient of any age, who lacks capacity or competence, it can only be given in an emergency following the conditions set out in section 64G which reflect the similar scheme in the MCA. The alternative mechanism is via recall to hospital but the recall criteria set out at 11.3 above apply equally to patients lacking capacity.
- 17.15 In an emergency, treatment for Part 4A patients who have not been recalled can be given by anyone (it need not be an Approved Clinician or the RC) but only if the treatment is immediately necessary to:
- Save the patient's life
 - Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences, which cannot be reversed
 - Alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed, and does not entail significant physical hazard; OR
 - Prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed, and does not entail significant physical hazard.
 - For ECT (or medication administered as part of ECT), only the first two categories apply.
- 17.16 In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting CTO patient without first recalling them to hospital.
- 17.17 In non-emergency situations (excluding ECT for which reference should be made to the Trust's ECT policy) a patient may lack capacity and object to treatment but where physical force is not required he or she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO.
- 17.18 Forms CTO11 and/or CTO12 should be kept with the original CTO and detention papers, with a scanned copy placed on the patient's EPR system by the patient's care coordinator.

18. TREATMENT DURING RECALL (SECTION 62A)

- 18.1 Part 4A (see section 17 above) does not apply to the treatment of CTO patients who have been recalled to hospital, unless or until they are released from the resulting detention in hospital.

- 18.2 Part 4 applies to such patients instead, but with the following differences.
- 18.3 **First**, treatment which would otherwise require a certificate under section 58 or 58A (i.e. any of the certificates T2, T3, T4 or T5) can be given without such a certificate if it is expressly approved instead by the patient's part 4A certificate, CTO11 (if the patient has one).
- 18.4 For these purposes, a treatment is only expressly approved by a part 4A Certificate (CTO11) if the SOAD who gave the certificate explicitly states in it that the treatment in question may be given to a patient who has been recalled.
- 18.5 Such approval may be subject to conditions which must be followed. The conditions could be different from those which apply when the patient has not been recalled. A SOAD might, for example, specify that treatment on recall may only be given if a patient who has the capacity to consent to it does so.
- 18.6 A part 4A certificate (CTO11) cannot authorise treatment under section 58A for which there would be no authority under part 4A itself, if the patient had not been recalled. In particular, it cannot authorise treatment without the consent of a person who has the capacity (or, in the case of a patient under 16, the competence) to consent to the ECT (or other treatment) in question. Nor can it authorise section 58A treatment contrary to a valid and applicable advance decision, or the decision of an attorney, deputy or the Court of Protection.
- 18.7 **Second**, medication which would otherwise require a certificate (T2 or T3) under section 58 can be given without such a certificate if the certificate requirement in part 4A would not yet apply to the treatment because less than one month has passed since the making of the patient's CTO.
- 18.8 In other words, no certificate is required for the administration of most medication to a patient who has been a CTO patient for less than a month.
- 18.9 **Third**, treatment that was already in progress on the basis of a part 4A certificate (CTO11) before the patient was recalled can be continued temporarily without a certificate, even if the part 4A certificate does not expressly approve it, if the approved clinician in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. This also applies if treatment was already being continued after the withdrawal of a part 4A certificate (CQC may, rarely, notify the AC that a part 4A certificate will cease to apply on a certain date).
- 18.10 This exception only applies pending compliance with section 58 or 58A. In other words, it applies only for the time it takes to obtain the certificate that would normally be required, or for a SOAD to decide that it is not appropriate to issue such a certificate.
- 18.11 These exemptions to the requirements for certificates under part 4 also apply to patients whose CTOs have been revoked. For section 58 type

treatments, the first and second exemptions, described in paragraphs 18.4 and 18.8 above, apply only pending compliance with section 58 itself.

