

COMMUNITY TREATMENT ORDER PROCEDURAL GUIDELINES

PROCEDURE REFERENCE NUMBER	MHAPG30	
VERSION NUMBER	1	
REPLACES SEPT DOCUMENT	MHAPG30	
REPLACES NEP DOCUMENT	CP5/CTO/04/16	
KEY CHANGES FROM PREVIOUS VERSION	Harmonisation of SEPT and NEP documents bringing both in line with changes to the Mental Health Act 1983 Code of Practice – revised edition April 2015	
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CONSULTATION GROUPS	MHA administrators, AMHPs, Consultant Social Workers, Consultant Psychiatrists, Clinical Directors and relevant directors Trustwide	
IMPLEMENTATION DATE	July 2017	
AMENDMENT DATE(S)	N/A	
LAST REVIEW DATE	July 2017	
NEXT REVIEW DATE	July 2020	
APPROVAL BY CLINICAL GOVERNANCE & QUALITY COMMITTEE	20 September 2017	
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PROCEDURE SUMMARY		
Community Treatment Orders may enable patients with an established history of repeated re-admission to hospital to remain safely in the community by helping them to engage with treatment and community services through agreement with explicit treatment conditions. This will support the Trust's wish to minimize the use of detention and to promote the patient's independence in the community.		
The Trust monitors the implementation of and compliance with this procedure in the following ways;		
The Director responsible for monitoring and reviewing this procedure is The Executive Director of Corporate Governance Mental Health Act Administrators will make arrangements for a periodic audit of the effectiveness of CTOs to be undertaken which will review and evaluate the effectiveness of these orders (i.e. in terms of reducing the frequency of re-admission to hospital and ensuring compliance with essential conditions included in the order).		
Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

**The Director responsible for monitoring and reviewing this procedure is
Director of Mental Health**

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Assurance Statement

These procedures set out the required arrangements to identify and manage patients who are eligible for Community Treatment Orders under Section 17(a) of the Mental Health Act 1983 Code of Practice – revised edition April 2015.

The purpose of these guidelines is to enable patients with an established history of repeated re-admission to hospital to remain safely in the community by helping them to engage with treatment and community services through agreement by helping them to engage with treatment and community services through agreement with explicit treatment conditions.

This will support the Trust's wish to minimize the use of detention and to promote the patient's independence in the community.

These guidelines and the associate policy apply to all staff employed within or seconded to the Trust.

1.0 INTRODUCTION

1.1 This policy sets out the legal framework for the operation of an order made under Section 17A of the Act which is known as a 'Community Treatment Order' (CTO). The title of this policy has been changed to reflect the fact that the previous term 'Supervised Community Treatment' no longer exists.

1.2 The purpose of a 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. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The term 'patient' is used throughout to reflect the language of the Code of Practice.

1.3 This policy should be read in conjunction with Chapter 29 of the Mental Health Act 1983 Code of Practice – revised edition April 2015 which offers guidance on the operation of the Act. The guiding principles set out in Chapter 1 of the Code in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs

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2.0 SCOPE

- 2.1 This policy should be read in conjunction with relevant chapters of the Code of Practice as revised in April, 2015 which offers guidance on the operation of the Act. Chapters 25, 27, 29 and 32 focus on Community Treatment Orders. The five overarching principles of the Code should be considered when making decisions about any course of action under the Act.
- 2.2 **Guiding Principles**
- Least restrictive option and maximising independence***
- Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible
- Empowerment and involvement***
- Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reason for this
- Respect and dignity***
- Patients, their families and carers should be treated with respect and dignity and listened to by professionals
- Purpose and effectiveness***
- Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines
- Efficiency and equity***
- Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention
- 2.3 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 (e.g. ECT).
- 2.4 The purpose of this policy is to ensure that there is lawful and appropriate use of CTOs and that the legal rights of any service user subject to a CTO are upheld at all stages. There is no lower age limit for CTO.

3.0 DEFINITIONS

- 3.1 **Community Treatment Order** is an order made under Section 17A of the Mental Health Act 1983 (as amended) which requires an unrestricted patient usually detained under Section 3 or Section 37 to be discharged subject to certain conditions and liable to recall to hospital.

