

Appendix A

Guidance for Practitioners: Community Treatment Order (CTO)

May 2016

Content

Page 3 Introduction, Purpose of CTO and Eligibility Criteria
Page 4 Part 1 Assessment for CTO, CTOs and S17 Leave
Page 5 Action upon Tribunal Recommendation, Care Planning, Treatment and Support in the Community
Page 6 Role of the Responsible Clinician (RC), Role of the Approved Mental Health Professional (AMHP)
Page 7 Role of the Care Coordinator, Role of the Hospital Managers,
Page 8 Part 2 Making the CTO, Conditions to be attached to the CTO
Page 11 Part 3 Monitoring CTO Patients, varying and suspending conditions
Page 12 Responding to concerns raised by the Patients Carer or Relative.
Page 13 Part 4 Reviewing/Extending the CTO
Page 15 Part 5 Right of Application to the Hospital Managers or the Mental Health Review Tribunal (MHRT)
Page 16 Part 6 Discharge from CTO
Page 17 Part 7 Recall to Hospital
Page 18 Procedure for Recall to Hospital
Page 19 Conveying Patients who are recalled to hospital
Page 20 Administration of Recalled Patients
Page 21 Part 8 Revoking the CTO
Page 22 Part 9 Medical treatment of CTO Patients (Part 4A)
Page 23 Exceptions to the certification requirement.
Page 24 Withdrawal of part 4A Certificates
Page 24 Cases where certificates are not required as “treatment is immediately necessary”, CTO patients recalled to hospital [S62(A)]
Page 26 Second Opinion Approved Doctor (SOAD) visit
Page 28, Part 10. Absence without Leave, Recalled patients who are absent without leave, Patients absent without leave as deadline for extension report approaches.
Page 29 Confirmation of CTO for patients who have been absent without leave for more than 28 days
Page 29 Patients who return from absence without leave and whose CTO would have otherwise expired, Patients who are imprisoned etc.
Page 30 Prescription Charges
Page 31 Part 11. Effect on CTO of New Applications for Admission or Guardianship under Part 2
Page 32 References.
Page 33-35 Appendices
Page 36 CTO Checklist
Page 37 Notice of discharge from a CTO under Section 23
Page 38 S64H: Continuation of treatment given to CTO patient who lacks capacity to consent to treatment pending CTO11.
Page 39-40 emergency treatment of CTO patients lacking capacity Section 64G Form
Page 41-42 Record of Capacity to consent to treatment of CTO patients
Page 43 CTO Flow Chart
Page 44 Flow Chart of Medical Treatment for CTO patients in the Community
Page 45 Procedure for CTO Recall Sec 135 (2)

INTRODUCTION

This document aims to describe the structure and the protocols and processes in Sheffield that are in place to allow Community Treatment Orders to be effective. For more details of CTO see the references at the end of this document.

Please Note: This is not a definitive statement in relation to the legislation on CTO, as it is likely that case-law will influence changes. However it is intended as guidance for practitioners. Further reference can be made by consulting the Revised Code of Practice for the Mental Health Act and the Reference Guide to the Mental Health Act

A flowchart and accompanying notes of the CTO process appears on page 39-40 of this guide.

PURPOSE OF CTO

The purpose of CTO 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.

ELIGIBILITY CRITERIA

Only patients who are detained in hospital for treatment under section 3, or are unrestricted Part 3 patients, can be considered for CTO. Patients detained in hospital for assessment under section 2 of the Act are not eligible. CTO is an option only for patients who meet all the following criteria:

1. The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
2. It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
3. Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital;
4. It is necessary that the RC should be able to exercise the power to recall the patient to hospital; and
5. Appropriate medical treatment is available for the patient.

Part 1 ASSESSMENT FOR CTO

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.

The key factor in the decision is whether the patient can safely be treated for mental disorder in the community only if the Responsible Clinician (RC) can exercise the power to recall the patient to hospital for treatment if that becomes necessary

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

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

A CTO might be appropriate regardless of whether or not a patient has previously had repeated admissions, the patient's history and treatment needs will be relevant to the decision.

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.

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 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.

An Approved Mental Health Professional (AMHP) must decide whether to agree with the patient's RC that the patient meets the criteria for CTO, and (if so) whether CTO is appropriate.

Whilst it is the RC and the AMHP who must ultimately make a decision as to a CTO, any patient who meets the criteria for this should already be engaged in the CPA process whilst in hospital, and already have a care coordinator. A decision to place on a CTO should have been discussed at a CPA meeting prior to discharge, and the care plan for that client should reflect this.

The Acute In-Patient Admission Discharge Pathway specifies the requirements for CPA reviews before discharge from hospital.

Patients do not have to consent formally to CTO. But in practice, patients will need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

Community Treatment Orders and S17 Leave

In the event of the person being on S17 leave for 7 days or more the RC must consider a CTO. In the event of a CTO not being appropriate the reasons must be recorded in the patient's notes.

Leave of absence may be useful in the longer term (more than seven consecutive days) where the clinical team wish to see how the patient manages outside hospital before making the decision to discharge. Leave for a longer period should also be for a specific purpose or a fixed period, and not normally more than one month. For most patients who are able to live in the community, a CTO should be considered a better option than longer-term leave for the ongoing management of their care.

Reflecting this, whenever considering longer-term leave for a patient (that is, for more than seven consecutive days), the responsible clinician must first consider whether the patient should be discharged onto a CTO instead. Any decision to authorise section 17 leave for more than seven days on a second occasion should be fully documented, including why a CTO or discharge is not.

Action upon Tribunal Recommendation

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 CTO. In that event, the RC should carry out the assessment of the patient's suitability for CTO in the usual way. It will be for the RC to decide whether or not CTO is appropriate for that patient.

Care Planning, Treatment and Support in the Community

Good care planning, in line with the Care Programme Approach (CPA) will be essential to the success of CTO. A care coordinator is likely to be a different person from the RC, but need not be.

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;
- 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 CTO. A patient who does not have a GP should be encouraged and helped to register with a practice.

- Culturally appropriate services, if available, and/or interpreters (if needed) should be included throughout the process

If a different RC is to take over responsibility for the patient in the community, it will be essential to liaise with that clinician, and the CMHT, at an early stage. A CPA/S117 meeting involving the community team should be held prior to discharge on CTO. Arrangements for a second opinion appointed doctor (SOAD) visit to provide the Part 4A certificate should be documented.

In the administration of a CTO, it is important that the RC and the Care Coordinator communicate closely about how they will work together, as there is an overlap in their roles in the administration of the care plan. The care coordinator oversees and coordinates the care plan as for any other client on CPA, while the RC has an overall responsibility for a patient in the community.

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.

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.

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

Patients on 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 Sheffield Health and Social Care Trust and local social services authority (LSSA) must continue to provide aftercare services under section 117 for as long as the patient remains on CTO.

The care plan should be reviewed regularly, and the services required may vary should the patient's needs change.

