# Community Treatment Orders (CTO) – 8.xx



# SECTION: 8 – MENTAL HEALTH LEGISLATION

# POLICY AND PROCEDURE NO: 8.XX

**NATURE AND SCOPE: MULTI AGENCY**

**SUBJECT: COMMUNITY TREATMENT ORDERS**

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| --- |
| **This policy/procedure relates to suitable patients being safely treated in the community rather than under detention in hospital and provides a way to help prevent relapse and any harm to the patient or to others, that this might cause.** **Community Treatment Orders provide a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment, if necessary.** |

**DATE OF LATEST RATIFICATION:**

**RATIFIED BY:**

**IMPLEMENTATION DATE:**

**REVIEW DATE:**

**ASSOCIATED TRUST POLICIES**

**& PROCEDURES:** Section 17 Leave of Absence for Patients Detained Under MHA 1983 – 8.03

Section 18 Absence without Leave for Patients Detained Under MHA 1983 – 8.04

Section 132 Informing Patients of Their Rights under MHA 1 983 – 8.05

Section 5 Holding Power - 8.06

Arranging a SOAD Visit – 8.10

DoL Safeguards – 8.12

Consent to Examination or Treatment – 1.03

**Joint Protocol for Service user missing from Adult Mental Health Services (2015)**

**NOTTINGHAMSHIRE HEALTHCARE NHS TRUST NOTTINGHAMSHIRE COUNTY COUNCIL AND NOTTINGHAM CITY COUNCIL**

**COMMUNITY TREATMENT ORDER POLICY**

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**NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST, NOTTINGHAMSHIRE COUNTY COUNCIL AND NOTTINGHAM CITY COUNCIL**

**COMMUNITY TREATMENT ORDER POLICY**

**1.0 INTRODUCTION**

* 1. This policy sets out the legal framework for the operation of an order made under section 17A of the Act which is known as a ‘Community Treatment Order’ (CTO).
	2. This policy should be read in conjunction with relevant chapters of the Code of Practice to the Mental Health Act (the code) which offers guidance on the operation of the Act and the Department of Health/NIMHE, Supervised Community Treatment: A Guide for Practitioners, October 2008. 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.
	3. This policy is multi-agency and as such applies to all Nottinghamshire Healthcare Foundation Trust staff and those working in Nottingham City, Nottinghamshire County Council and local authorities/agencies who have agreed to the content of the policy and its associated processes/procedures which are based on legislative requirements and the MHA Code of Practice (2015).
	4. Staff must give consideration to other relevant legislation, for example the Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards), the Human Rights Act 1998, the Equality Act 2010 and the Data Protection Act 1998.
1. **SCOPE AND PURPOSE OF THIS POLICY**

2.1 This joint policy sets out procedural requirements, where these are explicit in the Act or Code, but guidelines may be produced locally which while complying with this policy, provide advice on more specific matters. Where appropriate, reference should be made to other policies within each organisation.

* 1. The purposes of this policy are to:
* Ensure that there is lawful and appropriate use of CTO and that the legal rights of any patient subject to CTO are upheld at all stages. There is no lower age limit for CTO.
* To protect the staff in the Trust and Local Authorities from litigation and to assist staff in undertaking their duties.
* All staff working with individuals who suffer from mental disorder need to ensure that their actions fall within the framework of the Mental Health Act and the guiding principles.

**3.0 DECISION TO USE CTO, SECTION 17 LEAVE OR GUARDIANSHIP**

* 1. There are three ways in which an unrestricted patient may be subject to the powers of the Act while living in the community: guardianship, leave of absence and CTO.
	2. The Code sets out a table of pointers for CTO or longer term leave of absence and CTO or guardianship. This may be of assistance to Responsible Clinicians and is replicated below.
	3. Clinicians must consider the use of a CTO for patients being granted Section 17 leave for more than 7 consecutive days.
	4. If a CTO is going to be pursued, Clinicians should evidence that less restrictive alternatives have been considered, including Guardianship.

|  |  |
| --- | --- |
| **Factors suggesting longer-term leave** | **Factors suggesting CTO** |
| * 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 CTO.
 | * 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 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.
 |

**Table 2: CTO or longer-term leave of absence: relevant factors to consider**[[1]](#footnote-1)

|  |  |
| --- | --- |
| **Factors suggesting guardianship** | **Factors suggesting CTO** |
| * The focus is on the patient’s general welfare, rather than specifically on medical treatment,
* There is little risk of the patient needing to be admitted compulsorily and quickly to hospital,
* There is a need for enforceable power to require the patient to reside at a particular place.
 | * The main focus in on ensuring that the patient continues to receive necessary medical treatment for mental disorder, without having to be detained again.
* Compulsory recall may well be necessary, and speed is likely to be important.
 |

**Table 3: CTO or guardianship: relevant factors to consider**

**4.0** **THE MENTAL CAPACITY ACT** **DEPRIVATION OF LIBERTY SAFEGUARDS AND CTO**

4.1 Patients who are on a CTO and who lack capacity to consent to the arrangements required for their care or treatment, may occasionally need to be detained in a care home for further care or treatment for their mental disorder in circumstances in which recall to hospital for this purpose is not considered necessary. The same might apply to admission to a care home or hospital because of physical health problems.

4.2 If so, the procedures for the deprivation of liberty safeguards in the MCA should be followed. Deprivation of liberty (DoL) under the MCA can exist (whether by the DoL safeguards, in a Care Home, or an order of the Court of Protection in supported living) alongside a CTO, provided that there is no conflict with the conditions of the CTO set by the patient’s Responsible Clinician (RC).

4.3 Where patients on a CTO who lack capacity to consent to the arrangements required for their care or treatment need to be detained in hospital for further treatment for mental disorder, they should be recalled under section 17E of the Act itself. The MCA deprivation of liberty safeguards cannot be used instead.

See also paragraph 7.4 below.

