Livewell Southwest

# Section 17A
# Community Treatment Orders
# (Supervised Community Treatment)

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# Section 17A Community Treatment Orders (Supervised Community Treatment)

## 1 Introduction

1.1 Community Treatment Orders (CTO) came into force on 3rd November 2008. This document has been reproduced from chapter 25 "Supervised Community Treatment" contained in the Mental Health Act 1983 Code of Practice (CoP) and from the relevant chapters of the Mental Health Act 1983 Reference Guide. Whilst this document has been amended to reflect local practice, it fundamentally has remained unchanged from the guidance contained within these documents.

1.2 The Mental Health Act 1983 (MHA'83) does not use the term supervised community treatment (SCT) except in headings. It refers instead to people being given community treatment orders (CTOs) and therefore becoming "community patients". The Code of Practice and the Reference Guide refers to SCT and SCT patients. This policy will also refer to SCT and SCT patients, to avoid confusion with the large majority of patients receiving healthcare services in the community who are not subject to any special measures under the Act.

## 2 Purpose

2.1 Section 17A is a power under the MHA'83, the purpose of which is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.

2.2 SCT provides 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.

2.3 The purpose of this document is to provide guidance to all staff working with SCT patients on how they should proceed when carrying out their duties under the Act. This document will also provide guidance regarding the limitation of Section 17A and the measures which are in place to protect the SCT patient's rights.

2.4 The purpose of the CoP is to provide guidance to registered medical practitioners (doctors), approved clinicians (AC), managers and staff of hospitals and approved mental health professionals (AMHPs) on how they should proceed when undertaking duties under the Act. Whilst the Act does not impose a legal duty to comply with the CoP those listed above must have regard to the CoP. Any departure from the CoP could give rise to legal challenge; therefore the reasons for departure must be recorded.

## 3 Duties

3.1 Responsible Clinicians, (RCs), ACs, AMHPs, managers and staff of Livewell

Southwest have a responsibility to ensure that patients subject to S17A are treated lawfully and in accordance with the guiding principles of the Code of Practice.

3.2 Any course of action taken under the Mental Health Act 1983 (MHA'83) (as amended) must be done with consideration to the Guiding Principles contained within chapter 1 of the Code of Practice 2008. Section 118 of the Act states the Code of Practice (CoP) shall include a statement of principles which will inform decisions under the Act.

The Guiding Principles are:

- Purpose Principle.
- Least Restriction Principle.
- Respect Principle.
- Participation Principle.
- Effectiveness, Efficiency and Equity Principle.

3.3 Chapter 1 of the CoP, **Statement of Guiding Principles** states, "This chapter provides a set of principles which should be considered when making decisions about a course of action under the Act". All professionals involved with the care and treatment of persons who are subject to SCT must be familiar with the Principles contained in chapter 1 of the CoP.

3.4 All practitioners involved in the use of SCTs should attend training relating to the use of SCT.

# 4 Definitions

### 4.1 The Act

Unless otherwise stated, the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

### 4.2 Approved Clinician (AC)

A mental health professional approved by the Secretary of State to act as an approved clinician under the Mental Health Act (MHA). Some decisions under the Act can only be taken by approved clinicians. All Responsible Clinicians (RC) must be approved clinicians.

### 4.3 Approved Mental Health Act Professional (AMHP)

A social worker or other professional approved by a local social services authority to carry out a variety of functions under the Mental Health Act.

### 4.4 Community Treatment Order (CTO)

Written authorisation, on a statutory form for the discharge of a patient from detention in hospital into supervised community treatment.

4.5 **Responsible Clinician (RC)**

The approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on supervised community treatment) can only be taken by the responsible clinician.

4.6 **Supervised Community Treatment (SCT)**

Arrangements under which patients can be discharged from detention in hospital, but remain subject to the Act in the community. Patients on SCT are expected to comply with conditions set out in the community treatment order, and can be recalled to hospital if treatment in hospital is required again.

## 5 Who can be discharged onto a CTO?

5.1 Only patients who are detained in hospital for treatment under section 3 of the Act, or are unrestricted Part 3 patients, can be considered for a CTO. Patients detained in hospital for assessment under section 2 of the Act are not eligible.

5.2 The criteria which needs to be fulfilled if a CTO is to be put in place is that:

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

**Assessment for a CTO**

5.3 The decision as to whether a CTO is the right option for any eligible patient is taken by the RC and requires the agreement of an AMHP. The AMHP is to be contacted in the same way they are contacted for any other Mental Health Act assessments. 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. Consultation at an early stage with the patient and those involved in the patient's care will be important. It is expected that a meeting will be convened to discuss and plan the CTO. (See Appendix A for Practice Guidance).

A patients RC must consider placing the patient on a CTO if they are granting Section 17 Leave of Absence for a period exceeding 7 days. The Section 17 Leave form provides space to record the decision regarding granting of S17 instead of a CTO. The rationale for not using a CTO must be recorded in the clinical record.

5.4 In assessing the patient's suitability for a CTO, the RC 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. The key factor in the decision is whether the patient can safely be treated for mental disorder in the community only if the RC can exercise the power to recall the patient to hospital for treatment if it becomes necessary.

5.5 In making that decision the RC must assess what risk there would be of the patient's condition deteriorating after discharge, for example as a result of refusing or neglecting to receive treatment.

5.6 In assessing that risk the RC must take into consideration:

- the patient's history of mental disorder; and
- any other relevant factors.

5.7 Whether a patient has previously had repeated admissions, the patient's history may be relevant to the decision. For example, a tendency to fail to follow a treatment plan or to discontinue medication in the community, making relapse more likely, may suggest a risk justifying use of a CTO.

5.8 Other relevant factors will vary but are likely to include the patient's current mental state, the patient's insight and attitude to treatment, and the circumstances into which the patient would be discharged.

5.9 Taken together, all these factors should help the RC to assess the risk of the patient's condition deteriorating after discharge, and inform the decision as to whether continue detention, a CTO or discharge would be the right option for the patient at that particular time.

5.10 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. The RC must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify the power to recall the patient to hospital for treatment.

5.11 Patients do not have to consent formally to a CTO. But in practice, patients will need to be involved in decisions about the treatment to be provided in the community, how and where it is to be given, and be prepared to co-operate with the proposed treatment and care plan. Without this cooperation the CTO is likely to be less effective.

**Action upon Tribunal recommendation**

5.12 When a detained patient makes an application to the Tribunal for discharge, the Tribunal may decide not to order discharge, but to recommend that the RC should consider whether the patient should go onto a CTO. In that event, the RC should carry out the assessment of the patient's suitability for a CTO in the

usual way. It will be for the RC to decide whether or not a CTO is appropriate for that patient.

5.13 A detailed record of the assessment must be recorded in the patients clinical record. Whatever decision is made regarding a CTO, the decision and reasons for the decision must be communicated to the Tribunal. If the recommendation is not complied with the Tribunal may wish to reconvene to reconsider the patients' case.

## 6 Care planning, treatment and support in the community

6.1 Good care planning, in line with the Care Programme Approach (CPA) will be essential to the success of a CTO. A care co-ordinator will need to be identified; and should be involved in the CTO planning process, as soon as the RC considers the use of a CTO. This is likely to be a different person from the RC, but need not be. If a different RC is to take over responsibility for the patient, it will be essential to liaise with that clinician, and the community team, at an early stage. It is expected they community team will be involved in the planning phase of the CTO.

6.2 The care plan should be prepared in the light of consultation with the patient and (subject to the normal considerations of patient confidentiality):

- the nearest relative;
- any carers;
- anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf i.e. persons with Lasting Power of Attorney relating to welfare matters;
- the multi-disciplinary team involved in the patient's care; and
- the patient's GP (if there is one). It is important that the patient's GP should be aware that the patient is to go onto a CTO. The GP will be informed in writing of the CTO by the Mental Health Act Office once the CTO has commenced. A patient who does not have a GP should be encouraged and helped to register with a practice.

