Policy Document Control Page

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Review

Review Date: October 2018

Responsibility of: Mental Health Law Manager

Designation: On behalf of the Mental Health Law Scrutiny Group

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 16th May 2016

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GUIDING PRINCIPLES

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

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 reasons 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.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

1. INTRODUCTION

1.1 The aim of this policy is to provide clear guidance to all staff with regard to Community Treatment Orders (CTO) under section 17(A-G) of the Mental Health Act 1983 (MHA).

1.2 This policy aims to ensure that all initiatives, actions, and interventions introduced in respect of CTOs are developed in accordance with relevant statute law and best practice.

2. AIMS OF THE POLICY

2.1 The aim of this policy is to ensure that the use of CTOs within the Trust is as far as possible controlled within the legal framework represented by the MHA. It aims to give assurance to patients that CTOs will be used in accordance with the law and in response to patient's needs. CTOs 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 (CoP 25.3).The guiding principles of treating patients using the least restrictive option, maximising independence, purpose and effectiveness should be considered when discussing CTOs and possible conditions. The conditions, with the exception of the mandatory conditions are not directly enforceable. If a patient fails to comply with any condition, the Responsible Clinician (RC) may take that failure into account when considering whether it is necessary to use the power to recall the patient to hospital for treatment. The conditions of a CTO must not deprive a person of their liberty. A deprivation of liberty in relation to a person who lacks capacity may be authorised by an authorisation under Schedule A1 to the Mental Capacity Act 2005 or a Court of Protection order. The objective of this policy is to ensure the lawful application of CTOs by practitioners so risks to patients, carers, staff and others will be minimised. This policy should be read alongside the revised MHA Code of Practice and the MHA Reference Guide to the Act (both published 2015).

2.2 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.

2.3 This policy complements (and should be read in conjunction with) the following Trust policies:

- CL3 Care Programme Approach (CPA) Policy
- CL6 Patients Absent Without Leave Policy
- Section 17 (Leave of Absence) Policy
- CL21 Section 136 MHA 1983 - Removal to a Place of Safety Policy
- CL31 Section 135 Mental Health Act 1983 – Warrant to Search & Remove Patients

- CL33 Report Writing and Attendance at (Mental Health) Tribunals and Hospital Managers' Hearings Policy
- CL36 Section 132, 132A, and 133 MHA (provision of information) Policy
- CL49 Mental Health Act 1983 Section 117 Policy
- CL58 Treatment of patients subject to the Mental Health Act 1983 Part 4 &
- Part 4a V3
- CL61 Admission, Entry & Exit Policy for Mental Health Ward
- CL2 Consent to Examination or Treatment Policy V7
- CL81 Electro Convulsive Therapy Policy
- CL87 Victims Policy
- CL91 Nearest Relative Policy
- CO4 Confidentiality Policy
- Risk Assessment and Management Policies (CL19, CL88, CL94)

3. SCOPE

3.1 This policy applies to:

- All patients (either in hospital or in the community) liable to be detained under the Mental Health Act 1983 (MHA) for treatment under section 3 or any unrestricted part 3 patients. CTOs may not be made in respect of patients detained in hospital on the basis of an application for admission for assessment under section 2 or 4, nor in the case of restricted patients.

- All staff employed by Pennine Care NHS Foundation Trust including agency, contractors or anyone providing a service on behalf of the Trust in clinical and non-clinical settings whose work directly or indirectly involves patients subject to the MHA both in hospital and the community.

4. DEFINITIONS

4.1 Community Treatment Order (CTO)

4.1.1 A Community Treatment Order (CTO) refers to the legal authority that enables a patient to receive care and treatment in the community, subject to the power of recall to hospital for further medical treatment if and when necessary.

4.1.2 Care must be taken not to confuse the term CTO (as it applies to the Mental Health Act 1983) with Compulsory Treatment Orders that apply in Scotland (also abbreviated to CTO).

4.1.3 Care must also be taken not to confuse the term CTO (as it applies to the Mental Health Act 1983) with the more general term of Community Treatment (CT) that may apply to anybody receiving care and/or treatment outside of hospital.

4.2 **Patient**
The term patient has been used throughout this policy although it is accepted other terminology may be appropriate such as service user.

4.3 **Approved Clinician (AC)**
A mental health professional approved by the Secretary of State or a person or body exercising the approval function of the Secretary of State to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

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

4.5 **Approved Mental Health Professional (AMHP)**
A social worker or other professional approved by a local authority to carry out a variety of functions under the Act.

4.6 **Healthcare Professional**
This includes all staff who may be involved in patient care and has been used to encompass both qualified and non-qualified staff.

4.7 **Independent Mental Health Advocate (IMHA) and IMHA Services**
An advocate available to offer help to patients under arrangements which are specifically required to be made under the Act. The Act calls patients who are eligible for these services 'qualifying patients'. The services which make independent mental health advocates available to patients are called independent mental health advocate (IMHA) services.

4.8 **Independent Mental Capacity Advocate (IMCA)**
An advocate able to offer help to patients who lack capacity under arrangements which are specifically required to be made under the Mental Capacity Act 2005.

4.9 **Responsible Hospital**
The hospital whose managers are responsible for a patient subject to a community treatment order. To begin with, at least, this is the hospital in which the patient was detained before being discharged onto a community treatment order.

4.10 **Must and should**
Within this policy we use the terms 'must' and 'should' and they are to be interpreted as follows:

- Must – is used to indicate the requirement is a legal or overriding duty or principle.
- Should – Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this.

5 RESPONSIBILITIES

5.1 The Trust Board remain responsible for making suitable organisational arrangements to support the effective implementation of this policy. The Trust Board delegate the monitoring and responsibility of this policy to the Mental Health Law Scrutiny Group (MHLSG) who may request the advice and involvement of other departments i.e. Audit, Medical Staffing, as and when necessary.

5.2 The Medical Director; is responsible for ensuring the requirements of this policy are adhered to via the MHLSG.

5.3 Team and Departmental Managers are responsible for the distribution and implementation of policies across services.

5.4 The Trust Mental Health Law Manager has responsibility for ensuring legislation is embedded within training, audit and policy requirements. This includes the responsibility for updating and implementing this policy on at least a bi-annual basis.

5.5 Line Managers must ensure staff under their charge are aware of this policy and the principles of applying legislation and best practice guidance in managing patients subject to CTO and that this is apparent and evident in their working practices. Any incidents or breaches of policy should be reported in accordance with the Trust Incident Reporting policy CO10 and any investigations or actions supported by Line Managers. Line Managers are also required to report any practical issues to the Trust Mental Health Law Manager to facilitate policy change if necessary.

5.6 All clinical and non-clinical health/social care professionals and practitioners are responsible for the lawful application of CTOs, ensuring patients legal rights are promoted and protected when carrying out their professional roles and responsibilities throughout the patients care and treatment in the community or when they are recalled to hospital for treatment. This includes ensuring patients are aware of their legal rights under CTOs, that the conditions set as part of their CTO or their care plan does not amount to a deprivation of their liberty (a deprivation of liberty in relation to a person who lacks capacity may be authorised by an authorisation under Schedule A1 to the Mental Capacity Act 2005 or a Court of Protection order) and that they are only treated in line with the requirements of the Act.

6. ELIGIBILITY

6.1 Only patients who are detained in hospital for treatment under section 3 of the Act, or are unrestricted part 3 patients, can be considered for a CTO.

Patients may become CTO patients if they are detained on the basis of	Section
An application for admission for treatment	section 3
A hospital order (without a restriction order)	section 37 or 51
A hospital direction (but no longer a limitation direction)	section 45A
A transfer direction (without a restriction direction)	section 47 or 48
or If they are treated as being subject to one of the above, eg as a result of transfer from guardianship or from outside England or Wales	

7. EXCLUSIONS

7.1 Patients held or detained under any one of sections 2, 4, 5(2), 5(4), 35, 36, 38, 37/41, 45A (where the limitation has **NOT** been lifted), 47/49 or 48/49, 135 or 136 **CANNOT** be made subject to a Community Treatment Order.

8. FACTORS TO CONSIDER

8.1 The decision as to whether a CTO is the right option for any patient is taken by the Responsible Clinician) and requires the agreement of an approved mental health professional (AMHP). The Responsible Clinician should consider the principles, in particular the least restrictive option and maximising independence principle. A CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. In particular, the Responsible Clinician should consider whether the power to recall the patient is necessary and whether the patient can be treated in the community without that power. Consultation at an early stage with the patient and those involved in the patient's care will be important, including family and carers.

8.2 CTOs will be one of the treatment options considered by the RC when:

- A detained patient's progress is reviewed
- A detained patient is being considered for s17 leave of absence the duration of which is more than 7 consecutive days. CTO must be considered before any eligible detained patient is given leave for more than 7 consecutive days (or has their leave extended so it lasts more than 7 consecutive days.
- The Mental Health Tribunal (MHT) makes a recommendation that a CTO should be considered for a patient, although the decision to proceed with a CTO remains with the patients RC, even in in this situation.

8.3 Although there is a duty placed on the RC to consider CTO for any patient to whom they grant leave under s17 for more than 7 consecutive days, there is no requirement to make the person subject to a CTO. However where leave is granted in this way and CTO is not felt to be appropriate, the RC must document reasons why CTO is not appropriate in the circumstances in the patient's notes.

8.4 A CTO 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 in-patient for the time being, but where the Responsible Clinician needs to be able to recall the patient to hospital if necessary. The tables below highlights some of the factors when considering long term s17 leave of absence in comparison to using CTOs or CTOs in comparison to using Guardianship.

8.5 **CTO or long term leave of absence: relevant factors to consider.**

Factors suggesting longer-term leave	Factors suggesting a CTO
• Discharge from hospital is for a specific purpose or a fixed period. • The patient's discharge from hospital is deliberately on a 'trial' basis. • The patient is likely to need further in-patient treatment without their consent or compliance. • There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a CTO.	• There is confidence that the patient is ready for discharge from hospital on an indefinite basis. • There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given. • The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary. • The risk of arrangements in the community breaking down, or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify a CTO, but not to the extent that it is very likely to happen.

