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Community Treatment Order Procedure
Mental Health Act 1983

Introduction and Aim

This document supports the Community Treatment Order (CTO) Policy, Mental Health Act 1983.

To ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs.

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This procedure describes the following with regards to a CTO;

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patients' subject to a CTO

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read	• The Mental Health Act 1983 (as amended by the Mental

alongside this Procedure	Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Community Treatment Order Policy Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Mental Health and Capacity Legislation Committee

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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	26/06/2018	02/07/2018	New document

2	28/04/2022	05/08/22	• *Removal of glossary of terms.* • *Amended paragraphs throughout for clarity.* • *Removed paragraphs that weren't relevant due to change in processes.*

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1. INTRODUCTION

This procedure sets out to describe the process of using Community Treatment Orders (CTO). Those on CTOs will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTOs.

CTOs provide a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, a CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of Community Treatment Orders (CTOs) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (“the Code of Practice”).

CTOs are intended 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 harm to the patient or to others. It is one of a range of options for mental health treatment in the community and is implemented through the making of a CTO.

3. SCOPE

This procedure is applicable to employees within All Mental Health inpatient settings, community settings and general hospital settings where patients are subject to Community Treatment Orders.

4. MATTERS FOR CONSIDERATION FOR CARE IN THE COMMUNITY

To support and deliver care in the community for a patient detained on a treatment order (e.g. Section 3), the options include:

- Section 17 leave of absence. This can be short term or for extended leave of absence;
- Section 117 aftercare;
- Transfer onto guardianship; or
- Community treatment order.

5. WHO IS ELIGIBLE FOR CTO?

To be considered for CTO a patient must be currently detained under section 3 of the Mental Health Act (MHA) or an unrestricted Part 3 patient (section 37, section 45A, section 47 or section 48). Those detained for assessment on section 2 are not eligible. Furthermore, a CTO can only be used for patients whose treatment needs have already been assessed in hospital under one of the above-mentioned detention orders and they meet the eligibility criteria.

6. ELIGIBILITY CRITERIA

The patient's treatment needs have already been fully assessed under section 3 or as an unrestricted Part 3 patient and the patient is still liable to be detained. An individual patient can be discharged onto a CTO if they satisfy the eligibility criteria, 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 other persons that they 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 s17E(1) of the Act to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

7. RECOMMENDATIONS BY THE MENTAL HEALTH REVIEW TRIBUNAL (MHRT)

The MHRT may decide not to discharge a patient who has made such an application to them. The MHRT may decide, instead, to recommend that the RC should consider whether the patient should go onto a CTO (qualifying patients only). The RC will carry out the assessment of the patient's suitability for a CTO in the usual way.

However, it will be for the RC to decide whether or not a CTO is appropriate for that patient. The assessment may have to be carried out within a period of time as allowed for by the MHRT.

8. RISK ASSESSMENT

Whilst determining whether the criteria for a CTO is met, the RC shall consider, having regard to the patient's history of mental disorder and any other relevant factors, what risks there would be of a deterioration of the patient's condition if they were not detained in a hospital. The following must be assessed:

- Failure to follow a treatment plan;
- Patient's insight and attitude to treatment;
- The risk of patient's condition deteriorating after discharge;
- The risk of harm arising from the patient's disorder is sufficiently serious to justify the power of recall;
- The co-operation of the patient in consenting to the proposed treatment.

9. ASSESSMENT FOR CTO

The Responsible Clinician and the Approved Mental Health Professional (AMHP) will need to consider whether the objectives of a CTO could safely and effectively be achieved in a less restrictive way. If the RC grants the patient leave for 7 or more consecutive days, they have to consider a CTO. The RC will decide whether a CTO is the right option for any patient and will require the agreement of the AMHP. The RC must be satisfied that appropriate treatment is, or would be available for the CTO patient in the community. The key factor is whether the patient

can safely be treated for mental disorder in the community with the RC's power to recall the patient to hospital for treatment if necessary. The RC would also assess the 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. CONSULTATION

When the RC considers that a patient may be suitable for a CTO, the first step would be to consult with those involved in the care of the patient including the care coordinator and, where applicable, a different RC who will take over the responsibility for the patient in the community. Consultation is necessary when a CTO is first considered but it should also take place on any review of a CTO, when a change of condition is considered and prior to recall of a community patient unless the need for recall is too urgent.