**5.0 CRITERIA AND PROCESS FOR MAKING A CTO**

5.1 The following criteria must be met in all cases before a CTO can be made by the patient’s RC.

* 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/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 (*The RC must confirm that he/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).*[[2]](#footnote-2)
* 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.
	1. The following conditions are mandatory in all cases:
* The patient must make him/herself available for examination to determine whether to extend the community treatment period.[[3]](#footnote-3)
* The patient must make him/herself available for examination by a second opinion appointed doctor (SOAD) when requested.[[4]](#footnote-4)

**Process**

During ward round it is identified that the patient is making progress – a discussion is held about possible plans towards discharge and a CTO is considered. The ward team will identify who will be completing the Risk Assessments & Care Plans for discharge. This should be discussed with the **MDT** including **the community team** which will be involved in a discharge package & **an AMHP.**

The ward should identify a person to invite the community team and request an AMHP to attend the next ward round. The MDT / Community Team are an integral part of the discussions that take place to decide if the CTO is appropriate and the least restrictive option. A community team may have a much better idea of the challenges a patient may present in the community which could be quite different from a ward/hospital setting.

The family / friends may also have valuable input to what would be helpful and practical to maintain recovery in the community and may want to be part of the ward round (if the patient is in agreement with them being there)

The Responsible Clinician is the lead professional regarding a CTO and must be clear that the legal requirements are met before signing the CTO. The RC needs to make contact with the community RC and offer them the opportunity to be involved in the meeting or at least discuss the idea with them

The AMHP Team will require:

* + The personal details of the patient
	+ Key professional persons names and numbers on the ward and in the community
	+ Relative’s names and numbers
	+ Who the current RC is and who the community RC will be
	+ Date and time of the ward round / meeting to discuss the CTO
	+ The County AMHP Team will allocate an AMHP to attend the meeting
	+ There could be a discussion around other discharge options – it is okay to ask an AMHP to attend the meeting even if there are different opinions of what would be suitable for a patient
	+ A risk assessment and care plans are essential to plan a safe discharge

An AMHP must be involved in discussion with the RC to reach agreement that 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.

The AMHP will need to be satisfied that the CTO is appropriate and necessary for the patient and the least restrictive option. The AMHP will need to talk to the Nearest Relative (as defined by the Mental Health Act – this is ***NOT*** always the Next of Kin) and consult them about the CTO.

The CTO can only go ahead if the RC and the AMHP **both agree** to the CTO under the principles of the Mental Health Act. **N.B.** If the AMHP does not agree, it is not appropriate for the RC to seek another AMHP for an alternative view.

* 1. An order is made by the RC completing Part 1, the AMHP completing Part 2 and finally the RC completing Part 3 of Form CTO1. An AMHP report will also be completed.

**N.B. At the time of completing the CTO1, the RC may also need to complete a Form CTO 12 or a SOAD request form (see part 11 below).**

* 1. 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 as being effective from, for a period of up to six months.
	2. There is no mechanism for retrospectively amending or rectifying a defective Form CTO1, once handed to the Hospital Managers.

**6.0 CARE PLANNING AND CTO**

6.1 A care plan should be prepared and subject to the usual considerations of patient confidentiality, the following parties should be consulted by the RC:

* 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).

6.2 Aftercare is a vital component in patients’ overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills or learning new skills in order to cope with life outside hospital. Before placing a patient onto a CTO, the responsible clinician should ensure that the patient’s needs for after-care have been fully assessed, discussed with the patient and addressed in their care plan.

* 1. The Code of Practice (29.20) states that “good care planning … will be essential to the success of a CTO.” It states that “a care co-ordinator will need to be identified”, in practice this could be the CPN, Social Worker or an Occupational Therapist – whoever is best placed to take on the role.
	2. To reflect the development of community based services and ensure best practice, the inpatient RC should involve the community RC at an early stage to help determine whether a CTO is appropriate and specifically in any conditions to be attached to it. This will greatly assist in the delivery of a seamless transfer of care from hospital to the community and vice versa, although the final decision rests with the current RC.

It is acknowledged that carers and relatives are normally in closer or more frequent contact with a patient on a CTO, therefore concerns raised by them about a patient’s mental health deteriorating or failure to comply with the conditions of a CTO must be given due weight by the responsible team in deciding what action to take.

1. **CONDITIONS ATTACHED TO A CTO**

7.1 There are two conditions, set out at 5.2 above, which are mandatory in all cases. An RC may, with the agreement of the AMHP, set other conditions which they think are necessary or appropriate to achieve one or more of the goals set out at 5.3 above.

7.2 Advice on setting other conditions is provided by the Code which the RC and AMHP should always consider.[[5]](#footnote-5) It is important that the reason for any condition is explained to the patient and others, where appropriate, and that this is recorded in the healthcare records. In all cases, there should be a link between the person’s mental disorder and any condition imposed on a CTO.

7.3 Where there is a disagreement between the RC and the AMHP about the necessity or appropriateness of a particular condition or conditions, it would not be acceptable for an RC to use his/her right to significantly vary conditions shortly after discharge to overcome a legitimate objection by an AMHP.[[6]](#footnote-6)

**N.B. Conditions are not enforceable within the community. If the Patient is not abiding by the conditions this may be taken into account when considering exercising the power of recall to hospital.**

7.4 Any conditions which have the effect of placing a patient who lacks capacity to consent under the complete and effective control of the staff in a supported living or hostel at all timeswould be unlawful without either an authorisation by the Court of Protection or under the Mental Capacity Act Deprivation of Liberty Safeguards process. Conditions which effectively amount to detention in another form or by another route, wherever the patient is living, should be avoided if possible.

7.5 The Tribunal service is under an obligation to consider whether the implementation of CTO conditions which amount to a deprivation of liberty have a lawful basis (*PJ v A Local Health Board and others [2015] UKUT 0480*). Case law is developing on the subject of CTO conditions and deprivation of liberty, so legal advice may need to be sought on a case by case basis.

1. **PROVISION OF INFORMATION ON MAKING AN ORDER**

8.1 The RC should inform the patient and others who were consulted, of the decision to discharge a patient onto a CTO, including any conditions applied to the CTO and services available for the patient. This will normally include making a copy of the CTO documentation available to the patient and any professionals who were consulted as part of the process.

8.2 The Hospital Managers will ensure that the patient is provided with information verbally by the care co-ordinator or other appropriate person. This will be recorded on a Rights Form, which is then copied to the person holding the CTO documentation. An information leaflet will be provided to the patient, by post, from the Mental Health Act Administrator (or equivalent) and to the nearest relative, unless the patient objects.