- 18.12 The following table (from p.212 of The Reference Guide) summarises the certification requirements for CTO patients upon recall or immediately after revocation:

<i>Medication which needs a certificate after 3 months under section 58</i>	<i>ECT and other section 58 and 58A treatments</i>
It is specifically authorised in the part 4A certificate (CTO11) for use on recall; or	It is specifically authorised in the part 4A certificate (CTO11) for use on recall; or
A section 58 (T2 or T3) or 58A (T4, T5 or T6)) certificate is not required for a CTO patient who has been recalled to hospital, or for a patient whose CTO has just been revoked, if:	
Before the patient was recalled, it was properly being provided on the basis of a part 4A certificate (CTO11) (including one which had been withdrawn) and is only being continued to avoid serious suffering to the patient and pending a new certificate, or	Before the patient was recalled, it was properly being provided on the basis of a part 4A certificate (CTO11) (including one which had been withdrawn) and is only being continued to avoid serious suffering to the patient and pending a new certificate, or
It is permitted under part 4 anyway without a certificate because it is immediately necessary, or	It is permitted under part 4 anyway without a certificate because it is immediately necessary.
It is less than one month since the patient became a CTO patient.	

19 REPORTS TO CQC ON TREATMENT GIVEN IN ACCORDANCE WITH A PART 4A CERTIFICATE (CTO11) - (SECTION 64h (4) and 61(1))

- 19.1 Where treatment has been given on the basis of a part 4A certificate (CTO11), the person in charge of the treatment must send CQC a report under section 64H on the treatment and the patient's condition when requested to do so by CQC.
- 19.2 In addition, a report must be given automatically to CQC under section 61 if treatment is given on the basis of a part 4A certificate (CTO11) to a CTO patient who has been recalled to hospital, including one whose CTO is then revoked, in lieu of a SOAD certificate under section 58 (T3) or 58A (T4). This will only apply to treatment to which the patient either did not, or could not consent.

19.3 In such cases, a report must be submitted by the approved clinician in charge of the treatment at the same time it would have to be given if the treatment had, in fact, been given on the basis of section 58 or 58A SOAD certificate (T3 or T4). This means the approved clinician must make a report to CQC on the next occasion that the responsible clinician submits a report under section 20 to renew the patient's detention, under section 20A to extend the patient's CTO, or under section 21B to confirm the patient's detention or CTO after absence without leave for more than 28 days.

19.4 The processes above will be coordinated by the MHA Administration team.

20. **RECALLED CTO PATIENTS WHO ARE ABSENT WITHOUT LEAVE (SECTIONS 18 and 21(4)) (See paragraphs 14.11-17 above for rules about AWOL during or after detention in prison)**

20.1 Where CTO patients are at any time absent from the hospital to which they have been recalled, or to which they have been transferred while recalled, they are considered to be AWOL. They may be taken into custody under section 18 and taken to the hospital by any AMHP, police officer, or other constable, any officer on the staff of the hospital in question, or by any person authorised in writing by the responsible clinician or the hospital managers of that hospital. See the Trust's AWOL policy for details.

20.2 This may only be done during the period before:

- the CTO expires, ignoring any extra time that would be allowed if the patient were to return or be taken into custody right at the end of that period, or
- the end of the six months starting with the first day of the absence without leave, if that is later.

20.3 For these purposes, the fact that the responsible clinician has already made a report extending the patient's CTO (form CTO7) is irrelevant unless the extended period has already started when the patient goes absent.

20.4 If patients are taken into custody, or come to the hospital voluntarily, before the end of the period during which they could be taken into custody, the 72 hours for which they can be detained effectively starts again on their arrival at the hospital. In other words, they can be detained for a further 72 hours, even if they had already been detained for part of that period before they went AWOL.

Confirmation of CTOs for patients who have been absent without leave for more than 28 days (section 21B and regulations 14(3) and 26)

20.5 Where recalled CTO patients are taken into custody, or attend the relevant hospital voluntarily, after being AWOL for more than 28 days, their responsible clinician must examine them and, if appropriate, submit

a report using form CTO8 to the managers of the responsible hospital (for this purpose- the MHA administration team) confirming that the conditions for the CTO are met. This is equivalent to the procedures for detained part 2 patients.