The patient does not have to consent formally to a CTO. However, in practice patients need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

The RC must be fully aware of the diverse needs of the patient when considering a CTO and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

11. WHO TO CONSULT

- The patient, who may be supported by a Independent Mental Health Advocate (IMHA);
- Approved Mental Health Professional (AMHP)
- The care coordinator;
- A different RC (if applicable) who will take over responsibility for the CTO patient;
- The nearest relative/carers (unless the patient objects or it is not reasonably practical)
- The multi-disciplinary team involved in the care of the patient;
- Anyone with authority to act on behalf of the patient under the MCA 2005, such as an attorney or a deputy;
- The GP; it is important for the GP to be aware that the patient is to go onto a CTO. A patient without a GP should be encouraged and helped to register with a practice; and
- Other relevant professionals.

12. WHO MAKES THE DECISION

The RC and the AMHP make the decision as to whether a CTO is the right option for the patient. They would also have considered whether there is a less restrictive way to achieve the same objectives. The RC must be satisfied that the relevant criteria are met. An AMHP must state in writing that they agree with that opinion and that it is appropriate to make the order. This will be done by completing the appropriate part of Form CP1.

13. THE ROLE OF THE APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

The AMHP must reach an independent professional view. The AMHP should ensure that they consider the patient's wider social circumstances including any cultural issues. They should also consider any support networks the patient may have, the potential impact on the patient's family, employment and educational circumstances.

If the AMHP does not agree that a CTO should be made or does not agree to the conditions, the CTO cannot proceed. It would not be appropriate for the RC to approach another AMHP in the absence of changes to the plan. Where such disagreement occurs, an alternative plan should be developed by the relevant professionals.

When an AMHP disagrees to the making of a CTO, they should make a written entry to that effect in the patient's notes on PARIS.

14. CARE AND TREATMENT PLANNING MEETING

CTO patients are entitled to aftercare services under section 117 of the Act. The care and treatment plan will reflect the needs to be met by the services from the Health Board and the Local Social Services Authority (LSSA). Such care plans, coherent with CTO, must be in line with the requirements of care and treatment planning and a care coordinator will need to be identified. Good care planning will be essential to the success of a CTO. This would include an appropriate package of treatment and support services and the identification of a care coordinator. There would be a record of the patient having an attorney if applicable and also of any advance decisions.

15. CONDITIONS

A CTO will specify the conditions to which the patient is to be subject whilst on a CTO. All CTOs must include the ''mandatory conditions'':

- A condition that the patient must make themselves available for examination when an extension of the CTO is being considered; and
- Where necessary to make themselves available for examination to allow a second opinion approved doctor (SOAD) to provide a Part 4A certificate authorising the patient's treatment in the community.

The MHA Code of Practice for Wales suggests that the RC with the agreement of the AMHP may also set other conditions that are necessary or appropriate to ensure one or more of the following purposes:

- Ensuring that the patient receives medical treatment;
- Preventing risk of harm to the patient's health or safety;
- The protection of other persons.

With the exception of the two mandatory conditions, other conditions are in themselves not enforceable. The reasons for any conditions should be explained to the patient and others and be recorded in the patient's notes on PARIS.

Where applicable the RC should take account of any representation from a victim or their family,

where the provisions of the Domestic Violence, Crime and Victims Act 2004 apply.

The conditions might include stipulating:

- Where a community patient is to live;
- The arrangements for receiving treatment in the community;
- The avoidance of the use of illegal drugs and/or alcohol where their use has led to relapse in their mental disorder.

16. COMPLETING A COMMUNITY TREATMENT ORDER

The RC is responsible for initiating the process. The patient is entitled to ask the IMHA to support them at this point. Staff should assist the patient in contacting the IMHA if requested. The decision to go ahead is a joint one by the RC and the AMHP (who may be a member of the multidisciplinary team).