6.3 The care plan should set out the practicalities of how the patient will receive treatment, care and support from day to day, and should not place undue reliance on carers or members of the patient's family. If the patient so wishes, help should be given to access independent advocacy or other support where this is available.

6.4 The care plan should take account of the patient's age. Where the patient is under the age of 18 the RC and the AMHP should bear in mind that the most age-appropriate treatment will normally be that provided by child and adolescent mental health services (CAMHS). It may also be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need.

6.5 Similarly, specialist services for older people may have a role in the delivery of services for older CTO patients.

**Treatment in the Community**

6.6 If the patient requires medication as treatment for their mental disorder the RC must ensure the appropriate certification is in place, before the treatment can be given. GPs must not prescribe medication for the treatment of the patients' mental disorder, without authorisation from the RC.

6.7 If a patient on a CTO requires treatment, for their mental disorder, in the community, the RC should ensure that the patient receives this from an appropriate person, who may be a member of the Community Mental Health Team or the patient's GP.

6.8 Treatment cannot be given against the patient's wishes, whilst in the community. In addition to the certificate requirements, there must always be authority to give the treatment i.e. consent. If a patient has capacity to consent to the treatment in question, the patient's own consent provides the authority for giving it. Persons aged 16 or over are deemed to have capacity to consent, as defined by the Mental Capacity Act 2005 (MCA), unless it is proved that they lack the capacity to make the decision.

6.9 If a patient with capacity refuses to give their consent to the treatment, the treatment cannot be administered to the patient in the community, even when there is a statutory form CTO11/12 approving the treatment. The patient would need to be recalled to hospital, if the recall criteria can be satisfied.

If someone is empowered under the MCA to consent on the patient's behalf i.e. has a Lasting Power of Attorney, is a deputy or authority has been provided via the court of protection then that other person's consent would provide the necessary authority to administer the treatment.

6.10 Patients may have made an advance decision or statement of wishes about treatment to which practitioners will need to have regard. Patients who lack capacity cannot be given treatment in the community which goes against a valid and applicable advance decision, unless it is an emergency, i.e. to save the patient's life, to prevent serious deterioration or alleviate serious suffering, and/or is the least intrusive way to prevent the patient from being a danger to themselves or to others. To be given the treatment, they would have to be recalled to hospital. Chapter 17 of the CoP provides further guidance relating to wishes expressed in advance.

**Part 4A Certificate**

6.11 A Part 4A Certificate (CTO11/CTO12) is required 1 month after the commencement of the SCT, or at the end of the initial 3-month consent to treatment period whichever is later. This is known as the certificate requirement.

6.12 If a patient is refusing to consent to the treatment or lacks the capacity to consent , the Approved Clinician (AC) must request a SOAD to complete a Form

CTO11. The request for the SOAD is made via the CQC website https://webdataforms.cqc.org.uk/Checkbox/SOAD.aspx. A copy must be printed before being submitted and forwarded to the MHA Office. Details of the capacity assessment must be recorded in the patient's clinical record.

The AC must submit the SOAD request at the same time as completing the CTO Application (CTO1) to allow sufficient time for the SOAD to visit. It will be the responsibility of the Care Coordinator to arrange with the SOAD the exact details of the visit and to liaise with the patient accordingly.

6.13 If a patient has capacity and is consenting to the treatment, the AC in charge of the Treatment must complete a Form CTO12. This form confirms the treatment for mental disorder the patient has given informed consent to. The AC must record details of the capacity assessment and how consent was obtained on the reverse of the form, or in the patients' record.

6.14 The CTO11/12 provides a description of the treatment or plan of treatment that has been agreed as appropriate and can also provide a treatment plan following any recall to hospital under Section 17E. Only medication for mental disorder which is stipulated on the form can be lawfully administered. The SOAD may stipulate conditions to the treatment plan which may include time limits to any CTO11 issued. Any conditions imposed will be noted on the form, and must be complied with.

A copy of the CTO11/12 will be sent to the GP by the MHA Office. This is to ensure only those stipulated medications are administered/prescribed by the GP. The form will be uploaded to the electronic patient record for use by clinicians. The AC and Care Coordinator will be notified that the form has been issued.

6.15 It is the responsibility of the AC in charge of the treatment to ensure the patient is being treated lawfully. It is good practice for the AC to review the Part 4A certificate at regular intervals, and as a minimum standard when the CTO is extended for a further period. The AC must provide a fresh CTO12 or request a further SOAD visit if there is a change in the patients consent status or a change to the treatment plan that is not covered by the existing certificate.

**Emergency Treatment (Section 64)**

6.16 If at the 1 month point, it has not been possible to obtain the CTO11, for patients who are refusing or incapable of giving their consent to the treatment, the AC should consider continuing with the treatment under S64 of the Act.

6.17 The grounds for administering medication in these circumstances are governed by Section 64C (2)(c) and 64G), and state:

"the certificate requirement does not apply if the treatment is immediately necessary ".

'Immediately necessary' is interpreted in this section to mean that treatment must be immediately necessary either to:

- save the patient's life; or
- prevent serious deterioration of the patient's condition (being not irreversible); or
- alleviate serious suffering (being neither irreversible nor hazardous); or
- prevent the patient from behaving violently or being a danger to self or others (being the minimum interference necessary and neither irreversible nor hazardous).

6.18 A locally produced form to record authorisation of Section 64 emergency treatment has been produced and is at Appendix B, and is available on the Intranet.

6.10 Section 64 can also be used when there is a need to change the patient's medication and it cannot be delayed until the SOAD completes a fresh CTO11. A fresh SOAD request must accompany a Section 64 form completed in these circumstances.

6.20 After the initial 1 month period (or at the end of the initial 3-month consent to treatment period, whichever is later) the AC responsible for the patient's medication must ensure that either a CTO11/12 or S64 form is in place to ensure the medication is administered in accordance with the Act.

6.21 The MHA Office will notify the AC and care co-ordinator if the CTO11/12 has not been authorised within the necessary timescales. The AC will then be required to decide if authorisation under section 64 is necessary and complete the appropriate form and make an entry in the patients' record. If there is no certificate in place, the medication should not be administered, even if the patient is consenting.

6.22 If medication has been provided and is not covered by the certificate, and incident form must be completed. The patient will need to be advised of the error and offered assistance to make a complaint or seek legal advice. The MHA Office and RC must be informed, and fresh certification will need to be provided as a matter of urgency. The error and action taken must be documented in the patients' clinical record.

**S117 – Aftercare**

6.23 Patients on a CTO are entitled to after-care services under section 117 of the Act. The after-care arrangements should be drawn up as part of the normal care planning arrangements. The Clinical Commissioning Group and local social services authority (LSSA) must continue to provide aftercare services under section 117 for as long as the patient remains on a CTO. Before the patient is placed on a CTO a S117 review must take place. This should be part of the CTO planning meeting and will be a good opportunity to identify what care is required and how it will be provided.

6.24 The care plan should be completed prior to the commencement of the CTO and a copy should be submitted to the MHA Office along with the application.

The care plan should be reviewed regularly, as the services required may vary should the patient's needs change. As a minimum standard the care plan must be reviewed in accordance with the CPA Policy (i.e. 6 monthly).

## 7 Making the community treatment order

7.1 Placing a patient on a Community Treatment Order (CTO) should be a planned activity. It is expected that before the CTO1 Application form is completed a CTO Planning Meeting will be held. The following should be in attendance:

- Patient.
- Responsible Clinician.
- Community Responsible Clinician (if the RC will change on start of the CTO).
- Care Coordinator.
- Carer (if applicable).
- Approved Mental Health Professional (AMHP).
- IMHA if requested by the patient.

7.2 The purpose of the meeting is to ensure the patient and professionals are all present to discuss the appropriateness of placing the patient on the CTO and any alternative options that need to be considered. The meeting will identify in a multi-disciplinary approach, based on the risk assessment and patients' presentation, the conditions that are necessary and appropriate to be attached to the CTO. To ensure that all parties are fully involved in the discussion and understand the conditions applied and the legal effect of the CTO.