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- 3.2 **Responsible Clinician** is the Consultant Psychiatrist (or other approved clinician) who is in charge of a CTO patient at any given point. When moving between the community and inpatient services, there will usually be a change of RC. Out of hours, there is a Duty Consultant who in emergencies may assume RC responsibility for patients within their designated service.
- 3.3 **Hospital Managers** is a term used in the Act for the detaining authority or the body responsible for the use of compulsion i.e. Trust Board. However day to day responsibility for receipt and scrutiny of statutory documentation is delegate as per the Trust's delegated responsibilities.
- 3.4 **AMHPs (Approved Mental Health Act Professionals)** are trained to implement elements of the Mental Health Act 1983, revised April 2015, in conjunction with medical practitioners. They have received specific training to least at Level 7 on the National Qualifications Framework, such as an MSc in Mental Health or PGDip in Mental Health Studies relating to the application of the Mental Health Act, usually lasting one or two years and perform the pivotal role in assessing and deciding whether there are grounds to detain mentally disordered people who meet the statutory criteria. The AMHP is also an important healthcare professional when making decisions under guardianship or community treatment orders. The role to apply for a section is with the AMHP, who will decide if this is required after detailed assessment and consultations with the medical doctors.

4.0 PURPOSE OF COMMUNITY TREATMENT ORDER

- 4.1 *'The purpose of a 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. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs'.* COP 29.5
- 4.2 CTO provides a framework for the management of patient care in the community and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if necessary.

5.0 WHO SHOULD BE CONSIDERED FOR A COMMUNITY TREATMENT ORDER?

- 5.1 There is no lower age limit for a CTO. The following criteria must be met in all cases before a CTO 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 3 of the Act, including a patient currently on Section 17 leave from hospital.
It is not applicable to patients on restriction orders
 - The patient must be suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
 - It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment

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- Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital
- It is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Act to recall the patient to hospital, and
- Appropriate medical treatment is available for the patient
- The RC must be satisfied that the risk of harm arising from the patient's mental disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. COP 29.16
- A patient's suitability for a Community Treatment Order is initially assessed by the RC in consultation with the Multi-Disciplinary Team (MDT). Following this the RC must request an Approved Mental Health Practitioner (AMHP) to make an assessment. Both of them have to agree that a Community Treatment Order can be implemented in order for the Community Treatment Order application to be made. They must also agree the content of all the specified conditions in the order. COP 29.27 - 29.33

6.0 CRITERIA AND MANDATORY CONDITIONS

6.1 Mandatory Conditions

- The patient must make him or herself available for examination to determine whether to extend the community treatment period
- The patient must make him or herself available for examination by a Second Opinion Appointed Doctor when requested. However, this only applies if the RC is unable to certify that the patient has capacity and is consenting to treatment

6.2 An AMHP 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:-

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

If the AMHP does not agree with the RC that the patient should be discharged onto a CTO, the CTO cannot be made. The RC should not approach another AMHP for an alternative interview. COP 29.25

6.3 The inpatient Responsible Clinician has responsibility to send a referral (**See appendix 1**) to the locality team manager for the area, to set up a pre-CTO recommendation meeting.

An order is made by the RC completing Parts 1 & 3 with the AMHP completing Part 2 of the form CTO1. The AMHP should meet with the patient before deciding whether to agree that the CTO should be made.

6.4 The completed form must be given to the Hospital Managers as soon as practicable. However, there is no statutory form to record receipt of the order. When all parts of the form are completed, signed and dated by the RC, the CTO automatically takes effect on the date and time specified on the form for a period

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of up to six months.

6.5 There is no mechanism for retrospectively amending or rectifying a defective CTO1 once handed to the Hospital Manager, it is therefore essential where practicable, the form or a copy of it is seen by or at least discussed with the Mental Health Act Administrator before acting on it.

7.0 CARE PLANNING AND COMMUNITY TREATMENT ORDER

- 7.1 A care plan **MUST** be prepared and include details of who is responsible for prescribing medication and who has clinical responsibility for the patient's physical health.
- 7.2 The care plan must include –
- A statement of the patient's needs for future treatment in the community and any conditions;
 - Details of how and where the patient is to receive treatment. This will include medication (included on Part 4A Certificate – Form CT011) and therapies. The location may be their home, community-based setting or hospital;
- 7.3 PLEASE NOTE - FORCE CANNOT BE USED TO GIVE A TREATMENT IF THE SERVICE USER OBJECTS TO IT, EXCEPT IN AN EMERGENCY.
- 7.4 The patient should have a discharge CPA meeting and a copy of the Care Plan before they are discharged from hospital onto the CTO
- 7.5 The following parties should be consulted, subject to the usual considerations of patient confidentiality:
- The nearest relative;
 - Any carers;
 - Where the RC planning the CTO will not be the RC providing care following discharge, the RC recommending the CTO must liaise with the proposed future community RC on the appropriateness of the CTO, and the potential conditions, to reflect the development of community based services and ensure best practice. This will greatly assist in the delivery of seamless transfer of care from the hospital to the community and vice versa although the final decision rests with the current RC.
 - 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 service user's care;
 - The service user's GP. Where there is none, engagement and help should be given to enable the service user to register with a GP practice;
- 7.6 There are two conditions set out at 6.1 which are mandatory in all cases

