

Community Treatment Order Policy

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Version Control Summary

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1.3	20 th January 2016	Johanna Turner	Final	Updated following changes to MHA Code of Practice
1.4	February 2021	Sazi Banda/David Markovitch	Final	Updated in line with Review Date and current Devon Partnership NHS Trust v SSHC [2021] High Court Judgement – 9.1 3.8 Once the CTO is completed, the statutory forms must be sent to the local Mental Health Law office via email. The forms can now be submitted by electronic means due to the changes in MHA Regulations. 7.4 CTO recall <u>cannot</u> be furnished by electronic means to the service user

				with the changes to MHA Regulations 10.3 Nearest Relative request for discharge of Part II CTO service user can be made by email.
1.5	21 st March 2022	Guy Davis	Final	References to sending documents via electronic means, added throughout.

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1.0 Introduction:

- 1.1 From 3 November 2008, the Mental Health Act 1983, as amended by the Mental Health Act 2007 ('the Act') introduced a scheme to provide treatment of mental disorder in a community setting. 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)'
- 1.2 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. 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.

2.0 Executive Summary:

- 2.1 This Trust-wide 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 Trust policies, namely the "Consent to Treatment Policy", the "Advance Decision to Refuse Treatment Policy", the 'Responsible Clinician and Nominated Deputy Policy', the Mental Capacity Act Policy' and "Missing and Absent without Leave Policy".
- 2.2 The purpose of this policy is to ensure that there is lawful and appropriate use of CTO's, and that the legal rights of any patient subject to a CTO order are upheld at all stages. There is no lower age limit for CTO's.

3.0 Criteria & Process for making a CTO:

- 3.1 The following criteria must be met in all cases before a community treatment order can be made by the patient's Responsible Clinician ('RC'):
 - The patient must be currently liable to detention for treatment under section 3 or an unrestricted section under Part III of the Act; this can also include a patient currently on section 17 leave from hospital.¹ It is not applicable for patients on restriction orders
 - In the RC's opinion, the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment
 - It is necessary for the patient's health or safety or the protection of other people that such treatment should be received
 - Such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment
 - It is necessary that the RC should be able to recall the patient to Hospital.
 - 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
- 3.2 The following conditions are mandatory in all cases:

¹ For a full list of eligible sections see Department of Health (2015) *Reference Guide to the Mental Health Act 1983 as amended by the Mental Health Act 2007- Chapter, 26 - Figure 75.*

- The patient must make him or herself available for examination to determine whether to extend the community treatment period²
- The patient must make him or herself available for examination to enable for the certificate under Part 4A of the Act to be given, if required³

Other non-mandatory conditions may be set (see Para 5.4 in this policy onwards)

3.3 An Approved Mental Health Professional (AMHP) (who could be working in the same team as the RC⁴) must agree in writing that the patient meets the criteria for a CTO, a CTO is appropriate and any conditions made are necessary or appropriate for one or more of the following reasons:

- to ensure the patient receives medical treatment;
- to prevent risk of harm to patient's health or safety;
- to protect other persons.

The Code of Practice at 29.25 states that if the AMHP does not agree then the CTO cannot be made. Faced with a disagreement, the RC should not attempt to seek an alternative view from another AMHP. Should circumstances change or further information come to light, further consideration could be given and ideally the original AMHP should be consulted with an explanation clearly documented if this is not practicable