7.3 This meeting should be combined with a CPA/S117 Aftercare review meeting. This will provide an opportunity to review the patients care plan and Aftercare needs. By have a MDT approach the clinical tam will be able to familiarise themselves with the needs of the patient and understand their own responsibilities.

7.4 This meeting will also provide an opportunity for the clinical team to fulfil other legal requirements in relation to the CTO. At this meeting once the decision has been made to place the patient on a CTO it is expected that the appropriate clinician will also complete the following:

- Inform the patient of their rights under the MHA (S132A) normally done by the care coordinator.
- Assess the patients' capacity to consent to treatment for mental disorder, and to provide a CTO12 or complete a SOAD request. This will be done by the RC who will be managing the CTO.
- Update the Risk Assessment. This will be done by the care coordinator.
- Agree the care plan. The care plan should relate to any conditions that have been attached to the CTO. This will be done by the care coordinator following the involvement of relevant professionals/agencies.

7.5 The following documentation is to accompany the CTO1:

- Copy of CTO care plan (signed by patient and care coordinator).

- Copy of Updated Risk Assessment.
- Completed CTO12 Certificate **or** copy of SOAD request.
- Copy of letter from RC to patient (Appendix E).
- If RC is to change a copy of letter to the patient confirming change of RC.
- Section 132A rights form or confirmation that it has been completed on S1.
- Copy of MHA Assessment (completed by AMHP).

See Practice Note at Appendix A.

**Role of the Approved Mental Health Professional (AMHP)**

7.6 The AMHP must decide whether or not to that the patient meets the criteria for a CTO, and (if so) whether a CTO is appropriate. Even if the criteria are met, it does not mean that the patient must be discharged onto a CTO. In making that decision, the AMHP should consider the wider social context for the patient. Relevant factors may include any support networks the patient may have, the potential impact on the rest of the patient's family, and employment issues.

7.7 The AMHP should consider how the patient's social and cultural background may influence the family environment in which they will be living and the support structures potentially available. No assumptions should be made simply on the basis of the patient's ethnicity or social or cultural background.

7.8 The Act does not specify who the AMHP should be. It may (but need not) be an AMHP who is already involved in the patient's care and treatment as part of the multi-disciplinary team. It can be an AMHP acting on behalf of any willing LSSA. LSSAs may agree with each other and with hospital managers the arrangements that are likely to be most convenient and best for patients. If no other LSSA is willing, responsibility for ensuring that an AMHP considers the case should lie with the LSSA which would become responsible under section 117 for the patient's after-care if the patient were discharged.

7.9 If the AMHP does not agree with the RC that the patient should go onto a CTO, then the CTO cannot go ahead. A record of the AMHP's decision and the full reasons for it should be kept in the patient's clinical record. It would not be appropriate for the RC to approach another AMHP for an alternative view. It may be necessary for the RC to hold a multi-disciplinary team meeting to discuss the reasons for the AMHP decisions and to discuss any alternatives they may have suggested.

7.10 If the RC and AMHP agree that the patient should be discharged onto a CTO, they should complete the relevant statutory form (CTO1) and send it to the hospital managers (MHA Office).

The RC must specify on the form the date and time that the community treatment order (CTO) is to be effective from. **This date is when the authority for the CTO starts**, and may be a short while after the date on which the form is signed, to allow time for arrangements to be put in place for the patient's discharge.

7.11 The CTO will commence initially for a period of 6 months from the date and time stipulated on the CTO1, and not from the date the form was signed.

**Conditions to be attached to the community treatment order**

7.12 The CTO will include the conditions with which the patient is required to comply while on a CTO. There are two conditions which are included in all cases. Patients are required to make themselves available for medical examination:

- when needed for consideration of extension of the CTO; and
- to enable a Part 4A certificate to be given.

7.13 RCs may also, with the AMHP's agreement, set other conditions which they think are 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;
- protect other people.

7.14 Conditions may be set for any or all of these purposes, but not for any other reason. The AMHP's agreement to the proposed conditions must be obtained before the CTO can be made.

7.15 In considering what conditions might be necessary or appropriate, the RC should always keep in view the patient's specific cultural needs and background. The patient, and (subject to the normal considerations of patient confidentiality) any others with an interest such as a parent or carer, should be consulted.

7.16 The conditions should:

- be kept to a minimum number consistent with achieving their purpose;
- restrict the patient's liberty as little as possible while being consistent with achieving their purpose;
- have a clear rationale, linked to one or more of the purposes in **paragraph 7.13**; and
- be clearly and precisely expressed, so that the patient can readily understand what is expected;
- be clearly linked to the risk assessment and care plan.

7.17 The nature of the conditions will depend on the patient's individual circumstances. Subject to **paragraph 7.13**, 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. The Guiding Principles previously listed should be used to help inform the decisions made under the Act and regarding the conditions to be attached.

7.18 The reasons for any conditions should be explained to the patient and others, as appropriate, and recorded in the patient's clinical record and on the care plan. It will be important, if a 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.

7.19 The conditions must not deprive the patient of their liberty. If the patients' treatment amounts to conditions of deprivation, that deprivation can only be lawful if authorised under a procedure prescribed by law. The Act does not permit a patient to be deprived of their liberty as part of the CTO. In cases where a patient is suspected of being deprived of their liberty, consideration must be given to using the Mental Capacity Act 2005 (if applicable). Advice must be sought from the MHA/Deputy MHA Manager.

**Information for CTO patients and others**

7.20 As soon as the decision is made to discharge a patient onto a CTO, the RC should inform the patient and others consulted of the decision, the conditions to be attached to the CTO, and the services which will be available for the patient in the community. This must be done in writing (Appendix C) and a copy is to be submitted to the MHA Office attached to the CTO paperwork.

7.21 There is a duty on hospital managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing and must be done as soon as practicable after the patient goes onto a CTO by their care co-ordinator as part of the CTO planning meeting.

Section 132A information must be given to the patient at the commencement of the CTO, when there is a change to their care plan or the conditions, if the patient is recalled; the CTO is revoked or extended. A copy of the information will be provided to the nearest relative unless the patient objects.

Please refer to the Mental Health Act 1983 – Section 132, 132A, 133 and 134 – Hospital Managers Information Policy.

**Rights of Victims – Duty on Hospital Managers**

7.22 The Domestic Violence, Crime and Victims Act 2004 places a number of duties on hospital managers in relation to certain unrestricted Part 3 patients (those detained under section 37 or 47 without restrictions) who have committed sexual or violent crimes. This includes liaising with victims in order to:

- advise victims if the patients discharge is being considered or if the patient is about to be discharged;
- forward representations made by victims to people responsible for making decisions on discharge or CTOs and for passing information received from those people to the victim;
- informing victims who have asked to be told, if the patients is to go onto a CTO and of any conditions on the CTO relating to contact with them or their family, any variation of the conditions and the date on which the order will cease; and
- informing RC's of any representations made by the victim about the conditions attached to the CTO.

7.23 The MHA Office will maintain a register to identify patients concerned and to record if the victim wishes to be informed or make representations. The RC and clinical team will be informed by the MHA Office if this duty applies.

# 8 Monitoring CTO patients

8.1 It will be important to maintain close contact with a patient on a CTO and to monitor their mental health and wellbeing after they leave hospital. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and the way in which local services are organised. All those involved will need to agree to the arrangements. Respective responsibilities should be clearly set out in the patient's care plan. The care co-ordinator will normally be responsible for co-ordinating the care plan, working with the RC (if they are different people), the team responsible for the patient's care and any others with an interest.

8.2 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 RC 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 CTO to continue safely and which the patient would accept, the RC should consider offering such treatment if appropriate. If so, the care or treatment plan, and if necessary the conditions of the CTO, should be varied accordingly (note that a revised Part 4A certificate may also be required).

8.3 If the patient is not complying with any condition of the CTO the reasons for this will need to be properly investigated. Recall to hospital may need to be considered if it is no longer safe and appropriate for the patient to remain in the community. The conditions may need to be reviewed – for example, if the patient's health has improved a particular condition may no longer be relevant or necessary. The RC may vary conditions as appropriate (see **paragraphs 8.4-8.9)**. Changes may also be needed to the patient's care or treatment plan.