- The RC completes Part 1 of the Statutory Form CP1;
- The AMHP completes Part 2 of the Form CP1;
- The RC completes Part 3 of the Form CP1;
- As soon as reasonably practical the RC shall furnish to the Mental Health Act Department (on behalf of the managers of the responsible hospital) with the duly completed Form CP1 together with an up-to-date risk assessment and care and treatment plan;
- The Mental Health Act Department will ensure that a copy of the Form CP1 is scanned onto PARIS and the original kept in the patients legal file;
- The date on which the patient is discharged on CTO shall be the date on Part 3 of the duly completed Form CP1;
- The community patient is informed of the effect of CTO by the care coordinator or Responsible Clinician and the Mental Health Act Department;
- A copy of the CP1 is sent to the patients GP

17. COMMENCEMENT OF CTO

The day on which the CTO is made is determined by the date on the duly completed Part 3 of Form CP1. Hence, that will be the date on which the patient shall be discharged onto a CTO. Similarly, for patients who are already on s17 leave, they will instead be ‘transferred’ onto a CTO from that date. This date may be a short period after the date on which the form is signed, to allow for arrangements to be put in place for the patient’s discharge.

When the CTO is in force, the hospital managers’ authority to detain is suspended and the patient becomes a ‘community patient’ and the community treatment order they are subject to will expire after six months, at which point the RC will decide whether to extend the CTO or discharge it.

18. DURATION OF CTO

The CTO will be in force, until:

- The community treatment period expires;

- The patient is discharged by the Responsible Clinician or Hospital Managers under s23 or under a direction by the MHRT under s72 (1)(c);
- (For Part 2 Patients) the nearest relative applies for discharge and it is not barred by the RC;
- The patient no longer satisfies all the criteria for CTO;
- The CTO is revoked under s17F.

19. COMMUNITY TREATMENT ORDER PERIOD

The community treatment period shall cease to be in force on expiry of the period of six months beginning with the day on which it was made. The day it was made is arrived at by the date on the duly completed Part 3 of Form CP1. Unless the CTO has previously ceased to be in force, it can be extended for a period of six months and thereafter for a period of one year at a time.

20. GIVING INFORMATION TO THE PATIENT

Following the decision to make the CTO, the RC should inform the patient and others consulted, verbally and in writing of:

- The decision;
- The conditions to be applied to the CTO; and
- The services which will be available for the patient in the community.

Unless the patient objects, the nearest relative should be informed where practicable of the conditions to be applied and of their right to apply for the discharge of the patient from CTO.

21. GIVING INFORMATION ABOUT THE INDEPENDENT MENTAL HEALTH ADVOCATE TO THE PATIENT

CTO Patients are qualifying patients for the purpose of accessing the services of the Independent Mental Health Advocate (IMHA). The care coordinator will give CTO patients information both orally and in writing as soon as practicable after the patient goes onto CTO about the availability of the IMHA service.

The care coordinator, as soon as practicable after a CTO is applied must complete a rights form with the patient and ensure they have a CTO information leaflet. The Mental Health Act Department will send such information to the Nearest Relative, unless the patient objects (or does not have a Nearest Relative).

22. VARIATIONS IN/SUSPENSION OF ANY CONDITIONS OF A CTO

With exception of the two mandatory conditions, the RC may vary or suspend any of the above conditions applied to a CTO. There is no requirement for the RC to obtain an AMHP's agreement before doing so. Unless there is an urgent need to vary, it would be good practice to obtain an AMHP's agreement before doing so. Any variation of the conditions by the RC shall be recorded on Form CP2. The RC may by order in writing vary the conditions of the CTO from time to time. Additionally, the RC may suspend any condition specified in the CTO. The RC may consider any failure to comply with the conditions warrant for recalling the patient, however,

failure to comply with the conditions is not in itself enough to justify the power to recall. The RC should record any decision to suspend conditions in the patient's notes on PARIS, with reasons.