Role of the RC

It is the RC's responsibility to:

- Undertake a Risk Assessment- assess the risk of relapse in the community or the possibility that recall may be needed for other reasons, on the basis of the patient's history and progress.
- Establish whether the criteria for CTO are met and seek the agreement of an AMHP.
- Consult with the patient and all interested parties

- Consider CTO as an option where the Tribunal has recommended it.
- The Community RC has the responsibility to make a referral for a SOAD assessment.
- The Community AC becomes the RC on the date of commencement of the CTO as specified on Form CTO1.
- Complete CTO12 consent to treatment, when certification is required, and the patient, who has capacity to consent to treatment, has consented to treatment.
- Arrange for SOAD visit with the view of completing CTO11, when certification is required, if the patient lack capacity to consent to treatment

Role of the AMHP

- The AMHP must decide whether to agree with the patient's RC that the patient meets the criteria for CTO, and (if so) whether CTO is appropriate. Even if the criteria for CTO are met, it does not mean that the patient must be discharged onto 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.
- 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. But no assumptions should be made simply on the basis of the patient's ethnicity or social or cultural background.
- The Act does not specify who this 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.
- If the AMHP does not agree with the RC that the patient should go onto CTO, then CTO cannot go ahead. A record of the AMHP's decision and the full reasons for it should be kept in the patient's notes. It would not be appropriate for the RC to approach another AMHP for an alternative view.
- Unlike an admission to hospital it is not a requirement for the AMHP to consult with the Nearest Relative in respect of an CTO application.

Role of the Care Coordinator

(or in their absence a suitably qualified and experienced professional with knowledge of the patient, the Team Manager to designate a deputy if the Care Coordinator is not available)

- Arrange for a SOAD to examine the persons records
- Arrange for the SOAD to visit the patient in a mutually agreed location
- Ensure that the patient is reminded of their rights at regular intervals, and they complete the form 'Rights Given to Detained Patients' and that this is posted to the Mental Health Act Administrator.
- Ensure that the patient is regularly updated with information.

Role of the Hospital Managers

Note: these duties are delegated to the Mental Health Act Administrator

- Maintain an accurate and accessible database of patients subject to CTO
- Send a standard letter to the GP (signed by the Trusts Medical Director) informing them that the patient is subject to a CTO and that all medication for mental disorder is subject to Part 4A of the mental health act. More detailed information about the patient to the GP should be sent from the RC
- Send a prompt to the RC to arrange for the SOAD assessment when required.

Part 2 MAKING THE CTO

If the RC and AMHP agree that the patient should be discharged onto CTO, they should complete the Form CTO1 and send it to the Mental Health Act Administrator. The RC must specify on the form the date that the CTO is to be made. This date is the authority for CTO to begin, 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.

Conditions to be attached to the Community Treatment Order

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

1. When needed for consideration of extension of the CTO; and
2. If necessary, to allow a SOAD to provide a Part 4A certificate authorising treatment.

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.

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.

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.

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; and
- be clearly and precisely expressed, so that the patient can readily understand what is expected. It may be necessary to use Interpreters in some cases to achieve this.

The nature of the conditions will depend on the patient's individual circumstances; 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.

In the case of people who have committed Chapter 2 offences under the Domestic Violence Crime and Victims Act and are unrestricted patients, the victim has the right to make representations to the appropriate RC and AMHP. This will be managed through Mental Health Act Administrator, who will work in conjunction with the South Yorkshire Probation Service. (see Extension of Victims' Rights Policy)

The reasons for any conditions should be explained to the patient and others, as appropriate, and recorded in the patient's notes. It will be important, if CTO is to be successful, that the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply.

It is good practice to attach to the CTO a copy of the care plan to be provided in the community. If the patient agrees, then a copy of their care plan should also be sent to their GP, if the GP is involved in delivering part of that care plan. The GP will be notified in the usual way about the patient's medication.

The RC does not have to take personal charge of prescribing medication (and some RC's may not be qualified to prescribe). Arrangements can be made for someone else to prescribe, including a GP.

If a patient, who has capacity to consent to treatment consents to treatment, the AC in charge of medical treatment will complete CTO12 when certification is required.

It should be noted that if an CTO patient lacks capacity to consent to treatment for mental disorder and no-one else is eligible to consent on their behalf (e.g. deputy. LPA or Court of Protection), the treatment can normally only be administered to the patient by or under the direction of an AC who is qualified to prescribe that treatment. SOAD would be asked to certify the treatment by completing CTO11.

Prior to leaving hospital the Senior Nurse in charge of the shift (thereafter known as 'shift coordinator) should ensure that the patient has:

- A copy of the form CTO1 and CPA or equivalent care plan
- A copy of the agreements made for after- care
- The name and phone number of their RC, their Care Coordinator or other named team member and a written appointment for their first visit
- The name and phone number of their GP
- Written details of how and where treatment will be given (if already agreed with the patient)
- Information on how to contact services an emergency.
- Information of how to contact the out-of-hours services for physical health care/emergency GP care.
- An understanding of their rights to appeal, their right to an IMHA and the nature of the CTO.

Part 3 MONITORING CTO PATIENTS

It will be important to maintain close contact with a patient on 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, but the CPA process provides a framework for review. 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. Change of RC should be arranged through a CPA meeting, and the patient and other relevant people (e.g. NR, Mental Health Act Office, GP) should be informed in writing.

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

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. Changes may also be needed to the patient's care or treatment plan.

Varying and Suspending Conditions

The RC has the power to vary the conditions of the patient's CTO, or to suspend any of them, using Form CTO2. 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.

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 notes, with reasons.

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.

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. As when the conditions were first set, the patient will need to agree to try to keep to any new or varied conditions if CTO is to work successfully, and any help the patient needs to comply with them should be made available. Any variation in the conditions must be recorded on the relevant statutory form, which should be sent to the hospital managers.

Responding to concerns raised by the Patient's Carer or Relatives

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. 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 CTO is working for that patient and whether the criteria for recall to hospital might be met.

Part 4 REVIEWING/EXTENDING THE CTO

CTOs have the same duration periods as Section 3, i.e. 6 months, plus 6 months plus annual extension. Extension to CTO is covered by section 20A of the MHA. There is no limit to the number of times a CTO can be extended.

The Medical Health Act Administrator will contact the RC and inform them of the requirement to examine the patient and extend the CTO with 2 months prior to expiry.

Only RCs may formally extend the period of a patient's CTO by extending the period of the community treatment order (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 CTO under section 20A of the Act are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment. The decision to extend the CTO should be made within the context of CPA and involve multi-disciplinary discussion. The involvement of the patient and family/carers will be central to this process. The RC will record the assessment and discussion in the patients notes.

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. But before RCs can submit that report, they must obtain the written agreement of an AMHP. This does not have to be the same AMHP who originally agreed that the patient should become an 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 local social services authority (LSSA). The role of the AMHP is to consider whether or not the criteria for extending CTO are met and, if so, whether an extension is appropriate. To extend CTO, form CTO7 will be completed and sent to Mental Health Act Office. The Mental health Act Managers will then meet to consider the proposed extension.

If the AMHP does not agree to the extension, the RC should consider immediate discharge from the CTO; the current order may continue to its expiry date, but cannot be extended if the AMHP does not agree.

If, in exceptional circumstances, it is decided that the agreement of a different AMHP should be sought, that decision should be drawn to the attention of the hospital managers if, as a result, an extension report is made.

Note: It is expected that any exceptional circumstances will centre around issues of personal and public safety.

Review of a CTO

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

Reviews should cover whether 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 CTO must be discharged without delay

Part 5 RIGHT OF APPLICATION TO THE HOSPITAL MANAGERS OR THE MHT

The Hospital Managers have a duty to ensure that patients understand their rights to apply for a Tribunal hearing, and to free legal advice and representation.

An CTO patient may apply to be discharged from their order to the Hospital Managers at any time and/or to the MHT once during each period (i.e. once in the first six months, once in the second 6 months and once in each subsequent 12-month extension period).

In addition the Hospital Managers have duty to refer a CTO patient to the MHT if they have not applied for a Tribunal within the 6 months from the date of admission under detention. (Tribunal hearing whilst under a section 2 are to be ignored when calculating whether a referral must be made after 6 months.)