8.3 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)
* 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 (Mental Health) or Hospital Managers.
* Independent Mental Health Advocacy Services.
* The role of the Care Quality Commission or any subsequent body.
* Treatment rights while subject to CTO in the community.

8.4 Care co-ordinators should make further attempts to ensure that the patient understands their rights at the time that a CTO is renewed. This should be documented.

* 1. **REFERRAL TO AN INDEPENDENT MENTAL HEALTH ADVOCATE – (IMHA)**
	2. Patients are eligible for support from an IMHA if they are on a Community Treatment Order.[[7]](#footnote-7)
	3. The Hospital Managers of the responsible hospital have the duty to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA Services and how they can obtain that help. This must include giving the relevant information both orally and in writing. The Hospital Managers must also take whatever steps are practicable to give a copy of the written information to the patient’s nearest relative, unless the patient requests otherwise.
	4. A qualifying patient may request the support of an IMHA at any time after they become a qualifying patient. Requests for an IMHA can also be made by the patient’s nearest relative, an AMHP or the patient’s RC, but patients may refuse to be interviewed and do not have to accept help from an IMHA if they do not want it.
	5. AMHPs and RCs should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA’s visit but are unable or unlikely for whatever reason to request an IMHA’s help themselves. Before making the request for an IMHA to visit they should first discuss the idea with the patient and give them to opportunity to decide for themselves whether to request an IMHA to visit where they know, or strongly suspect, that the patient does not want an IMHA’s help.
	6. Notes must be kept of any discussion regarding the right to an Independent Mental Health Advocate which must include the response of the patient and evidence of the referral where one has taken place.

**10.0 VARYING AND SUSPENDING CONDITIONS**

10.1 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 the patient) but must record, with reasons, any decision to suspend in the healthcare records. In either case, a decision to vary or suspend should be relayed to the Mental Health Act Administrator (or equivalent) 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. However, it would **not** be good practice to vary conditions which had recently been agreed with an AMHP without discussion with that AMHP (MHA Code 29.40).

**11.0 TREATMENT WHILE IN THE COMMUNITY (PART 4A OF THE ACT):**

11.1 The treatment of CTO patients’, who have not been recalled to hospital, including patients who are in hospital on a voluntary basis not having been recalled, is dealt with under Part 4A of the Act. The Code refers to them for convenience as ‘Part 4A patients’ and provides detailed guidance on their treatment in chapters 24 and 25.

* 1. There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria set out at 12.2 below.
	2. 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 MHA may not generally be used to give non-recalled 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.
	3. Non-recalled Part 4A patients over the age of 16, 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 16, treatment cannot be given where an attorney or deputy refuses on the patient’s behalf. If the patient is over 18, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under MCA.[[8]](#footnote-8)
	4. 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.[[9]](#footnote-9) The alternative mechanism is via recall to hospital.
	5. 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.

* 1. 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.[[10]](#footnote-10) These are only exceptional circumstances in which force can be used to treat an objecting CTO patient without first recalling them to hospital.
	2. In non-emergency situations (excluding ECT for which reference should be made to paras. 24.18-24.24 of the Code and the Trust’s ECT policy) a patient may lack capacity and object to treatment but where physical force is not required, he/she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO.
	3. A certificate is required from the period of one month after the CTO has begun or three months following first administration of medication for a mental disorder whichever the later. The certificate will either be a CTO12 where the patient’s RC certifies that the patient has capacity and is consenting, or a CTO11 which is completed by a SOAD. The CTO 11 does not signify capacity or otherwise, merely that the treatment is appropriate to be given. A CTO 11 does not authorise the giving of medication to a non-consenting patient who has capacity unless the patient is recalled and it states that treatment can be given upon recall to hospital.
	4. The SOAD will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply. When consulted by the SOAD, the RC should ensure that discussion takes place with regard to appropriate inpatient treatment.
	5. Form CTO11 or CTO12 should be kept with the original CTO and detention papers but a copy must be kept in the clinical records. Copies of current certificates must also be attached to the patient’s drug card. The RC and care co-ordinator must continue to ensure that the drug card tallies with the drugs described on the certificate.
	6. The arrangements surrounding the SOAD’s examination will be complicated by the fact that the patient is in the community, so an appropriate person should be asked to confirm arrangements with the SOAD and coordinate the process. This may be a care coordinator.

11.13 Other than in exceptional circumstances, SOAD examinations will be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit a CTO patient in a hostel or home, the SOAD will always be accompanied by an appropriate member of the care team.

**12.0 RECALL FROM CTO**

* 1. Where a patient breaches a condition of their CTO for example by refusing necessary treatment which is leading to relapse 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/she believes it is no longer safe or appropriate for the person to remain in the community; the RC may recall the patient to hospital. The RC has responsibility for co-ordinating the recall process and to ensure that the hospital to which the patient is recalled is ready to receive the patient.[[11]](#footnote-11) Recall need not be to a bed but can be to an out patient’s clinic if an inpatient bed stay is not required. It is not appropriate to remove a person from a CTO and then immediately re detain the patient in order to obtain a bed.

If a bed subsequently becomes unavailable within four hours an IR1 and a SUI must be completed. The process of recall should be given the same priority as that for an initial detention.

* 1. To ensure compliance with the Code, recall should only be considered if:[[12]](#footnote-12)
* The patient needs to receive treatment for mental disorder in hospital (either as an inpatient or as an outpatient) **AND**
* There would be a risk of harm to the health and 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 3.2 above, unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered.
	1. The RC must complete a written notice of recall to hospital (Form CTO3) which is effective only when served on the patient.

**N.B. It is imperative that the RC who is to issue notice of recall is correctly identified as the RC or the AC who is temporarily acting as RC (the on call RC). Incorrect identification of the RC (for example a more junior doctor who was not the RC or designated on call RC) would make the recall unlawful (see appendix LSMSC protocol).**

* 1. Where possible, this notice should be handed to the patient personally. This could be done by a CPN or care co-ordinator. Notice would be deemed to be served as soon as the patient takes hold of the Form. If that is not possible (or the patient refuses to accept it), notice can be hand delivered to the patient’s usual or last known address. In this case, notice will take effect immediately after midnight following delivery even though it may not have been received by the patient.
	2. If that method is not possible, notice can be posted by first class post. Notice is deemed served on the second working day after posting. Once notice has been lawfully served, the patient can be taken and conveyed to hospital and will be absent without leave if he/she fails to return to hospital.