- 3.4 Section 17A of the MHA 1983 states that an order is made by the RC completing Part 1 of the form CTO1. Then an AMHP completes Part 2 of form CTO1. Finally, the RC, completes Part 3 of the form CTO1. Once signed by the RC, the CTO order automatically takes effect on the date and time specified on part 3 of the form, for a period of up to six months. All of the above can be done by sending documents via electronic means.
- 3.5 Although it must be given to the Hospital Managers as soon as practicable, there is no statutory form to record receipt of the CTO. Therefore it is the responsibility of the RC to ensure that all completed CTOs are furnished via electronic means to the Mental Health Law office, as soon as is practicable after completion.
- 3.6 Once the CTO1 has been completed by the current RC, it is acceptable for a different Approved Clinician (AC) to assume the role of RC regarding the care and treatment of the patient in the community.
- 3.7 As there is no mechanism in the Mental Health Act for retrospectively amending or rectifying a defective form CTO1 once it has taken effect, it is essential that where practicable, any queries relating to the completion of the CTO1 is discussed with a Mental Health Law Supervisor (or equivalent) before it is completed.
- 3.8 Once the CTO is completed, the statutory forms should be sent to the Mental Health Law office via electronic means.

² Form CTO1 contains a statement to this effect: 'The patient is to make himself or herself available for examination under section 20A, as requested.'

³ 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 himself or herself available for examination to enable the certificate to be given, as requested.'

⁴ Statutory Instrument 1205 (2008) Mental Health, England. *The Mental Health (Conflicts of Interest)(England) Regulations 2008*, regulation 6(1)(b) does not apply to the making of a Community Treatment Order as a community treatment order does not fall within the scope of section 11(1) of the Act.

- 3.9 The Mental Health Law office will ensure CTO paperwork is uploaded onto the electronic patient record system, which is currently RIO. The care coordinator should also clearly document within the patient's s132a rights form within RIO, that the provision of information to the patient regarding rights (including access to an Independent Mental Health Advocate) has been discussed with the patient. The trusts 'rights template' should be used for this purpose and is available within RIO, in the patients's case record under heading Mental Health Act and Mental Capacity Act. (see Para 6.2 of this policy).

4.0 Care Planning and CTOs:

- 4.1 A care plan should be prepared and, subject to the usual considerations of patient confidentiality, the following parties should be consulted if appropriate:

- The Patient
- The Nearest Relative
- Any carers
- Any advocate involved in the patient's care
- 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.

Patients must be given the opportunity to be involved as far as is practicable with planning, developing and reviewing their own care and treatment in accordance with 29.20 of the Mental Health Act Code of Practice Empowerment and Involvement principle (see Para 1.2 above). Where practicable, all patients should be given a copy of their care plan that reflects the legal framework (the CTO and related conditions) under which they are being treated.

- 4.2 In common with other Care Programme Approach arrangements, a care coordinator needs to be identified for patient's subject to a community treatment order.
- 4.3 To reflect the development of community based services and ensure best practice, any prospective RC should be involved at an early stage in determining whether a CTO is appropriate and specifically any conditions to be attached to it. This will greatly assist in the delivery of seamless transfer of care from hospital to community and vice versa although the final decision to make the order rests with the current RC.

5.0 Conditions attached to a CTO:

- 5.1 There are two conditions set out at Para 3.2 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 Para 3.3 above.
- 5.2 Advice on setting other conditions is provided by the Code, which the RC and AMHP should always consider.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 clinical records. In all cases, there should a link between the person's mental disorder and any condition imposed on a CTO.

⁵ The Code, paras. 29.27 – 29.33

- 5.3 Where there is disagreement between the RC and AMHP about the necessity or appropriateness of a particular condition or conditions, it would not be acceptable for an RC to use his or her right to significantly vary conditions (see Para 5.4 below) shortly after discharge to overcome a legitimate objection by an AMHP.⁶
- 5.4 Once an order has been made, the RC may subsequently vary the conditions of the CTO (using form CTO2) or suspend any of them where appropriate (e.g. to allow for a temporary absence of the patient) but must record, with reasons, any decision to suspend in the clinical records. In either case, the form CTO2 should be relayed to the Mental Health Law Office 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. The patient **MUST** be informed of the variation of conditions; this is the responsibility of the RC.