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- 7.7 The RC may, with the AMHPs agreement and following discussions with the patient, set other conditions which are identified as being necessary or appropriate to:
- Ensure that the patient receives medical treatment for mental disorder
 - Prevent a risk of harm to the patient's health or safety as a result of mental disorder, and
 - Protect other people from a similar risk

Conditions may be set for any or all of these purposes, but not for any other reason. COP 29.29

- 7.8 Conditions should be stated clearly having regard to the least restrictive principle and may include:
- Where and when the patient is to receive treatment in the community
 - Where the patient is to live
 - Avoidance of known risk factors or high risk situations relevant to the patient's mental disorder COP 29.32

- 7.9 The RC may vary the conditions of the CTO completing a Form CTO2 or suspend any of them where appropriate – e.g. to allow temporary absence of patient, but must record the reasons, and any decision to suspend on the clinical information system Mobius or Paris. In either case, a decision to vary or suspend should be relayed to the Mental Health Act Administrator holding the CTO documentation to enable them to update their records. Any condition no longer required should be removed. It is not necessary to seek the agreement of an AMHP to vary or suspend conditions. However, good practice dictates, the RC should have discussed any changes to a recently agreed CTO with the AMHP and the CPA Care Co-ordinator.

- 7.10 It is important to discuss any proposed changes to the conditions with the patient and ensure that the patient and anyone else affected by the changes such as their family and carers where appropriate and subject to the patient's right to confidentiality knows that they are being consulted and why. COP 29.43

- 7.11 Failure to comply with a condition apart from the mandatory conditions at 6.1 does not in itself trigger the power of recall.

8.0 PROVISION OF INFORMATION

- 8.1 The RC should inform the patient and others who were consulted, of the decision to discharge a patient onto CTO including any conditions applied to the CTO and services available for the patient. This will include making a copy of the CTO documentation available to the patient and any professional who was consulted as part of the process. The conditions of the CTO must be included in the patient's care plan.

- 8.2 There is a duty on the Hospital Managers to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving information both orally and in writing and must be done as soon as practicable after the patient goes onto the CTO by the Care Co-ordinator or other

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appropriate person. This will be recorded on a Section 132 Rights Form which is then copied to the person holding the CTO documentation. An information leaflet will be provided to the patient by the Mental Health Act Administrator and to the nearest relative, unless the patient objects.

The Domestic Violence Crime and Victims Act (2004) place a number of duties on Hospital Managers in relation to certain unrestricted Part 3 patients. COP 40.

8.3 Information in writing given to the patient must be provided in a language and format that the patient can understand taking into account any cultural, ethnic or disability issues (and if it is appropriate this can be copied to the nearest relative). This information will include reference to their rights and the following matters:

- Appeals to the Mental Health Review Tribunal (MHRT);
- Recall, revocation or discharge by RC;
- Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours' notice requirement), MHRT or Hospital Managers;
- Independent Mental Health Advocacy Services (IMHA)
- The role of the Care Quality Commission or any subsequent body;
- Treatment rights while subject to CTO in the community.

9.0 MONITORING OF COMMUNITY TREATMENT ORDER PATIENTS

9.1 It is important to maintain close contact with patients on a CTO to enable close monitoring of their mental health. The type and scope of these arrangements will depend on the patient's individual needs and circumstances including cultural, disability, ethnic or gender needs.

9.2 Respective responsibilities should be set out in the patient's care plan. The CPA Care Co-ordinator will be responsible for co-ordinating the care plan and working with the Responsible Clinician.

9.3 Appropriate action will need to be taken if the patient becomes unwell – if the patient refuses crucial treatment an urgent review of the situation will be needed – recalling the patient to hospital will be an option if the risk justifies this or there is no safe alternative that is acceptable to the patient and Responsible Clinician.

9.4 If the patient is not compliant with any condition of the CTO, the reasons for this needs to be properly investigated. A recall to hospital may be needed if it is no longer safe and appropriate for the patient to remain in the community.

10.0 REVIEW OF A COMMUNITY TREATMENT ORDER

10.1 It is a statutory requirement under the Act for a CTO to be reviewed. It is good practice to do this as part of the CPA care review process.

10.2 Reviews of CTO's should cover whether the CTO is meeting the treatment needs and as to whether the patient continues to satisfy all the criteria for a CTO. Where they do not – they must be discharged without delay.

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11.0 RECALL FROM A COMMUNITY TREATMENT ORDER

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

11.2 The power of recall is to provide a means to respond to evidence of relapse or high risk behaviour before a situation becomes critical leading to harm to the patient or to others. The RC may recall a CTO patient to hospital for treatment if:

- The patient needs to receive treatment for mental disorder in hospital – either as an inpatient or outpatient or
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled

11.3 Where a patient breaches a condition of their CTO or refuses necessary treatment they should always be given the opportunity to comply with the condition before recall is considered unless there is a risk of harm to their health or safety or to others.