As soon as practicable, the RC shall furnish to the Mental Health Act Department a duly completed Form CP2. The Mental Health Act Department will ensure that a copy is sent to the care coordinator along with any other appropriate professionals and that the information about any such changes is brought to the attention of the patient and anyone affected by the changes. The patient must understand the reasons for the changes and how to comply with them. The original Form CP2 will be filed with the Form CP1 in the patient's legal file and uploaded to PARIS.

23. CHANGE OF RESPONSIBLE CLINICIAN

In certain circumstances, the RC for an inpatient may not be the RC for a community patient. In such cases, at an early stage of planning for the CTO the RC must liaise with the different RC to take over responsibility for the patient. Hence, as part of the CTP review, on the inpatient unit both the community team and the different RC who will take over the responsibility for the CTO patient must attend such reviews. Alternatively, transfer can take place during a CTP review and the CTO patient informed accordingly.

24. MEDICAL TREATMENT FOR MENTAL DISORDER IN THE COMMUNITY (PART 4A)

The provision of medical treatment for mental disorder is governed by Part 4A of the Act. There are two types of requirements in Part 4A, namely authority and certification. In all cases, the person giving the treatment must have the authority to do so and the certificate requirement must be met for section 58 and 58A type treatment. The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for treatment under Part 4 of the Act. There is no certificate requirement for the first month (1-month rule) from when a patient is put onto a CTO, or 3 months from when the medication was first given to the patient, whichever is later. After this time, a certificate is required either by the AC in charge of the treatment or from a SOAD.

To a negligible extent, those on CTO who are under the age of 16 may have the competence to consent to the treatment. The MCA 2005 is not directly relevant. The child's own consent will provide the authority. However, the Act also requires a SOAD or the AC in charge of their treatment to certify this on a Part 4A certificate. Under 16-year olds, who do not have competence, can be treated by the AC in charge of the treatment or someone acting under the AC's direction provided certain conditions are satisfied.

CTO patients with capacity to consent cannot be treated in the community against their wishes. There are no exceptions to this rule, even in emergencies. A CTO patient will be recalled to hospital when treatment for the patient's mental disorder is clinically necessary and the patient is not consenting.

The authority to treat patients who lack capacity to consent to a treatment may come from an attorney, a deputy or the Court of Protection. The AC in charge of the treatment would be able to provide treatment to the person who lacks capacity, provided certain conditions are met (see Ch 24.17 of the Code). The only exceptions, under section 64G, will be in emergencies where

patients lack the capacity to consent to treatment which is immediately necessary to prevent harm to the patient and is a proportionate response to that harm.

25. ARRANGING FOR A SOAD VISIT

If a SOAD is required to provide treatment under Part 4A, the RC should complete an Electronic SOAD Request Form and identify the two consultees. The care coordinator is ideally placed to be one of the consultees. The consultees should be registered staff members who have been professionally concerned with the patient's medical treatment such as a doctor, CPN, OT or AMHP, but neither consultee can be the patient's RC or the AC in charge of the treatment in question.

In circumstances whereby, the care coordinator would be on leave, the RC should identify another consultee who has been professionally concerned with the patient's medical treatment to speak to the SOAD.

26. CTO PATIENT – IDENTIFYING ATTORNEY / ADVANCE DECISIONS

If the patient lacks capacity to consent to treatment, the care coordinator or RC/AC will inform the SOAD if the patient has an attorney or deputy and details of any advance decisions or any expressed views, wishes or feelings, both past and present.

27. SOAD VISIT

Before the SOAD will issue a certificate, they will check the relevant documents and information relating to the patient. They will need to satisfy themselves that the patient's CTO papers are in order, check the patient's case notes, a recent medical report, if available, medication chart and they will interview the patient either via telephone or in person if the SOAD feels it is appropriate; and it is the duty of the Hospital Managers to find a suitable location for this interview. The SOAD will also interview the AC and the statutory consultees to ensure the proposed treatment plan is appropriate for that patient. A statutory consultee form will need to be completed as soon as possible after the discussion with the SOAD.
The Mental Health Act Department will provide the case notes and current detention papers to HIW. Once the SOAD has decided to issue a certificate it will be emailed to the Mental Health Act Departments generic inbox to process.