6.0 Provision of Information on making an Order:

- 6.1 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 – see Code of Practice 29.34.
- 6.2 The patient should be provided with information verbally by the care co-ordinator or other appropriate person. This will be recorded on the ‘rights template’, and is available within RIO, in the patient’s case record under heading Mental Health Act and Mental Capacity Act – s132 rights/s132a rights hyperlink. An information leaflet will be provided in writing to the patient by the Mental Health Law Office and to the nearest relative unless the patient objects.
- 6.3 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) and the Hospital Managers;
 - Recall, Revocation or Discharge of the CTO by the RC;
 - Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours’ notice requirement), discharge by the First Tier Tribunal (Mental Health) or Hospital Managers;
 - Access to Independent Mental Health Advocacy services⁷
 - The Role of the Care Quality Commission;
 - Treatment rights while subject to CTO in the community.

7.0 Recall from CTO:

- 7.1 Where a change of RC on recall is anticipated, best practice requires that they should be made aware of and involved in any of the following actions required of the current RC as soon as practicable.
- 7.2 Where a patient breaches a condition of their CTO, refuses necessary treatment which indicates risk of 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

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.

⁷ Independent Mental Health Advocacy services under the Act are introduced from April 2009.

he or she believes the criteria for recall is met, the RC may recall the patient to hospital.

7.3 To ensure compliance with the Mental Health Act and the Code of Practice,⁸ recall should only be considered if:

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

Or

- The patient has broken one of the two mandatory conditions outlined at Para 3.2 above unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered. Other conditions which have been breached may not lead to recall if the breaking of the conditions do not satisfy the criteria as outlined.

7.4 The RC must complete a written notice of recall to hospital (form CTO3) which is effective only when served on the patient. Where possible, this notice should be handed to the patient personally, or otherwise be sent by first-class post or delivered by hand to the patient's usual or last known address. If access cannot be gained to the patient, consideration could be given to obtaining a warrant under section 135(2) of the Act. Table 1 below summarises the reasons for and effect of each method of serving a Notice of Recall. This notice cannot be served on the patient by electronic means, but a copy should be sent via electronic means to the MHL office.

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

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

7.5 The RC should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide treatment although this may be given on an out-patient basis, if appropriate. Conveyance to that hospital should be in the least

⁸ The Code paras. 29.45 - 29.51

restrictive manner possible. Reference should be made to any policies agreed locally with the police and any guidance provided by a police force.⁹

- 7.6 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. It is the responsibility of the admitting nurse or team leader to complete form CTO4 recording the date and time of the patient's arrival at the hospital or out-patient setting following recall to hospital. This is the record of when the 72-hour detention period under recall began and a copy should be sent via electronic means to the MHL office.
- 7.7 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 to transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to.¹⁰
- 7.8 As soon as practicable, the patient should be given information verbally and in writing about their rights following their arrival after the recall notice, and the impact if any, on their treatment rights which are set out in a separate section below. The provision of supervised community treatment rights must be recorded in the same manner used for other detained patients.
- 7.9 Following arrival after the recall notice, the RC and clinical team should consider the circumstances of the recall and in particular, whether the 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. No s17 Leave can be granted by the RC whilst the service user remains under recall by virtue of s17D(2)(b). The RC may end the recall at anytime during the 72 hour period at their discretion.
- 7.10 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. To avoid confusion or failure to adhere to the intended statutory scheme, it is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in the clinical records.
- 7.11 However recall is permissible in relation to an existing inpatient¹¹. If the informal community patient wishes to leave the ward and following a risk assessment it is deemed inappropriate for the patient to leave, a decision to formally recall the patient should be made and form CTO3 served to give authority to detain.
- 7.12 The holding power under section 5(2) or section 5(4) must not by virtue of section 5(6), be used as an alternative to recall in this situation. Local Procedures need to be established to ensure recall notices can be served outside of office hours (please refer to the Trusts 'Responsible Clinician and Nominated Deputy Policy' for further guidance regarding cover arrangements in the absence of the 'regular' RC')