A CTO patient who is in hospital who refuses to accept the notice of recall must have a risk assessment to determine whether the patient is safe to leave the hospital. **Section 5(4) or section 5(2) cannot be used to prevent the patient from leaving. In some circumstances, the use of common law to prevent harm to the person or to others may need to occur in an emergency until such time as notice of recall is deemed served at the start of the next day.**

In some circumstances following lawful service of notice it may be necessary to obtain a section 135 (2) warrant in order to enter the premises. This could be obtained by the care co-ordinator - who may be a CPN. In each case it is important to have clear evidence of the timing of service of the recall notice and ensure that the warrant is not executed unless the recall notice is deemed legally effective.

* 1. Table 1 below summarises the reasons for and effect of each method of Serving a Notice or 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 SOAD, but situation is not urgent. | Deliver form by first-class mail to address where patient is believed to be. | Served on the second working day after posting e.g. posted on 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.Following lawful service of notice, consider whether s.135(2) warrant should be sought. | 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. |

**Table 1: Appropriate Method by which to Serve a Notice of Recall**

* 1. The RC should ensure that the hospital to which the patient is recalled is ready to receive him/her and to provide treatment, although this may be given on an outpatient basis, if appropriate. Conveyance to that hospital should be in the least restrictive manner possible. Reference should be made to any policies agreed locally with the Police and any guidance provided by the Police Force.
	2. 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.
	3. The 72 hour period of recall does not begin until the patient arrives at the hospital.
	4. Transfer after recall, to a hospital managed by another organisation requires that arrangements for the transfer are properly in place and that Form CTO6 is completed to provide authority for transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to.[[13]](#footnote-13)
	5. As soon as practicable, the patient shall be 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 13.1 – 13.5 below. The provision of CTO rights must be recorded in the same manner used for other detained patients.
	6. Where a change of RC on recall is anticipated, best practice requires that they should be made aware of and be involved in any of the following actions required of the RC, as soon as practicable. See the appendix protocol at the end of the policy.
	7. 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. The RC may allow the patient to leave the hospital at any time during the 72 hour recall period at which time the recall period ceases and the CTO resumes.
	8. 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.[[14]](#footnote-14) 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 healthcare records. A CTO patient can agree to be admitted informally to hospital without a recall procedure being used or can elect to remain in hospital after the period of recall has elapsed. **Should that patient then wish to leave, the holding powers set out in section 5(2) or 5(4) cannot be used. See Section 5(6) of the Mental Health Act (1983). Notice of recall must be served.**
	9. There may be rare occasions when a person making an application to detain under section 2 or 3 does not know that a CTO is in place. If a person subject to a CTO is admitted to hospital under Section 2 of the Mental Health Act, the Section 2 must be discharged as soon as it is realised that there is a CTO in place. The application for assessment under section 2 does not affect the currency of the CTO. If the patient is detained under section 3 where it cannot reasonably be known that there is a CTO in place (a patient from out of area for example) the patient’s CTO will cease to have an effect if they were also on a section 3 (not hospital order or direction) prior to going on the CTO.

**13.0 TREATMENT ON RECALL (PART IV OF THE ACT):**

13.1 When a patient on a CTO is recalled, they will become subject to the provisions of section 62A.

* 1. If a Second Opinion Appointed Doctor (‘SOAD’) has approved any treatment (on a Form CTO11) in the event of the patient’s recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the SOAD has indicated otherwise, the certificate will authorise treatment (other than ECT) whether the patient has or does not have capacity to refuse it.
	2. A CTO12 may authorise treatment if the patient still has the capacity to agree to the treatment and does so.
	3. On recall, treatment that was already being given as described on Form CTO11 may continue to be given if the approved clinician in charge of the treatment considers that stopping it would cause the patient serious suffering, but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

13.4 It is not good practice on recall, to rely on a certificate that was issued while a patient was detained prior to going on to a CTO even if it remains technically valid. A new certificate should be obtained.[[15]](#footnote-15)

1. **REVOCATION OF CTO OR RETURN TO COMMUNITY**

14.1 If inpatient 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 CTO and document that they have done so.

* 1. To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. The RC will request a meeting with an AMHP to discuss the need for revocation. In order for revocation to proceed, an AMHP, having considered the wider social context for the patients, must also agree with the RC’s assessment for the CTO to be revoked. This need not be an AMHP already involved in the patient’s care and treatment.
	2. 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 healthcare records, the patient must be discharged from hospital at the end of the 72 hour period and the CTO continues. It is not appropriate for an RC to approach another AMHP for an alternative view.
	3. Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 & 3 and the AMHP completing Part 2 of the Form CTO5. The AMHP will also complete a report. The revocation takes effect immediately once it is signed. The form must be forwarded to the Mental Health Act Administrator (or equivalent), as soon as practicable.
	4. 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.
	5. 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.
	6. If following recall, a patient’s CTO is revoked, the Hospital Managers (or equivalent) must refer the patient’s case to the FTT (Mental Health) as soon as possible.
1. **EXTENDING THE COMMUNITY TREATMENT PERIOD**

15.1 A CTO can be extended following examination of the patient by the RC within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met.[[16]](#footnote-16) These mirror the criteria and mandatory conditions described at 3.1 – 3.3 above with the additional requirement that the RC must also consult one or more other persons who have been professionally concerned with the patient’s medical treatment. Where the RC is not a registered medical practitioner, they should consult a doctor.[[17]](#footnote-17)

15.2 As when making the original CTO, the RC must obtain the written agreement of an AMHP that the conditions for extending CTO are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed Form CTO1. To enable the AMHP to make an informed decision about renewal, the RC and the Care-Coordinator should arrange to meet with the patient and the AMHP to discuss the CTO. This could be within the format of a CPA review. The AMHP will then complete the Local CTO AMHP report.

* + 1. The RC completes and signs Part 1 and the AMHP completes Part 2 of the Form. The RC will then complete Part 3 of the CTO7, addressing the report to the relevant Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital’s internal mail system. It is then received by the Mental Health Act Administrator (or other authorised person) who completes Part 4.