28. EFFECT OF CTO

The application for treatment will not cease to have effect because the patient has become a 'CTO patient'. However, whilst the patient remains on a CTO:

- The authority of the managers to detain him (section 6(2)) with regard to that application shall be suspended; and
- Any reference however expressed in this or any other legislation to patients liable to be detained or detained under this Act shall not include that patient on a CTO.
- Furthermore, whilst the patient remains on CTO, section 20 shall not apply to the patient, however, section 20A will apply.

The authority for the detention of the patient shall not expire during any period in which that

authority is suspended.

29. APPLICATION FOR DISCHARGE FROM CTO

CTO patients are entitled to request the hospital managers consider their discharge from CTO. Additionally, their nearest relative can apply for their discharge from CTO giving 72 hours' notice, unless the RC issues Form NR1 barring the discharge.

The effect of discharge is to end the CTO and the suspended liability to detention. The patient can no longer be recalled to hospital or required to stay in hospital.

30. MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

CTO patients are entitled to apply to the MHRT once during each period of detention. The hospital managers will refer them every 3 years if they haven't appealed to the MHRT within that time and when the patient has been revoked from their CTO. The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for referrals to the MHRT.

31. INFORMING CTO PATIENTS OF LOCATION OF THE MHRT HEARING

The MHRT hearings will be conducted either via teleconference or Teams and potentially face to face if appropriate. When the date of the hearing has been set, the Mental Health Act Department will inform the patients RC, social work team and community nurse, or ward nurse if the patient is informal. It is the MDT's responsibility to inform the patient of these details.

32. ACCESS TO PATIENTS' CLINICAL RECORDS

The medical member of the Tribunal may want to examine the patient before the hearing takes place. Hospital Managers must ensure that the medical member can see the patient in private and any records relating to the patient's detention or treatment will be produced for their inspection. The patient should be told of the visit in advance so that they can be available to meet the medical member. The medical member may speak to the patient via the telephone or video. The Mental Health Act Department are responsible for sending any information to the MHRT.

33. LEGAL REPRESENTATION

Patients should be informed that they are entitled to free legal advice and representation. Hospital Managers and Local Social Services Authorities should inform patients of their rights to present their own case to the Tribunal or to be represented by someone else. A list of solicitors who undertake tribunal work should be available for use by patients – this is especially important for CTO patients who may not have daily contact with professionals.

34. ATTENDANCE AT HEARINGS

It is important that the RC and other relevant staff involved in the patient's care should attend for the full hearing, as their evidence will be crucial in the decision reached by the Tribunal as to whether the patient still meets the criteria for CTO under the Act.

Patients do not need to attend the hearing but should be encouraged to do so, unless it would be detrimental to their health or wellbeing. The RC, allocated social worker, community nurse/care coordinator and other relevant staff should attend the full hearing so they are aware of all the evidence and the tribunal's decision and reasons.

35. MONITORING CTO PATIENTS

CTO should form a part of the patient's care and treatment plan, in accordance with section 8 of the Mental Health (Wales) Measure 2010 and regulations pursuant to it.

It will be important to maintain close contact with a patient on a CTO and to monitor their mental health and wellbeing. The care coordinator will normally be responsible for coordinating the care and treatment plan, working with the RC, the team responsible for the patient's care and any others with an interest. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and would include access to services provided locally. 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 reasons for a failure to comply with any condition must be considered and if necessary reviewed. The patient's compliance with the conditions will be a key indication of how the CTO is working in practice.

If the patient refuses crucial treatment, an urgent review of the situation will be needed. If suitable alternative treatment is available which would allow the CTO to continue safely and which the patient would accept, the RC should consider such treatment if this can be offered.

A failure to comply with a condition is not in itself enough to justify recall. Each case should be considered on its own merits and any actions are proportionate to the level of risk posed by the patient's non-compliance.