8.6 **CTO or Guardianship: relevant factors to consider**

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

9. RELEVANT CRITERIA

9.1 A CTO is an option **only** for patients who meet the criteria set out in the Act, which are that:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment

- It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment

- Subject to the patient being liable to be recalled as mentioned below, 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.

10. ASSESSMENT FOR CTO

10.1 In assessing the patient's suitability for a CTO, the Responsible Clinician must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others, and that appropriate treatment is, or would be, available for the patient in the community.

10.2 In making a decision to place the patient on a CTO the Responsible Clinician must assess what risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

10.3 In assessing that risk the Responsible Clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.

10.4 Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse, the circumstances into which the patient would be discharged, and the willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

10.5 Taken together, all these factors should help the Responsible Clinician to assess the risk of the patient's condition deteriorating significantly after discharge, and inform the decision as to whether continued detention, a CTO or discharge would be the right option for the patient at that particular time. The Responsible Clinician should consider the likelihood that a CTO will benefit the patient and take account of the patient's views about the use of a CTO.

10.6 A risk that the patient's condition will deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The Responsible Clinician must be satisfied that the risk of harm arising from the patient's 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. Such evidence may include:

- A clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital
- Clear evidence that there is a positive response to medication without an undue burden of side effects
- Evidence that the CTO will promote recovery
- Evidence that recall may be necessary (rather than informal admission or reassessment under the Act).

10.7 Patients do not have to give formal consent to a CTO. But in practice, patients should 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. The Responsible Clinician should inform the patient of the essential legal and factual grounds for the CTO and other information about the CTO both orally and in writing.

10.8 The Responsible Clinician'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.

10.9 The Responsible Clinician must decide that CTO is the right option for a patient and this decision must have the agreement of an Approved Mental Health Professional (AMHP). It is the responsibility of the Responsible Clinician to ensure timely referrals to the AMHP service. Wherever possible this should be at least two weeks prior to the expected completion of a CTO application. The AMHP should meet with the patient before deciding whether to agree that the CTO should be made. In practice the referral of a CTO application to an AMHP may be delegated to ward staff. If the patient will have a different RC once in the community then it is the current RC's responsibility to involve the Community RC at the earliest opportunity. This discussion with the Community RC must be documented in the patient's healthcare records. They should be informed of MDT's as they may be able to offer previous knowledge of the patient and compliance in community including suggested conditions.

10.10 Good practice will require the consultation and involvement with the patient throughout the process, the AMHP who will be completing the CTO1, Care Coordinator and any others involved in the patient's care will be important. The AMHP plays a key role in the application of CTO and in addition to endorsing the Responsible Clinician's opinion that all criteria are met and agree it is

appropriate for the patient to be subject to CTO their knowledge and skills of alternatives and community issues is a vital element of the assessment process. As a minimum the Trust expects the AMHP, Care Coordinator and patient to be involved in considering the alternatives to CTO. It would also be good practice to involve an independent advocate who can offer additional support to guide the patient through the process.

10.11 Referrals should be made to the AMHP at the earliest possible stage of the process. The RC and Care Coordinator are responsible for organising review and will make sure detailed records are made in the patients care plans to show treatment, conditions, Section 117 and contingency plans.

10.12 The Responsible Clinician and AMHP need to inform the MHL Office of the CTO application as soon as a potential discharge date is identified. The CTO statutory forms are not subject to section 15 of the Mental Health Act which means they cannot be amended once they have been submitted to the Hospital Managers. This means certain errors in the paperwork could potentially invalidate the section and result in the CTO being discharged. MHL Offices will support clinicians and also ensure scrutiny of documents is completed within a maximum of two working days from receipt of the statutory paperwork.

11. TRIBUNAL RECOMMENDATION FOR CTO

11.1 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 Responsible Clinician should consider a CTO. In that event, the Responsible Clinician should carry out the assessment of the patient's suitability in the usual way.

11.2 It will be for the Responsible Clinician to decide whether or not a CTO is appropriate for that patient taking into account the factors outlined above in this policy. The Responsible Clinician should record the reasons for their decision. In cases where the Tribunal grants a delayed discharge from Section 3 the patient cannot be considered for a CTO. This is because all CTOs need an underlying section to be valid.

12. CARE-PLANNING, TREATMENT AND SUPPORT IN THE COMMUNITY

12.1 Good care-planning, as per the Care Programme Approach (CPA) (or its equivalent) will be essential to the success of a CTO. A care co-ordinator will need to be identified in advance of discharge planning.

12.2 Patients on a CTO are entitled to after-care services under section 117 of the Act. The after-care arrangements should be drawn up as part of the normal care planning arrangements. The clinical commissioning group and local authority must continue to provide after-care services under section 117 for as long as the patient remains on a CTO. The CTO care plan should be prepared in (or following) close partnership with the patient from the onset. This should be clearly stated in line with the Trust's policy on CPA.

12.3 Subject to the normal considerations of patient confidentiality consultation should also take place between:

- The nearest relative
- Any carers
- Anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf specifically someone with a valid Lasting Power of Attorney or a Court Appointed Deputy
- The multi-disciplinary team involved in the patient's care
- IMHA, IMCA or Independent Advocate
- The patient's GP - It is important that the patient's GP should be aware that the patient is to go onto a CTO. A patient who does not have a GP should be encouraged and helped to register with a practice.
- In line with the Victims Policy, victims or MAPPA may need to be made aware of the plans for CTO. The Domestic Violence, Crime and Victims Act 2004 (DVCVA) as amended by the Mental Health Act 2007 places a number of duties on hospital managers in relation to certain unrestricted part 3 patients who have committed sexual or violent crimes. This includes where applicable the RC/AMHP ensuring the following information is communicated to victims: whether a CTO is to be made, including allowing the victim to make representations on the need for a CTO (and forwarding these to people responsible for making decisions on discharge), including allowing representations about the conditions attached to the CTO, any conditions on the CTO relating to the victim or their family, and any variation of the conditions and when the CTO ceases.

12.4 If a different Responsible Clinician is to take over responsibility for the patient, it will be essential to liaise with that clinician, and the community team, at an early stage and no less than one week prior to discharge.

12.5 Care planning requires a thorough assessment of the patient's needs and wishes. The care plan should include as a minimum:

- The practicalities of how the patient will receive treatment, care and support and who will provide this from day to day
- Continuing mental healthcare, whether in the community or on an outpatient basis

- Information regarding recall processes, including who should be told of recall, who should deliver recall, arrange transport to hospital, secure property, etc.
- Names and telephone contacts for those involved and emergency/out of hours contacts
- Contact details for GP
- Arrangements made for monitoring the conditions
- A treatment plan which details any medical, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration.
- Where needed, arrangements should be made for a second opinion appointed doctor (SOAD) to provide the part 4A certificate to enable

treatment to be given where the patient lacks capacity to consent or refuse treatment

- Details regarding any prescribed medications (which will be authorised by the RC on statutory treatment form CTO12 if the patient has capacity and is giving on-going consent to the treatment or where authorised by the SOAD if the patient is unable to give capacitated consent on statutory form CTO11)
- Details of any actions to address physical health problems or reduce the likelihood of health inequalities
- Details of how the person will be supported to achieve their personal goals
- Support provided in relation to social needs such as housing, occupation, finances etc.
- Support provided to carers
- Actions to be taken in the event of a deterioration of persons' presentation, and guidance on actions to be taken in the event of a crisis.
- The psychological needs of the patient and, where appropriate, of their carers
- Identified risks and safety issues
- Any specific needs arising from, e.g. co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder
- Any specific needs arising from drug, alcohol or substance misuse (if relevant)
- Any parenting or caring needs
- Social, cultural or spiritual needs
- Involvement of authorities and agencies in a different area, if the patient is not going to live locally
- The involvement of other agencies, service or voluntary organisations (if relevant)

12.6 The care plan should not place undue reliance on carers or members of the patient's family.

12.7 If the patient so wishes, help should be given to access independent advocacy or other support where this is available. This is in keeping the guiding principles of the Act and supports a preventative approach in cases where communication is breaking down between the patient and services. Patients must be informed that help and support is available and how they can obtain this help. Information should be provided orally and in writing.

12.8 The care plan should be recorded in writing and a copy given to the patient. Once plans are agreed, it is essential that any changes are discussed with the patient as well as others involved with the patient before they are implemented.

12.9 The care plan should be reviewed regularly in line with the Trust CPA policy, and the services required may vary should the patient's needs change. It is the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed between all parties, including the patient, that it is no longer necessary. In particular, the care plan will need to be reviewed if the patient moves to another area. The care co-

ordinator in the original area will be responsible for making transfer arrangements if commissioning responsibility consequently passes to authorities in the new area.

12.10 The planning of after-care needs to start as soon as the patient is admitted to hospital. Clinical commissioning groups (CCGs) and local authorities should take reasonable steps to identify appropriate after-care services for patients in good time for their eventual discharge from hospital onto a CTO.

12.11 The professionals concerned should, in discussion with the patient, establish an agreed outline of the patient's needs and agree a timescale for the implementation of the various aspects of the plan. All key people with specific responsibilities with regard to the patient should be properly identified.

12.12 Recall processes for patients should also be included in the care plans. This should include what behaviour may prompt consideration of recall and how the notice of recall may be served on the patient if necessary. This acts as a prompt for discussion with the patient to ensure they are involved in planning and to allow them to give information on how they would like this to be dealt with if necessary.

12.13 The care plan and monitoring arrangements for a CTO patient should principally be concerned with the patient's health, wellbeing and social circumstances rather than on the conditions set.

12.14 Professionals with specialist expertise should also be involved in care planning for people with autistic spectrum disorders or learning disabilities.

12.15 It is important that those who are involved are able to take decisions regarding their own involvement and, as far as possible, that of their organisation. If approval for plans needs to be obtained from more senior levels, it is important that this causes no delay to the implementation of the care plan.