11.4 The RC must be satisfied that the criteria are met before using the recall power. Any action taken should be proportionate to the level of risk and whether recalling the patient to hospital is justified in all the circumstances e.g. if they might agree to admission to hospital on a voluntary basis.

11.5 The RC is responsible for co-ordinating the recall process and must in every case 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 delivered by hand to the patient's usual or last known address. If the notice needs to be posted to the patient, First Class post should be used and the notice is deemed to have been served on the second working day. A notice handed to the patient is effective immediately, however if the patient refuses to accept the notice or is unavailable, once the notice is delivered to their last known address, the notice is deemed as being served the day after it was delivered – this does not have to be a full working day, it can be immediately after midnight following delivery. If access cannot be gained to the patient, consideration should be given to obtaining a warrant under Section 135(2) of the Act. See table below for guidance in relation to methods of serving a Notice of Recall.

11.6 Failure to meet a condition should not necessarily result in an automatic recall. Equally even if the patient is fully compliant with all the conditions, recall can still be made if the patient's health deteriorates significantly to an extent necessitating hospital treatment.

11.7 Prior to obtaining a Section 135(2) Warrant, a decision must be made and agreed between the RC, Care Co-ordinator and receiving ward as to who should apply for the Warrant and execute it.

11.8 The recall notice must be made out to the hospital where the patient is to be recalled to. However, the hospital need not be the patient's responsible hospital

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(the hospital where the patient was detained before going onto a CTO). Should a recall notice be made out to one hospital but is sent to another hospital, a new recall notice will be required immediately in order for the hospital to accept the patient. A copy of the recall notice should be sent to the hospital managers of the hospital to where the patient is being recalled.

Patient Circumstances	Appropriate Method of Serving From CTO3	Notice Effective
Patient can be approached in person and may be at or in hospital already	Deliver form by hand personally	Effective immediately
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 – if appropriate consider whether a S135(2) warrant should be sought	Notice deemed to be served after midnight on the day it was delivered. It does not matter whether it is a working day, a weekend or a holiday. It does not matter whether it is actually received by the patient or not
Patient not available in person e.g. has failed to attend requested SOAD 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 working day after posting – e.g. posted Friday, effective from Tuesday

11.9 The RC should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide appropriate treatment.

11.10 Whilst recall must be to a hospital, the required treatment may be given on an outpatient basis, if appropriate.

11.11 Conveyance to that hospital should be in the least restrictive manner possible.

11.12 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. A Form CTO6 is not required for transfers within the same organisation but the receiving hospital must complete a Form CTO4 recording the date and time of the patient's initial recall to hospital.

11.13 Transfer after recall to a hospital managed by another organisation requires that arrangements for the transfer are properly in place and that a 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 72 hours' time limit is adhered to.

11.14 As soon as practicable, the patient shall be given information verbally and in writing about their rights following recall and the impact, if any on their treatment rights. The provisions of CTO rights must be recorded in the same manner used for other detained patients.

11.15 Following recall, the RC and clinical team will consider the circumstances of the recall and in particular whether CTO remains the right option for the patient. They must consult the patient and subject to the usual considerations about

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involved a nearest relative and any other carer and decide whether a variation in the conditions or change in the care plan or both is appropriate. The RC may allow the patient to go on leave outside the hospital at any time during the 72 hour recall period.

11.16 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 this should not happen. Recall is permissible in relation to an existing patient. To avoid confusion or failure to adhere to the intended statutory scheme, it is essential that the circumstances surround the admission and confirmation that the patient gave valid consent is properly recorded in the clinical records (Paris or Mobius).

11.17 Should a patient who was on a CTO who agrees to be in hospital informally becomes unwell and it becomes necessary to detain the patient formally in hospital, the process or 'recall' must be used and under no circumstances should a Section 5(2) be implemented or a Section 136

12.0 EMERGENCY RECALL PROCEDURE

12.1 In the event of a patient needing to be recalled to hospital as an emergency as a result of a sudden deterioration in mental state and presenting as a risk to self or others, the following process should be followed:

- The Responsible Clinician has responsibility for co-ordinating the recall process, unless it has been agreed locally that someone else will do this. Out of hours, this defaults to the on-call Responsible Clinician
- All on-call Responsible Clinicians should ensure when carrying out on-call duties that they have in their possession, or ready access to, the form CTO3 – Notice of Recall to Hospital, available on the Trust Intranet.
- The Clinician requesting the recall must liaise with the on-call Responsible Clinician stating both the rationale for recall and associated risks and, where practicable, make available the current care plan and a copy of the CTO1 – Community Treatment Order
- Where possible/practicable the CTO1 should be collected by a clinician from the on-call Responsible Clinician. Where this is not possible for geographical reason, a taxi firm previously approved for this purpose should be contacted and instructed to convey the CTO3 which should be contained within a secure envelope. The seal of the envelope must be then signed by the on-call Responsible Clinician, handed to the taxi driver for onward conveyance to the clinician/team initiating the recall.