36. RESPONDING TO CONCERNS RAISED BY CARERS AND OTHERS

The care coordinator/community mental health team must give due weight to any concerns raised that the patient is not complying with any conditions and/or that their mental health is deteriorating. The care coordinator/community mental health team (CMHT)/out-of-hours services will deal with any such concern as an urgent referral. The practitioner concerned will access the CTO patient's records including the care plan and risk assessment.

The practitioner concerned will also obtain all the relevant details of the concerns to make a decision as to whether to meet with the person who raised the concerns and/or the CTO patient. Depending on the risk, the practitioner concerned/care coordinator will discuss the concerns with the RC/on-call consultant so that the RC/on-call consultant can decide whether to recall the CTO patient or not.

37. ADMISSION TO HOSPITAL OF CTO PATIENTS ON A VOLUNTARY BASIS

CTO patients may agree to be admitted to hospital on a voluntary basis. On such occasions the CTO patient would **not** have been recalled to hospital by their RC. CTO patients who are in hospital on a voluntary basis can be recalled if there is a need to. However, as Part 4A patients the medical treatment they may receive is governed by the rules applied to CTO patients as in Chapter 25 of the Code.

The Mental Health Act Department will send a reminder to the RC after 1 month of the patient being in hospital informally to undertake a review to determine if the patient still satisfies all the criteria for CTO, whilst the patient remains on the ward.

38. PROCEDURE FOR RECALL OF CTO PATIENTS TO HOSPITAL

The power to recall includes circumstances when the community patient is already in hospital at the time the power of recall is exercised. The RC may recall a community patient if they are of the opinion that:

- The patient requires medical treatment for his mental disorder in hospital; and
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient was not recalled to hospital for that purpose.

The notice in writing to recall a community patient to a named hospital shall be sufficient authority for the managers of that hospital to detain the patient in hospital.

All patients on a CTO have a hospital which is responsible for oversight of their case while they are in the community. The Act refers to this hospital as the "responsible hospital''. There is no special procedure to follow if the CTO patient is re-assigned to another hospital which is under the same managers.

The RC may recall a patient to a hospital other than the responsible hospital. In such instances, the RC has responsibility for coordinating the recall process, unless agreed with someone else. The power of recall will be carried out by notice in writing to the patient. The RC will complete Form CP5 to recall a community patient. Two copies of the completed Form CP5 must be taken. One copy is to be kept on the patient's records by the community mental health team, one copy must be given to the patient and the original must be faxed or scanned and e-mailed before being forwarded to the Mental Health Act Department.

It will not usually be appropriate to post a notice of recall to the CTO patient. It is important that, whenever possible, the notice should be handed to the patient personally. When the need for recall is urgent, it will be important that there is certainty as to the timing of the delivery of the notice. When such a notice of recall is handed to the patient, it is effective immediately. This may not be possible if the patient's whereabouts are unknown, or if the patient is unavailable or simply refuses to accept the notice.

Regulation 3 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 states that a notice of recall may be served by delivery to the patient's usual or last known address. Delivery of the recall notice relating to a CTO is secured by delivery in person or by pre-paid post.

SERVING THE NOTICE – WHEN NOT HANDED TO A CTO PATIENT

- If it is urgent, 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 beginning immediately after midnight following delivery.
- First class post can be used. The notice is deemed to be served on the second working

day after posting. Sufficient time must be allowed, as detailed above, for the patient to receive the notice before any action is taken to ensure compliance.

Once the notice of recall is duly served the patient can be treated as absent without leave (AWOL Section 18) if that is necessary and taken and conveyed to hospital. Should the police be informed, the care coordinator would inform the police that the CTO patient has been duly recalled and is now AWOL.

There may be cases whereby the patient's whereabouts are known but access to the patient cannot be obtained. In such cases, it may be necessary to consider whether a warrant issued under section 135 (2) is needed.

39. COMMUNITY PATIENTS WHO ARE ABSENT WITHOUT LEAVE

Patients on a CTO are considered to be absent without leave (AWOL) if:

- They fail to return to hospital when they are recalled; or
- They abscond from hospital following recall.