⁹ In London see, Mental Health Project Team, Territorial Policing Headquarters, Metropolitan Police (2011) *Operational Guidance for Police Officers and Staff responding to Incidents involving someone with a Mental Illness*, 1st January 2011 (published under Freedom of Information Act Scheme at http://www.met.police.uk/foi/pdfs/policies/mental_health_policy.pdf)

¹⁰ Statutory Instrument 1184 (2008) Mental Health, England. *The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008*, regulation 9(3)-9(5)

¹¹ This position is confirmed by s17E(4), *The Act*

8.0 Revocation of CTO or return to Community:

- 8.1 If in-patient treatment is required for longer than 72 hours from arrival in hospital, the RC should consider revoking the community treatment order.
- 8.2 To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. An AMHP, having considered the wider social context for the patients, must also agree with the RC's assessment, before the CTO may be revoked. This need not be an AMHP already involved in the patient's care and treatment.
- 8.3 If the AMHP does not agree that the CTO should be revoked, their decision and the reasons for it must be fully documented in the clinical records, and the patient must be discharged from hospital by the end of the 72 hours and the CTO continues. (Alternatively, the Patient could be discharged from the CTO altogether, in which case original section the patient was subject to immediately before the CTO began would be discharged also.) At 29.67 of the code of practice, it states that it is not appropriate for a RC to approach another AMHP for an alternative view.
- 8.4 The RC may start the revocation process by completing Part 1 of the CTO5. If the AMHP agrees they complete Part 2 of the CTO5. And then the RC will complete Part 3 of the CTO5. The revocation takes effect immediately once all parts of the CTO5 have been signed. A copy should be sent via electronic means to the MHL office.
- 8.5 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.
- 8.6 The patient must be informed of their rights following revocation and this must be evidenced within RIO via the following hyperlink - Rights - S132 (detained) & S132A (CTO).
- 8.7 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.

9.0 Extending the CTO Period:

- 9.1 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 and **must** by face to face examination¹². The RC must determine that the conditions for extension are met.¹³ These mirror the criteria and mandatory conditions described at 3.1-3.2 above with the additional requirement that the RC must also consult at least one other person who has been professionally concerned with the patient's medical treatment. If the RC is not a registered medical practitioner, this policy dictates that the person with whom the RC consults, must be a registered medical practitioner.
- 9.2 As when making the original CTO, the RC must obtain the written agreement of an AMHP that the conditions for extending the community treatment order are met

¹² High Court - Devon Partnership NHS Trust v SSHC [2021] EWHC 101 (Admin)

¹³ *The Act*, s20A(6)

and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1.

- 9.3 The RC completes Part 1, the AMHP completes Part 2 of form CTO7 and then the RC completes and signs Part 3, addressing the report to the relevant Hospital Managers. The completed report will be effective once a copy has been sent via electronic means to the MHL office. It is then received by a Mental Health Law Office (or other authorised person) who completes Part 4.
- 9.4 Once received, the Hospital Managers must undertake a review of the report provided on form CTO7¹⁴. 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.
- 9.5 Special provisions for extending the CTO period apply to patients who have been unlawfully at large ('absent without leave') which are set out in sections 21A & 21B of the Act. After an absence of more than 28 days, form CTO8 must be completed to extend the CTO period – see also para 15.0 below.
- 9.6 Where the criteria for extending a 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 by completing Section 23 form. This does not apply to a case where an AMHP does not agree to extension. In such a case, the RC may choose to exercise his or her right of discharge or may allow the CTO to lapse.
- 9.7 Extension periods for CTO mirror the renewal scheme for section 3 patients: the initial CTO lasts for up to six months, if extended lasts for a further six months and thereafter, up to one year on each extension.