13.0 CONVEYING A PATIENT TO HOSPITAL

13.1 The decision how to convey a patient back to hospital is made by the RC following an appropriate risk assessment.

13.2 The patient should be conveyed in the least restrictive manner – if appropriate the patient may be accompanied by a relative, carer etc.

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13.3 A CTO patient who has been recalled can be conveyed by any officer on the staff of the hospital to which the patient is recalled, any Police Officer, any AMHP or any other person authorised in writing by the Responsible Clinician or Managers of the Hospital. COP 17.33 – 17.35

13.4 Guidance in paragraphs 17.33 – 17.35 of the Code of Practice regarding conveyance to hospital applies except that an AMHP will not necessarily be involved in conveyance.

13.5 There should be documented a transport risk assessment. Police liaison and involvement will need to be considered where there is potential risk of resistance, violence and aggression.

13.6 The Responsible Clinician should ensure that the hospital is ready to receive the patient and provide treatment. Recall must be to hospital however, the required treatment may be given on an outpatient basis – the patient does not have to stay overnight.

13.7 The 'hospital' need not be the hospital that the patient was detained in prior to going on a CTO or under the same management. COP 29.60

14.0 ON ARRIVAL AT HOSPITAL – THE FIRST 24 HOURS

14.1 The Clinical Team is to assess the patient's condition, provide treatment as necessary and determine the next steps.

14.2 At this point the patient may be well enough to return to the community once treatment has been given or require a longer period of assessment/treatment in hospital.

14.3 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 service user remains on CTO even if they remain in hospital for one or more nights.

14.4 Once 72 hours from the time of admission has elapsed, the patient must be allowed to leave if the Responsible Clinician has not revoked the CTO. On leaving the hospital, the patient remains on a Community Treatment Order.

15.0 REVOKING A COMMUNITY TREATMENT ORDER

15.1 Having assessed the patient following recall, the RC must determine what should happen next. During this maximum 72 hour period from arrival in hospital, the patient remains a CTO patient even if they remain for one or more nights.

15.2 The RC may allow the patient to leave the hospital at any time within this period. Once this period ends, the patient must be allowed to leave if the RC has not revoked the CTO. Although not specifically covered by the legislative scheme, the Code of Practice acknowledges that there is no impediment to a patient agreeing to remain in hospital on a voluntary basis where they have the capacity to choose to do so for a brief period. COP 29.49

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15.3 To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. An AMHP must also agree with the RC's assessment. This need not be an AMHP already involved in the patient's care and treatment.

15.4 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 (Paris). The patient must be discharged from hospital at the end of the 72 hours and the CTO continues. It is not appropriate for an RC to approach another AMHP for an alternative view.

15.5 Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 & 3 and the AMHP completing Part 2 of the Form CTO5. The revocation takes effect immediately once signed. The form must be forwarded to the Mental Health Act Administrator as soon as practicable. The RC or AMHP must give the patient or arrange for the patient to be given oral reasons for revoking the CTO before it is revoked.

15.6 The effect of completing a Form CTO5 is that the patient reverts to being detained under their original section of the Act as 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.

15.7 On revocation a Form CTO5 must be copied to the Managers of the Hospital to which the patient was recalled via the MHA Office if the patient was transferred during the period of recall. The Hospital Managers have certain duties in this situation including referring the patient to the Mental Health Review Tribunal without delay.

15.8 It is the responsibility of the Hospital Managers to ensure that no patient is detained following recall for longer than 72 hours unless the CTO is revoked. Through the MHA Office, the statutory documentation will be checked to monitor the patient's length of stay following the time of the detention after recall. Where this period is exceeded, this will be reported as with all other MHA exceptions to the Trust's Director of Nursing & Quality. If a patient's CTO is revoked and they are detained in a hospital other than the one which was the responsible hospital at the time of recall – the Hospital Managers of the new hospital must send a copy of the revocation form to the area Mental Health Act Administrator.

15.9 Mental Health Act Administrators have a duty to refer patients whose CTOs have been revoked to the Tribunal.

16.0 EXTENDING A COMMUNITY TREATMENT ORDER

- 16.1
- A CTO can be extended following examination of the patient by the RC within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met.¹ These conditions mirror the criteria

¹ *The Act, s20A(6)*

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and mandatory conditions described in paragraphs 5 and 6 above with the additional requirement that the RC must also consult one or more persons who have been professionally concerned with the patient's medical treatment but of whom are of different disciplines to the RC.