Hospital Managers must also refer the case to the Tribunal if, for those patients aged 18 or over, a period of more than three years has passed without the patients case being considered by the Tribunal. For patients under 18yrs a reference must be made every year if no application is made

If the CTO is revoked the Hospital Managers must make a reference to the Tribunal as soon as possible after the CTO is revoked.

It is the duty of staff involved in a patient's care to prove the case for compulsion NOT the duty of the patient to prove that they do not. Sufficient evidence to support this, in the form of clinical and social reports will need to be submitted.

Hospital Managers should inform patients of their right to present their own case to the MHT and their right to be represented by someone else. Staff should be available to help patients make their application. This is especially important for CTO patients who may not have daily contact with professionals.

Part 6: DISCHARGE FROM CTO

CTO patients may be discharged in the same way as detained patients, by the Tribunal, the hospital managers, or (for Part 2 patients) the nearest relative. If the nearest relative orders discharge, the RC could bar the discharge on grounds of dangerousness. This will prompt a review by the Hospital Managers.

The RC may also discharge an CTO patient at any time and must do so if the patient no longer meets the criteria for CTO. **A patient's CTO should not simply be allowed to lapse. The order for discharge must be in writing and sent to the mental health act office.**

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. On discharge from CTO, the team should ensure that any after-care services the patient continues to need under section 117 of the Act will be available.

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

Part 7: RECALL TO HOSPITAL

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.

The RC may recall a patient on 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.

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 SOAD to complete a Part 4A certificate. 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 (e.g. not fully understanding the conditions due to language barriers) and should take any further action accordingly.

The RC, must authorise the recall but need not examine the patient before issuing the recall notice. The RC needs to be satisfied that the criteria are met before using this power but can act upon reports which provide an account of the patient's current behaviour and situation. 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.

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.

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

Recall to hospital for treatment should not become a regular or normal event for any patient on 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, CTO continues to be appropriate.

Once a recall notice is issued there is no provision in the MHA to revoke the notice.

Procedure for Recall to Hospital (Please refer to the Trust S135 guidance)

The RC has responsibility for coordinating the recall process. It will be important to ensure that the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed.

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.

Once the recall notice has been served, the patient can, if necessary, be treated as **absent without leave (see SHSC Missing Persons Policy)**, 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.

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. 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.

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.

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.

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.

The RC should ensure that the hospital to which the patient is recalled has a bed available, they are 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. The hospital need not be the patient's responsible hospital (that is, the hospital where the patient was detained immediately before going onto CTO) or under the same management as that hospital. A copy of the notice of recall, which provides the authority to detain the patient, should be sent to the managers of the hospital to which the patient is being recalled. In the latter case, a change in the "Responsible Hospital" is needed. The Mental Health Act administrator will do that by completing the necessary form.

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. 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 an CTO patient, even if they remain in hospital for one or more nights. The RC may allow the patient to leave the hospital at any time within the 72-hour period.

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 CTO as before. In considering the options, the RC and the clinical team will need to consider the reasons why it was necessary to exercise the recall power and whether 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).

Where a patient who is subject to a CTO is recalled to hospital then it would usually be the In-Patient Consultant for the admitting ward who would be the most appropriate to be the patients RC for the Recall period (up to 72 hours) and this will be the default standard practice.

However in some circumstances (e.g. where recall is for the specific purpose of compulsory treatment) it may be more appropriate for the existing Community RC to keep overall responsibility for the patients care and treatment. Where this is the case then this needs to be documented and communicated to the Mental Health Act Office

Conveying CTO Patients who are recalled to Hospital

In order to recall a patient, a properly completed notice of recall is necessary. This needs to be served on the patient in accordance with the regulations outlined above. This provides the authority to convey an CTO patient to hospital compulsorily if necessary.

A properly recalled patient can be conveyed by any staff of the hospital to which the patient is recalled, any police officer, any AMHP or any other person authorised in writing by the RC or the managers of the hospital. Individual circumstances will determine the most appropriate person to convey.

Administration of Recalled patients

The Shift Coordinator will require:

- Access to Care Plan
- Access to Risk assessment
- Part 4A Certificate
- List of medication to be given during recall

The Shift Coordinator must:

- Complete the receipt of patient Form CTO4
- Send the CTO4 to Mental Health Act Administrator and a copy to the RC

The patient may be transferred to another hospital under different Managers after the completion of a CTO6.

Treatment is authorised by the Act for an CTO patient on recall if one of the following applies:

- it is authorised on the Part 4A certificate
- discontinuing treatment would cause serious suffering to the patient (62A(6))
- the patient went onto CTO less than a month ago(64B(4))
- it's less than 3 months since the medication was first given(58(1)(b))
- a certificate under Part 4 (s58(3)(a) or (b)) is put in place
- the treatment is immediately necessary (s62).

More details on medical treatment are included below (see Part 9)

Part 8 REVOKING THE CTO

If the patient requires in-patient treatment for longer than 72 hours after arrival at the hospital, the RC should consider revoking the CTO. The patient must be recalled to hospital in order to revoke the CTO.

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.

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 decisions about applications for admissions under the Act.

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 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 CTO. A record of the AMHP's decision and the full reasons for it should be kept in the patient's notes. It would not be appropriate for the RC to approach another AMHP for an alternative view.

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 CTO, except that a new detention period of six months begins for the purposes of review and applications to the Tribunal

On revocation of the CTO the AC at the receiving hospital becomes the RC once the patient has been admitted.

The RC must arrange a SOAD visit to allow a Part 4 certificate to be issued.

Part 9 MEDICAL TREATMENT OF CTO PATIENTS (PART 4A)

A) CTO patients who are not recalled to hospital

Medical treatment for mental disorder may not be given (by anyone, in any circumstances) to CTO patients who have not been recalled to hospital, unless the requirements of Part 4A of the Act are met.

The requirements of Part 4A are of two types – authority and certification:

- In all cases, the person giving the treatment must have the authority to do so.
- In most cases, if the treatment is a section 58 (medication) or 58A (ECT) type treatment, the certificate requirement must also be met. Whether or not the certificate requirement also applies, there must always be authority to give the treatment.

“Authority”

If the patient has the capacity to consent to the treatment in question, the patient’s own consent provides the authority for giving it. Patients aged 16 or over have the capacity to consent unless they lack the capacity to make the decision, as defined in the Mental Capacity Act 2005 (MCA). If someone else is empowered under the MCA to consent on the patient’s behalf when the patient lacks the capacity to consent themselves, then that other person’s consent to the treatment would provide the necessary authority. That other person could be an attorney (donee), a deputy or the Court of Protection itself. By definition, decisions of attorneys, deputies and the Court of Protection will only be relevant where patients lack the capacity to take the relevant decisions for themselves.

However, it has to be noted that the MCA cannot be used to treat Part 4A patients. The best interest test from the MCA does not apply to treatment for mental disorder if the CTO patient falls under Part 4A of the MHA.

Certificate requirement – CTO patients of any age

If the treatment in question is a section 58 (medication for mental disorder) or 58A (ECT) type treatment, then as well as there being authority to give the treatment, it is normally necessary for the treatment in question to have been approved by a Part 4A certificate (there are few exceptions which are set out below)..