A patient, who is AWOL, may be taken into custody by an AMHP, an officer of the staff of the responsible hospital, a constable or anyone authorised in writing by the RC or the Hospital Managers, and returned to the hospital to which they were recalled.

That may only be done before:

- The time at which the CTO is due to expire (assuming it were not to be extended); or
- The end of the six months beginning with the first day of the AWOL, if that is later.

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, even if they had already been detained for part of that period before they went AWOL.

Special arrangements apply if a patient is AWOL at any point during the week which ends on the day their CTO is due to expire, and an extension report has yet to be made. The arrangements are equivalent to those of Part 2 detained patients.

If a patient is taken into custody, or comes to the hospital voluntarily, within 28 days, an examination and the report under section 20A may be furnished to the managers to extend the CTO.

If patients are taken into custody, or come to the hospital voluntarily, after being absent for more than 28 days, their CTO expires at the end of the week starting on the day of their arrival at the hospital unless the RC furnishes a report to the managers within that time to extend the CTO using Form CP 4. The CTO may also be revoked under section 21B(4)(a).

40. POWERS IN RESPECT OF RECALLED PATIENTS

The community patient may be recalled to a hospital other than the responsible hospital.

- The recalled patient may be transferred to another hospital.
- Subject to meeting the necessary conditions and written agreement of an AMHP, the RC may by order in writing revoke the CTO.
- The RC may at any time release the patient but not after the CTO has been revoked.
- If the CTO has not been revoked or the recalled patient released at the end of 72 hours, the patient shall be released from hospital. However, a released patient remains subject to the CTO. The ‘‘holding powers’’ of section 5 may not be used to keep the patient in hospital after the end of the 72-hour period.

The period of 72 hours begins when the patient arrives at the hospital he has been recalled to and not when the notice of recall has been issued or received. Form CP6 should be completed by the Mental Health Act Department or Shift Coordinator when the patient arrives noting the date and time of arrival.

Section 5(6) makes it clear that a patient subject to CTO is not to be held on either section 5(2) or section 5(4) of the Act.

41. POWER OF RECALL TO A HOSPITAL OTHER THAN THE RESPONSIBLE HOSPITAL

The hospital managers (or a person authorised by them) from the hospital which the patient is to be transferred from must use Form TC6 to authorise the transfer to the managers of the hospital to which the patient is being transferred to.

A copy of the duly completed Form CP5 to recall the patient will be provided to the managers of the hospital to which the patient is recalled as soon as possible after it is served to the patient. This will provide sufficient authority for the managers of the named hospital to detain the patient. The legislation allows a recalled patient to be transferred to another hospital provided it is done within the 72-hour period.

A transfer between hospitals while a patient is recalled does not change the responsible hospital.

42. TRANSFER OF A RECALLED PATIENT

A CTO patient who has been duly recalled may be transferred to another hospital managed by the same hospital managers. There is only the transfer arrangement, as an internal issue, to be carried out so as not to negatively affect the continuity of care. This can only be done within the same 72-hour period. The nurse in charge of the receiving unit must know the time at which the 72 hours started and must ensure that the Form CP6 is duly completed and returned to the Mental Health Act Department.

43. TRANSFER OF A RECALLED CTO PATIENT TO A HOSPITAL UNDER DIFFERENT MANAGERS

A recalled CTO patient may also be transferred to another hospital under different managers. In such cases the transfer must be effectuated within the 72-hour period. The Mental Health Act Department or Shift Coordinator, on behalf of the Hospital Managers, must complete Part 1 of

Form TC5. Part 2 of the form must be completed by someone authorised by the managers of the receiving hospital.

When Part 2 is duly completed, a copy of the completed Form TC5 must be scanned to the Mental Health Act Department. The Mental Health Act Department must notify:

- The patient, in writing, of the name and address of the responsible hospital and the details of the hospital managers; and
- The patient's nearest relative of the name and address of the responsible hospital and the details of the hospital managers (if the patient does not object).