15.4 Once received, the Managers must undertake a review of the report provided on Form CTO7 which may vary in uncontested cases.[[18]](#footnote-18) 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.[[19]](#footnote-19)

15.5 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:[[20]](#footnote-20)

* Is the patient still suffering from mental disorder?
* If so, is the disorder of a nature or degree which makes 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 RC to be able to exercise the power to recall the patient to hospital, if that is needed?

15.6 The Code then requires that if the 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.

15.7 Where the answer to all of these questions is “yes”, but the RC has made a report under s.25 barring discharge by the nearest relative (see 10.3 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/herself?

15.8 Where three or 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.

15.9 Special provisions for extending the community treatment period apply to patients who have been unlawfully at large (‘absent without leave’).[[21]](#footnote-21) After an absence of more than 28 days, Form CTO8 must be completed to extend the CTO period.

15.10 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/her right of discharge or may allow the CTO to lapse.

* 1. Extension periods for CTO mirror the renewal scheme for s.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 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.

**16.0 COMMUNITY TREATMENT ORDERS AND THE PATIENT WHO IS ABSENT WITHOUT LEAVE**

16.1 Section 18 of the Mental Health Act identifies the circumstances when a patient is deemed to be absent without leave (AWOL).

16.2 In respect of patients on a CTO a patient is deemed to be absent without leave if he/she has:

* Failed to attend hospital when recalled
* Absconded from hospital after being recalled there
	1. CTO patients who are AWOL may be taken into custody and returned to the hospital to which they have been recalled. Where entry to premises has been denied, a warrant under section 135(2) is required.
	2. The following personnel are authorised to retake CTO patients:-
* An AMHP
* A Police Officer
* A member of staff of the hospital to which they have been recalled,
* Anyone authorised in writing by the managers of the hospital to which they have been recalled.
* The patient’s RC
	1. AWOL CTO Patients who are returned to hospital within 28 days

16.5.1 The RC should consider examining the patient to determine whether or not a CTO is still appropriate.

16.5.2 If the patient returns (or is returned) within the 28 day period AND there is **more** than 72 hours to go before the CTO would ordinarily expire:-

16.5.3 The 72 hour recall period commences at the date and time of return and the RC and AMHP must review the patient’s circumstances within that 72 hour period in the normal way.

16.5.4 If the patient’s circumstances are not reviewed within the 72 hour period then he/she is automatically returned on to the CTO in the normal way.

16.5.5 If the patient returns (or is returned) within the 28 day period with **less** than 72 hours to go before the CTO would ordinarily expire:-

16.5.6 The CTO expiry date is extended by 72 hours to allow the RC and AMHP to review the patient’s circumstances in the normal way.

16.5.7 If the patient’s circumstances are not reviewed within the 72 hour period then he/she is automatically discharged from all detention powers (including the CTO).

* 1. AWOL CTO Patients who are returned to hospital after 28 days

16.6.1 A patient who is absent without leave remains liable to be returned to hospital any time within:-

* EITHER 6 months from the day he/she went AWOL OR when the Community Treatment Order would ordinarily expire, **whichever comes last.**
* Once the patient returns (or is returned) within the allotted time-frame, the RC must review the patient’s circumstances within the 72 hour period in the normal way.

16.6.2 If the RC concludes that the patient needs to remain on a CTO then:-

* The RC must complete Form CTO8 (section 21B) within the 72 hour period after first consulting with an AMHP and at least one other person who is professionally concerned with the patient’s medical treatment (who must agree with the RC).
* If at this time, there is **less** than two months to run before the CTO would expire, the Form CTO8 has the effect of extending (renewing) the order.
* If at this time there is **more** than two months to run before the CTO expires, the Form CTO8 does not extend (renew) it and Form CTO7 (Section 20A) would be used for this purpose in the normal way.

16.6.3 If the RC concludes that the CTO needs to be revoked then this is conducted within the 72 hour period in the normal way. There is no requirement to complete a CTO 8 (Section 21B(4A)).

16.6.4 If the patient returns (or is returned) after 28 days of having gone AWOL BUT with less than 72 hours before the patient is no longer subject to Section 18 powers:-

* The RC is granted 72 hours to examine the patient starting from the date and time he/she returns (or is returned) to hospital.
* During this 72 hour period the RC may still decide to extend or revoke the CTO in the usual way.
* If the RC does not complete the process within the 72 hour period then all formal powers (including the CTO) end forthwith.

**17.0** **COMMUNITY TREATMENT ORDERS AND SECTION 136 – PLACE OF SAFETY**

17.1 If a patient who is on a CTO is arrested by the police under Section 136 and taken to a place of safety, the patient’s RC should be contacted immediately. If this arrest takes place out of hours the on call RC should be contacted. If formal admission is required, this should be done using the power of recall under Section 17E. A Mental Health Act assessment is not needed and there is no need to contact an AMHP.

**18.0 COMMUNITY TREATMENT ORDERS AND PEOPLE SENTENCED TO PRISON**

18.1 A patient who is on a CTO will automatically cease to be a CTO patient if he/she remains in custody for longer than six months in total.

* 1. Such patients will remain on a CTO for any period spent in custody that does not exceed six months in total, even where it is anticipated that they will serve a prison sentence greater than six months.
	2. A patient may, however, be discharged from a CTO at any time.
	3. A patient who is released from custody within six months will be treated as if he/she had gone AWOL on the day of release provided that he/she has been formally recalled to hospital in the usual way.
	4. A patient may be recalled to hospital EITHER when he/she is first imprisoned OR on the day of release.
	5. **Where the CTO has expired (or is about to expire) at the point of release from prison**:-

18.6.1 If a patient is recalled to hospital at the point of imprisonment AND if prior to release from prison the CTO expires (or is about to expire) THEN the CTO is extended by 7 days (with the date of release from prison being taken as Day 1). This is to enable the RC to have time to examine the patient and submit a report extending the CTO (if appropriate) under Section 20A.

18.6.2 In these circumstances a patient released from prison may only be *automatically* taken into custody and returned to hospital if:-

* The recall notice is served at the beginning of the prison sentence

AND

* The patient is taken into custody and returned to hospital with 28 days of the prison release date.

18.7 **Where the CTO is still active at the point of release from prison:-**

18.7.1 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).