10.0 Discharge from Compulsion under the Act:

- 10.1 'Discharge' for a CTO patient, regardless of who orders it, means complete release from liability to compulsion under the Act in hospital or in the community. It is not the same as 'recall' or 'revocation' which are described at paras 7.0 and 8.0 above nor the process of 'discharge subject to being liable to recall' which follows the making of a CTO.
- 10.2 The RC can discharge a patient from a CTO at any time in writing by completing the local discharge from liability to detention form under section 23 of the Act¹⁵ and providing it to the Managers of the responsible hospital. There is no statutory form for this purpose, nor a statutory requirement to consult with any other person.
- 10.3 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 and can now be received by email to the Mental Health Law Department.
- 10.4 Within the permitted 72 hours, the RC may sign a report barring discharge under section 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

¹⁴ *The Code*, paras. 38.11 - 38.12

¹⁵ An order for discharge is made under s23(2)(a) if a Community Treatment Order has been revoked or s23(2)(c) if a Community Treatment Order is still in force

to him or herself'. Where a report is made, the nearest relative will be advised by the Mental Health Law office of their right to apply to the First Tier Tribunal (Mental Health). If a Tribunal application is not made, Mental Health Law office may arrange a review by the Hospital Managers.

- 10.5 If the RC does not sign such a report, discharge from compulsion by the nearest relative takes effect after 72 hours or at a point after that which the nearest relative may 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. There is no power of discharge available to the nearest relative, Hospital Managers or First Tier Tribunal (Mental Health) to discharge specifically from a recall period; only the CTO as a whole.
- 10.6 The First Tier Tribunal (Mental Health) can discharge a CTO patient other than during the 72 hour period of recall of such a patient. If following recall, a patient's CTO is revoked, the Mental Health Law office will refer the patient's case to the First Tier Tribunal (Mental Health) as soon as possible. All circumstances where there is a duty to refer a case to the First Tier Tribunal (Mental Health) are set out in section 68 of the Act.
- 10.7 An application for discharge can be made once by a patient to the First Tier Tribunal (Mental Health) during any period of their CTO. Any withdrawn application is disregarded and does not interfere with this right. The First Tier Tribunal (Mental Health) cannot vary conditions on a CTO imposed by the RC and although it can make a recommendation, cannot oblige an RC to make a CTO for a detained patient. The First Tier Tribunal (Mental Health) application rights of both patients and their nearest relatives are set out in section 66 of the Act.
- 10.8 It may be appropriate for the First Tier Tribunal (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 – during Covid-19 pandemic hearings are being held virtually.
- 10.9 If a patient is detained in another hospital under section 3 or equivalent, (other than by their CTO being revoked) this will automatically discharge the existing CTO and its underlying section. A CTO can only be recommenced by starting a fresh assessment again. Detention under section 2 will not affect a current CTO.¹⁶ 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 section 22 of the Mental Health Act. Detention in custody for a period of more than six months will automatically bring the CTO to an end.

11.0 Transfer between Hospitals and Jurisdictions

- 11.1 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.
- 11.2 The responsible hospital for a patient subject to a CTO in the community (who may have been recalled to hospital) may be assigned to another hospital managed by a different organisation, with their agreement on completion of form CTO10. This process does not include the physical transfer of a patient which is

¹⁶ Admission under section 2 should not normally be considered as a legitimate alternative to recall or revocation of a community treatment order.

dealt with above. It is referred to as an 'assignment of responsibility for community patients'¹⁷

- 11.3 Assignment of responsibility for community patients between hospitals within the same organisation requires no statutory paperwork but the Managers of the hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give the name and address of the responsible hospital even if it is part of the same organisation. This function is the responsibility of the Mental Health Law office.
- 11.4 In any case, the new hospital becomes the responsible hospital and as such is treated as if it were the detaining authority when the patient was originally detained in hospital (and is now subject to recall to) prior to going onto a CTO.
- 11.5 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 Rights¹⁸.
- 11.6 Once a CTO has been revoked, transfer between hospitals under different managers is the same as for any other patient who is currently liable to detention using form H4.
- 11.7 Where a community patient under broadly equivalent legislation in Scotland, the Isle of Man or any of the Channel Islands is removed to England, their arrival in England is recorded using form M1 (date of reception of a patient in England) and where they are to be treated as if they were subject to a CTO, form CTO9 is completed by the RC (Part 1) and an AMHP (Part 2). As when making a new CTO, any conditions must be specified on form CTO9 and have the written agreement of an AMHP.