- 20.6 The criteria for continuing the CTO are the same as the criteria for extending it, described at paragraph 13.3 above.
- 20.7 Unless such a report is submitted, a patient's CTO expires automatically at the end of the week starting with the day on which they arrive at the hospital.
- 20.8 Responsible clinicians must make a report during this period if they think that the conditions are met. The responsible clinician must first consult one or more other people who have been professionally concerned with the patient's medical treatment and an AMHP who is acting on behalf of a local authority. There is no requirement in this case to obtain a statement of agreement from the AMHP.
- 20.9 The MHA administrator will record their receipt of the report in part 2 of the same form CTO8.
- 20.10 A report submitted under this procedure will extend the patient's CTO if it would otherwise already have expired, or if it would expire on the day the report is submitted to the managers). If so, the RC must ensure that the steps described in paragraphs 8.3 and 8.4 above are taken to arrange for the patient and, where relevant, the nearest relative to be informed.
- 20.11 In addition, if the patient's CTO is due to expire during the period of two months starting with the day on which the report is given to the managers, the responsible clinician may, but need not, indicate on the form that it is also to act as an extension report which would otherwise have to be made during that period under section 20A.
- 20.12 In that case, unless they decide to discharge the patient (via a hospital managers hearing), the managers must take steps to arrange for the patient and, where relevant, the nearest relative to be informed of the report in the same way as if it were a report under section 20A itself. See paragraphs 8.3 and 8.4 above.

Patients who return from absence without leave and whose CTO would otherwise have expired [sections 21, 21A and 21B and regulation 26]

- 20.13 In some cases, the responsible clinician's report under section 20A or 21B extending the CTO of a patient who has been AWOL will be made on or after the day the CTO was originally due to expire because the period for which the CTO is in force has been extended by section 21. If so, that report is treated as having retrospectively extended the CTO from when it would otherwise have expired in the normal way.
- 20.14 In the rare circumstances where the patient's CTO would otherwise have expired twice since they went AWOL, the responsible clinician's report

under section 21B is treated as having extended the CTO on both occasions.

- 20.15 If a patient's CTO is extended retrospectively, either once or twice, in this way, the RC or the care coordinator must take whatever steps are reasonably practicable to arrange for the patient to be told about the extension. They must also take such steps to arrange for the person they think is the nearest relative to be informed, unless the patient has requested otherwise, or does not have a nearest relative. The RC or care coordinator must record in the notes their attempts (whether successful or not) to contact the patient and the nearest relative.
- 20.16 The patient must be told of the retrospective extension both orally and in writing. Information given to nearest relatives must be in writing, but may be communicated by electronic means (e.g. email) if the nearest relative agrees.
- 20.17 While the patient is AWOL, every effort should be made to ascertain the patient's whereabouts and return them to hospital. Procedures relevant to returning patients to hospital, outlined in the Trust's AWOL policy, should be followed. The police should be informed where appropriate and their assistance sought where necessary. A warrant will be required to enter and remove the patient from their home (see Appendix A, and the Trust's AWOL policy, which includes detailed guidance on obtaining and using warrants under S135 (2)).

21 EFFECT OF A CTO ON NEW APPLICATIONS FOR ADMISSION OR GUARDIANSHIP UNDER PART 2 (SECTIONS 6(4) AND 8(5))

- 21.1 Because CTO patients can be recalled to hospital for treatment if required, it should not be necessary to make applications for their detention. In practice this may happen if the people making the application do not know that the patient is a CTO patient.
- 21.2 An application for admission for assessment under section 2 or 4 does not affect the patient's CTO.
- 21.3 But if a CTO patient is detained on the basis of an application for admission for treatment under section 3, the patient will automatically cease to be a CTO patient if, immediately before going onto the CTO, the patient had been detained on the basis of a previous application under section 3, rather than an order or direction under part 3.
- 21.4 The same applies if such a patient is received into guardianship as a result of an application under part 2. That is because an application under section 3, or the reception of a patient into guardianship under part 2, automatically brings to an end any previous application for detention or guardianship under part 2.
- 21.5 If a patient stops being a CTO patient because of an application for admission for treatment under section 3, a new CTO would have to be made for the patient to go back onto a CTO when they no longer needed to be detained in hospital.

21.6 An application for admission for treatment under section 3 does not end a patient's CTO if, immediately before going onto CTO, the patient had been detained on the basis of a hospital order, hospital direction or transfer direction under part 3 of the Act.

21.7 In the unlikely event of this rare situation arising the RC should consider discharging the section 3 whilst at the same time recalling the patient by handing them a form CTO3. This would immediately end the section 3 and start the 72 hour recall process which should be dealt with in the same way as any recall.

22 **EFFECT OF NEW ORDERS OR DIRECTIONS UNDER PART 3 ON CTO (SECTION 40(5))**

22.1 If a CTO patient is admitted to hospital as the result of a hospital order, hospital and limitation direction or transfer direction, or given a guardianship order under part 3 of the Act, they automatically cease to be a CTO patient. That is because the new order or direction brings to an end the application, order or direction to which the patient was subject immediately before going onto CTO.