13. AGE APPROPRIATE SERVICES

13.1 The care plan should take account of the patient's age:

13.1.1 Where the patient is under the age of 18 the Responsible Clinician and the care co-ordinator should bear in mind that the most age-appropriate treatment should be that provided by a child and adolescent mental health service (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.

13.1.2 Similar specialist services for older people may also have a role in the delivery of services for older patients; and particular care should be taken to ensure that the concepts of participation and proportionality are applied to older patients.

14. ROLE OF THE AMHP

14.1 The AMHP must decide whether to agree with the patient's Responsible Clinician that the patient meets the criteria for a CTO, and (if so) whether a CTO is appropriate. The AMHP should meet with the patient before deciding whether to agree that the CTO should be made. Even if the criteria for a CTO are met, it does not mean that the patient must be discharged onto a CTO.

14.2 In making that decision, the AMHP should consider:

- The wider social context for the patient.
- Relevant clinical history
- Relevant factors may include any support networks the patient may have, the potential impact on the rest of the patient's family, and their need for support in providing care and employment issues.
- 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. However, no assumptions should be made on the basis of the patient's ethnicity or social or cultural background about what care and support can be provided by the family.
- Good practice would also require the AMHP to consult with the Nearest Relative or someone close to the patient with their agreement.
- The appropriateness of alternative provisions under the Act, including guardianship, leave of absence, deprivation of liberty and Court of Protection Order.
- The AMHP is also required to work in accordance with the guiding principles including considering alternatives to satisfy the least restrictive principle.

14.3 To facilitate this, the AMHP must be involved from the earliest possible stage. In contrast to emergency MHA admissions, the planning for CTO should allow the AMHP to be involved in the discharge planning. The Responsible Clinician is required to inform the AMHP service as soon as possible when considering CTO. In practice this may be delegated to ward staff.

14.4 If the following assessment and discussion with the Responsible Clinician the AMHP does not agree the patient should go onto a CTO, or if they do not agree with the conditions attached, then the CTO cannot go ahead. A record of the AMHPs decision and the full reasons for it should be kept in the patient's notes. **It is not appropriate for the Responsible Clinician to approach another AMHP for an alternative view.**

14.5 This AMHP 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 local authority, and local authorities may agree with each other and with hospital managers the arrangements that are likely to be most convenient and best for patients. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which would become responsible under section 117 for the patient's after-care if the patient were discharged.

15. MAKING THE COMMUNITY TREATMENT ORDER

15.1 If the Responsible Clinician and AMHP agree that the patient should be discharged onto a CTO, they should complete the relevant statutory form (CTO1) and send it to the hospital managers. A fully completed and signed/dated form CTO1 provides the authority to discharge a patient from detention and on to a CTO. Part 1 of the form must be completed by the RC; Part 2 of the form is then completed by the AMHP. Part 3 of the form is completed by the RC after the AMHP has signed and dated Part 2. Part 3 of the form must be dated on the same date the AMHP signed and dated Part 2 or after the AMHP has signed and dated Part 2, it cannot be dated prior to the AMHPs date/signature. The Responsible Clinician must also specify on the form the date that the CTO is to take effect. This date is the authority for a 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.

15.2 The involvement of the AMHP service by the Responsible Clinician from the initial point of considering a CTO will assist in ensuring assessments for CTOs can be arranged in a timely manner and help assist in facilitating a safe discharge of the patient from hospital. Responsible Clinician's and AMHP's should arrange joint assessment where possible. Where this is not possible, Responsible Clinician's, Care Coordinator's and nursing staff must consider the considerable length of time it can require to complete assessments prior to signing the forms and allow for this process and co-ordination of the assessments in their expected date for discharge of the patient from the ward when speaking to patients and carers.

15.3 To allow for appropriate assessments and planning, the Trust expects CTO processes to take approximately two weeks.

15.4 Although legislation does not specify a maximum time frame between the AMHP and Responsible Clinician assessments taking place in order to complete their respective parts of the statutory CTO1 form, the Trust standard is no more than 14 days where this is possible. Anything beyond this period should be discussed with the MHL Office before forms are signed off.

15.5 The Mental Health Law Office must have confirmed that the CTO is valid before the patient is discharged from hospital.

15.6 The AMHP is required to sign part 2 of the CTO1 form if they agree with the opinion of the RC in part 1 that it is appropriate to make the order. The AMHP should ensure part 3 of the form is NOT signed before part 2 of the CTO1 as the MHA requires the AMHP to have offered their views prior to the Responsible Clinician furnishing the report to the Hospital Managers. If Part 2 is signed after Part 3 this may render the CTO invalid and the process will either need to start again or the patient may be off section altogether. Advice on individual situations should be sought from the local MHL Office.

15.7 Once a completed CTO is given to the MHL Office they will check the paperwork to ensure it is valid. The authority to detain the patient is

suspended from the date and time the CTO is to take affect and will remain dormant until such the time that the CTO is revoked following recall when the authority to detain is reactivated. If the patient has not left hospital on the date and time specified in the CTO1 they remain has an informal patient. However the CTO is in force and as such subject to Part4A treatment rules and regulations.

15.8 The RC is responsible for ensuring the patient is informed about the completion of the CTO and of the conditions applied. The nearest relative should also be informed (unless the patient objects or it is impracticable) about the effect of the CTO and of their right of discharge the patient from the order.

15.9 The MHL Office will also write to the patient and their nearest relative (unless the patient objects) as soon as possible when the CTO is put in place to inform them of their right to appeal and enclose a copy of the CTO patient/NR rights leaflet. The MHL Office will also ask the RC to complete a capacity to consent to treatment record to accompany a CTO12 statutory certificate if the patient has capacity to give informed consent to their treatment plan or complete a SOAD request for a patient who has been assessed as lacking capacity to consent to their proposed treatment plan for the SOAD to consider issuing a CTO11 treatment form. The MHL Office will be responsible for updating the register and NCRS/PARIS with details of the CTO, input diary dates for key stages in relation to reminders and triggers as per the office standards protocol in relation to the completion of the s132A patient rights monitoring form, treatment reminders, Tribunal auto-referral dates, renewal reminders etc. Letters confirming the application of the CTO will also be copied to the GP, Care Coordinator, AMHP Team and the Responsible Clinician. Letters will include a copy of the CTO1 to offer information to the parties involved on the conditions of the CTO. To facilitate this - the team should ensure the Care Plan is available to the MHL Office. All administrative functions should take place within 2 working days of the CTO being completed.

15.10 Responsible Clinician's must ensure an outpatient appointment with the patient is booked in within one month of the patient being discharged on to a CTO to consider the patients capacity to consent and the statutory treatment form under Part 4A of the MHA which must be in place within one month of the patient being discharged onto a CTO[1] if this was not already completed soon after the completion of the CTO1 paperwork. Responsible Clinician's must also ensure an outpatient appointment is booked in two months prior to expiry of the section to allow for an assessment to consider extending the CTO.

[1] Neither a part 4A certificate nor a part 4A consent certificate is required for section 58 type treatment to be given:
• where less than three months have passed since the patient was first given the treatment during an unbroken period of detention and discharge onto a CTO (or an unbroken succession of periods of detention and CTO), or
• during the first month following a patient's discharge from detention onto a CTO (even if the three-month period referred to in section 58 has already expired or expires during that first month)

16. CONDITIONS TO BE ATTACHED TO THE COMMUNITY TREATMENT ORDER

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

- When needed for consideration of extension of the CTO, and
- If necessary, to allow a second opinion approved doctor (SOAD) to provide a part 4A certificate authorising treatment.

16.2 Responsible Clinicians may also, 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
- Protect other people from a similar risk of harm.

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

16.4 In considering what conditions might be necessary or appropriate, the responsible clinician should always keep in view the patient's diverse needs and circumstances. The patient, and (subject to the normal considerations of patient confidentiality) and others with an interest such as a parent (and any others with parental responsibility) or carer, should be consulted.

16.5 The conditions of a CTO must not deprive a person of their liberty. In its 19 March 2014 judgment (Cheshire West)[2] the Supreme Court clarified that there is a deprivation of liberty in circumstances where a person is under supervision and control, is not free to leave and lacks capacity to consent to these arrangements. The Supreme Court noted that factors which are not relevant in determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The relative normality of the placement, whatever the comparison made, is not relevant. A deprivation of liberty in relation to a person who lacks capacity may be authorised by an authorisation under Schedule A1 to the Mental Capacity Act 2005 or a Court of Protection order. A DoL authorisation can run alongside a CTO as long as the conditions of the CTO do not conflict with the authorisation. 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 their care plan and recovery goal

[2] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014. WLR 2. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

16.6 Have a clear rationale, linked to one or more of the purposes in paragraph 16.2 above, and be clearly and precisely expressed, so that the patient can readily understand what is expected.

16.7 The nature of the conditions will depend on the patient's individual circumstances. They should be stated clearly having regard to the least restriction principle. Subject to paragraph above 16.5, 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.

16.8 **The conditions, with the exception of the mandatory conditions are not directly enforceable.** If a patient fails to comply with any condition, the Responsible Clinician may take that failure into account when considering whether it is necessary to use the power to recall the patient to hospital. The reasons for any condition should be explained to the patient and others, as appropriate e.g. the patient's independent mental health advocate (IMHA), family and carers and, in the case of a child or young person, the person(s) with parental responsibility and recorded in the patient's notes. It will be important, if the 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 helpful if families can have access to support so they can help the patient to comply. The patient should have a discharge CPA meeting and a copy of the care plan before they are discharged from hospital onto the CTO.

17. INFORMATION FOR CTO PATIENTS AND OTHERS

17.1 As soon as the decision is made to discharge a patient onto a CTO, the Responsible Clinician should inform the patient and others consulted of the decision or delegate the responsibility to inform, the conditions to be applied to the CTO and the services which will be available for the patient in the community, including the continued right to an IMHA.