The requirement of Part 4A certificate is met either by

1. CTO12 form completed by the RC confirming that the patient has capacity/competence to give consent and has consented to medication, or
2. a certificate (CTO11) given by a SOAD (if the patient lacks capacity/competence to consent or has capacity but refused to consent) saying that it is appropriate for one or more section 58 or section 58A type treatment to be given to an CTO patient. The SOAD must specify on the certificate the treatments to which it applies and any time limits and conditions to which the approval of any or all of those treatments is subject. The SOAD may also specify which (if any) of the treatments approved on the certificate may be given to the patient on recall to hospital without the need for a separate certificate under Part 4 of the Act. Before issuing the certificate, the SOAD must consult two other people who have been professionally concerned with the patient’s medical treatment. Only one of these

two people may be a doctor and neither may be the patient's RC or the approved clinician in charge of any of the treatments that are to be specified on the certificate. **As a result the certificate would not authorise any treatment if, at the time it is proposed to give the treatment, the person who is not the patient's RC or approved clinician in charge of the treatment is question happens to be one of the two people who were originally consulted by the SOAD before issuing the certificate.** For these purposes, SOADs may at any reasonable time visit and interview CTO patients in a hospital, another establishment as defined in the Care Standards Act 2000 (e.g. a care home or children's home) or any other place to which they are given access. They may also require the production of and inspect records relating to the patient's treatment there. Anyone who obstructed their access to patients or their records without reasonable cause would be guilty of the offence of obstruction under section 129 of the Act.

Exceptions to the certification requirement

A certificate is not required for any medication which is a section 58 type treatment:

- during the period of one month starting with the day on which the patient became (or last became) an CTO patient; or
- if less than three months has passed since the patient was first administered medication during an unbroken period of detention and CTO (or an unbroken succession of periods of detention and CTO).

However, even if a certificate is not necessary (for whichever reason), there must still be authority to give the treatment, as described earlier.

- Emergency treatment under section 64G

In an emergency, treatment can also be given to Part 4A patients **who lack capacity** (and who have not been recalled to hospital) by anyone, whether or not they are acting under the direction of an approved clinician.

It is an emergency 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.

If the treatment is ECT (or medication administered as part of ECT), only the first two categories above apply.

Where treatment is immediately necessary in these terms, it can be given even though it conflicts with an advance decision or the decision of someone who has the authority under the MCA to refuse it on the patient's behalf.

In addition, force may be used (whether or not the patient objects), provided that:

- the treatment is necessary to prevent harm to the patient; and
- the force used is proportionate to the likelihood of the patient suffering harm and to the seriousness of that harm.

These are the only circumstances in which force may be used to treat CTO patients who object, without recalling them to hospital. This exception is for situations where the patient's interests would be better served by being given urgently needed treatment by force outside hospital rather than being recalled to hospital. This might, for example, be where the situation is so urgent that recall is not realistic, or where taking the patient to hospital would exacerbate their condition, damage their recovery or cause them unnecessary anxiety or suffering. Situations like this should be exceptional.

Withdrawal of Part 4A certificates

The CQC) may at any time notify the person in charge of the treatment in question that a Part 4A certificate will cease to apply from a certain date. Once the certificate ceases to apply, it can no longer be used to comply with whatever certificate requirement needs to be met. Treatment which cannot be given without a certificate must either be stopped completely or suspended while a new certificate is sought.

However, pending compliance with the relevant requirement for a certificate, treatment may be continued temporarily if the person in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. (This continues to apply even if the patient is recalled to hospital).

Cases where certificates are not required as "treatment is immediately necessary" [S64(B)]

Certificate requirement does not apply when treatment is immediately necessary (**with the patient's consent if s/he has capacity or with the consent of Deputy, LPA or Court of protection if the patient lacks capacity**) which is.

- immediately necessary to save the patient's life;
- a treatment which is not irreversible, but which is immediately necessary to prevent a serious deterioration of the patient's condition;
- a treatment which is not irreversible or hazardous, but which is immediately necessary to alleviate serious suffering by the patient; or
- a treatment which is not irreversible or hazardous, but which is immediately necessary to prevent the patient from behaving violently or being a danger to himself or to others, and represents the minimum interference necessary to do so.

These are strict tests. It is not enough for there to be an urgent need for treatment or for the clinicians involved to believe the treatment is necessary or beneficial. Urgent treatment under these sections can continue only for as long as it remains immediately necessary. If it is no longer immediately necessary, the normal requirements for certificates apply.

B) CTO patients recalled to hospital [S62(A)]

Part 4A does not apply to the treatment of CTO patients who have been recalled to hospital, unless or until they are released from the resulting detention in hospital. Part 4

applies to such patients instead, and treatment could be given if a certificate under Part 4 (s58(3)(a) or (b)) is put in place following recall. However there are three differences:

- First, treatment which would otherwise require a certificate under section 58 or 58A can be given without such a certificate if it is expressly approved instead by Part 4A certificate (if the patient has one). For these purposes, a treatment is only expressly approved by a Part 4A certificate if the SOAD who gave the certificate explicitly states in it that the treatment in question may be given to a patient who has been recalled. Such approval may be subject to conditions, which could be different from those which apply when the patient has not been recalled. A SOAD might, for example, specify that treatment on recall may only be given if a patient who has the capacity to consent to it does so. However, a Part 4A certificate cannot authorise treatment under section 58A for which there would be no authority under Part 4A itself, if the patient had not been recalled. In particular, it cannot authorise treatment without the consent of a person who has the capacity (or, in the case of a patient under 16, the competence) to consent to the ECT. Nor can it authorise section 58A treatment contrary to a valid and applicable advance decision, or the decision of an attorney, deputy or the Court of Protection.
- Second, medication which would otherwise require a certificate under section 58 can be given without such a certificate if the certificate requirement in Part 4A would not yet apply to the treatment because less than one month has passed since the making of the patient's community treatment order (CTO) or it's less than 3 months since the medication was first given(58(1)(b))
- Third, treatment that was already in progress on the basis of a Part 4A certificate before the patient was recalled can be continued temporarily without a certificate, even if the Part 4A certificate does not expressly approve it, if the approved clinician in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. This also applies if treatment was already being continued after the withdrawal of a Part 4A certificate. However, this exemption only applies pending compliance with section 58 or 58A. In other words, it applies only for the time it takes to obtain the certificate that would normally be required, or for a SOAD to decide that it is not appropriate to issue such a certificate.

These exemptions to the requirements for certificates under Part 4 continue if CTOs have been revoked.

C) CTO patients in hospital without having been recalled

Part 4A continues to apply to CTO patients who are in hospital, either voluntarily or when complying with a condition of their CTOs without having been recalled.

Reports to CQC on treatment given in accordance with a Part 4A certificate

Where treatment has been given on the basis of a Part 4A certificate, the person in charge of the treatment must send the CQC a report under section

64H on the treatment and the patient's condition when requested to do so by the CQC. In addition, a report must be given automatically to the CQC under section 61 if treatment is given on the basis of a Part 4A certificate to an CTO patient who has been recalled to hospital (including one whose CTO is then revoked), in lieu of a SOAD certificate under section 58 or 58A. This will only apply to treatment to which the patient either did not, or could not, consent. In such cases, a report must be submitted by the approved clinician in charge of the treatment at the same time it would have to be given if the treatment had, in fact, been given on the basis of a section 58 or 58A SOAD certificate. This means the approved clinician must make a report to CQC on the next occasion that the RC submits a report under section 20A to extend the patient's CTO, or under section 21B to confirm the patient's CTO after absence without leave for more than 28 days.

SOAD Visit

For CTO patients, it is the responsibility of the RC to make a referral to the CQC for a Second Opinion Approved Doctor and then to inform the Care Coordinator. The Care Coordinator will ensure that arrangements are made for the SOAD to see the patient at a mutually agreed place, e.g. at an out patient clinic or somewhere that the patient might visit regularly. The location should be discussed and agreed with the patient prior to them leaving the hospital. Venues in a community setting should be used where possible but the need to ensure that the SOAD has access to notes on INSIGHT may mean that a hospital ward may be the most convenient location if the visit will be taking place out of hours.