- The RC completes and signs Part 1 and later Part 3, the AMHP completes Part 2 of form CTO7 addressing the report to the relevant Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital's internal mail system. It is then received by a Mental Health Act Administrator (or other authorised person) who completes Part 4.
- As when making the original CTO order, the RC must obtain the written agreement of an AMHP that the conditions for extending the CTO are met and where they are met, along with the agreement of a second professional that extension is appropriate. The AMHP need not be the AMHP who originally signed the form CTO1.
- Once received, the Managers must undertake a review of the report provided on the form CTO7 which may vary in uncontested cases². Where practicable, this should be done before the new period of extension takes effect but the completed form CTO7 itself provides lawful authority for the patient's continued CTO. Such reports will be dealt with in the same way as reports made to renew detention under the Act, although it may be appropriate to arrange the Managers' review at a more convenient location other than the hospital in which the patient was originally detained.

16.2 The Code sets out questions that a panel of Managers should address in the order given whenever they review a report made using a form CTO7:³

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interest of the patient's health or safety or the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the Responsible Clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
- The Code then requires that if three or more members of the panel (being a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is "no", the patient should be discharged.
- Where the answer to all these questions is "yes", but the RC has made a report under Section 25 barring discharge by the nearest relative (discussed further below) the following question must then be addressed:
 - Would the patient, if discharged, be likely to act in a manner that is dangerous to other persons or to themselves?

² *The Code*, paras. 38.11 – 38.14

³ *The Code*, paras. 38.18

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- Where three or more members of the panel (being a majority) disagree with the RC and conclude that the answer is “no”, they should usually discharge the patient. However, they retain a residual discretion not to discharge in such cases, so should always go on to consider whether there are exceptional reasons why the patient should not be discharged.
- 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, a form CTO8 must be completed to extend the CTO period.
- Where the criteria for extending CTO are not met and consequently the RC does not plan to make a report to the Managers using a form CTO7 (or where applicable, form CTO8), the patient should be discharged by the RC rather than waiting for the current CTO to expire. This does not apply to a case where an AMHP does not agree to extension. In such a case, the RC may choose to exercise his or her right of discharge or may allow the CTO to lapse. However, it is not good practice to allow a CTO to simply lapse. COP 29.76
- 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. The new period of CTO is calculated from the day after the date on which the current order would have otherwise come to an end if it had lapsed.

17.0 DISCHARGE FROM A COMMUNITY TREATMENT ORDER

17.1 Patients detained on a CTO may be discharged by the Tribunal, hospital managers, nearest relative or the RC. Discharge from CTO means complete release from liability to detention under the Act in hospital or in the community.

17.2 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(2)(a) of the Act.

If the patient is discharged by the Tribunal or hospital managers there is no statutory form for this purpose, nor any statutory requirement to consult with any other person.

17.3 A Part 2 CTO patient's nearest relative can apply for discharge, however there is no available power in relation to Part 3 CTO patients nearest relatives to order discharge in the same way. An order requesting discharge must be put in writing giving at least 72 hours' notice but need not be in any specific form.

17.4 Within the 72 hour period, 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 to him or herself'. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness. Where a report is made, the nearest relative must be advised of the right to apply to the Tribunal.

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17.5 If the RC does not sign such a report, discharge by the nearest relative takes effect after 72 hours has elapsed. Where a patient has been recalled to hospital, there is no power of discharge available to the nearest relative, Hospital Managers or Tribunal.

17.6 The Hospital Managers have the power to discharge a CTO patient exercisable by 3 or more members of a panel – being a majority on agreement that one of the criteria for a CTO or its extension is no longer met and consequently, the CTO is no longer appropriate or necessary.

17.7 The Tribunal can discharge a CTO patient except during the 72 hour period of recall of such a patient. If following recall, a patient's CTO is revoked, the Mental Health Act Administrator must refer the patient's case to the Tribunal as soon as possible. All circumstances where there is a duty to refer a case to the Tribunal are set out in Section 68 of the Mental Health Act.

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

17.9 It may be appropriate for the Tribunal 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.

17.10 It is not necessary to make an application for detention of a patient who is already on a CTO, because of the power of recall. Although, in practice this may happen if the people making the application do not know that the patient is already on a CTO.

- If an application under section 2 or 4 is made, this will have no effect on the patient's CTO.
- If a CTO patient under Part 2 of the Act, who immediately before going onto a CTO was detained on a section 3, is then made the subject of a new section 3 application, the CTO will automatically cease to have effect.
- An application under section 3 does not end a patient's CTO if, immediately before going onto a CTO, the patient had been detained on the basis of a hospital order, hospital direction or transfer direction under Part 3 of the Act.
- Should a CTO patient be admitted to hospital as the result of a hospital order, hospital and limitation direction or transfer direction, or given a guardianship order under Part 3 of the Act, the CTO automatically ceases to have effect. COP 26.141
- Should a hospital order, hospital and limitation direction or guardianship order, or conviction on which a CTO is based upon is quashed on appeal section 22 will apply as if the order or direction had never happened and the patient had instead been in prison. This may mean that the patient will continue to be on a CTO if less than six months has passed since the

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quashed order or direction was given.