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17.2 The information given to the patients prior to application for CTO must be done in a way that is appropriate for that patient. Impact of being on a CTO must be explained to them and to facilitate this IMHA should be offered to all patients being considered for a CTO. Time must be allowed for the patient to be as informed as possible and to understand the power as it will apply to them. The MHL Office may be contacted for support with this.

17.3 There is a duty on hospital managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing and must be done as soon as practicable after the patient goes onto the CTO by the Responsible Clinician or by another member of the professional team. The MHL Office also takes responsibility for ensuring patients are informed of their rights

and this is done in writing including the statutory duty to inform CTO patients that the IMHA Service is still available to them.

17.4 A copy of this information must also be provided to the Nearest Relative (subject to the normal considerations about involving nearest relatives)[3] and should also be given to the carer, if different. Section 133 of the Act requires staff consider informing the NR at the earliest point of planning the discharge and sets a standard of at least seven days prior to discharge. In practice this may be carried out by any member of the MDT or MHL Office.

18. MONITORING CTO PATIENTS

18.1 It is important to maintain contact with a patient on a CTO and to monitor their mental health and wellbeing closely after they leave hospital. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and the way in which local services are organised for the patient. 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 would normally be responsible for co-ordinating the care plan, working with the Responsible Clinician (if they are different people), and the team responsible for the patient's care, family carers and any others with an interest.

18.2 *Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder or withdraws consent to treatment (or begins to object to it). The Responsible Clinician should consider, with the patient (and others where appropriate), the reasons for this and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow the patient to continue safely on a CTO and which the patient would accept, the Responsible Clinician 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).*

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

18.4 Alternatively, after review it may be concluded that the CTO is failing to promote recovery and then consideration needs to be given to discharging the CTO and taking a different approach.

[3] Paragraphs 4.32-4.37 of the CoP (2015).

19. VARYING AND SUSPENDING CONDITIONS

19.1 The Responsible Clinician has the power to unilaterally vary the conditions of the patient's CTO, or to suspend any of them. However, it would **not** be good practice to vary conditions which had **recently** been agreed with an AMHP without discussion with that AMHP. These changes would normally be following a Multi-Disciplinary Team meeting.

19.2 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.

19.3 Suspension of one or more of the conditions may be appropriate to allow for a temporary change in circumstances e.g. holiday, acute hospital admission, or a change in treatment regime. Suspending conditions may be a useful way to test whether they are still needed and could be part of a planned reduction of conditions leading to the patient's possible discharge from the CTO. The Responsible Clinician should record any decision to suspend conditions in the patient's notes, with reasons.

19.4 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. As when the conditions were first set, the patient's views about the changes should be sought and considered before a change is made; and the Responsible Clinician should discuss with the patient whether they will be able to keep to any new or varied conditions. The patient and their nearest relative (where appropriate) should be informed of any changes to the conditions. Any help the patient needs to comply with them should be made available. Families and/or carers should be supported to help the patient.

19.5 Any variation or suspension in the conditions must be recorded by the Responsible Clinician on the relevant statutory form (CTO2), which must be sent to the MHL Office in the first instance.

19.6 A record of discussions with the patient and others, along with the rationale for making any changes should be recorded in the patient's notes and copied into the patient's care plan.

20. RESPONDING TO CONCERNS RAISED BY THE PATIENT'S CARER

20.1 Particular and prompt attention should be paid to carers 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 in deciding what action to take. Carers are typically in much more frequent contact with the patient than professionals, even under well-run care plans. Their concerns may prompt a review of how a CTO is working for that patient and whether the criteria for recall to hospital might be

met or whether more support in the community should be put in place. The managers of responsible hospitals should ensure that local protocols are in place to cover how concerns raised should be addressed and taken forward (see also MHA Code of Practice (2015) paragraphs 10.3 – 10.6 Sharing Information). Staff should also refer to the Trust policy on Sharing Information CO13.

21. RECALL TO HOSPITAL

21.1 The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk. The Responsible Clinician does not have to interview or examine the patient in person before deciding to recall them.

21.2 The Responsible Clinician may recall a patient on a CTO to hospital for treatment if:

- The patient needs to receive treatment for mental disorder in hospital (either as an in-patient or as an out-patient).

AND

- There would be a risk of harm to the health or safety of the patient or to other people if the patient were not recalled.

- A patient may also be recalled to hospital if they break EITHER of the two mandatory conditions which must be included in all CTOs i.e. by failing to make themselves available for medical examination either to allow consideration of extension of the CTO or to allow a SOAD to give a part 4A certificate for proposed section 58 or section 58A treatment.

21.3 The patient must 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.

21.4 Before exercising the recall power for this reason, the Responsible Clinician should consider whether the patient has a valid reason for failing to comply, and should take any further action accordingly.

21.5 The Responsible Clinician must be satisfied that the criteria for recall are met before using the recall power. Any action must be necessary and 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 (unless the patient objects or it is not reasonably practicable) the nearest relative, carers and, in the case of children and young people, person(s) with parental responsibility may resolve the problem and so avert the need for recall.

21.6 The Responsible Clinician 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.**

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

21.8 Recall to hospital for treatment should not become a regular or normal event for any patient on a CTO. If recall is being used frequently, the Responsible Clinician 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, continuing use of a CTO is appropriate or if other options need to be reviewed.

21.9 The team should also consider the appropriateness of recall to an outpatient area for assessment or treatment as this allows a less restrictive approach to recall to a ward area.

22. PROCEDURE FOR RECALL TO HOSPITAL

Recall allows the clinical team to assess and/or treat the patient in a hospital for their mental disorder, reduce and manage risks and assess the reasons for a patient failing to comply with the conditions set out in their CTO.

Recall can be to any location in a hospital that is appropriate for their treatment.

Patients may be offered voluntary admissions at an earlier stage.

Clinicians working with recalled patients should bear in mind that recall is not the same as emergency powers in the Mental Health Act such as s.136, where assessments to transfer them to longer term section is required in as short a time frame as possible. The power of recall allows the 72 hours to be used to try to assist the patient in returning to the community if possible.

The AMHP service should be contacted as soon as possible in the process to notify them an assessment for revocation may be necessary within 72 hours.

22.1 The Responsible Clinician has responsibility for coordinating the recall process, unless it has been agreed in the care plan that someone else will do this including informing the MHL Office. Often in practice this will be carried out by the Care Coordinator on the Responsible Clinician's behalf. The family and carers involved in providing support to the patient should also be informed.

Wherever possible the Responsible Clinician should give the patient, or arrange for the patient to be given, oral reasons for the recall before it happens, taking into account any risks arising from giving notice of the recall.

22.2 The practical impact of recalling the patient on the patient's domestic circumstances must be taken into account and managed accordingly. Patients may be recalled even if they are already in hospital at the time. This could happen, for example, if a patient attends hospital either voluntarily or to comply with a condition of the CTO, but then refuses to accept the treatment the Responsible Clinician thinks is needed. If the patient, or someone else, would be at risk if the patient does not have that treatment, the patient could be formally recalled to allow the treatment to be given without the patient's consent.

22.3 The Responsible Clinician must complete a written notice of recall to hospital (statutory form CTO3), which is effective only when served on the patient. A copy of this must also be sent to the hospital/ward the patient has been recalled to as well as the MHL Office. A copy should also be kept in the notes so as to be available to the on call team who may be required to follow-up the recall process. 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.

22.4 The notice in form CTO3 may only be served on the patient in one of the three ways set out in the table below. The time at which it is deemed to have been served – in other words, when the patient is deemed to have received the notice – depends on the way in which it is served, again as set out in the table below.

Service of notices recalling CTO patients to hospital

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 (even on a weekend or bank holiday), it is deemed to have been served immediately after midnight that night.
Sending it by pre-paid first class post (or its equivalent) to the patient at the patient's usual or last known address	On 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. Weekends and public holidays do not count as business days.

22.5 Sending a notice of recall to the patient by post will only occur in exceptional cases (e.g. where all other options have been exhausted or as an option where

the patient has failed to attend for medical examination as required by the conditions of the CTO AND where the need for the examination is not urgent.

22.6 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. 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.

22.7 Where the recall notice is posted, first class postage/recorded delivery only should be used. This will mean the notice is effective from the second working day following posting (see table above) to allow sufficient time for the patient to receive the notice before any action is taken to ensure compliance.

22.8 If the patient's whereabouts are known but access to the patient cannot be obtained, it might be necessary to consider whether a warrant issued under section 135(2) is needed.

22.9 Unlike Section 135 (1) a warrant under Section 135 (2) does not necessarily have to be obtained by an AMHP. Any officer authorised under the MHA can apply for a warrant under S.135(2). This can be an AMHP, nurse, care coordinator or police officer. If a warrant has been issued under S135 (2), the police officer need only be accompanied by one person authorised to retake the patient (this could be a doctor, Care Coordinator or AMHP). Refer to AWOL policy for further details.

22.10 Once the recall notice has been served, the patient can, if necessary, be treated as absent without leave, and taken and transported to hospital they have been recalled to (and a patient who leaves the hospital they have been recalled to without permission can be returned there under section 18 and by any AMHP, police officer, or other constable, any officer on the staff of the hospital in question, or by any person authorised in writing by the Responsible Clinician or the hospital managers of that hospital. If patients are taken into custody, or come to the hospital voluntarily, before the end of the period during which they could be taken into custody, the 72 hours 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.

22.11 If police involvement is necessary when notifying Greater Manchester Police in these circumstances, the trust will need to provide full details of the patient and full details of what enquiries have already been made to try and locate him/her. Contact will initially be made with the Operational Communications Branch (OCB) on 0161 872 5050. An incident Log (FWIN) will be created and the matter will be referred to the Duty Inspector of the relevant policing area. It is probable that the Inspector, or officer tasked with the enquiry, will wish to contact the Trust

for further detail. The telephone number for the relevant contact must be provided when the initial request for assistance is made.

22.12 The patient should be transported to hospital in the least restrictive manner possible. If appropriate, the patient might be accompanied by a family member, carer or friend.