18.7.2 In these circumstances a patient can, if necessary, be recalled to hospital in order to be examined with a view to making a report extending their CTO. If they fail 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.

**19.0 TRANSFER BETWEEN HOSPITALS AND JURISDICTIONS**

19.1 Paragraphs 7.5 – 7.6 above describe 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 organisations. It does not necessarily mean that there is a transfer of the patient’s responsible hospital.

* 1. The responsible hospital for a patient subject to 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’.[[22]](#footnote-22)
	2. Assignment of responsibility for community patients between hospitals within the same organisation requires no statutory paperwork but the Hospital Managers of the receiving hospital must write to the patient informing him/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.

19.4 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 on to a CTO.

19.5 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.[[23]](#footnote-23)

* 1. 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.
	2. 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.

**20.0 DISCHARGE FROM LIABILITY TO DETENTION:**

20.1 ‘Discharge’ for a CTO patient, regardless of who orders it, means complete release from liability to detention under the Act in hospital or in the community. It is not the same as ‘recall’ or ‘revocation’ which are described at 7 and 8 above or the process of ‘discharge subject to …. being liable to recall’[[24]](#footnote-24) which follows the making of a CTO order.

20.2 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 S.23 of the Act[[25]](#footnote-25) and providing it to the Managers of the responsible hospital. There is no statutory form for this purpose or any statutory requirement to consult with any other person.

20.3 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, an illustrative example of which may be found on page 356 of the 2015 Code.

20.4 Within the permitted 72 hours, the RC may sign a report barring discharge under S.25 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’. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness (see 9.7 above). Where a report is made, the nearest relative must be advised of their right to apply to the FTT (Mental Health).

20.5 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 (Mental Health).

20.6 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, 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.

20.7 An application for discharge can be made once by a patient to the FTT (Mental Health) during any period of a CTO. Any withdrawn application is disregarded and does not interfere with this right. The FTT (Mental Health) cannot vary conditions on a CTO imposed by the RC and although it can make a recommendation, it cannot oblige an RC to make a CTO for a detained patient. The Tribunal application rights of both patients and their nearest relative are set out in Section 66 of the Act.

20.8 It may be appropriate for the FTT (Mental Health) 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.

20.9 If a Part II patient (i.e. liable to recall to underlying Section 3) 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 3. A CTO can only be recommended by starting a fresh assessment. This does not affect Part III patients (i.e. liable to recall to underlying Section 37 or equivalent). Detention under Section 2 will not affect a current CTO.[[26]](#footnote-26) Detention in prison or elsewhere of less than six months’ duration will allow a CTO to continue or to be extended in accordance with the provisions set out in 9.9 above. Detention in custody for a period of more than six months will automatically bring the CTO to an end in all cases.

**21.0 DEFINITIONS**

* AMHP – Approved Mental Health Professional
* Community patient – a patient in respect of whom a CTO is in place
* Certificate – CTO11 and CTO12
* CTO – Community Treatment Order
* LSSA – Local Social Services Authority
* MCA – Mental Capacity Act 2005
* MHA / the Act – the Mental Health Act 1983 amended by the Mental Health Act 2007
* RC – Responsible Clinician
* Section 117 After Care – after care under the MHA for which the patient cannot be charged
* SOAD – Second Opinion Appointed Doctor
* FTT (Mental Health) - First Tier Tribunal (Mental Health)

**22.0 RESPONSIBILITIES**

22.1 Executive Directors, Clinical Directors and General Managers will be responsible for ensuring that local procedures are agreed for each Care Group they manage and that these are updated periodically.

**23.0 COMPLIANCE STATEMENT**

23.1 It is the responsibility of all staff likely to be involved in working with people in receipt of Community Treatment Orders to be fully conversant with this document.

**24.0 TRAINING**

24.1 Mental Health Act Training.

**25.0 TARGET AUDIENCE**

25.1 All staff who care for patients detained under the Mental Health Act 1983.

**26.0 REVIEW DATE**

26.1 This policy will be reviewed in 2 years or in light of organisational or legislative changes.

**27.0 CONSULTATION**

27.1 Executive Leadership Council.

**28.0 LEGISLATION COMPLIANCE**

28.1 This document is compliant with the Human Rights Act 1998, the Mental Capacity Act 2005, the Care Programme Approach and all other legal requirements.

28.2 This policy must be read in conjunction with Chapters 29, 31 and 32 of the Mental Health Act Code of Practice 2015.

**29.0 EQUALITY IMPACT ASSESSMENT**

29.1 Nottinghamshire Healthcare NHS Foundation Trust recognises that all sections of society may experience prejudice and discrimination.

29.2 This policy has been assessed using the Equality Impact Assessment Screening Tool. The assessment concluded that the policy, properly followed, would have no adverse impact on individuals from any of the nine protected characteristics in the Equality Act 2010 namely age, disability, gender, sexual orientation and gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief.

**30.0 CHAMPION AND EXPERT WRITER**

30.1 The Champion of this policy for Nottinghamshire Healthcare NHS Trust is the Executive Medical Director. For Nottinghamshire County Council the champion is the Group Manager for Younger Adults. For Nottingham City Council the champion is the Head of Specialist Services. The Expert Writers are the Nottinghamshire Multi Agency Policy & Procedure Review Group.

**Policy/Procedure for: COMMUNITY TREATMENT ORDERS**

**Issue:**  **23**

**Status:**

**Author Name and Title: Nottinghamshire Multi Agency Policy and Procedure Review Group**

**Issue Date:**

**Review Date:**

**Approved by:**

**Distribution/Access: APPENDIX 1 : Flowcharts**

**Community Treatment Orders**

**Section 3 or unrestricted Section 37 patient**

**Chapter 29 MHA Code of Practice (2015)**

**The RC considers that the CTO criteria are met (s17A) (5)**

**The RC consults the patient and all relevant parties**

**The inpatient RC identifies the proposed community RC and discusses proposed discretionary conditions with proposed community RC and proposed discharge care plan with proposed community care co-ordinator**

**The RC arranges a multi-agency discharge meeting/CPA meeting and invites relevant parties including an AMHP from the relevant Local Authority**

**If the RC feels that the criteria are met, the RC completes Form CTO1 Part 1**

**If AMHP agrees with RC, the AMHP completes part 2 of Form CTO1**

**If the AMHP is in agreement and has completed Part 2 of the CTO1, the RC will complete Part 3 and set the date for discharge onto the CTO**