17.11 Detention in prison or elsewhere of less than six months' duration will allow a CTO to continue or to be extended – detention in custody for a period of more than six months will automatically bring the CTO to an end in all cases.

18.0 TRANSFERS BETWEEN HOSPITALS AND JURISDICTIONS

18.1 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 a Form CTO10 – this is an assignment of responsibility for community patients.

18.2 Assignment of responsibility for community patients between hospitals within the same organisation requires no statutory paperwork but the Managers of the receiving hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give their name and address even if part of the same organisation.

18.3 In any case, the new hospital become the responsible hospital and as such is treated as if it were the detaining authority when the patient was originally detained in hospital (and is now subject to recall to) prior to going on a CTO.

18.4 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 a Form H4.

18.5 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 a 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, a 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 the Form CTO9 and have the written agreement of an AMHP.

19.0 DECISION WHETHER TO USE COMMUNITY TREATMENT ORDER OR SECTION 17 LEAVE

19.1 Section 17 (relating to leave of absence from hospital) of the Act is amended so that when considering granting longer term leave, an RC must consider whether a CTO is the more appropriate way of managing the patient in the community. This applies to S17 leave for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).

These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for a CTO.

19.2 An RC may still legitimately authorise longer-term leave where it is the more suitable option but must prove that he/she has considered whether CTO is more appropriate.

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19.3 The RC must record in the patient's health and social care records that he/she has considered whether longer-term leave or CTO is appropriate with reasons when authorising or reviewing such leave. This question should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, S17 leave forms will carry a tick-box statement to the effect that CTO has been considered where appropriate.

19.4 A CTO (Section 17A) is used where it is necessary for the patient's health or safety or for the protection of others to continue to receive treatment after their discharge from hospital. It seeks to prevent the 'revolving door' scenario and the harm which could arise from relapse. It is a more structured system than leave of absence and has more safeguards for patients. A key feature of the CTO framework is that it is suitable only where there is no reason to think that the patient will need further treatment as a detained inpatient for the time being, but where the RC needs to be able to recall the patient to hospital if necessary. COP 31.6

19.5 The Code details Leave of Absence criteria for CTO or longer-term leave of absence which may be of assistance to RCs and is replicated overleaf. (A further table contrasting CTO and guardianship can also be found in the Code of Practice – Chapter 31.

20.0 FACTORS SUGGESTING LONGER TERM LEAVE OR COMMUNITY TREATMENT ORDER

Factors suggesting longer-term leave	Factors suggesting CTO
<ul style="list-style-type: none">• Discharge from hospital is for a specific purpose or a fixed period.• The patient's discharge from hospital is deliberately on a "trial" basis.• The patient is likely to need further in-patient treatment without their consent or compliance.• There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for 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 CTO, but not to the extent that it is very likely to happen.

21.0 WISHES EXPRESSED IN ADVANCE

21.1 There may be times when, because of their mental disorder, patients who are subject to compulsory measures under the Act are unable or unwilling to express their views, or participate as fully as they otherwise would in decisions about their care or treatment under the Act. In such cases, patient's past wishes and feelings, so far as they are known – take on a greater significance.

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22.0 COMMUNITY TREATMENT ORDER AND GUARDIANSHIP – CHILDREN AND YOUNG PEOPLE UNDER 18 YEARS

22.1 There is no lower age limit for a CTO. The number of children and young people whose clinical and family circumstances make them suitable to move from being detained to being a community patient is likely to be small, but it should be used where appropriate.– COP Chapters 29 and 31

22.2 Parents (or other people with responsibility) cannot consent (or refuse consent) to treatment for mental disorder on a child or young person's behalf while the child or young person is on a CTO.

If community patients under the age of 18 are living with one or both parents, the RC should consult with the parent(s) about the particular treatment (subject to the normal considerations of patient confidentiality). This dialogue should continue throughout the period of the CTO. If a parent is unhappy with the particular treatment or conditions attached to the CTO, and the child is not competent to consent (or young person lacks capacity to consent) a review by the child or young person's team should take place. This will be to consider whether the treatment and care plan and CTO in general are still appropriate for them. COP Chapter 19

22.3 The powers of Guardianship under the Act apply to individuals aged 16 and over and may be appropriate for young people aged 16 and 17. COP Chapter 30

23.0 TREATMENT ON RECALL – PART 4 OF THE MENTAL HEALTH ACT

23.1 When a patient on a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients – Sections 57, 58, 58A and 63 of the Mental Health Act. 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.