22.13 The person coordinating the recall must liaise with the bed managers of the hospital that is named on the recall notice and should ensure that they are ready to receive the patient and to provide treatment. If the bed is identified in any other hospital than the one named on recall then a new recall must be completed. Recall will be unlawful if the hospital on the recall isn't the one the patient is returned to and no authority will exist for conveyance or detention.

22.14 The person coordinating recall must also ensure that an AMHP is informed of the recall at the earliest opportunity so they are aware of assessments taking place over the 72 hour recall period.

22.15 The timing of the recall is an important consideration due to the working patterns of Responsible Clinician's. This should be included in all decision making and where there is potential for the Responsible Clinician to be unavailable[4] contact should be made with the on call consultant and discuss whether or not an assessment may need to be completed on their behalf i.e. at the weekend.

While recall must be to a hospital, the required treatment may then be given on an outpatient basis (i.e. hospital outpatient department), if appropriate.

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

22.17 When the patient arrives at hospital after recall, the start of the patient's detention must be recorded by the admitting nurse/charge nurse in writing, using form CTO4.This information and a copy of the CTO3 and CTO4 must be sent to the MHL Office in the first instance. This will allow the admitting/charge nurse and the MHL Office to determine the expiry of the 72 hour detention period under recall. Accurate recording of admission times on NCRS/PARIS is also necessary by the ward administrative support and this will be double checked by the MHL Office to avoid unlawfully keeping the patient beyond the 72 hours. The MHL Office will be able to provide information about current treatment forms in place and discuss consent to treatment requirements during the recall period, (**see section 25.** of this policy and refer to the Policy on Treatment of Patients subject to the Mental Health Act 1983 – Part 4 and Part 4A and Appendix 2 of this policy).

[4] Para 36.3 Code of Practice, Responsible Clinician is not available (e.g. during non-working hours, annual leave, etc)

22.18 As soon as practicable, the nurse/clinical team of the hospital to which a patient is recalled must take whatever steps are reasonably practicable under s132 of the MHA to arrange for the patient to be informed, orally and in writing, of the provisions of the Act under which the patient has been recalled and the effect of those provisions, e.g. that the patient may be detained for up to 72 hours.

22.19 Following recall and admission of the patient the clinical team will need to assess the patient's condition, provide the necessary treatment (**see section 25.1** of this policy and refer to the Policy on Treatment of patients subject to the Mental Health Act 1983 – Part 4 and Part 4A and Appendix 2 of this policy) and determine the next steps. The Responsible Clinician must take whatever steps are reasonably practicable to ensure that that patient understands the provisions of part 4 of the Act to the extent that they are relevant to the patient's case. Part 4 of the Act deals with treatment for mental disorder, especially treatment without consent.

22.20 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 Responsible Clinician to determine what should happen next. During this period the patient remains a CTO patient, even if they remain in hospital for one or more nights. The Responsible Clinician 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 Responsible Clinician has not revoked the CTO (see below). On leaving hospital the patient will remain on the CTO as before. Section 5(2) cannot be used to extend the 72-hour period.

22.21 The patient may elect to remain in hospital as a voluntary patient following recall and will remain subject to the CTO. Staff should be aware that the powers under section 5 of the MHA are not available to them in the case of voluntary CTO inpatients. If the patient wishes to leave and there is evidence of relapse/risk to self/others relating to the mental disorder and or where the patient refuses to accept the treatment the Responsible Clinician thinks is needed, the patient could be formally recalled by the Responsible Clinician under CTO3 to allow the treatment to be given without the patient's consent. The practice of repeat recalls in a short time frame will need to be monitored and is not considered good practice.

22.22 In considering the options, the Responsible Clinician and the clinical team will need to consider whether a CTO remains the right option for that patient. They will also need to consider, with the patient, the nearest relative (subject to the normal considerations about involving nearest relatives), and any carers (and in the case of children and young people, those with parental responsibility), 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).

22.23 While patients are being detained in hospital on recall, the managers of the hospital in question may authorise their transfer to another hospital. The

maximum 72 hour period of detention in hospital on recall continues to run from the original time that the patient was detained, despite the transfer. No particular procedure need be followed if the patient is to be transferred to a hospital under the management of the same hospital managers. To authorise transfer from a hospital in England to a hospital under different management, whether in England or Wales, the hospital managers of the first hospital must use form CTO6. They may not authorise the transfer unless they are satisfied that arrangements have been made for the patient's admission to the new hospital. The hospital managers of the hospital from which the patient is to be transferred must give the managers of the new hospital a copy of the record of the time the patient was detained as a result of being recalled to hospital (i.e. form CTO4). This must be done before, or at the time, that the patient is transferred. The hospital managers of the new hospital must record the time of the patient's admission there using the same form CTO6 on which the transfer was originally authorised.

23 REVOKING THE CTO

23.1 If the patient requires in-patient treatment for longer than 72 hours after arrival at the hospital following recall, the Responsible Clinician should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under the powers of the Act. The Responsible Clinician and an AMHP should reassess the patient before revoking their CTO. They must do so if necessary to satisfy themselves that the patient again needs to be admitted to hospital for medical treatment under the Act.

23.2 The CTO may be revoked if:

- The Responsible Clinician 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.

23.3 In making the decision as to whether it is appropriate to revoke a CTO, the AMHP should consider the wider social context for the person concerned, in the same way as when making decisions about applications for admissions under the Act.

23.4 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 local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which has been responsible for the patient's after-care.

23.5 If the AMHP does not agree that the CTO should be revoked, then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will therefore remain on a CTO. A record of the AMHPs decision and the full reasons for it should be kept in the patient's notes. **N.B. It**

would not be appropriate for the Responsible Clinician to approach another AMHP for an alternative view.

23.6 If the Responsible Clinician and the AMHP agree that the CTO should be revoked, they must complete the relevant statutory form CTO5. Part 1 of the CTO5 form must first be completed by the Responsible Clinician, part 2 of the form must then be completed by the AMHP and part 3 will need to be completed by the Responsible Clinician. All the parts must be completed in the order stipulated and all three parts must be completed for the revocation to take legal effect. The form must be sent to the MHL Office in the first instance. The Responsible Clinician or the AMHP must give the patient (or arrange for the patient to be given) oral reasons for revoking the CTO before it is revoked. The patient is then detained again under the powers of the Act exactly as before going onto a CTO, except that a new detention period of six months begins for the purposes of review and applications to the Tribunal (see also MHA Code of Practice (2015) paragraphs 25.31, 25.36). Please note the 3 month Section 58 rule does NOT apply (**see section 25.** of this policy and refer to the policy on Treatment of patients subject to the Mental Health Act 1983 – Part 4 and Part 4A and Appendix 2 of this policy). If a patient's CTO is revoked and the patient is detained in a hospital other than the one which was the responsible hospital at the time of recall, the hospital managers of the new hospital must send a copy of the revocation form to the managers of the original hospital.

23.7 Written reasons for the revocation should also be given to the patient and (where appropriate) their nearest relative. Hospital managers should notify the patient and (where appropriate) their nearest relative when they have referred the patient's case to the Tribunal without delay.

23.8 The Nearest Relative should be informed at the earliest opportunity in this process with the patient's agreement.

23.9 The hospital managers of the hospital in which the patient is now detained must refer the patient's case to the Tribunal as soon as practicable after the revocation of the CTO.

24. HOSPITAL MANAGERS' RESPONSIBILITIES

24.1 The Hospital Managers duties are delegated through the board to qualified nursing staff and the Mental Health Law Offices.

24.2 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.

24.3 The relevant statutory form must be completed on the patient's arrival at hospital.

24.4 Hospital managers should ensure that arrangements are in place to monitor the patient's length of stay following the time of detention after recall, as recorded on the form, so that the maximum period of detention is not exceeded.

24.5 The hospital managers should also ensure that arrangements are in place to cover any necessary transfers of responsibility between Responsible Clinicians in the community and in hospital.

24.6 If a patient's CTO is revoked and the patient is detained in a hospital other than the one which was the responsible hospital at the time of recall, the hospital managers of the new hospital must send a copy of the revocation form to the managers of the original hospital.

24.7 The Mental Health Law Office have a duty to ensure that a patient whose CTO is revoked is referred to the Tribunal without delay (under delegated authority from the Hospital Managers). Case law has acknowledged that referral is necessary at the earliest opportunity and the Trust sets a target of two working days from revocation for the referral to be electronically submitted to the Mental Health Tribunal.

24.8 The Act requires that hospital managers ensure that patients on a CTO understand important information about how the Act applies to them as soon as practicable after the start of the CTO. This includes ensuring that the patient is informed of their legal rights both orally and in writing including their access to appeals and the functions of the Care Quality Commission. Further details are contained in the MHA Code of Practice (2015) paragraphs 4.9 – 4.27. For further information please refer to the Trust policy on s132.

24.9 The MHL offices will facilitate all actions required for CTO patients within a maximum of two working days from receipt of the relevant statutory paperwork. This ensures the patients and teams are informed of the status of patients and validity of sections. This includes application, revocation and renewal of orders.

25. TREATMENT

25.1.1 A different set of treatment rules apply to patients on CTOs who have not been recalled to hospital by their Responsible Clinician. The rules differ depending on whether or not the patient has the capacity to consent or refuse the treatment in question. Such patients can only be given treatment if they consent or, if they lack the capacity to consent, do not actively object.

25.1.2 Refusal to consent to treatment in itself does not automatically justify a recall to hospital and fuller consideration of the patient's presentation, risk to self/others and circumstances is required when considering whether a recall to hospital is warranted.

25.1.3 Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it.

25.1.4 Permission given under any unfair or undue pressure is not consent.

25.1.5 By definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it.

25.1.6 It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.

25.1.7 The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand 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.

25.1.8 A record should be kept of information provided to patients. Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Act (i.e. following recall to hospital). A record should be kept of the information provided to patients.