The agreed location should be included in the referral to the CQC for the SOAD visit.

Patient's notes should be available at the second opinion location and arrangements should be in place for the SOAD to speak with the RC, statutory consultees (i.e. 2 professionals involved in the care of the person, not the RC, and only one of them could be a doctor) and attorney or deputy if applicable. The Care Coordinator needs to ensure that the SOAD is given appropriate access to electronic patient records. This may mean facilitating access to the electronic records or providing printed copies of electronic reports.

It is accepted that there may be occasions where it is more appropriate to visit an individual at a nursing home or residential care home setting. In exceptional circumstances, it may be necessary for SOAD to visit someone at their own home. If this arises, the SOAD would be accompanied by a professional involved in supporting that individual whilst living in the community, and this person would also be one of the "statutory consultees". Prior negotiation will need to take place to identify the most appropriate place for the SOAD to examine the patient's records.

CTO patients who are consenting to their treatment

Action Required from 1 June 2012

Certification is still not required during the first month of CTO or three months of treatment under the Act, whichever is the later. If the patient continues to give consent at the end of the relevant period, the clinician in charge of the treatment will now certify the patient's consent on the new Form CTO12, and the certification requirements will

be met. (Prior to the changes, certification had to be completed by a SOAD on Form CTO 11)

The Form CTO11 is no longer valid. The clinician in charge of that treatment should instead issue a Form CTO12, certifying the patient's consent and the certification requirement will be met.

The Form CTO 11 is no longer required. The clinician in charge of that treatment should instead issue a Form CTO12, certifying the patient's consent and the certification requirement will be met.

CTO patients who lack capacity or competence to give consent

if a patient lacks capacity to consent to treatment after the first month of treatment under a CTO (of the first three months of treatment as a patient subject to the CTO, whichever is later), then a SOAD should still certify that treatment is appropriate on Form CTO11

CTO Patients who refuse treatment

If a CTO patient refuses to consent. CQC is sometimes asked to arrange a SOAD visit to consider certifying on from CTO11 that;

- a) Certain treatment proposed for the patient while in the community is appropriate, even though such certification provides no authority to give the treatment where a patient refuses consent; and /or
- b) Certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital.

ECT treatment and CTO patients

For CTO patients who are aged 18years or over, the Form CTO12 can be used to certify consent to ECT treatment in the rare circumstances where this might be considered.

However, the new regulations don not alter the previous position that ECT treatment cannot be given to **any** patient who is not yet 18 (regardless of whether or not the patient is detained or subject to CTO) unless a second opinion appointed doctor has certified that the patient consents to ECT and that the treatment is appropriate on Form T5

Part 10: ABSENCE WITHOUT LEAVE

A) RECALLED CTO PATIENTS WHO ARE ABSENT WITHOUT LEAVE

Where CTO patients are at any time absent from the hospital to which they have been recalled (or to which they have been transferred while recalled) they are considered to be AWOL. They may therefore be taken into custody under section 18 and taken to the hospital by any AMHP, any police officer (or other constable), any officer on the staff of the hospital in question, or any person authorised in writing by the managers of that hospital. But that may only be done during the period before:

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

For these purposes, the fact that the RC has already made a report extending the patient's CTO is irrelevant unless the extended period has already started when the patient goes absent.

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

If a patient is taken into custody, or comes to the hospital voluntarily, after being absent for more than 28 days (e.g. on or after 29 January if they went absent on 1 January), their CTO expires at the end of the week starting with the day of their arrival at the hospital unless it is confirmed by the RC (see below).

B) PATIENTS ABSENT WITHOUT LEAVE AS DEADLINE FOR EXTENSION REPORT APPROACHES

Special arrangements apply if a patient is AWOL at any point during the week which ends on the day their CTO is due to expire, and an extension report has yet to be made.

If a patient has not been taken into custody, or does not attend the hospital voluntarily, before the end of the period during which they can be taken into custody, their CTO expires and no extension report can be made. However, if a patient is taken into custody, or attends the hospital voluntarily, during that period, their CTO is treated as not expiring until the end of the week starting with the day they arrive at the hospital. RCs therefore have a week from the day of the patient's arrival at the hospital to submit the extension report. So, if the patient arrives on Monday, the RC has until the end of the following Sunday to submit the report.

If a patient is taken into custody, or attends the hospital voluntarily, during the 28 days starting with the day they went AWOL (e.g. before the end of 28 January, if they went AWOL on 1 January), the extension report is to be made in the normal way – and must therefore be agreed by an AMHP.

However, if a patient is taken into custody, or attends the hospital voluntarily, after more than 28 days, it is not normally necessary to make an extension report under section 20A. That is because the patient's CTO has anyway to be confirmed by a report under section 21B, and that report can also serve as an extension report in place of a report under section 20A.

C) CONFIRMATION OF CTO FOR PATIENTS WHO HAVE BEEN ABSENT WITHOUT LEAVE FOR MORE THAN 28 DAYS

Where a recalled CTO patient is taken into custody, or attends the relevant hospital voluntarily, after being AWOL for more than 28 days, their RC must examine them and, if appropriate, submit a report using Form CTO8 to the managers of the responsible hospital confirming that the conditions for continuing the CTO are met. The criteria for continuing the CTO are the same as the criteria for extending it.

RCs must make a report during this period if they think that the conditions are met. But they must first consult one or more other people who have been professionally concerned with the patient's medical treatment and an AMHP. (There is no requirement in this case to obtain a statement of agreement from the AMHP).

The managers of the responsible hospital must record their receipt of the report in Part 2 of the same Form CTO8.

A report submitted under this procedure will extend the patient's CTO if it would otherwise already have expired (or if it would expire on the day the report is submitted to the managers). If so, the managers must take the steps described there to arrange for the patient and (where relevant) the nearest relative to be informed.

Unless such a report is submitted, a patient's CTO expires automatically at the end of the week starting with the day on which they arrive at the hospital. However, a report is not required if the patient's CTO is revoked during that period.

If a patient's CTO is due to expire during the period of two months starting with the day on which the report is given to the managers, the RC may (but need not) indicate on the form that it is also to act as an extension report (which would otherwise have to be made during that period under section 20A). In that case, unless they decide to discharge the patient, the managers must take steps to arrange for the patient and (where relevant) the nearest relative to be informed of the report in the same way as if it were a report under section 20A itself.

D) PATIENTS WHO RETURN FROM ABSENCE WITHOUT LEAVE AND WHOSE CTO WOULD OTHERWISE HAVE EXPIRED

In some cases, the RC's report under section 20A or 21B extending the CTO of a patient who has been AWOL will be made on or after the day the CTO was originally due to expire. If so, that report is treated as having retrospectively extended the CTO from when it would otherwise have expired in the normal way.

In the rare circumstances where the patient's CTO would otherwise have expired twice since they went AWOL, the RC's report under section 21B is treated as having extended the CTO on both occasions. If a patient's CTO is extended retrospectively (either once or twice) in this way, the hospital managers must take whatever steps are reasonably practicable to arrange for the patient to be told about the extension. The patient must be told of the retrospective extension both orally and in writing. They must also take such steps to arrange for the person they think is the nearest relative to be informed, unless the patient has requested otherwise (or does not have a nearest relative). Information given to the nearest relative must be in writing, but may be communicated by electronic means (e.g. e-mail) if the nearest relative agrees.