12.0 Decision to use a CTO or Section 17 Leave:

- 12.1 Section 17 (s17) (relating to leave of absence from hospital) of the Act states that when considering granting longer term leave, an RC must consider whether a CTO might be the more appropriate way of managing the patient in the community. This applies to s17 leave being considered for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).
- 12.2 These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for a CTO. The RC may still legitimately authorise longer-term leave where it is the more suitable option but must document that he/she has considered whether a CTO is more appropriate.
- 12.3 This issue should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, s17 leave forms provide a space for the RC to record their reasons, if applicable, that a CTO has been considered where appropriate and why the use of s17 was preferred.
- 12.4 The Code sets out a table of pointers for a CTO or longer-term leave of absence which may be of assistance to RC's and is replicated below. (A further table contrasting a CTO and guardianship can also be found in the Code at Para. 31.7)

¹⁷ *The Act*, s19A

¹⁸ *The Code*, para 37.18

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

Table 2: a CTO or longer-term leave of absence: relevant factors to consider¹⁹

13.0 Treatment on Recall or Revocation (Part IV of the Act):

- 13.1 For patients liable to detention under the Act other than community treatment patients, the administration of medication for the treatment of mental disorder after three months is authorised by a valid consent certificate (form T2) or second opinion certificate (form T3). The former is only valid as long as the patient is able and willing to give consent, the latter permits specified medication to be given even in the absence of consent or lack of capacity to consent.
- 13.2 When a patient subject to a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients.²⁰ If treatment does not include psychotropic medication or Electroconvulsive Therapy ('ECT') and a patient with capacity consents to it, it may be given under the direction of the RC.
- 13.3 If a Second Opinion Appointed Doctor ('SOAD') has approved any treatment (on 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 Electro Convulsive Therapy) whether the patient has or does not have capacity to refuse it.
- 13.4 On recall, treatment that was already being given as described on form CTO11 (but not authorised for administration on recall), may continue to be given if the Approved Clinician (AC) in charge of the treatment considers that stopping it would cause the patient serious suffering. Otherwise, the criteria under section 58 or section 62 may need to be considered.

¹⁹ Reproduced from *the Code*, para. 31.7

²⁰ Sections 57, 58, 58A and 63, *The Act*

- 13.5 Following revocation of the CTO, steps must be taken at the earliest opportunity to obtain fresh authorisation certificated by forms T2 or T3, with Section 62 criteria being considered in the meantime where necessary.
- 13.6 The Code of Practice at 25.84 states that Practitioners should not rely on a certificate that was issued while a patient was detained prior to going onto CTO even if it remains technically valid. A new certificate should be obtained as necessary.²¹

14.0 Treatment while in the Community (Part 4A of the Act):

- 14.1 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.
- 14.2 There are different rules for Part 4A patients who have capacity to consent to specified treatments for mental disorder 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 7.3 above. It is the responsibility of the AC in charge of the treatment to undertake an assessment of the patient's capacity and whether they consent to treatment or not at the point of making the CTO. This must be documented clearly in the patient's notes and reviewed on a regular basis; at least during each CPA meeting, upon extension of the order or upon any change in treatment. A change in AC in charge will also require a fresh assessment of capacity and consent.
- 14.3 The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 ('MCA') including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give CTO patients any treatment for mental disorder (if they lack capacity) 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 community treatment patient.
- 14.4 The MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is 'Gillick competent' in accordance with a landmark ruling of the House of Lords²². This is sometimes referred to as 'Fraser competency' acknowledging the Law Lord who set out the principles to be applied in determining such competency.
- 14.5 Part 4A patients over the age of sixteen, who lack capacity, may be given specified treatments on the authority of an attorney²³ or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient's behalf. If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under the MCA.²⁴

²¹ *The Code*, para. 25.84

²² *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)

²³ Young people aged 16 and 17 do not have the power, under the Mental Capacity Act to make a lasting power of attorney nor make valid and applicable advanced decisions to refuse treatment.