25.2 CTO patients who consent to treatment

25.2.1 After one month of the patient being discharged on to a CTO, treatment can only continue if authorised by a part 4A certificate. Where a patient is considered to have capacity and to be consenting to their proposed treatment plan (or, if they are under 16, is competent to consent) then the Responsible Clinician can complete a CTO12 form. Exceptions would be where the 3 month rule under section 58 still applies and the RC would complete the CTO12 at the end of the period. The RC must also evidence the patient's capacity to consent to the treatment on the Trust capacity to consent to treatment record. The person giving the treatment (i.e the RC or someone acting under the direction of the RC) must ensure there is always the authority to treat as well as the relevant certificate to treat (i.e. patient's capacity to consent to the proposed treatment to the prescribed medication authorised on the CTO12 certificate continues to apply and are relevant at the time of administering treatment).

25.2.2 When a CTO patient with capacity refuses to consent to a particular treatment it is good practice for the staff involved to ascertain whether the patient is also making an advance decision to refuse that treatment in future if they lose capacity. If the patient confirms they would not want that treatment at any point this should be clearly documented in the patients' notes/care plan and the MHL Office should be notified[5].

25.2.3 Remember the patients refusal to consent to treatment at a particular time in itself does not automatically justify a recall to hospital and fuller consideration of the patient's presentation, risk to self/others and circumstances is required when considering whether a recall to hospital is warranted.

[5] Advance decisions for non-life saving treatment can be taken verbally. The MHL Office will be aware of the procedure to be followed so it is only necessary for the clinician to document the details in the patient notes/care plan and discuss with the patient. Ensuring their capacity is recorded clearly in the notes.

25.3 **CTO patients who lack capacity or competence to give consent**

25.3.1 If a patient lacks capacity to consent to treatment within the first month of being discharged onto a CTO then the Responsible Clinician will be required to take immediate steps to complete a SOAD request so that the certificate requirements are in place one month from the patient being discharged onto a CTO unless of course s58 is still applicable for the time being. The SOAD will need to certify that treatment is appropriate on form CTO11. The Responsible Clinician should discuss this with the patient prior to the patient leaving the hospital or within the first month of the patient being discharged onto a CTO and discuss any suitable places for the patient to be seen by the SOAD. This may be at an outpatient clinic or somewhere the patient visits regularly. Arrangements must also be made for the SOAD to have access to the patient's notes in the agreed location.

25.3.2 As well as the certificate requirement one month from the patient being discharged on to a CTO if a CTO patient lacks capacity, treatment could be given to them in the community under the direction of the RC unless:

- The treatment – for a patient 18 or over – was contrary to a valid and applicable advance decision by the patient.
- The treatment for a patient 16 or over – was contrary to someone authorised under the MCA to refuse the treatment (i.e. attorney, deputy, or court of protection).
- Force was needed to administer the medication and the patient was objecting to the treatment (this applies to patients of any age).

25.4 Treatment of non-recalled CTO patients – emergency treatment (section 64G)

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

25.4.2 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 patients 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.

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

25.4.4 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.

25.4.5 These are the only circumstances in which force may be used to treat patients on CTOs 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 patients to hospital would exacerbate their condition, damage their recovery or cause them unnecessary anxiety or suffering. **Situations like this should be exceptional.**

25.4.6 When giving part 4A certificates, SOADs do not have to certify whether a patient has, or lacks, capacity to consent to the treatments in question, nor whether a patient with capacity is consenting or refusing. They may make it a condition of their approval that particular treatments are given only in certain circumstances. For example, they might specify that a particular treatment is to be given only with the patient's consent. Similarly, they might specify that a medication may be given up to a certain dosage if the patient lacks capacity to consent, but that a higher dosage may be given with the patient's consent. Approved clinicians should ensure that SOADs are informed if the hospital knows that the patient has an attorney or deputy who is authorised under the MCA to make decisions on the patient's behalf about medical treatment. Details of any relevant advance decisions, or advance statements of views, wishes or feelings, should already be recorded in the patient's notes. If they are not, they should be drawn to the SOAD's attention.

25.6 ECT Treatment and CTO patients

25.6.1 For CTO patients who are aged 18 years or over, Form CTO12 can be used to certify the patient's informed and capacitated consent to ECT treatment in the rare circumstances where this might be considered. For further guidance please refer to the Trust policy CL58 on Treatment of patients subject to the Mental Health Act 1983 – Part 4 and Part 4A.

25.7 Recalled Patients

25.7.1 If the patient is recalled they are subject to s.58 and 58A treatment rules under the MHA (see Appendix 2) in the same way as other detained patients. However there are 3 exceptions to this:

- A certificate under section 58 is not needed for medications if less than one month has passed since the patient was discharged from hospital and became a CTO patient.

- A certificate is not needed if the treatment is explicitly authorised for administration on recall on the patients Part 4A certificate. This will be documented on form CTO11.
- Treatment that was already being given in the community on the basis of a Part 4A certificate may be continued even if not authorised specifically for administration on recall if the Responsible Clinician considers discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with s.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. The Responsible Clinician must however in the meantime complete form 62A where the criteria for s62A is met.

25.7.2 During recall if the patient has capacity and is consenting to the proposed treatment, treatment can be authorised by the Responsible Clinician by completing a T2 form.

25.8 SOAD Visit not completed within One Month

25.8.1 Where a SOAD visit has not been completed within the first month of CTO as required by the Act the following must be completed:

- The MHL Office must notify the Responsible Clinician and continue to contact the CQC office on at least a weekly basis to try to ensure the visit takes place. Each contact must be recorded in the MHL Register.

- The Responsible Clinician must review the treatment plan and the patient's capacity and consent to the medications they are taking in the community to ensure they can continue using the criteria set out in Sections 64A-G.

25.8.2 The certificate requirement [i.e. the need for CTO11 or CTO12] does not apply if the treatment is "immediately necessary" and the patient has capacity to consent to it and does consent to it. This also applies to incapacitated patients where a donee or deputy has consented to the treatment on that patient's behalf.

25.8.3 Because of the 'immediately necessary' requirement, this provision should only be used until the SOAD visit is complete - it does not dispense with the need for a SOAD visit.

25.8.4 The CQC has taken the opinion that these 'emergency ' provisions can extend to be used to ensure that a patient's medication levels does not drop below the therapeutic dose – i.e. it is not necessary to wait for a relapse to show before authorising treatment under these powers .

25.8.5 Responsible Clinicians must complete the Trust Section 64 form as well as the Trust capacity to consent to treatment record and must also record clearly when authorising treatment under this provision that the reason that it has been necessary to use these powers is because the SOAD visit has yet to take place.

25.8.6 The use of these section provisions will be closely monitored by the Mental Health Law Scrutiny Group using the Mental Health Law Registers. MHL Office will prompt the completion of this form if it is unlikely that the SOAD will visit within a month of the patient being discharged onto a CTO.

25.8.7 (Further guidance on the treatment of CTO patients can be found in the Policy on treatment of patients detained under the Mental Health Act 1983)

26. REVIEW OF CTO

26.1 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.

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

26.3 Any concerns raised by the team or patient should be escalated to the MHL Office in the first instance. This does not affect the patient's right to complain through normal procedures or to seek a route of complaint through the Care Quality Commission or other external agency.

27. EXTENSION OF CTO

27.1 Unless extended, a CTO expires at the end of the six months starting with the day on which it is made. So, if it is made on 1 January, it expires at the end of 30 June. If is not extended and the CTO expires, the patient's underlying authority for detention (whether it is an application for admission for treatment under part 2 or an order or direction under part 3) also ceases to have effect.

27.2 A CTO can be extended for a further six months, and then for a year at a time. At some point during the final two months of the first and each subsequent period for which the CTO is in force, the Responsible Clinician must personally examine the patient in order to decide whether the patient meets the conditions for extension. The Responsible Clinician may recall the patient to hospital for this purpose, because being available for this examination is one of the mandatory conditions to be included in all CTOs.

27.3 The conditions for extension, which mirror the criteria for making a CTO in the first place, are that:

- the patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment
- it is necessary for the patient's health or safety or for the protection of other persons that the patient should receive such treatment
- subject to the patient continuing to be liable to be recalled as mentioned below, such treatment can be provided without the patient being detained in a hospital

- it is necessary that the Responsible Clinician should continue to be able to exercise the power of recall under section 17E(1) to recall the patient to hospital, and
- appropriate medical treatment is available for the patient.

27.4 In determining whether the fourth criterion, power of recall, above is met, the factors which Responsible Clinicians must consider include the same factors they are required always to consider when making CTOs initially.

27.5 The Responsible Clinician should also consult the wider multi-disciplinary team (MDT). Where appropriate, this should include the patient, nearest relative, the independent mental health advocate (IMHA) and/or other representative, family and carers, the local authority and clinical commissioning group responsible for the patient's after-care and any other key service providers. Consultation should take place during a care programme approach (CPA) assessment and before the Responsible Clinician decides whether or not to extend the CTO.

27.6 When deciding whether to extend the period of a CTO the Responsible Clinician, second professional and AMHP should all consider carefully whether or not the criteria for extending the CTO are met and, if so, whether an extension is appropriate. For example, the longer patients have been on a CTO without the need to exercise the power to recall them to hospital, the more important it will become to question whether that criterion is still satisfied.

27.7 If the Responsible Clinician thinks the criteria are met, they must make a report to that effect to the hospital managers under section 20A (form CTO7).

27.8 Responsible Clinicians:
- must first consult one or more other people who have been professionally concerned with the patient's medical treatment, and
- may not make the report unless an AMHP acting on behalf of a local authority confirms in writing that the criteria are met and that it is appropriate to extend the CTO.

27.9 The report, and the AMHP's statement of agreement, must be made using form CTO7 and sent to the managers of the responsible hospital, who must record their receipt of it in part 4 of the form.

27.10 The effect of the report is to extend the CTO for a further six months or a year, as applicable, from the date it would otherwise expire, not the date of the report itself.