E) PATIENTS WHO ARE IMPRISONED, ETC

Special rules apply to CTO patients who are imprisoned, remanded or otherwise detained in custody by any court in the UK. Such patients automatically cease to be CTO patients if they remain in custody for longer than six months in total. Until then, they formally remain CTO patients (unless discharged from their CTO in the interim). If they are released from custody during that six month period, they are treated as if they had gone AWOL on the day of their release.

Because patients in this situation are treated as being AWOL, if such an CTO patient's CTO would otherwise have expired, or is about to expire, it will not in fact expire until the end of the week starting with the day of the patient's return to hospital (if the patient had already been recalled to hospital when first imprisoned) or (if not) with the day of the patient's release from custody. The effect of this is that, if the patient's CTO is otherwise due to expire, RCs will always have at least a week in which to examine the patient and submit a report extending the CTO (if appropriate) under section 20A.

Although an CTO patient released from custody after less than six months is treated as having gone AWOL, they may only automatically be taken into custody and returned to a hospital if they had already been recalled to that hospital when they were first imprisoned. Even then, this can only be done during the 28 day period starting with the date of their release.

However, the normal rules about recalling patients to hospital apply to patients released from custody during whatever period remains of their CTO (including the one week extension, where relevant). So such a patient can, if necessary, be recalled to hospital in order to be examined with a view to making a report extending their CTO. If they failed to attend, they would be considered AWOL in the normal way, and could therefore be taken into custody at any time during the six months starting with the day they failed to attend.

Prescription Charges

Department of Health Guidance indicates that CTO patients should be exempt from prescription charges. However there is currently no arrangement in place to enable GP prescriptions to be made without charge in circumstances where an CTO patient is not otherwise eligible for an exemption from charges. Many CTO patients will be eligible for exemptions on other grounds, however where this is not the case then SHSC Pharmacy Department may be able to arrange for prescriptions to be made from SHSC Pharmacy without charge.

Part 11 EFFECT ON CTO OF NEW APPLICATIONS FOR ADMISSION OR GUARDIANSHIP UNDER PART 2

Because CTO patients can be recalled to hospital for treatment if required, it should not be necessary to make applications for their detention. In practice, however, this may happen if the people making the application do not know that the patient is an CTO patient. An application for admission for assessment under section 2 or 4 does not affect the patient's CTO. It would continue to be valid if the patient's CTO status is unknown. But if it's then discovered that the patient is an CTO patient, that would call into question the continuing need for detention under section 2 - the patient's clinical needs are likely to be well established and it would be difficult to justify the need for detention for assessment. So if it becomes known that a patient detained under section 2 is also on CTO the correct processes of recall and revocation, if appropriate, should be followed. For the same reason there should be no question of using section 2 if the patient's CTO status is known at the outset.

However, if an CTO patient is detained on the basis of an application for admission for treatment under section 3, they will automatically cease to be an CTO patient if, immediately before going onto CTO, they had been detained on the basis of a previous application under section 3 (rather than hospital order, hospital direction or transfer direction under Part 3 of the Act). The same applies if such a patient is received into guardianship as a result of an application under Part 2. That is because an application under section 3, or the reception of a patient into guardianship under Part 2, automatically brings to an end any previous application for detention or guardianship under Part 2.

If a patient stops being a CTO patient because of an application for admission for treatment under section 3, a new CTO would have to be made for the patient to go back onto CTO when they no longer needed to be detained in hospital.

16. REFERENCES

- Revised Code of Practice: Mental Health Act 1983, The Stationery Office (TSO), 2015
- Reference guide to the Mental Health Act 1983: Department of Health, 2015

APPENDIX 1

INFORMATION TO BE GIVEN

Patients on Community Treatment Orders must be given information about how the Act applies to them. This should be given as soon as practicable after the start of the Community Treatment Order and must also be given to patients who are recalled to hospital. Practicability encompasses having regard to the patients current mental state of mind and ability to understand the information.

The information should be given by a senior nurse on the ward, which could be the named nurse, prior to discharge on to the CTO and again by the care coordinator once the CTO is implemented. . However the giving of information relating to the consent to treatment provisions may more appropriately be undertaken by the patient's RC.

Information must be given both orally and in writing. These are not alternatives. All relevant information must be conveyed in a way the patient understands. Where an interpreter is needed, every effort should be made to identify who is appropriate given patient's gender, religion, age, language dialect and cultural background. Only in exceptional circumstances should the patient's relative and friends be used as interpreters.

The patient must be informed of the effects of the CTO including the conditions which they are required to keep and the circumstances in which their RC may recall them to hospital.

As part of this they should be told the reasons for the CTO, the maximum length of the current period of CTO, that their CTO may be ended at any time if it is no longer required or the criteria are no longer met. It should also be explained that they will not automatically be discharged when the current CTO period ends nor that the CTO will automatically be extended when the current period ends.

It is particularly important that patients on CTOs are informed of their rights of appeal to the MHT and the hospital managers and are supported in this process.

Those with responsibility for giving information should ensure that patients are reminded from time to time of their rights and the effect of the Act.

It is a requirement of the Code of Practice that a record is kept of the information given, including how, when, where and by whom it was given. The record should also show the patients wishes in relation to the giving of the relevant information to the nearest relative. The person giving the information must ensure that whenever a patient is given an explanation of his/her rights under the Act, the Trust's 'Record of Mental Health Act 1983 Information Given to Detained Patients' is completed and sent to the Mental Health Act Administrator and any supplementary information is recorded in the patient's notes.

Appendix 2

Guidance on Recall of CTO patients

1. The purpose of the power of recall is to enable the RC to treat the patient in hospital. Only the RC of the patient has the power of recall. This power cannot be delegated

2. Who the RC is a matter of fact. If the RC is not available, the RC will be the AC covering him/her. By Default, the on call Consultant Psychiatrist will be the RC out of hours.

3. the recall does not have to be to the hospital from which the patient was discharged, but can be to any hospital appropriate for the patient and their treatment.

4. Patients recalled to hospital do not have to be admitted as in-patients. They could be recalled for out-patient treatment instead for example

5. Failure to meet a condition is not in itself enough to justify recall but the RC can take such non-compliance into account when considering if recall is necessary. However, if the failure to comply means immediate risk of harm to the patient or to someone else, then the patient falls under the criteria for recall.

6. Criteria for Recall

The RC may recall a patient on CTO to hospital for treatment if:

- The patient needs to receive treatment for a mental disorder in hospital; and
- There would be risk of harm to the health or safety of the patient. Or to other persons. If the patient was not recalled.

There is also a power to recall patients to hospital if they fail to comply with one of the mandatory conditions to attend for examination by RC for the purpose of renewal of CTO or by SOAD for the purpose of Part 4A certificate.

7. There is no clear statutory obligation to see the patient in person before recall. The wording is that the RC may recall a community patient to hospital if in his opinion However, the recall should be handed to the patient by hand if at all possible. As any of the compulsory powers, it would be good practice for the RC to see the patient before deciding to recall. The patient might have a very good reason for breaking conditions of CTO. The patient might agree to informal admission or agree to comply for treatment once seen by the RC. Only if face to face assessment is not possible or practical (e/g the patient's whereabouts is not known or quite far from where the RC is based) the RC could complete the recall notice if s/he believes this is the best course of action

8. The RC should ensure that the hospital is 'ready' to receive the patient.

9. The recall notice gives the authority to convey the patient to hospital, by whoever authorised by the RC. However, the patient could return to hospital on his own accord, or with family member without the need for conveyance.

10. S136 or S4 should not be used if it is known that the patient is under CTO as they are similar in purpose and duration to the recall.