### Varying and suspending conditions

8.4 The RC has the power to vary the conditions of the patient's CTO, or to suspend any of them. The RC 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.

Any variations to the conditions should be discussed with the care co-ordinator and a new care plan created, to reflect a change to the conditions. Changes to the conditions must be recorded on form CTO2 and sent to the MHA office with a copy of the new care plan. The MHA office will then write to the patient to confirm the new conditions.

8.5 Suspension of one or more of the conditions may be appropriate to allow for a temporary change in circumstances, for example, the patient's temporary absence or a change in treatment regime. The RC should record any decision to suspend conditions in the patient's clinical record, with reasons i.e. the patient may have a residency condition but wishes to go on holiday, the RC may suspend the residency condition for the duration of the holiday, so the patient does not feel as though they are not complying with a condition. The MHA Office must be informed if any conditions are suspended and the duration of the suspension.

8.6 A variation of the conditions might be appropriate where the patient's treatment needs or living circumstances have changed. Any condition no longer required should be removed. This must be done by the completion of form CTO2.

8.7 It will be important to discuss any proposed changes to the conditions with the patient and to ensure that the patient, and anyone else affected by the changes (subject to the patient's right to confidentiality), knows that they are being considered, and why. If the conditions are varied, the patient will need to agree to try to keep to any new or varied conditions if the CTO is to work successfully, and any help the patient needs to comply with the conditions should be made available to them.

8.8 Any variation in the conditions must be recorded on the relevant statutory form (CTO2), which should be sent to the hospital managers care of the MHA Office, Glenbourne.

**Responding to concerns raised by the patient's carer or relatives**

8.9 It is important that carers or relatives have the contact details of persons they need to contact with any concerns they may have about the patient. Particular attention should be paid to carers and relatives when they raise a concern that the patient is not complying with the conditions or that the patient's mental health appears to be deteriorating.

8.10 The team responsible for the patient, needs to give due weight to those concerns and any requests made by the carers or relatives in deciding what action to take. Carers and relatives are typically in much more frequent contact with the patient than professionals, even under well-run care plans. Their concerns may prompt a review of how a CTO is working for that patient and whether the criteria for recall to hospital might be met. Concerns from carers or relatives should be discussed and addressed as part of the MDT. Consideration should be given as to whether a full CPA review should take place.

## 9 Recall to hospital

9.1 The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or through a change in the patient's circumstances giving rise to increased risk.

9.2 The RC may recall a patient on a CTO to hospital for treatment 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.

9.3 A patient may also be recalled to hospital if they break either of the two mandatory conditions which must be included in all CTOs – that is, by failing to make themselves available for medical examination to allow consideration of extension of the CTO or to enable a Part 4A certificate to be completed.

The patient must always be given the opportunity to comply with the condition before recall is considered. Before exercising the recall power for this reason, the RC should consider whether the patient has a valid reason for failing to comply, and should take any further action accordingly.

9.4 The RC must be satisfied that the criteria are met before using the recall power. Any action should be proportionate to the level of risk. For some patients, the risk arising from a failure to comply with treatment could indicate an immediate need for recall. In other cases, negotiation with the patient – and with the nearest relative and any carer (unless the patient objects or it is not reasonably practicable) – may resolve the problem and so avert the need for recall.

9.5 The RC should consider in each case whether recalling the patient to hospital is justified in all the circumstances. For example, it might be sufficient to monitor a patient who has failed to comply with a condition to attend for treatment, before deciding whether the lack of treatment means that recall is necessary. A patient may also agree to admission to hospital on a voluntary basis. Failure to comply with a condition (apart from those relating to availability for medical examination, as above) does not in itself trigger recall. Only if the breach of a condition results in an increased risk of harm to the patient or to anyone else will recall be justified.

9.6 However, it may be necessary to recall a patient whose condition is deteriorating despite compliance with treatment and the conditions, if the risk cannot be managed otherwise.

9.7 Recall to hospital for treatment should not become a regular or normal event for any patient on a CTO. If recall is being used frequently, the RC should review the patient's treatment plan to consider whether it could be made more acceptable to the patient, or whether, in the individual circumstances of the case, SCT continues to be appropriate.

**Procedure for recall to hospital**

9.8 The RC has responsibility for coordinating the recall process. If out of hours or the patient's normal RC is not available due to leave or sickness, the acting RC

will fulfil this function. It will be important to ensure that the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed. It must be agreed between the RC and the care co-ordinator prior to the recall notice being served who will be responsible for particular actions, i.e. obtaining the warrant (if needed), arranging for police assistance if necessary and for transport to convey the patient to hospital. It will also be necessary to liaise with staff at the hospital as to timings and management difficulties relating to the individual.

9.9 The RC must complete a written notice of recall to hospital (Form CTO3), which is effective only when served on the patient. It is important that, wherever possible, the notice should be handed to the patient personally. Otherwise, the notice is served by delivery to the patient's usual or last known address. (See **paragraphs 9.11-9.16**.) Delivery of the notice will normally be carried out by the community team who are known to the patient, the care co-ordinator or the RC. Consideration should be given to requesting police assistance based on the patient's risk.

9.10 Once the recall notice has been served, the patient can, if necessary, be treated as absent without leave, and taken and conveyed to hospital (and a patient who leaves the hospital without permission can be returned there). The time at which the notice is deemed to be served will vary according to the method of delivery.

9.11 It will not usually be appropriate to post a notice of recall to the patient. This may, however, be an option if the patient has failed to attend for medical examination as required by the conditions of the CTO, despite having been requested to do so, when the need for the examination is not urgent (see **paragraph 9.5**). First class post should be used. The notice is deemed to be served on the second working day after posting, and it will be important to allow sufficient time for the patient to receive the notice before any action is taken to ensure compliance. If a recall notice is posted a record of the date of postage must be made in the patients clinical record and the MHA Office advised accordingly.

9.12 Where the need for recall is urgent, as will usually be the case, it will be important that there is certainty as to the timing of delivery of the notice.

A notice handed to the patient is effective immediately. However, it may not be possible to achieve this if the patient's whereabouts are unknown or if the patient is unavailable or simply refuses to accept the notice. In that event the notice should be delivered by hand to the patient's usual or last known address. The notice is then deemed to be served (even though it may not actually be received by the patient) on the day after it is delivered – that is, the day (which does not have to be a working day) beginning immediately after midnight following delivery. Consideration should be given to requesting police assistance based on the patient's risk.

9.13 If the patient's whereabouts are known but access to the patient cannot be obtained, it may be necessary to consider whether a warrant issued under section 135(2) is needed. A warrant must be obtained by the care co-ordinator

or the community team responsible for the patient. The duty AMHP will only assist if there are exceptional circumstances as to why they need to be involved in the recall. Guidance on How to Obtain a Warrant can be found in the S17 Leave of Absence Policy.

9.14 The patient should be conveyed to hospital in the least restrictive manner possible. If appropriate, the patient may be accompanied by a family member, carer or friend. Consideration should be given as to the patient's risk to themselves, others or their risk of absconding when deciding the appropriate conveying manner.

9.15 The RC should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide treatment. While recall must be to a hospital, the required treatment may then be given on an out-patient basis, if appropriate.

9.16 The hospital need not be the patient's responsible hospital (that is, the hospital where the patient was detained immediately before going onto a CTO) or under the same management as that hospital. A copy of the notice of recall (Form CTO3), which provides the authority to detain the patient, should be sent to the managers of the hospital to which the patient is being recalled. The MHA office must be given a copy of any recall notice issued to the patient.

9.17 On the patients arrival at the hospital Form CTO4 must be completed to record the time and date the start of the recall period. This will be the responsibility of the receiving nurse.

The 72 hours permitted for recall to hospital will commence at the time the patient arrives at the hospital. When the patient arrives at hospital after recall, the clinical team will need to assess the patient's condition, provide the necessary treatment and determine the next steps. It is important that a copy of the Part 4A Certificate is obtained to ensure treatment is administered lawfully and additional certification obtained as needed.