**The completed CTO papers are sent to the MHA office**

Recall **(always *before* revocation)**

**If the patient is non-compliant with conditions, mental health deteriorates or there is a change in circumstances, the care team will report to RC if not already aware.**

**RC will consider if recall is necessary. If so, the RC will identify a bed and once identified the RC completes Form CTO3. The patient can be recalled to any hospital which can be to a bed or to an outpatient’s clinic**

**The RC will make arrangements for service of recall on the patient (Note: the patient could be in hospital already)**

**Once the recall notice is deemed served, the RC in collaboration with the care coordinator and treating team will make arrangements for transportation of the patients and obtaining section 135(2) warrants where required.**

**Once patient is in hospital, the hospital staff will complete Form CTO4. The patient can be detained for a maximum of 72 hours only and can be transferred during those 72 hours. (Form CTO6 if different Trust)**

**During the 72 hours, the RC must decide whether the patient should:**

**1. Be discharged back into the community on a CTO**

**2. Remain on the ward as a voluntary patient but on the CTO**

**3. Remain on the ward as a voluntary patient but be discharged from the CTO (and therefore underlying s 3)**

**4. Be discharged from the CTO and back into the community**

**5. Be considered for revocation of the CTO**

**If Revocation is required:** (NOT unless recalled first)

**If the RC is of the opinion that the CTO should be revoked, then during the 72 hour recall period, they should request the attendance of an AMHP at the meeting to consider the need for revocation.**

**If the RC is of the opinion that the criteria for revocation are met, they should complete Part 1 of CTO 5.**

**If an AMHP is in agreement, they should complete part 2 of the CTO 5.**

**If the AMHP has signed part 2, the RC should then complete Part 3.**

**The underlying s3 or s37 is automatically restored as though it was the first s3 (i.e. 6 months until renewal).**

**If the CTO 5 is completed, the MHA Admin will refer the patient to the Tribunal**

**CTO Renewal**

The initial CTO lasts for up to 6 months and can be renewed for a further 6 months and then annually **Form CTO7**

Two months before the CTO is due to expire, the MHA Admin team writes to the RC and care co-ordinator requesting **Form CTO7** for renewal.

The RC arranges a meeting and invites the care coordinator and interested parties including the AMHP from the relevant authority to attend the meeting.

If the RC feels that the criteria are met, the RC will complete Part 1 of **Form CTO7.**

**Form CTO7** passed to AMHP from community team. If the AMHP is in agreement, then they will complete Part 2 of the CTO7.

If the AMHP is in agreement and has completed Part 2 of the CTO7, then the RC should complete Part 3 of the CTO7 and furnish to the MHA administration.

The MHA Administration will arrange a Hospital Managers’ Hearing.

Discharge

The Nearest Relative can apply for discharge.

The First Tier Tribunal can discharge

The Hospital Managers can discharge

The RC can discharge

If the CTO is not renewed on time (**Form CTO7)** it will expire and the underpinning section 3 or 37 will also end.

**APPENDIX 2**

# Community Treatment Orders – Guidance from Nottinghamshire Healthcare Foundation Trust LSMSC

**1: Introduction**

In Local Services within the Trust, there will be transition of patients from inpatient to community consultants (and vice versa) which requires close cooperation and communication if a Community Treatment Order (CTO) is to be implemented appropriately.

Good practice would dictate that there is clear documented discussion between the inpatient and outpatient Responsible Clinicians (RC) regarding the implementation of a CTO and also in relation to recall/revocation issues.

It should be clear to all who is the patient’s RC when the patient is an inpatient (‘Inpatient RC’) and who is the patient’s RC when the patient is still subject to their CTO (‘Community RC’).

Where there is movement between hospital and the community, successive RCs need to be identified in good time to enable the movement to take place.

There should also be clear guidance of cover arrangements for when the RC is not available e.g. non-working hours (on call system), study leave, sick leave and annual leave.

**2: Who is the patient’s RC?**

Normally it will be the Approved Clinician (AC) (currently the relevant consultant psychiatrist who is approved by the Secretary of State to act as an Approved Clinician for the purposes of the Mental Health Act 1983) who has overall responsibility for the patient’s care.

This is a non-delegable duty; however the role may be occupied on a temporary basis in the absence of the usual RC. Any AC can be the temporary RC, irrespective of status.

Currently in our Trust whoever is acting as the consultant in charge of the patients care is the RC. Therefore the on-call consultant is RC for all detained patients that they cover. The patient’s consultant can still act as the RC until they go off duty, irrespective of time. Cover consultants for study leave/ annual leave/ sick leave would be the RC. Junior doctors cannot act as the RC as they would not normally be an AC.

A CTO patient who has agreed to stay informally on the ward can do so.  While they are an inpatient the Inpatient Consultant will become their RC, although he should maintain communication with the Community RC as set out in this Protocol.  It should be noted by all clinicians involved that the CTO does not end when a patient is admitted informally.

**3: Initiating a CTO**

Although initiated by the Inpatient RC, the conditions can be varied or suspended by the Community RC if they consider it appropriate. Therefore it is essential that the key issues in relation to the CTO are agreed between the appropriate consultants and that this is documented. Any areas of disagreement should be discussed and documented before the CTO is in place (see the Protocol Communication Form).

**4: Discharge Planning**

Once the conditions attached to the CTO are agreed (between the Inpatient RC and AMHP) and the discharge date is anticipated, there should be direct contact between Inpatient RC and Community RC. Face to face contact is ideal, but only required if areas of disagreement need to be resolved. Otherwise telephone or email contact will suffice to ensure there is clarity about the handover of care. Once the patient is discharged the patient’s RC is the Community RC. Only in rare circumstances will this not be the case.

It is the responsibility of the Inpatient RC to write to the CQC for SOAD opinions at this point. The SOAD request should include a specific request to address what medication could be used in the event of a recall or revocation.

**5: In the community**

Whist the patient is on CTO in the community, the Community RC is the patient’s RC.

If there is transfer of care from one community team to another then it should be clearly documented when the transfer of RC occurs and the Mental Health Act office notified accordingly. The default position is that the consultant on RIO under whom the patients care comes is the RC unless it is recorded otherwise.