11. S3 will terminate CTO. It should not be used knowingly

12. S2 would not terminate CTO However S2 should not be used, if it is known that the patient is under CTO. If someone was detained under S2 and it was discovered that they are under CTO they should be assessed for recall and then revocation.

13. Serving the notice of recall

Method of serving the recall notice	Notice deemed to have been served
Delivering the notice by hand to the patient	As soon as it is given to the patient
Delivering the notice by hand to the patient's usual or last known address	At the start of day which follows the day on which it is delivered to that address. For example if it is delivered at noon, it is deemed to have been served immediately after midnight that night, even if it is a weekend or bank holiday
Sending it by pre-paid first class post (or its equivalent) to the patient at the patient's usual or last known address	At the start of the second business day after it is posted. For example, if it is posted on Monday, it is deemed to have been delivered on Wednesday but if it is posted on Friday it is deemed to have been delivered on Tuesday. Weekend and public holidays do not count as business days

If the patient does not return to hospital within these timescales s/he will be considered AWOL

Check List for CTO

Is the patient detained under section 3 or section 37?

Does the patient meet the criteria for CTO?

Are you satisfied that the power to Recall is necessary?

Has the risk of the patient's condition deteriorating after discharge been assessed?

Has an AMHP been identified?

Has a CPA meeting been held?

Has a discussion been had with the community RC taking over responsibility?

Has a discussion been had with the care co-ordinator?

Has a discussion been had with the patient?

Has discussion been had with other relevant people?

Have parts 1 & 2 been completed and sent to Medical Records for Scrutiny?

Has a SOAD been requested?

Are the non mandatory conditions necessary or appropriate for the one or more of the following reasons – ensuring that the patient receives medical treatment;

Preventing risk of harm to the patient's health or safety; of

Protecting other people

NOTICE OF DISCHARGE FROM CTO UNDER SECTION 23

Notice to Managers/Mental Health Act Office

Full name of patient.....

Insight No.....

Responsible Clinician:

Patient to be discharged from CTO on

(date).....

at

(time).....

Responsible Clinician (name):

Signature.....

Date.....

To be forwarded as soon as possible to:

Medical Records Department

**S64H FORM: CONTINUATION OF TREATMENT GIVEN
TO CTO PATIENT WHO LACKS CAPACITY TO CONSENT TO TREATMENT
PENDING SOAD VISIT**

Name of patient

Insight number

NHS number

Approved Clinician

Nature of Treatment

I confirm that:

1. Patient lacks capacity to consent to treatment
2. The treatment is not in conflict with a valid and applicable advance decision, objection by a deputy, donee or court of protection.
3. Patient is not objecting OR if objecting, force is not required to administer medication
4. Discontinuation of treatment is likely to cause serious suffering for the patient
5. Treatment is given by or under the direction of the Approved Clinician

Follow up action (e.g. has SOAD been requested?)

Signed
Responsible Clinician/Approved Clinician

Date

WHEN FULLY COMPLETED, THE ORIGINAL MUST BE SENT TO THE MENTAL HEALTH ACT ADMINISTRATION OFFICE

SECTION 64G FORM EMERGENCY TREATMENT OF CTO PATIENTS LACKING CAPACITY

Name of patient.....

Insight Number

Date of birth.....

Name of Approved Clinician/Responsible Clinician

1. Does the patient lack capacity to consent to treatment Yes/No

2. Is treatment is immediately necessary

a) Which is immediately necessary to save the patient's life or:

b) Which (not being irreversible) is immediately necessary to prevent a serious deterioration in his/her condition or:

c) Which (not being irreversible or hazardous), is immediately necessary to alleviate serious suffering by the patient or: (NOT APPLICABLE FOR ECT)

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 him/herself or others. (NOT APPLICABLE FOR ECT)

(For the purposes of this section treatment is irreversible if it has unfavourable irreversible physical or psychological consequences and hazardous if it entails significant physical hazard)

Delete the statutory criterion that does not apply.

If force is necessary to administer treatment:

3. Is it necessary to use force to prevent harm to the patient? Yes/No

4. Is the force used proportionate? Yes/No

Details of treatment (what is the proposed treatment and why is it immediately necessary to give the treatment?):

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

Steps taken to obtain a Second Opinion Approved Doctor Opinion

.....
.....
.....
.....
.....

Signed Date.....
(Approved Clinician/Responsible Clinician)

Print name

WHEN FULLY COMPLETED, THE ORIGINAL MUST BE SENT TO THE MENTAL HEALTH ACT ADMINISTRATION OFFICE

MENTAL HEALTH ACT 1983 Record of capacity/consent for CTO patients

Name of patient:

Date of birth:

Insight Number:

Name of Responsible Clinician:

Details of the proposed treatment

1. I explained in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it.	<input type="checkbox"/>
2. I explained to the patient that s/he has the right to withdraw their consent. I also explained the likely impact, on their health, of not receiving the treatment if s/he withdraws their consent. .	<input type="checkbox"/>

Details of the discussion

I have concluded that

1. <i>S/he understood the information about the proposed treatment</i>	<input type="checkbox"/>
2. <i>S/he was able to retain the relevant information</i>	<input type="checkbox"/>
3. <i>S/he was able to use/weigh the information</i>	<input type="checkbox"/>
4. <i>S/he communicated their agreement</i>	<input type="checkbox"/>

And either (Delete the statements that does not apply)

1. S/he has capacity and consented to the treatment plan and I have completed Form CTO12
2. S/he has capacity and refused to consent to the treatment plan. Treatment can not given in the community (unless it is immediately necessary and being given under section 64G)
3. S/he lacks the capacity to consent to the treatment plan. I am not aware of objection under MCA 2005 (advance decision or refusal by a Court appointed deputy or an attorney). A SOAD visit is being requested (or CTO11 is in place). Alternatively, a deputy or an attorney has consented to the treatment plan on behalf of the patient.