9.18 The patient may be well enough to return to the community once treatment has been given, or may need a longer period of assessment or treatment in hospital. The patient may be detained in hospital for a maximum of 72 hours after recall to allow the RC to determine what should happen next. During this period the patient remains a CTO patient, even if they remain in hospital for one or more nights. During the recall period the patient is "liable to be detained in hospital" and can therefore be treated for their mental disorder as if they were detained (subject to the certification requirements being met).

9.19 The RC may allow the patient to leave the hospital at any time within the 72-hour period; the reasons for this decision must be recorded in the patient's notes. Whilst the Act does not specifically permit the RC to grant a recalled CTO patient Section 17 leave, the RC may, in exceptional circumstances, permit the patient to be away from the hospital during the recall for limited periods of time. The reasons for this must be documented in the patients notes, with any absence from hospital being risk assessed prior to starting.

9.20 In addition there is nothing to prevent a recalled patient consenting to stay in hospital as an informal patient. A record of the patients consent to stay in hospital informally must be recorded in the clinical record.

9.21 In all circumstances the RC must complete the End of Recall Record Form (Appendix D) to record the date and time the recall ended, and the circumstances for the ending of the recall.

9.22 Once 72 hours from the time of admission have elapsed, the patient must be allowed to leave if the RC has not revoked the CTO. On leaving hospital the patient will remain on a CTO as before. Recall to hospital does not affect the expiry date of the CTO.

9.23 The RC and the clinical team will need to consider the reasons why it was necessary to exercise the recall power and whether a CTO remains the right option for that patient. They will also need to consider, with the patient, the nearest relative (subject to the normal considerations about involving nearest relatives), and any carers, what changes might be needed to help to prevent the circumstances that led to recall from recurring. It may be that a variation in the conditions is required, or a change in the care plan (or both).

**Treatment under recall**

9.24 In general, CTO patients recalled to hospital are subject to sections 58 and 58A (ECT) in the same way as other detained patients. But there are three exceptions, as follows:

- a certificate under section 58 (T Form) is not needed for medication if less than one month has passed since the patient was discharged from hospital and became a CTO patient (or they are still within the 3-month consent to treatment period, whichever is the later);

- a certificate is not needed under either section 58 or 58A if the treatment in question is already explicitly authorised for administration on recall on the patient's Part 4A certificate (Form CTO11),or if the treatment is stated on a Form CTO12; and

- treatment that was already being given on the basis of a Part 4A certificate (CTO11/12) may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with section 58 or 58A (as applicable) – in other words while steps are taken to obtain a new certificate i.e. S62 Emergency Treatment form.

9.25 SOADs giving Part 4A certificates (CTO11) need to consider what (if any) treatments to approve should the patient be recalled to hospital. They must also decide whether to impose any conditions on that approval. Unless they specify otherwise, the certificate will authorise the treatment even if the patient has capacity to refuse it (unless it is a section 58A type treatment).

9.26 The potential advantage of authorising treatments to be given on recall to hospital is that it will enable such treatments to be given quickly without the need to obtain a new certificate. However, SOADs should do so only where they believe they have sufficient information on which properly to make such a judgement.

9.27 The exceptions to the requirement to have a certificate under section 58 or 58A set out in **paragraph 9.24** continue to apply if the patient's community treatment order (CTO) is revoked, but only while steps are taken to comply with section 58 (where relevant). ACs should ensure that steps are put in hand to obtain a new SOAD certificate under section 58 or 58A, if one is needed, as soon as they revoke a CTO.

9.28 A CTO Recall Flowchart (Appendix E) has been developed to assist practitioners in complying with the certification requirements in relation to a recalled CTO patient.

9.29 Treatment given under recall must be authorised in line with the above. If the treatment in question is not stipulated on the CTO11/12 or Section 64 (if SOAD pending) the treatment cannot be given without obtaining fresh Part 4 certification (i.e. T form or S62).

## 10 Revoking the CTO

10.1 During the 72 hour period when the patient may be kept in hospital under recall, the RC must make the decision as to whether the treatment provided has been sufficient for the patient to be discharged from hospital under the CTO and return home. If the RC feels this is not the case, then they should recommend that the CTO be revoked and that the patient be re-admitted under S3, or their original detaining section.

10.2 The CTO may be revoked if:

- the RC considers that the patient again needs to be admitted to hospital for medical treatment under the Act; and
- an AMHP agrees with that assessment, and also believes that it is appropriate to revoke the CTO.

10.3 In making the decision as to whether it is appropriate to revoke a CTO, the AMHP should consider the wider social context for the patient, in the same way as when making a decision about an application for admission under the Act.

10.4 As before, the AMHP carrying out this role may (but need not) be already involved in the patient's care and treatment, or can be an AMHP acting on behalf of any willing LSSA. If no other LSSA is willing, responsibility for ensuring that an AMHP considers the case should lie with the LSSA which has been responsible for the patient's after-care.

10.5 If the AMHP does not agree that the CTO should be revoked, then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will therefore remain on a CTO. A record of the AMHP's decision and the full reasons for it should be recorded in the patient's clinical record. It would not be appropriate for the RC to approach another AMHP for an alternative view.

10.6 If the RC and the AMHP agree that the CTO should be revoked, they must complete the relevant statutory Form (CTO5) for the revocation to take legal effect, and send it to the hospital managers. The patient is then detained again under the powers of the Act exactly as before going onto a CTO, except that a new detention period of six months begins for the purposes of review and applications to the Tribunal.

10.7 On Revocation it will be the responsibility of the ward staff to ensure the patient is informed of their rights under section 132 of the Act.

**Treatment on Revocation**

10.8 Treatment authorised on a CTO11 for treatment under recall, or stated on a CTO12, can be administered to the patient following revocation, but only while steps are taken to comply with section 58 (where relevant) and if the AC in charge of the treatment considers that discontinuing it would cause the patient serious suffering.

10.9 The AC should ensure that steps are put in hand to obtain fresh certification under section 58 (or Section 58A) as a matter of urgency. This means if the patient is giving valid informed consent a fresh T2 form must be completed or if the patient is refusing or incapable of giving valid consent, a new SOAD request, and if applicable Section 62 authorisation, must be completed by the AC in charge of the treatment. Full details of capacity assessment and consent discussion must be recorded in the patients' clinical record.

## 11 Hospital managers' responsibilities

11.1 It is the responsibility of the hospital managers to ensure that no patient is detained following recall for longer than 72 hours unless the CTO is revoked. The relevant statutory form (CTO4) must be completed on the patient's arrival at hospital and delivered to the MHA Office. A breach of this procedure may lead to unlawful detention and could lead to serious repercussions. The MHA Office staff will therefore ensure that arrangements are in place to monitor the patient's length of stay following the time of detention after recall, so that the maximum period of recall is not exceeded.

11.2 When there is a transfer of responsibility between RCs, the current RC will need to write to the proposed RC informing of the transfer of their care, and the date this is to take effect. The proposed RC must confirm in writing the acceptance of the RC duties, again confirming the date of the change. Copies of the written communication must be copied to the Deputy MHA Manager. The written communication can be done by secure e-mail. The current RC will remain

responsible for the patient's care until there has been confirmation from the proposed RC they will take over as RC. It will be the responsibility of the current RC to inform the patient of the change and to provide the name and contact details of the proposed RC. A copy of this letter is to be sent to the MHA Office.

11.3 If a patient's CTO is revoked and the patient is detained in a hospital other than the one which was the responsible hospital at the time of recall, the MHA Office will contact the new hospital and obtain a copy of the revocation form. The MHA Office will send the relevant statutory forms to the new detaining hospital, and close down the open CTO on S1.

11.4 The hospital managers have a duty to ensure that a patient whose CTO is revoked is referred to the Tribunal without delay. This duty has been delegated to the MHA office staff.

### Hospital Managers Review Hearings

11.5 Hospital managers should ensure that all CTO patients are aware that they may ask to be discharged by the hospital managers and of the distinction between this and their right to apply for a Tribunal hearing. This is delegated to the clinical staff responsible for providing the patient with their Section 132A Rights.