27.11 The MHL Office will write to the Responsible Clinician two months before the expiry of the CTO requesting a review and confirmation of whether the CTO is to be renewed, a copy of this letter will also be sent to the patients Cara Co-ordinator so that they may also notify their AMHP team of a patient's CTO expiring in two months' time to allow AMHPs to co-ordinate any assessments required if the RC intends to extend the patients CTO.

27.12 If the Responsible Clinician intends to renew the CTO they must personally examine the patient and decide whether the criteria for extending the CTO are met. The AMHP service should be informed of the plans to extend the CTO as

early as possible and where possible at least 4 weeks before the CTO is due to expire. This is to allow the AMHP to undertake thorough assessments of the patient's wider social context for the patient, speak to interested parties (including the patient, family, carers, involve an IMHA where appropriate, read the patients notes and make sense of the information and opinion).

27.13 The MHL Office must be informed as soon as the Responsible Clinician decides that renewal is appropriate. This will allow a Hospital Managers hearing to be arranged. Wherever possible the hearing must take place before the expiry of the CTO.

27.14 The written agreement of an AMHP must be sought prior to the completed submission of the statutory renewal paperwork (CTO7) to the MHL Office. The written agreement does not have to be from the same AMHP who originally agreed to place the patient on CTO. Nor do they have to be involved in the patients care. There should not be lengthy time frames between the AMHP and RCs written agreements. This may be subject to monitoring through scrutiny of the statutory paperwork and any audits that are deemed appropriate.

27.15 A decision by a second professional not to agree to the renewal of detention does not bring a patient's current period of detention to an end before it is otherwise due to expire. Similarly, a decision by an AMHP not to agree to the extension of a patient's CTO does not end the existing period of CTO. But in both cases, it would normally be a reason for Responsible Clinicians to review whether they should use their power to discharge the patient.

27.16 If the AMHP agrees with plans to extend the CTO but does not agree with the conditions this must be discussed with the RC for them to consider amending the conditions or explaining reasons for them remaining the same.

27.17 If a patient or their carer does not contest the renewal but would like the conditions to be altered they must discuss this with the RC in the same process as any other stage in the CTO (s.17B) new conditions can be added to the CTO7 or if this has already been completed a CTO2 can be used.

27.18 Once the renewal form – CTO7 - has been completed this must be submitted to the MHL Office. It is recommended that this is submitted no less than two weeks before the CTO is due to expire. If this is not possible the MHL Office should be informed. The MHL Office will then take responsibility for ensuring the renewal of the order is confirmed in writing to all parties including the AMHP.

27.19 A Hospital Managers renewal hearing will then be arranged by the MHL Office to consider the renewal of CTO. Unless the Hospital Managers decide to discharge the patient they must arrange for the person to be told about the extension. This will be done via the MHL Office. The information will also be shared with the Nearest Relative unless specifically stated otherwise.

28 TRANSFER OF CTO

28.1 Transfers of CTO patients may be completed either into or away from Pennine Care. The transfer process for CTO is the same as with other detained patients and transfers must be agreed between RC's prior to the transfer taking place.

28.2 Due to the preparation and scrutiny of paperwork required, the MHL Office should be informed at the earliest opportunity so they can request or send copies of the CTO papers to or from the other location. It is expected that transfers will be planned for CTO patients and final agreement should not be made until the MHL Office has confirmed the CTO and original detention documentation is in order and a treatment certificate is in place with the RC and Care Coordinator.

28.3 The form CTO10 is used to transfer responsibility from the managers of one hospital to another. Once this is completed the MHL Office will write to the patient, NR, Community Team and RC to confirm the transfer date and provide the patient with s.132 information and new contact details including the IMHA service locally.

29. DISCHARGE FROM CTO

29.1 The Responsible Clinician may discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for CTO by making a written order under s.23 of the MHA. The order must be sent to the MHL Office as soon as practicable after it is made, but it is effective even before it is submitted to the managers.

29.2 The patient is discharged from CTO if:

- The CTO is not extended for any reason. (The CTO should not be allowed to lapse and should be ended as soon as an assessment takes place that concludes it is no longer required – Section 23 CTO).
- RC decides to discharge (Section 23 CTO)
- Mental Health Tribunal discharges the patient
- Hospital managers discharge the patient
- Nearest relative orders discharge (this can be barred by the RC using Form M2, a Managers Review will take place and nearest relative can appeal to tribunal).

29.3 The reasons for discharge must be explained to patient and nearest relative by the RC and/Care Coordinator.

29.4 The MHL Office will write to inform the patient and nearest relative, where authority exists to do so, of their discharge from detention in accordance with the Trust policy on Section 132.

29.5 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.

29.6 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.

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

30. EFFECT OF CTO ON NEW APPLICATIONS FOR ADMISSION OR GUARDIANSHIP UNDER PART 2

30.1 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 this may happen if the people making the application do not know that the patient is a CTO patient.

30.2 An application for admission for assessment under section 2 or 4 does not affect the patient's CTO.

30.3 But if a CTO patient is detained on the basis of an application for admission for treatment under section 3, the patient will automatically cease to be a CTO patient if, immediately before going onto the CTO, the patient had been detained on the basis of a previous application under section 3, rather than an order or direction under part 3.

30.4 The same applies if such a patient is received into guardianship as a result of an application under part 2.

30.5 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.

30.6 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 a CTO when they no longer needed to be detained in hospital.

30.7 An application for admission for treatment under section 3 does not end a patient's CTO if, immediately before going onto CTO, the patient had been detained on the basis of a hospital order, hospital direction or transfer direction under part 3 of the Act.

31 EFFECT ON CTO OF NEW ORDERS OR DIRECTIONS UNDER PART 3 [SECTION 40(5)]

31.1 If a CTO patient is 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, they automatically cease to be a CTO patient. That is because the new order or direction brings to an end the application, order or direction to which the patient was subject immediately before going onto CTO.

31.2 However, if a hospital order, hospital and limitation direction, or guardianship order (or the conviction on which it is based) is subsequently quashed on appeal, section 22 will apply as if the order or direction had never happened

and the patient had instead been in prison since the quashed order or direction was made. This may mean that the patient automatically becomes a CTO patient again if less than six months has passed since the quashed order or direction was given.

32 SECTION 135 AND 136 – CTO PATIENTS

32.1 Where a person is removed to a place of safety and there is reason to believe that the person may be subject to CTO, contact will need to be made with the Crisis Team or Emergency Duty Team (LA) of the local area to establish whether this is the case or the local MHL Office if during office hours.

32.2 If a person who is removed to a place of safety is subject to a CTO their recall to hospital needs to be considered. If it becomes apparent that this is the case, the professionals assessing the patient should make an effort to contact the patient's RC as soon as possible.

32.3 Where the person is known to be on CTO and compulsory admission is indicated, the recall power should be used. An application for detention cannot be made in respect of a person who is known to be on CTO.

32.4 Where the person is not known to be on CTO and compulsory admission to hospital has happened, once the professionals become aware that the person is on CTO the new detention falls away and the professionals should use recall and revocation. Unless the new detention is Section 3 – in which case the CTO would be ended by the new application.

33 CTO PATIENTS WHO ARE IMPRISONED

33.1 Special rules apply to CTO patients who are imprisoned, remanded or otherwise detained in custody by any court in the UK. These are similar to those for Part 2 detained patients.

33.2 Such patients automatically cease to be CTO patients if they remain in custody for longer than six months in total.

33.3 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.

33.4 Patients in this situation are treated as being AWOL, if such a 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.

33.5 The effect of this is that, if the patient's CTO is otherwise due to expire, Responsible Clinicians 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.

33.6 Although a 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.

33.7 The normal rules about recalling patients to hospital apply to patients released from custody during whatever period remains of their CTO.

34. MONITORING OF THIS POLICY

34.1 The Hospital Managers will monitor the use of this policy through the Local Mental Health Law Forum and the local incident reporting on a bi-monthly basis. MHL Administrators are responsible for escalating issues with the procedures and policy to the MHL Scrutiny Group as necessary.

34.2 Trust wide figures on the number of CTO patients will be submitted to the MHL Scrutiny Group and the Hospital Managers Committee on at least a yearly basis.

34.3 The processes and principles of this policy where applicable will be included in clinical audits where this is considered appropriate.

34.4 As part of the review, and monitoring of this policy local MHL Forums and the MHL Scrutiny Group will consider how any learning requirements will be addressed with staff.

35. REFERENCES

Department of Health (2015): Mental Health Act (1983) Code of Practice. The Stationery Office; London.