²⁴ See Chapter 9 of *The Code of Practice MHA*

- 14.6 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 of the Act, which reflect the similar scheme in the MCA²⁵. This is that the person believes that the patient lacks capacity, the treatment is immediately necessary (see below) and that any force used is a proportionate response to the likelihood of harm being suffered. The alternative mechanism is via recall to hospital but the recall criteria set out at 7.3 above apply equally to patients lacking capacity.
- 14.7 In an emergency, treatment for Part 4A patients who have not been recalled and who lack capacity, can be given by anyone (it need not be an AC 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 Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.

- 14.8 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.²⁶ These are the only exceptional circumstances in which force can be used to treat an objecting CTO patient, who doesn't have capacity, without first recalling them to hospital.
- 14.9 In non-emergency situations (excluding Electro Convulsive Therapy for which reference should be made to paragraphs 25.19 – 25.25 of the Code and the Trust's Electro Convulsive Therapy Policy) a patient may lack capacity and object to treatment but, where physical force is not required, he or she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO and thereafter if the following criteria (and the certificate criteria) is met under S64D:
- The treatment is given under the direction of the approved clinician in charge of the treatment
 - It is not inconsistent with a valid and applicable advance decision to refuse treatment
 - . it is not inconsistent with a decision by an attorney, deputy or a Court of Protection decision
- 14.10 After the first month, a SOAD (CTO11) or RC (CTO12) must certify that such treatment is appropriate on a Part 4A certificate depending on the patient's capacity to consent.

²⁵ See conditions set out in section 6 *Mental Capacity Act 2005*

²⁶ *The Code of Practice MHA*, para 24.26

- 14.11 The SOAD will consult with two other people who have been involved with the patient's care. These people are known as 'statutory consultees'.
- 14.12 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. See paragraph 13.3 above.
- 14.13 Form CTO11/CTO12 should be uploaded onto RIO under code 'CONS' must be and a copy attached to any community prescription chart or listed on the JAC system appropriately.
- 14.14 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 will usually be the care coordinator.
- 14.15 Other than in exceptional circumstances such as a pandemic, 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, who will act as one of the statutory consultees. At least one statutory consultee shall not be a Doctor and neither of the statutory consultee's can be either the RC or the "AC in charge of the treatment in question"
- 14.16 In the event that the patient has not been seen by a SOAD within the required time-frame (one month from CTO taking effect or three months from beginning of detention whichever is the later), and the AC in charge of the treatment is of the opinion that the treatment is immediately necessary for a patient who lacks capacity to consent to it, Section 64 may be used to authorise treatment whilst waiting for the SOAD to complete form CTO11. The AC must complete the Trust's Section 64 form which can be found at appendix 1. The original should be kept with the original CTO and detention papers uploaded on RIO and a copy attached to the community prescription chart.
- 14.17 If a person has capacity and is consenting to treatment in the community, the AC in charge of that treatment should complete form CTO12 certifying the patient has capacity and is consenting. If a person is judged to have capacity but is refusing treatment in the community, the SOAD will visit to consider certifying on form CTO11 that certain treatment proposed for the patient whilst in the community is appropriate even though such certification provides no authority to give it if the patient is refusing; and/or certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital. Form CTO12 should be kept with the original CTO and detention papers but a copy must be kept in the clinical records and a copy attached to any community prescription chart.
- 14.18 **Section 61** - It is a requirement for the AC in charge of the treatment (usually the RC) to complete a review of treatment and document it on the form and send to the CQC for a CTO patient if the CTO extension is furnished and during the preceding period the patient had been recalled to hospital **AND** was treated under the authority of the CTO11 because the SOAD has authorised treatment on recall **AND** the patient lacked capacity or refused that treatment at the time; or at any other time as required by the CQC.