11.6 Hospital managers:

- May undertake a review of whether or not a patient should be discharged at any time at their discretion;
- Must undertake a review if the patients RC submits to them a report under section 20A extending a CTO;
- Should consider holding a review when they receive a request from (or on behalf of) the patient; and
- Should consider holding a review when the RC makes a report to them under section 25 of the Act barring an order by the nearest relative for discharge.

## 12 Transfer and assignment of responsibility for CTO patients

### Transfer of recalled patients

12.1 The managers of a hospital to which a CTO patient has been recalled may authorise the patients' transfer to another hospital during the 72-hour maximum period of recall. The power to authorise the transfer of a recalled CTO patient has been delegated by the hospital managers to those who can authorise the transfer of a detained patient. The people exercising this power on the managers' behalf must ensure that the needs and interests of the patient are considered before a transfer is authorised, in the same way as when considering the transfer of any detained patients.

12.2 To authorise transfer from a hospital in England to a hospital under different managers, the original hospital must complete Part 1 on Form CTO6. The original form CTO6, along with the CTO3 and CTO4 recall paperwork should be sent, to the new hospital with the patient. The managers of the new hospital will then record the time of admission under part 2 of the CTO6. A copy of form

CTO6 must be given to the MHA Office.

The transfer of a recalled patient has no effect on the end of the 72 hour recall period. The recall period will still cease 72 hours after the patient was originally admitted i.e. date / time recorded on CTO4.

**Transfer of CTO patients to another Responsible Hospital**

12.3 Hospital managers may also reassign responsibility for CTO patients under section 19A so that a different hospital will become the patient's responsible hospital. The same considerations apply. If such a transfer is to take place a form CTO10 must be completed on behalf of the hospital managers of the originating hospital. They may only do so if the managers of the new hospital agree to the transfer and specify a date on which it is to take place. This agreement must be in writing. The reassignment of responsibility does not have any effect of the date on which the CTO is due to expire.

12.4 If a CTO patient is to be transferred to Plymouth Services, copies of the CTO statutory paperwork must be faxed to the MHA Office (01752 517985) for scrutiny. Agreement to the transfer of the patient must not be given until the MHA/Deputy MHA Manager has confirmed the statutory paperwork is in order.

The MHA/Deputy MHA Manager will then confirm in writing, on behalf of the hospital managers, that the transfer can take place.

## 13 Review of CTO

13.1 In addition to the statutory requirements in the Act for review of a CTO, it is good practice to review the patient's progress on a CTO as part of all reviews of the CPA care plan or its equivalent.

13.2 Reviews should cover whether the CTO is meeting the patient's treatment needs and, if not, what action is necessary to address this. A patient who no longer satisfies all the criteria for a CTO must be discharged without delay.

13.3 It is important for the patient to be aware of what they need to do to progress towards discharge from the CTO. This should be recorded in the care plan.

## 14 Extension of CTO

14.1 Only RCs may extend the period of a patient's CTO by extending the period of the CTO. To do so, RCs must examine the patient and decide, during the two months leading up to the day on which the patient's CTO is due to expire, whether the criteria for extending the CTO under section 20A are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment; this person must be different from the AMHP.

14.2 The extension of a CTO should be a planned event. A meeting should be convened with the following present:

- Patient.
- Responsible Clinician.
- Care Coordinator.
- Carer (if applicable).
- Approved Mental Health Professional (AMHP).
- IMHA (if requested by patient).

This meeting could be combined with a CPA/S117 Aftercare review meeting. This will provide an opportunity to review the patients care plan and Aftercare needs, and identify if any of the conditions need to be varied / removed.

14.3 Where RCs are satisfied that the criteria for extending the patient's CTO are met, they must submit a report to that effect to the managers of the responsible hospital (Form CTO7).

But before RCs can submit that report, they must first obtain the written agreement of an AMHP. This does not have to be the same AMHP who originally agreed that the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. It can be an AMHP acting on behalf of any willing LSSA. But if no other LSSA is willing, responsibility for ensuring that an AMHP considers the case should lie with the LSSA which is responsible under Section 117 for the patients after-care.

The role of the AMHP is to consider whether or not the criteria for extending the CTO are met, and if so, whether an extension is appropriate.

14.4 The criteria for extension (which mirror those for making a CTO in the first place) are that:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for them 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 RC should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

14.5 The CTO Extension Meeting will be expected to include/establish the following:

1. Review of the Conditions attached to the CTO.
2. Review of the Part 4A Certificate.
3. Review of the Care Plan.
4. Review of the Risk Assessment.
5. Reprovision of S132A Rights to the patient.

6. Discussions with patient regarding Hospital Managers Hearing for example: are they contesting the renewal, do they wish to have legal representation or do they wish to attend the hearing.

The following documents must accompany a CTO7 – Extension of Community Treatment Order form.

| | | |
|---|---|---|
| 1) | Form CTO7 – completed by RC and AMHP in consultation with another person who is professionally concerned with the patients treatment e.g. care coordinator. | |
| 2) | Reviewed Care Plan (signed by the patient and care coordinator). | |
| 3) | Updated Risk Assessment. | |
| 4) | S132A Rights Form or notification the form has been recorded on S1. | |
| 5) | Confirmation of Review of Conditions. | |
| 6) | Confirmation of Review of Part 4A Certificate and fresh certification if applicable. | |
| 7) | Confirmation of patients wishes re arrangements for the HM Hearing. | |

14.6 Form CTO7, once completed must be furnished to the hospital managers, via the MHA Office. A reviewed care plan and risk assessment should accompany the extension form, along with the CTO Extension Checklist (Appendix G).

14.7 The care co-ordinator must also inform the patient, both orally and in writing, of their Section 132A rights. This should be done as part of the CTO Extension Meeting.

14.8 A hospital managers hearing will be convened to consider if the extension criteria are met or not. The patient will be discharged by the hospital managers if they find that the CTO criteria are no longer met.

14.9 Unless extended, a CTO expires at the end of the six-month period starting with the day on which it is made, i.e. the date specified in form CTO1 as the date from which the CTO is to be effective. If is not extended and the CTO expires, the underlying authority for detention also cease to have effect.

14.10 A CTO can be extended initially for a further six months, and thereafter for a year at a time.

14.11 A practice note (Appendix F) and the CTO Extension Checklist have been produced to assist clinicians with the process of extending the CTO. The CTO Extension Checklist should be completed by a member of the Clinical Team and submitted with the CTO7 and accompanying paperwork. This will be sent out with each CTO extension reminder and will be available on Intranet.

## 15 Discharge from CTO

15.1 SCT patients may be discharged in the same way as detained patients, by the Tribunal, the hospital managers, or the nearest relative. The RC may also discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for a CTO. A patient's CTO should not simply be allowed to

lapse. The discharge must be recorded on the CTO Regrade Form (Appendix H). This form must be submitted to the MHA Office.

15.2 The reasons for discharge should be explained to the patient, and any concerns on the part of the patient, the nearest relative or any carer should be considered and dealt with as far as possible. The reasons for discharge and any concerns must be recorded it the patient's clinical record. On discharge from a CTO, the team should ensure that any after-care services the patient continues to need under section 117 of the Act will be available.

15.3 If guardianship is considered the better option for a patient on a CTO, an application may be made in the usual way.

## 16 Monitoring Compliance and Effectiveness

The compliance with this document will be audited by the Mental Health Manager / Deputy MHA Manager, and any issues reported to the Mental Health Act Governance Group.

Training will be provided to staff via the general Mental Health Act training sessions, and sessions are requested by individual teams.