**6: Recall/ revocation**

Once in the community if recall is necessary the Protocol Communication Form should be used to communicate the Community RC’s intentions to the inpatient consultant who is providing care. The Community RC will undertake the recall process where the patient is not physically in the hospital.

The inpatient RC automatically becomes the patients RC once the CTO is revoked.

Where a CTO patient is visiting Nottinghamshire, his/her RC remains the RC from the area of origin. Recall to hospital can only be undertaken by that RC or the on call consultant from that area. The CTO3 should be faxed through to Nottinghamshire in order for it to be served on the patient. The patient can then be recalled to a hospital in Nottinghamshire.

**7: Discharge back to the community**

If the patient complies with treatment and is settled they will be discharged within 72 hours. The Care Coordinator (CCO) will do the 7 day follow up and the Community RC will be informed.

Where the in-patient plan does not concord with that anticipated by the Community RC (as set out on the Protocol Communication Form or otherwise recorded in the notes) every effort will be made to contact the Community RC before a final decision is made. If no contact can be made then the ward consultant will make the decision regarding discharge/revocation as they feel appropriate.

**8: Transfer between wards**

It is preferable that a patient on recall from their CTO should not be moved wards unless there is good reason for that patient’s care (e.g. requiring PICU). The reason for this is that within 72 hours there needs to be a decision taken regarding this patient’s detention and transfers may hinder the clinical decision making in the patient’s case. If the patient is, however, moved then the new inpatient consultant automatically becomes the patient’s RC upon admission to the new ward.

**9: “Hospitals”**

In Local Services within the Trust, the premises used for recalling a CTO patient should be the 5 hospital bases, i.e. QMC, Highbury, Wells Road Centre, Millbrook or Bassetlaw.  A bed will need to be identified at a specific hospital as the Form CT03 – Recall to Hospital, needs to specify which hospital they are to be recalled to.  The RC should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide treatment. (MHA Code of Practice: 29.59).

**APPENDIX 3**

**Communication Form in relation to recall to hospital of a patient on a Community Treatment Order.**

This form is to assist the admitting ward in continuing the care plan of the Community RC. It should also be considered by the Inpatient RC and the Community RC as part of the discharge planning process.

The patient :………………………………………………………………….…..(name)

Is being recalled to hospital as:

1. They need to receive treatment for a mental disorder in hospital

Yes / No

2. There would be risk of harm to the health or safety of the patient, or to other persons, if the patient was not recalled.

Yes / No

I wish the person to be:

1. Given their medication and if they take it without difficulty to be discharged without being admitted to hospital

 Yes / No

Their medication is:

1. Admitted to hospital for 72 hours to determine if the CTO should be revoked

 Yes/ No

You may take that decision without further consultation

 Yes /No

I wish you to discuss this decision with me if you decide not to revoke

 Yes / No

(You must give a means of contact – see below)

Name of Responsible Clinician:

Mobile phone number/ how to contact the RC for discussion on the third day:

Signature

Date

**APPENDIX 4**

###### EMPLOYEE RECORD OF HAVING READ THE POLICY/PROCEDURE

**Title of Policy/Procedure: Community Treatment Orders**

I have read and understand the principles contained in the named policy/procedure.

|  |  |  |
| --- | --- | --- |
| PRINT FULL NAME | **SIGNATURE** | **DATE** |
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1. Reproduced from the MHA Code: Figure 18 page 350 [↑](#footnote-ref-1)
2. MHA Code 29.13 [↑](#footnote-ref-2)
3. Form CTO1 contains a statement to this effect: ‘The patient is to make him/herself available for examination under section 20A, as requested’. [↑](#footnote-ref-3)
4. Form CTO1 contains a statement to this effect: ‘If it is proposed to give a certificate under Part 4A of the Act in the patient’s case, the patient is to make him/herself available for examination to enable the certificate to be given, as requested.’ [↑](#footnote-ref-4)
5. MHA Code 29.27 – 29.33 [↑](#footnote-ref-5)
6. It is held that such an action may be in breach of the Public Law Principle of ‘Propriety of Purpose’ which requires that a statutory power can only be exercised for a legitimate purpose which Parliament intended. [↑](#footnote-ref-6)
7. The Act calls patients who are eligible for the support of an IMHA “qualifying patients”. [↑](#footnote-ref-7)
8. MHA Code Chapter 9 [↑](#footnote-ref-8)
9. Section 6 Mental Capacity Act 2005 [↑](#footnote-ref-9)
10. MHA Code 24.24 - 24.28 [↑](#footnote-ref-10)
11. MHA Code 29.52 and 29.59 [↑](#footnote-ref-11)
12. MHA Code 29.45 – 29.51 [↑](#footnote-ref-12)
13. The Mental Health Regulations 2008, Regulation 9(3)-9(5) [↑](#footnote-ref-13)
14. MHA s.17E(4) [↑](#footnote-ref-14)
15. MHA Code 25.85 [↑](#footnote-ref-15)
16. The Act, s.20A(6) [↑](#footnote-ref-16)
17. Although this is not an explicit requirement of the Act currently, this is a safeguard against potential future challenges to the validity of ‘medial evidence’. [↑](#footnote-ref-17)
18. MHA Code 38.41 -38.46 [↑](#footnote-ref-18)
19. MHA Code 38.35 [↑](#footnote-ref-19)
20. MHA Code 38.18 [↑](#footnote-ref-20)
21. The Act, s.21A & 21B [↑](#footnote-ref-21)
22. Section 19A [↑](#footnote-ref-22)
23. MHA Code 37.16 – 37.27 [↑](#footnote-ref-23)
24. Section 17A(1) [↑](#footnote-ref-24)
25. An order for discharge is made under S.23(2)(a) if CTO has been revoked or S.23(2)(c) if CTO is still in force. [↑](#footnote-ref-25)
26. Admission under S.2 should not normally be considered as a legitimate alternative to recall or revocation of a CTO but its appropriateness as a temporary alternative might be argued where a patient has been admitted for assessment under S.2 to an out of area hospital without their knowledge that he/she was subject to CTO. The least restrictive option in that situation might be to briefly continue with the S.2 rather than revoking the CTO if discharge back to CTO is imminent. [↑](#footnote-ref-26)