15.0 CTO Patients who are Absent Without Leave

- 15.1 CTO patients are considered absent without leave if they fail to return to hospital following recall, or who have absconded from hospital following being recalled.

- 15.2 CTO patients who are deemed absent without leave may be taken into custody under section 18 and returned to the hospital to which they have been recalled by an Approved Mental Health Professional (AMHP), a Police Officer, a member of staff (of the hospital to which they have been recalled) or anyone authorised in writing by the Hospital Managers or the RC within the relevant period (see 15.5). If the power of entry is required, an application using S135 (2) may be made for a warrant, authorising Police entry.
- 15.3 If a CTO patient is absent without leave, the Missing and Absent without Leave Policy MUST be implemented
- 15.4 A CTO patient cannot be taken back into custody after their CTO has ceased to be in force or six months have elapsed since the patient was first absent without leave, whichever is the later date.
- 15.5 If a CTO patient is absent without leave for more than 28 days, they must be re-examined by the RC on their return to establish whether they still meet the criteria for community treatment (Section 21B). If this does not happen, the CTO will expire automatically at the end of the week starting with the day of their arrival back to hospital. The RC must submit their report using CT08, following consultation with both an AMHP and another professional who has been professionally concerned with the patient. **If the RC is not a registered medical practitioner, the second consultee must always be a registered medical practitioner.**²⁷ A report is not required if the CTO is revoked instead. If a CT08 is completed after the CTO would have expired, it automatically extends the patients CTO from when it would otherwise have expired in the normal way. It may also act as an extension report if the CTO will expire in the next two months.
- 15.6 If a CTO patient returns to hospital within 28 days BUT the deadline for their extension report has approached and has not yet been made, i.e. at any point during the week which end on the day their CTO is due to expire, their CTO is treated as not expiring until the end of the week starting with when the day on which they returned. The RC therefore has a week to submit an extension report using CT07. An AMHP is required to also agree that the criteria are met and it is appropriate. The RC must also consult with another professional who has been professionally concerned with the care of the patient. **If the RC is not a registered medical practitioner, the second consultee must always be a registered medical practitioner.**²⁸

16 Monitoring

- 16.1 Internal procedures are in place to record the use of CTOs, their extensions, recall and revocations and treatment. This data is maintained by the Mental Health Law Offices and generates reports as required for assurance purposes including s132a rights.
- 16.2 Audits will be carried out of a random sample of CTO patients to ensure compliance with the Act, the Code and this policy. Results will be presented to the local directorate management team and the trusts quality committee.
- 16.3 The Trust provides Training on CTOs via face to face or eLearning as required.

²⁷ This is a Trust Policy requirement as opposed to the requirements of the MHA 1983

²⁸ This is a Trust Policy requirement as opposed to the requirements of the MHA 1983



Urgent treatment under section 64 Of the Mental Health Act 1983

Name of Patient: _____

Section: **17A - Community Treatment Order**

I am

I confirm that I am the Approved Clinician responsible for the above named patient and that the following treatment:

(Delete option that does not apply)

1. is emergency treatment which is authorised under Section 64G as the patient lacks the capacity to consent to it;

{PLEASE TICK}

AND

- a) is immediately necessary to save the patient's life { }; or
- b) which (not being irreversible) is immediately necessary to prevent a serious deterioration in their condition { }; or
- c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient { }; or
- d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others { }.

(Note: If treatment plan involves ECT only a) and b) of the above options apply)

I confirm that full details of this course of treatment under S64 is recorded in the case notes.

Signed _____

Date _____