**CTO Forms (CTO)**

| New Form N$^{o}$ | Used for Section | Name of Statutory Form (with notes if applicable) |
|---|---|---|
| CTO1 | 17A | Community treatment order. |
| CTO2 | 17B | Variation of condition of a community treatment order. |
| CTO3 | 17E | Community treatment order: notice of recall to hospital. |
| CTO4 | 17E | Community treatment order: record of patient's detention in hospital after recall. |
| CTO5 | 17F(4) | Revocation of community treatment order. |
| CTO6 | 17F(2) | Authority for transfer of recalled community patient to a hospital under different managers. |
| CTO7 | 20A | Community treatment order: report extending the community treatment period. |
| CTO8 | 21B | Authority for extension of community treatment period after absence without leave for more than 28 days. |
| CTO9 | | Community patients transferred to England. |
| CTO10 | 19A | Authority for assignment of responsibility for community patient to hospital under different managers. |
| CTO11 | 64C(4) | Certificate of appropriateness of treatment to be given to community patient (Part 4A certificate). |
| CTO12 | 64C(4A) | Certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate). |
| Non Statutory Forms | | |
| S62 | | Section 62 Urgent Treatment for patients detained in hospital. |
| Section 64C(2)(c) and 64G | | Refusing or Incapable CTO Patient – Urgent Treatment. |

**All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.**

**The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.**

**The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.**

Signed: Director of Operations

Date: 22nd April 2015

APPENDIX A

**Practice Note – Planning and Start of CTO**

Placing a patient on a Community Treatment Order (CTO) should be a planned activity. It is expected that before the CTO1 Application form is completed a CTO Planning Meeting will be held. The following should be in attendance:

- Patient.
- Responsible Clinician.
- Community Responsible Clinician (if the RC will change on start of the CTO).
- Care Coordinator.
- Carer (if applicable).
- Approved Mental Health Professional (AMHP).
- IMHA if requested by the patient.

Purpose of Meeting

- The patient and all relevant professionals and carers are present and able to discuss the purpose of the CTO and what this means to the patient.
- Identify the conditions (if any) to be attached to the CTO.
- Undertake S117 Review Meeting to identify Aftercare needs.
- Update the risk assessment prior to the CTO starting.
- Produce a care plan outlining the conditions and other care to be provided.
- Undertake statutory duties of MHA i.e. consent to treatment provisions and S132 rights.

The following documents should accompany the CTO:

| | | |
|---|---|---|
| 1) | CTO1. | |
| 2) | Care Plan (written for CTO and linked to conditions) signed by patient and Care Coordinator. | |
| 3) | Risk Assessment (Updated as part of planning meeting). | |
| 4) | S132A Rights Form or notification it has been completed on S1 – completed by the Care Coordinator. | |
| 5) | CTO12 or SOAD Request (completed by RC who will be managing the CTO). | |
| 6) | Letter from inpatient RC to patient confirming the conditions that are to be attached to the CTO, and who the Responsible Clinician will be (if changing on discharge from hospital). | |
| 7) | Confirmation of who will be the RC and date the change is to take effect. | |
| 8) | Copy of MHA Assessment – completed by AMHP. | |

All the above documents must accompany the Form CTO1 when submitted to the MHA Office.

APPENDIX B

| NHS No: |
|---|

**Mental Health Act 1983**

# Section 64C(2)(c) and 64G Form
Refusing or Incapable Patient

## Urgent Treatment

| |
|---|
| Full name of patient: |
| Address: |
| Details of the proposed treatment:<br><br>Patient is: Refusing to give consent / Incapable of giving informed consent (please delete as applicable) |

Please delete whichever is inappropriate

| | |
|---|---|
| **A** | It is immediately necessary to save the patient's life. |
| **B** | It is immediately necessary to prevent a serious deterioration of his / her condition and is not irreversible. |
| **C** | It is immediately necessary to alleviate serious suffering by the patient and is not irreversible or hazardous. (Not applicable for ECT) |
| **D** | It is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself / herself or to others and is not irreversible. (Not applicable for ECT) |

| |
|---|
| **The length of time for which the treatment is to be given**: |
| **Date second opinion requested**:<br>*(Second Opinion Appointed Doctor (SOAD) requests to be submitted via CQC Electronic Form)* |
| Signature of Responsible Clinician: _____<br>Print name: _____<br>Date: _____ |

Completed form to be forwarded to the MHA Office.

APPENDIX C

Livewell Southwest
Address

Tel: 01752
Fax: 01752

Ref:

Date:

**STRICTLY PRIVATE & CONFIDENTIAL** NHS N$^{o}$:

Patients Address

Dear

**Re: Application for Supervised Community Treatment (Section 17A Community Treatment Order) Mental Health Act 1983**

As you will remember, following our meeting on ……. I informed you that the clinical team had decided to make an application for you to be subject to Supervised Community Treatment (SCT), which allows you to be discharged from detention by means of a Community Treatment Order (CTO). You will remain liable to recall to hospital for further medical treatment if necessary.

…….. an Approved Mental Health Professional and I have made an application today to Livewell Southwest . They will be writing to you as soon as possible to let you know the application has been processed and the details relating to the Community Treatment Order.

Your needs for Section 117 aftercare have been fully assessed, discussed with you and included in you care plan, a copy of which is enclosed. Your Care Co-ordinator is …….

The conditions of your Community Treatment Order are as follows:

1. You are required to attend for medical examination when needed for consideration of extension of the Community Treatment Order;
2. You are required to attend for an examination to enable a Part 4A Certificate to be issued;
3. [add additional conditions as required].

The first 2 conditions are attached to all Community Treatment Orders, and there is a legal requirement to comply with each when requested. Non-compliance with these 2 conditions, can lead to recall to hospital to enable the medical examinations to take place.

……will be your Responsible Clinician in charge of the medical treatment for your mental disorder, who can be contacted at …….. on telephone number …… If you have any further health needs please speak to your own General Practitioner.

If you are not satisfied with any of the services provided, or anything you are asked to do, you should speak to your Care Co-ordinator or Responsible Clinician. You must however keep to the arrangements which have been made unless it is decided that they should be changed. If you do not do this it is possible that you will be recalled to hospital for further assessment and/or treatment.

You will have the right to ask the Hospital Managers of Livewell Southwest to end your Community Treatment Order. You will also have the right to appeal against the decision to put you on a Community Treatment Order to a Mental Health Tribunal. The details of how to contact the Hospital Managers and how to appeal to the Tribunal will be explained to you by your Care Co-ordinator.

Yours sincerely

Responsible Clinician

Enc

Cc Nearest Relative
Patient's GP
Mental Health Act Office
Care Coordinator

APPENDIX D

Livewell Southwest

| NHS No: |
|---|
| |

# Record of Ending of CTO Recall under S17E

To: The Hospital Managers
c/o The Mental Health Act Office

From: _____
Responsible Clinician

| Name of patient: | |
|---|---|
| Recalled to: | |
| Date Recall Period Started: | Time Recall Started: |
| Recall ended Date: | Time: |

| Outcome of Recall to Hospital: | | Please Tick |
|---|---|---|
| | Patient was discharged from Hospital | |
| | Patient to remain in hospital as an Informal Patient | |
| | CTO was revoked:<br>Date: _____ Time: _____ | |

Full reasons for decision:

_____

_____

_____

_____

_____

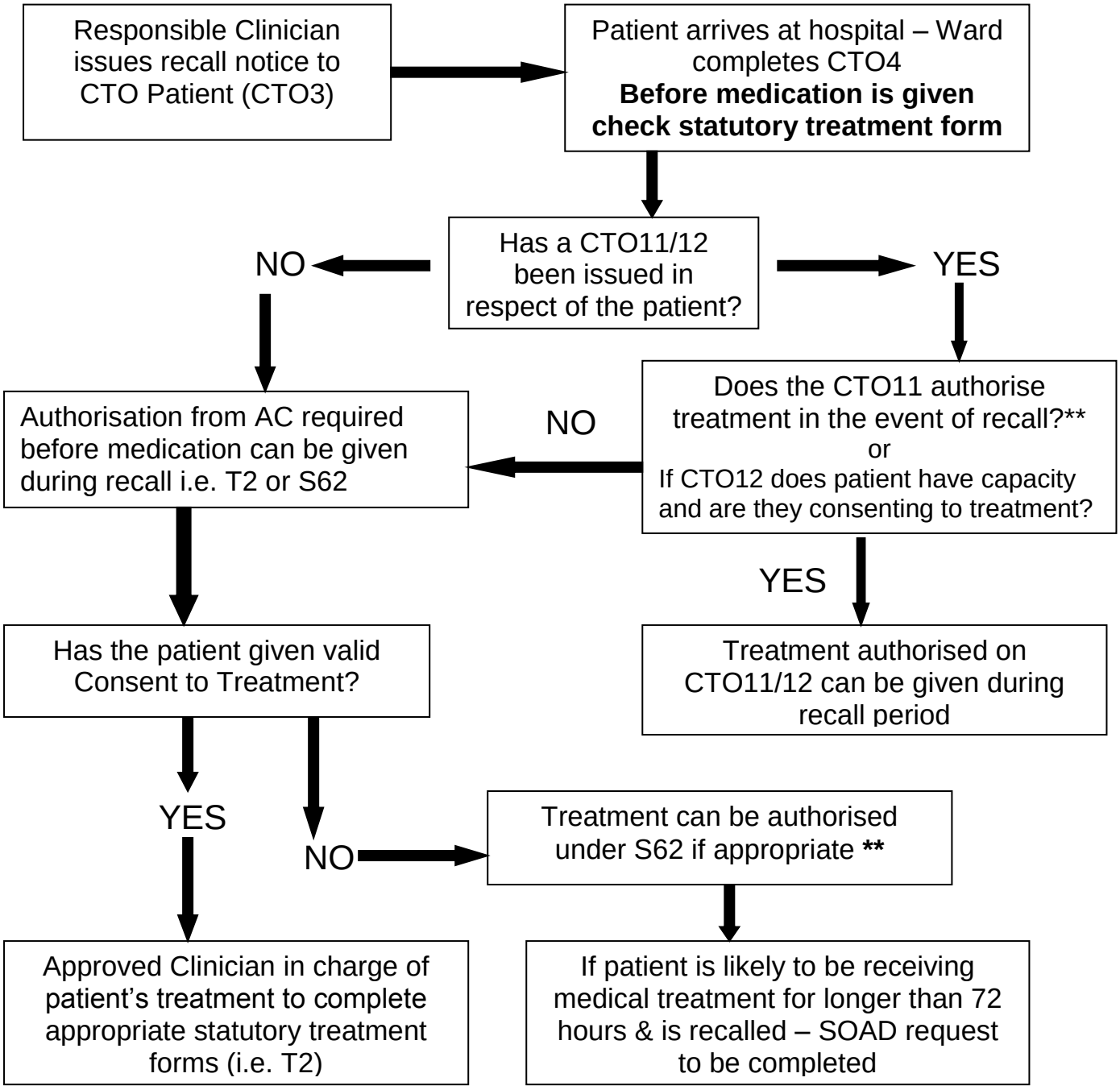
_____

_____

Signed: _____ Date: _____

Responsible Clinician Time: _____

# CTO Recall – Consent to Treatment Action Required




**REVOCATION OF CTO – Action to be taken at time of revocation**
The AC in charge of patients treatment must take steps as soon as possible to provide certification under Part IV either a T2 (if valid consent obtained) or to request a SOAD (if valid consent not obtained) and consider authorising treatment under s62. The CTO11/12 will only continue to authorise treatment if discontinuing it would cause serious suffering, **but** only whilst steps are being taken to obtain the appropriate certification.

******Treatment given on basis of CTO11/12 may be continued, even though not authorised for recall, if the AC in charge of patient's treatment considers that discontinuing it would cause serious suffering, **but** only whilst steps are being taken to obtain the appropriate Part IV certification (i.e. T2 or S62 / SOAD Request).

APPENDIX F

**Practice Note – Renewal of CTO**

The extension of a CTO should be a planned event. A meeting should be convened with the following present:

- Patient.
- Responsible Clinician.
- Care Coordinator.
- Carer (if applicable).
- Approved Mental Health Professional (AMHP).
- IMHA if requested by patient.

This meeting could be combined with a CPA/S117 Aftercare review meeting. This will provide an opportunity to review the patients care plan and Aftercare needs, and identify if any of the conditions need to be varied / removed.

The meeting will be expected to include/establish the following:

- Review of the Conditions attached to the CTO.
- Review of the Part 4A Certificate (CTO11/12).
- Review of the Care Plan.
- Review of the Risk Assessment.
- Reprovision of S132A Rights to the patient.
- Discussions with patient regarding Hospital Managers Hearing arrangements.

The following documents must accompany a CTO7 – Extension of Community Treatment Order form.

| | | |
|---|---|---|
| 1) | Form CTO7 – completed by RC and AMHP in consultation with another person who is professionally concerned with the patients treatment e.g. care coordinator. | |
| 2) | Reviewed Care Plan (signed by the patient and the care coordinator). | |
| 3) | Updated Risk Assessment. | |
| 4) | S132A Rights Form or confirmation the form has been completed on S1. | |
| 5) | Confirmation of Review of Conditions. | |
| 6) | Confirmation of Review of Part 4A Certificate or fresh certification if appropriate. | |
| 7) | Confirmation of patients wishes re HM Hearing arrangements. | |

NB: A patient who is subject to a CTO is not to be discharged from S117.

APPENDIX G

## CTO Renewal Checklist

| Patient Name: | | NHS N$^{o}$: | |
|---|---|---|---|
| CTO Start Date: | | Expiry Date: | |

1) Review of Conditions:

I have reviewed the conditions attached to the CTO, and confirm the following conditions remain necessary and appropriate:

1. You are required to attend for medical examination when needed for consideration of extension of the Community Treatment Order;
2. You are required to attend for medical examination, if necessary, with a Second Opinion Appointed Doctor who will authorise the treatment;*
3.
4.
5.

**OR**

I have varied the conditions and have attached a form CTO2* *(*please delete as applicable)*

2) Review of Consent to Treatment

I have reviewed the Part 4A Certification and:

- I confirm that the CTO12 dated _____ remains accurate and covers the treatment for mental disorder.*
- I confirm that the CTO11 dated _____ remains accurate and covers the treatment for mental disorder.*
- I have reviewed the certification and will provide a fresh CTO12 (copy attached) / or will request a SOAD (copy of SOAD request to be attached)* *(*please delete as applicable)*

3) A copy of updated Care Plan and Risk Assessment attached Yes / No

4) Patients' wishes regarding the Hospital Managers Hearing arrangements.

- They are / are not contesting the extension of the CTO.
- They do / do not want to attend the Hospital Managers Hearing.
- They do / do not wish to appoint a solicitor to represent them.
  Name of Solicitor: _____
- They do / do not want an IMHA to assist them with the hearing.
- They do / do not want their Nearest Relative / Friend invited to the hearing
  Name of Relative / Friend: _____
- They do / do not want their Nearest Relative informed of the extension of the CTO.

5) Patient has been informed of their S132A Rights (completed form attached/on S1*)

Signed: _____ Date: _____
Responsible Clinician

APPENDIX H

| NHS No: |
|---|
| |

# Section 23(2)(C) Form

**Mental Health Act 1983 Section 23(2)(C)**

**Responsible Clinician Discharge of a Patient from a Community Treatment Order**

To: The Hospital Managers
c/o The Mental Health Act Office

From: ……...
Responsible Clinician

| Name of patient: |
|---|
| Date of CTO: |

As Responsible Clinician for the above patient, I confirm that I examined my patient on *(date of examination)* ……. and hereby *(delete the phrase that does not apply).*

discharge him/her from the Community Treatment order and the liability to be recalled to hospital immediately

Or

discharge him/her from the Community Treatment order and the liability to be recalled to hospital on ..... (date).

Signed: _____
Responsible Clinician

_____
Print Name

Date: _____ Time: _____

In all circumstances a copy of the form must be given to the patient and appropriate ward or unit responsible for the patient. The original form must be sent to the Mental Health Act Office.

If you would like a copy of this form sent to Home Treatment Team ☐ or AOS ☐ or CMHT ☐ please tick as applicable.