22.2 If a hospital order, hospital and limitation direction, or guardianship order, or the conviction on which it is based, is subsequently quashed on appeal, section 22 will apply as if the order or direction had never happened and the patient had instead been in prison since the quashed order or direction was made. This may mean that the patient automatically becomes a CTO patient again if less than six months has passed since the quashed order or direction was given. (See paragraphs 14.11-17 above)

23 **DEPRIVATION OF LIBERTY WHILE ON A CTO**

23.1 Patients who are on a CTO or on leave, and who lack capacity to decide whether or not to consent to the arrangements required for their care or treatment, may occasionally need to be detained for further care or treatment for their mental disorder in circumstances in which recall to hospital for this purpose is not considered necessary. They might also need to be admitted to a care home or hospital because of physical health problems.

23.2 If they (patients who lack the capacity to consent to their care or accommodation) will be detained in a care home, a deprivation of liberty authorisation (DoL authorisation) or Court of Protection order under the Mental Capacity Act 2005 (MCA) must be obtained. Deprivation of liberty under the MCA can exist alongside a CTO or leave of absence, provided that there is no conflict with the conditions of the CTO or leave set by the patient's responsible clinician.

23.3 If they will be detained in a hospital for further treatment for mental disorder (whether or not they will also receive treatment for physical health problems), they should be recalled to be treated under the Mental Health Act.

23.4 For guidance on the use of a DoL authorisation or Court of Protection order in relation to a patient who is subject to guardianship, see chapter 30 of The Code of Practice.

23.5 With regard to the conditions imposed by the RC The Code of Practice states that “*The conditions must not deprive the patient of their liberty*” (para 29.31). The Court of Appeal (in the case of MM and PJ, 29.03.2017), however, has shown this to be incorrect. The conditions may authorise a deprivation of liberty, as long as the restrictions are less than those imposed on an inpatient (and they comply with the requirements of conditions set out in 6.2 above). The Court explained:

“ *the power to restrict the freedom of movement of a patient to the extent of objectively depriving him of his liberty by the conditions attached to a CTO is part of a statutory framework within which a CTO is intended to be a lesser restriction on freedom of movement than detention in hospital for medical treatment. This reflects an appropriate balance between safety and freedom of movement in conformity with the statutory purpose which is to achieve integration of a patient into the community with the minimum interference with the patient’s freedom of movement commensurate with the protection of the patient and the public.*” (Para 53 of the judgement). Full text of the judgement may be accessed here:

<http://www.serjeantsinn.com/wp-content/uploads/2017/03/C320154104-C320160561-29-03-17.pdf>

23.6 RCs imposing restrictions which may amount to a deprivation of the patient’s liberty must be able to demonstrate how the restrictions comply with the guiding principles in The Code of Practice.

24. TRAINING REQUIREMENTS

24.1 The Trust will work towards all staff being appropriately trained. The management of CTOs is included in the ‘Mental Health Act and all its paperwork’ training which all relevant staff are expected to attend.

25. MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring arrangements for compliance and effectiveness

Audits will be undertaken on the use of CTOs when deemed appropriate by the Mental Health Legislation Committee. Adherence to the procedural guidelines will be monitored.

Responsibilities for conducting the monitoring

The Chair of the Mental Health Legislation Committee will ensure that monitoring reports are timetabled within the reporting schedule and present on the appropriate agenda.

The Mental Health Legislation Committee will monitor procedural document compliance and effectiveness where they relate to CTO patients.

Methodology to be used for monitoring

Discussions of the following will be recorded within the MHL Committee minutes

- internal audits
- complaints monitoring
- incident reporting and monitoring via DATIX
- new significant risks to be added to the risk register.,

Frequency of monitoring

- half yearly reports to the Mental Health Legislation Committee
- half yearly, progress report of the MHLC annual work programme

Process for reviewing results and ensuring improvements in performance occur.

Any audit results will be discussed at the Mental Health Legislation Committee who will identify good practice, any shortfalls, action points and lessons learnt. The outcome of the Audit and any change in policy will be presented to the Senior Management Team who will be responsible for ensuring improvements, where necessary, are implemented.

26. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

26.1 References

MHA '83 Code of Practice – TSO 2015

Reference Guide to the MHA 1983 – TSO 2015

26.2 Cross reference to other procedural documents

Consent and Capacity to Consent to Treatment policy
Detained Patients AWOL (including Missing Persons Guidance) policy
Electroconvulsive Therapy (ECT) Protocol and Guidelines
Record Keeping and Records Management Policy
Section 17 Leave policy
Serious Incidents Requiring Investigation (SIRI) Policy
Untoward Events Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

27. APPENDICES

27.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	CTO Recall Process
Appendix B	Responsible Clinician's Letter of Recall Form
Appendix C	Letter for NR to notify of order of discharge

CTO Recall Process.

RC decides that recall is necessary. Completes form CTO3 and completes recall form providing patient with details about when and where they should present themselves (see template form over). RC takes care to complete the form correctly so that the patient knows when they are expected to come to hospital and when they would be AWOL.

CTO3 and letter delivered to patient in any of the three ways described in the table on p.16 of Trust CTO policy.

Patient presents themselves as required by RC

Patient fails to present themselves as required by RC

The 72 hour recall period starts from the time the patient is admitted to the hospital. This time must be recorded on Form CTO4.

Patient is AWOL from the time they did not present themselves. This may not equate with the time from which the CTO3 was deemed to be served. I.e. CTO3 'becomes valid' after midnight, but patient not required to come to hospital until 9am. Patient should not be considered AWOL until after 9am.

If a s.135 (2) warrant is required it will be for the RC in consultation with the care co-ordinator to decide who should apply for the warrant and then oversee its execution. Warrants may be applied for by: a constable, any officer on the staff of the hospital, any AMHP or any person authorised by the hospital managers. It is expected that the care coordinator will take on this role, and the RC should authorise them to do so in writing on behalf of the hospital managers if they are not an officer on the staff of the hospital or an AMHP. If they are not an AMHP they may seek guidance from an AMHP.

RECALLING SECTION 17A CLIENT (to be attached to CTO3)

Patient Name/Address	
Patient ID/ DOB	
Responsible Clinician	

As your Responsible Clinician I have decided that, *in the interests of your health **AND/ OR** safety or for the protection of other people (delete as appropriate)* it is necessary that you should return to hospital.

This form explains exactly when you are required to present yourself at hospital.

Method of delivery of the CTO3:	Given to you in person (immediately)	Delivered by hand to your last known address (after midnight of day of delivery)	Sent to your last known address by post (second working day after posting)
The earliest possible time you can be considered to have received the notification	(DATE/TIME)	(DATE/TIME)	(DATE/TIME)

I am therefore recalling you to

Ward Name/Address		
I require you to return:	IMMEDIATELY	NO LATER THAN (<i>STATE DATE /TIME</i>)

If you do not return the time specified you will be absent without leave, and may be returned to the ward by any member of the hospital staff, an approved mental health professional, a police officer or anyone authorised in writing by the hospital managers.

Yours sincerely,

Responsible Clinician Date.....Time.....

Cc: (*Name of person in charge of patient during leave*)

**Template letter
for nearest relatives to use to discharge a patient**

To the managers of [insert name and address of hospital in which the patient is detained, or (for a patient on a community treatment order) the responsible hospital.]

Order for discharge under section 23 of the Mental Health Act 1983

My name is [give your name] and my address is [give your address]
[Complete A, B or C below]

A. To the best of my knowledge and belief, I am the nearest relative (within the meaning of the Mental Health Act 1983) of [name of patient]. Or

B. I have been authorised to exercise the functions of the nearest relative of [name of patient] by the county court. Or

C. I have been authorised to exercise the functions of the nearest relative of [name of patient] by that person's nearest relative.

I give you notice of my intention to discharge the person named above, and I order their discharge from [*say when you want the patient discharged from detention or a community treatment order*].

(Please note: you must leave at least 72 hours between when the hospital managers get this letter and when you want the patient discharged.

The 72 hours start when:

- the notice is received by the hospital manager or an authorised person; or*
- if the notice is sent by pre-paid post, the day service is deemed to have taken place [for first class post, service is deemed on the second business day following posting, and for second class post, service is deemed on the fourth business day following posting; or*
- the notice is put into the internal mail system).*

Signed Date