23.2 A certificate is not required under section 58 or 58A if a Second Opinion Appointed Doctor (SOAD) has explicitly authorised its administration (other than ECT) upon recall as stated on the part 4A certificate.

23.3 On recall, treatment that was already being given as described on the Form CTO11 may continue to be given if the Approved Clinician in charge of the treatment considers that stopping it would cause the patient serious suffering. However, steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

24.0 TREATMENT WHILE IN THE COMMUNITY- PART 4A OF THE MENTAL HEALTH ACT

24.1 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 Part4A of the Act. The Code refers to them for convenience as Part 4A Patients and provides detailed guidance on their

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treatment in Chapters 24 and 25 of the Code of Practice.

24.2 There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria as follows:-

- The patient is currently liable for detention for treatment under Section 3 or an unrestricted section under Part 3 of the Act, including a patient currently on Section 17 Leave from hospital. It is not applicable to patients on restriction orders
- The RC must be satisfied that the risk of harm arising from the patient's mental disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual
- The RC's decision to place a patient on a CTO should only ever be made on clinical grounds where the patient meets the criteria in Section 17A of the Act

And the following mandatory conditions are in place:-

- The patient must make himself or herself available for examination to determine whether to extend the community treatment period
- The patient must make himself or herself available for examination by a Second Opinion Appointed Doctor when requested. However, this only applies if the RC is unable to certify that the patient has capacity and is consenting to treatment.

24.3 The Part 4A rules recognise and incorporates aspects of the Mental Capacity Act 2005 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 a CTO patient any treatment for mental disorder other than where an attorney, deputy or Court of Protection Order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient.

24.4 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 Lords. '*Gillick v West Norfolk and Wisbech Area Health Authority (1985) e All ER 402 (HL)*).

24.5 Part 4A patients over the age of sixteen, who lack capacity, may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient's behalf.

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24.6 If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under the MCA until the CTO patient is detained in hospital when Part 4 rules applies.

24.7 If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in Section 64G which reflect the similar scheme in the MCA – Section 6 MCA 2005. The alternative mechanism is via recall to hospital but the recall criteria apply equally to patients lacking capacity.

24.8 In an emergency, treatment for Part 4A patients who have not been recalled can be given by anyone (it need not be an Approved Clinician or the RC) but only if the treatment is immediately necessary to:

- Save the patient's life
- Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed
- Alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- Prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purposes, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard

Section 64G – Emergency Treatment for a Patient under CTO in the Community refers.

- For ECT or medication administered as part of ECT – the first two bullet points apply

24.9 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 MCA. These are the only exceptional circumstances where the patient's interests would be better served and in which force can be used to treat an objecting CTO patient without first recalling to hospital.

24.10 In non-emergency situations (excluding ECT for which reference would be made to paragraphs 25.19 to 25.25 of the Code of Practice) 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 onto a CTO.

24.11 After 28 days either the RC must certify that the patient has the capacity/competency to consent and does consent – Form CTO12 **OR** a SOAD must certify that such treatment is appropriate on a Part 4A Certificate – Form CTO11. The SOAD certifies the appropriateness of treatment and any conditions attached to it not necessarily whether a patient has or lacks capacity or is refusing. COP 25.32

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24.12 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.

24.13 The Form CTO11 should be kept with the original CTO application and detention papers but a copy must be kept in the clinical records and a scanned copy on the Paris or Mobius Clinical Information system.

24.14 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 co-ordinate the process – this will normally be their Care Co-ordinator.

24.15 Other than in exceptional circumstances, SOAD examinations will be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit a CTO patient in a hostel or home setting – the SOAD must always be accompanied by an appropriate member of the Multi-Disciplinary Team.

25.0 MONITORING AND REVIEW

25.1 Mental Health Act Administrators will make arrangements for a periodic audit of the effectiveness of CTOs to be undertaken which will review and evaluate the effectiveness of these orders (i.e. in terms of reducing the frequency of re-admission to hospital and ensuring compliance with essential conditions included in the order). Hospital managers will need to identify key variables for evaluation purposes. These may include the following factors:

- Changes in the number of hospital re-admissions and length of hospital stay both before and after the use of Supervised Community Treatment
- Compliance with attendance at out-patient reviews and prescribed medication
- Reductions in the level of criminal offending / illicit substance misuse
- Patient satisfaction

26.0 REFERENCES

Mental Health Act 1983 as amended by the Mental Health Act 2007

Mental Health Act 1983 as amended by the Mental Health Act 2007 Revised Code of Practice April 2015

Mental Capacity Act 2005

END