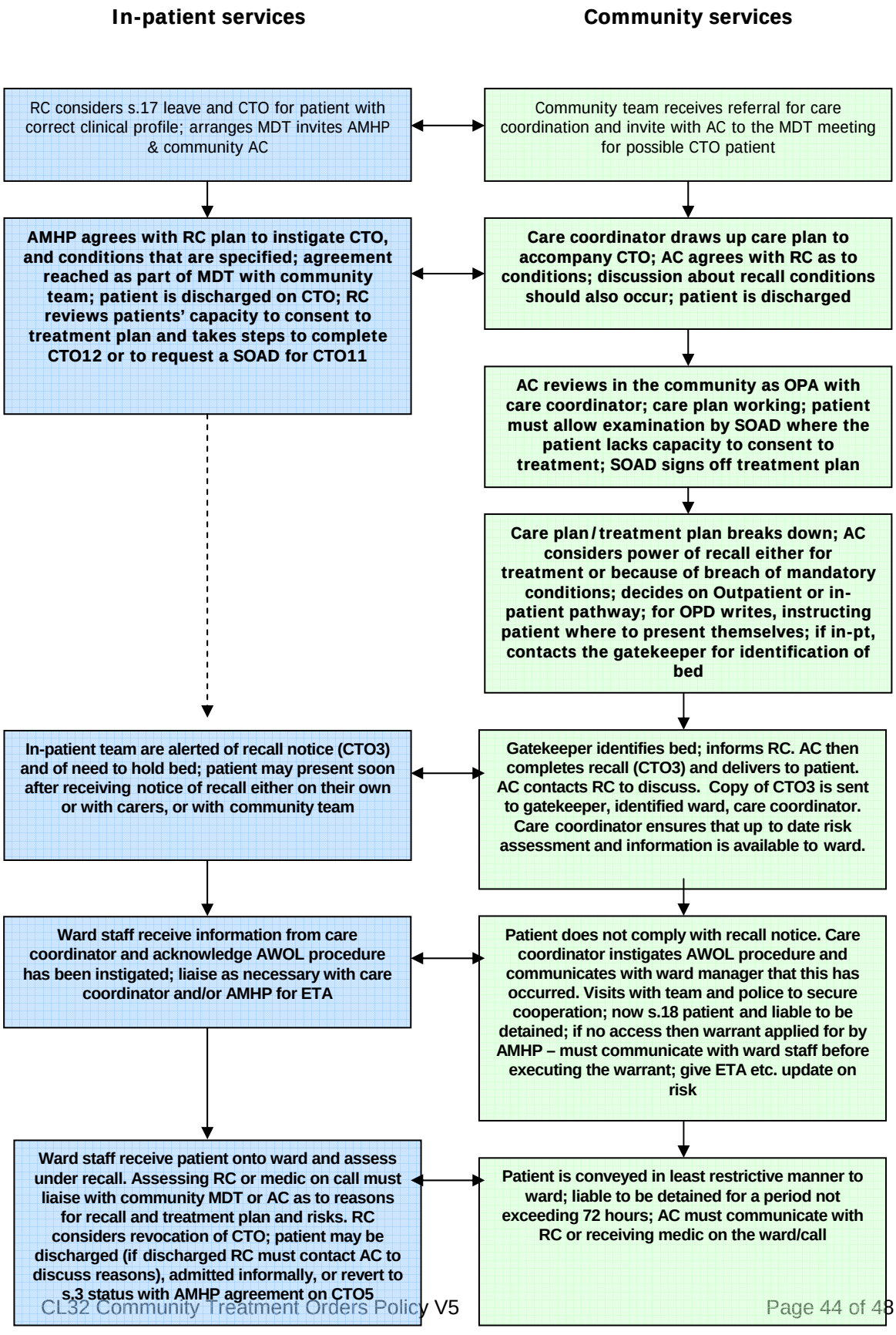
Department of Health (2015): Reference Guide to the Mental Health Act (1983)

NHS England (2015) Information on Cross-Border Healthcare for the NHS in England and Wales. Available at: http://www.england.nhs.uk/ourwork/part-rel/x-border-health/ (last accessed on 26.01.2016).

Appendix 1

THIS IS PROVIDED AS AN EXAMPLE OF A LOCAL SLP

NORTH DIVISION CTO Service Line Pathway



Appendix 1 **THIS IS PROVIDED AS AN EXAMPLE OF A LOCAL SLP**

First & second line of flow chart:
When the in-patient Responsible Clinician (RC) of a s.3 patient is considering s.17A then they must refer for a care coordinator and contact the community RC who would normally be responsible for that patient's care once discharged on the CTO. At an MDT ward-round both Consultants and the care coordinator should discuss the proposal of the CTO and reach broad agreement; this should then form the basis of the care plan prepared by the care coordinator and should accompany the **CTO1** after the in-patient RC has completed Part One and requested an AMHP (COP 29.22) to consider his request for a CTO. The AMHP in considering the request must be in possession of the CTO1 and the care plan. The AMHP will follow the Code of Practice in carrying out the duties required under s.17A. If in agreement with the CTO, the AMHP completes part 2 of CTO1 and will return it to the in-patient RC or Mental Health Law Administrator for completion; safe and supportive discharge arrangements should be in place, which includes clear communication with the community medic and the identified care coordinator (COP 29.20) before the patient is discharged from in-patient care. At the time of the patient being discharged, the Mental Health Law Administrator being in receipt of the completed CTO1, must request for the RC to examine/review the patients consent to treatment and either complete a CTO12 certifying the patent has capacity to consent to the treatment plan and consents to it or where the patient lacks capacity to consent the RC must request a Second Opinion Approved Doctor (SOAD) to examine the patient in order to complete a Part 4A certificate authorising the treatment under CTO. A certificate must be in place within one month of the patient being discharged on to a CTO unless s58 still applies.

Third line of flow chart:
It is the responsibility of the community RC to review the patient in the community with the care coordinator normally being responsible for implementing and monitoring the care plan (COP 29.36). It is one of the mandatory conditions of the CTO that if required the patient makes themselves available for examination by the SOAD; it will normally be the responsibility of the Hospital Managers to arrange for this examination to take place; consideration must be given to the geographical location of the patient's address and where possible the appointment should be in a local community setting.

Fourth line of flow chart:
The Code of Practice makes it clear that where there are concerns about the CTO working then the community RC should investigate why this is occurring and consider recall to hospital if this is an appropriate course of action if it is no longer safe and appropriate for the patient to remain in the community (COP 29.38); the community RC may also consider varying the conditions of the CTO. The community RC may also write to the patient and ask them to present at the appropriate Out Patient Department at a hospital for treatment if appropriate (COP 29.59).

The Code of Practice is very clear that any intention to recall the patient by the RC must be justified in *all the circumstances* (COP 29.49)

In our Division it is agreed that when the community RC decides that it is *justified* and *appropriate* to recall the patient to in-patient care, they should alert the gatekeeper or bed manager for the appropriate Borough that recall is intended and a bed be identified and secured. A bed must be identified within 24hrs and its whereabouts

communicated to the community RC. In considering the method of issuing the Notice of Recall the COP states that it should be delivered by hand (COP 29.53). However, in cases whereby the patient has not presented themselves for examination or in cases that are not deemed to be urgent or when the whereabouts of the patient are not known then first-class post must be used (contradiction with Trust Policy – Recorded Delivery). The COP has the following to say about the liability for detention once a Recall Notice has been issued by first-class post.

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. COP 29.55.

There is a consideration that if a bed is not identified within 24hrs then the community RC raises it with the Senior Manager on-call and completes an incident form.

Fifth line of flow chart:
The Gatekeeper or Bed manager for the Borough identifies a ward and a bed and communicates this to the community RC. The community RC then completes the notice of recall (CTO3) and unless agreed locally serves it on the patient; once served on the patient it is effective immediately (COP 29.52).

The community RC **must** contact the in-patient medic who is going to be responsible for the care and treatment of the patient during the recall period and communicate issues of risk, treatment *and* the justification for using the recall process. If the in-patient medic decides that the patient's discharge is appropriate during the recall period then they **must** contact the community RC to explain their reasons for the discharge and ensure that the community team and RC are able to continue to meet the conditions specified under CTO.

A copy of the CTO3 **must** be retained by the care coordinator and the community RC **and** sent to the Gatekeeper, the Ward Manager/Nurse in Charge and the Mental Health Law Administrator of the hospital identified in the recall notice. The key to a successful, safe and supported recall is good communication between community and in-patient services; **where a breakdown in communications occur it should attempt to be rectified by the relevant team managers and where appropriate the senior manager on call**.

It is the responsibility of the community team to ensure that an up to date risk assessment and a narrative about why the recall is necessary be sent to the receiving ward prior to the patient being liable to be detained. The community RC will ensure that as soon as the patient arrives on the ward that the medical notes for the patient will be sent as soon as possible.

Sixth line of flow-chart:
If it becomes apparent that the patient has not complied with the Recall Notice, then it shall be the responsibility of the care coordinator (community team) to instigate the AWOL procedure according to Pennine Care NHS Trust Policy. The community team must do this in liaison with the manager of the ward where the bed has been identified. The ward staff receive and acknowledge receipt of the information regarding the AWOL procedure.

The care coordinator (community team) must visit the home or last known address of the patient and attempt to secure the cooperation of the patient to return to the identified ward and hospital. If necessary, the care coordinator will liaise with Greater Manchester Police (Community Section) to accompany them; as the patient is now subject to s.18 (COP 28.3) of the Act they are liable to be detained. If after attempts to gain access to the patient the care coordinator is unsuccessful, then a request may be made to an AMHP if appropriate to apply for a warrant under s135 (2). A police constable must execute the warrant and either an AMHP or any other person authorised by the Hospital Managers must accompany the police. It is essential that the person/s accompanying the police in executing the warrant have good communication with the manager of the ward where the bed is identified; this is in order to communicate any changes in risk and to give an estimated time of arrival on the ward. Ward Manager ensures that the ward is in a position to receive the recalled patient. It is essential that the in-patient medic and the team are aware of any treatment that is authorised under the Recall time period.

Seventh line of flow-chart:
The patient is conveyed to the ward in the least restrictive manner possible by the most relevant person/authority (NWAS or GMP). The community team must ensure that the receiving ward is in possession of all relevant and necessary information as to the reasons for the recall. The ward must ensure that an assessment is completed as soon as possible and that any treatment authorised under Recall is facilitated.

It will be the responsibility of the community RC and the in-patient medic to communicate with each other prior to any decision being made in relation to discharge. The in-patient medic must decide whether or not to admit the patient as an informal patient, consider the use of the power of revocation or decide if discharge is the most appropriate course of action. If the decision is made to revoke the CTO then an appropriate amount of time must be allowed in order for an AMHP to assess all the circumstances of the case to see if s.3 status is necessary.

If the admitting staff team do not feel that the presentation of the patient and appropriate treatment is covered in the current Consent to Treatment form on the patient's medical notes then they must contact the medic or the on-call medic to come and assess the patient. If necessary the medic will then complete a s.62A form authorising any emergency treatment necessary. If this occurs the medic should begin the process of revocation forthwith and contact an AMHP. Also, if it is apparent that in-patient treatment is going to extend beyond the 72hours then the revocation of the CTO must be considered using the appropriate form.

If the patient's CTO is revoked then they will revert to s.3 status and the medic (Consultant) then becomes the Responsible Clinician for the patient and CTO ends.

Community Treatment Order
Part 4A Rules