Signed

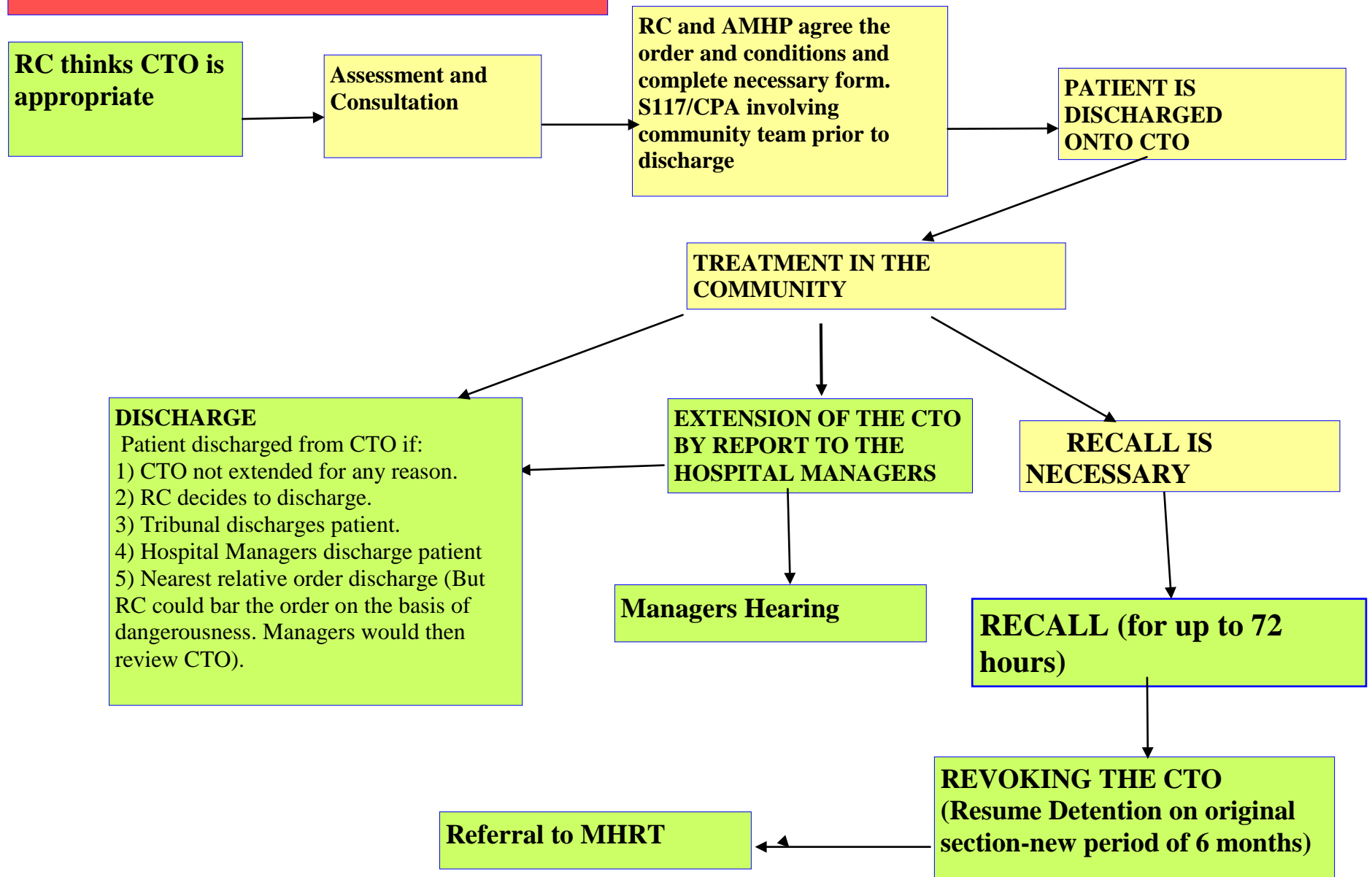
Date

Print name

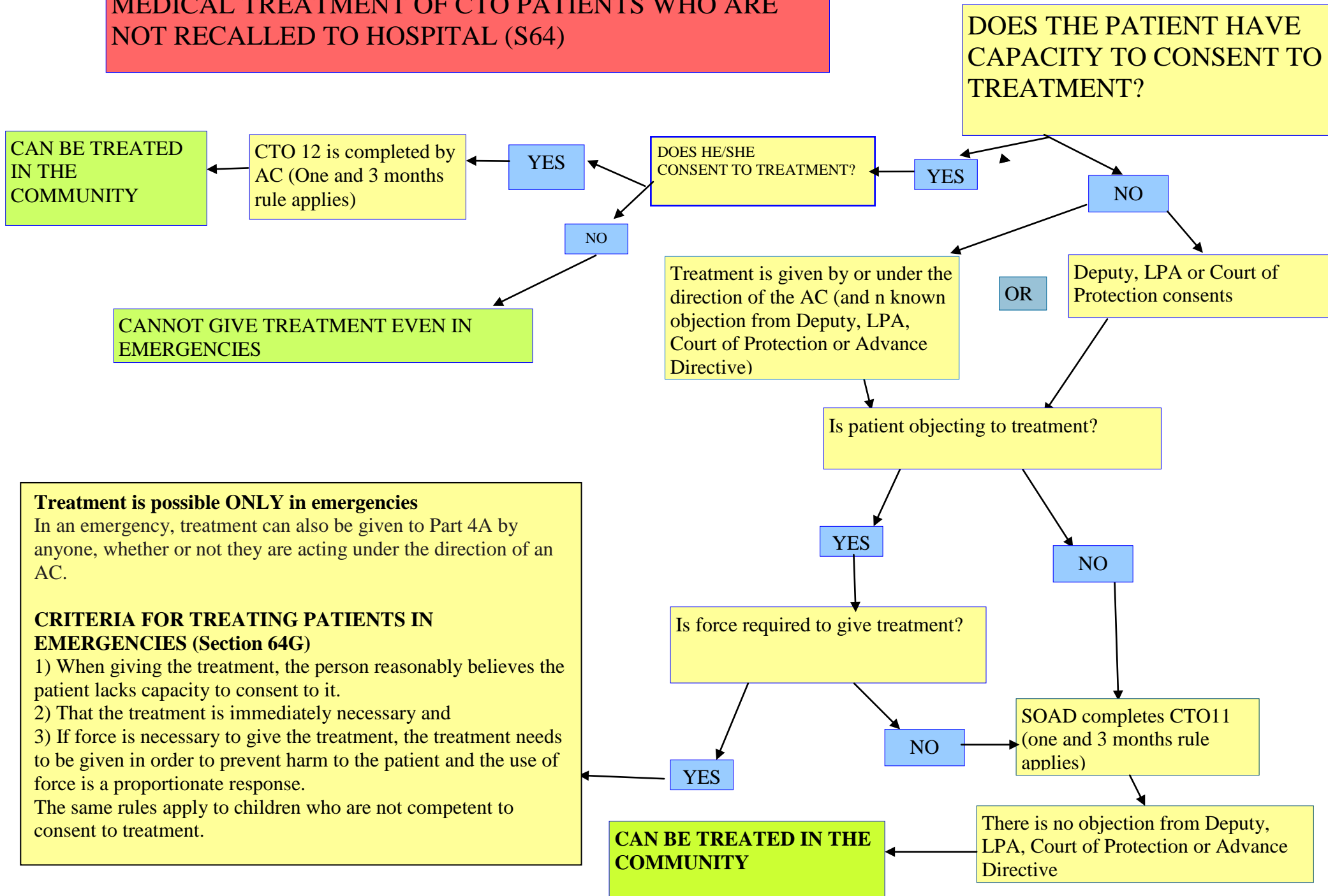
Designation

WHEN FULLY COMPLETED, THE ORIGINAL MUST BE SENT TO THE MENTAL HEALTH ACT ADMINISTRATION OFFICE

CTO FLOWCHART



MEDICAL TREATMENT OF CTO PATIENTS WHO ARE NOT RECALLED TO HOSPITAL (S64)



DOES THE PATIENT HAVE CAPACITY TO CONSENT TO TREATMENT?

DOES HE/SHE CONSENT TO TREATMENT?

CAN BE TREATED IN THE COMMUNITY

CTO 12 is completed by AC (One and 3 months rule applies)

CANNOT GIVE TREATMENT EVEN IN EMERGENCIES

Treatment is given by or under the direction of the AC (and n known objection from Deputy, LPA, Court of Protection or Advance Directive)

Deputy, LPA or Court of Protection consents

Is patient objecting to treatment?

Treatment is possible ONLY in emergencies
 In an emergency, treatment can also be given to Part 4A by anyone, whether or not they are acting under the direction of an AC.

CRITERIA FOR TREATING PATIENTS IN EMERGENCIES (Section 64G)

- 1) When giving the treatment, the person reasonably believes the patient lacks capacity to consent to it.
- 2) That the treatment is immediately necessary and
- 3) If force is necessary to give the treatment, the treatment needs to be given in order to prevent harm to the patient and the use of force is a proportionate response.

The same rules apply to children who are not competent to consent to treatment.

Is force required to give treatment?

SOAD completes CTO11 (one and 3 months rule applies)

CAN BE TREATED IN THE COMMUNITY

There is no objection from Deputy, LPA, Court of Protection or Advance Directive

Procedure for CTO Recall Sec 135 (2)