44. RECORDS TO BE KEPT FOR RECALLED PATIENT

The Mental Health Act Department, on behalf of the hospital managers, will keep a record of the time and date of the patient's detention as a result of the notice of recall given by the RC. The start time and date will be the time and date of the patient's arrival on the inpatient unit.

The Shift Coordinator or Mental Health Act Department must record the start date and time of the 72-hour period and also the release of the recalled patient, if the RC decides not to revoke the CTO, using Form CP6.

When completed the Form CP6 must be faxed or scanned and the original sent to the Mental Health Act Department who will keep a record of these times and dates on behalf of managers of the responsible hospital. A copy will be retained in the patient's notes.

Prior to the release, the care coordinator and anyone else involved must be informed of the CTO patient's release.

45. MEDICAL TREATMENT FOR MENTAL DISORDER – RECALLED PATIENTS

Though the CTO patient has been recalled to a hospital, the required treatment may be given on an outpatient basis when appropriate. CTO patients who have been recalled to hospital are subject to the same rules on medical treatment (with certain exceptions) as other detained patients and are subject to Part 4 of the Act.

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

Part 4 applies to such patients instead, but with three differences.

First, treatment which would otherwise require a certificate under section 58 or 58A can be given without such a certificate if it is expressly approved instead by the patient's Part 4A certificate (if the patient has one). It is expressly approved if the SOAD states in the certificate that the treatment in question may be given to a patient who has been recalled. The certificate may contain conditions. The conditions may, for example, be different for the patient who is not recalled. However, the Part 4A certificate cannot authorise section 58A treatment for which there would be no authority under Part 4A itself.

Second, medication which would otherwise require a certificate under section 58 can be given without such a certificate if the certificate requirement in Part 4A would not yet apply to the treatment because less than one month has passed since the making of the patient's CTO. In

other words, no certificate is required for the administration of most medications to a patient who has been a CTO patient for less than a month.

Third, treatment that was already being given on the basis of a Part 4A certificate before the patient was recalled to hospital may be continued temporarily, even though it is not authorised for administration on recall on the Part 4A certificate, if the person in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. However, this exception only applies pending a new certificate being obtained.

SOADs providing Part 4A certificates need to consider what treatments (if any) to approve, should the patient be recalled to hospital.

These exceptions also apply to CTO patients whose CTOs have been revoked except that, for section 58 type treatments, continuance with medication will continue pending compliance with section 58 requirements.

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

HIW may at any time notify the AC in charge of the treatment in question that a Part 4A certificate will cease to apply from a certain date.

46. REVOKING A COMMUNITY TREATMENT ORDER

A CTO may only be revoked while the patient is detained in a hospital as a result of being recalled. The RC may by order revoke the CTO if:

- In their opinion the patient again needs to be admitted to hospital for medical treatment under the Act; and
- The AMHP agrees in writing with the RC and that it is appropriate to revoke the CTO.

The RC's order revoking the CTO will be in the form of a duly completed Form CP7. The RC will complete Part 1 and the AMHP will complete Part 2 of the Form CP7. Again, as soon as practicable the original Form CP7 will be sent by post to the Mental Health Act Department after first faxing or scanning a copy to them.

The Mental Health Act Department, on behalf of the hospital managers, must refer the patient's case to the MHRT as soon as practicable after the revocation of the CTO. As soon as practicable, the Mental Health Act Department will inform the care coordinator and the relevant CMHT of the revocation of the CTO.

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 remain on a CTO. The AMHP's decision and full reasons should be recorded in the patient's notes on PARIS.

47. EFFECT OF REVOKING A COMMUNITY TREATMENT ORDER

Below is the effect of revoking the CTO in respect of the patient.

- Section 6(2) shall have effect as if the patient has never been discharged from hospital

on a CTO. The patient's detention under their original treatment order will be re-instated from the date of revocation.

- The provision of this or any other Act relating to patients being liable to be detained (or detained) in pursuance to an application for admission for treatment shall apply to the patient as was prior to the CTO being made.
- When the patient is being detained in a hospital other than the responsible hospital, the provisions of this Act will have the effect as if the application for admission for treatment were made to that other hospital and he had been admitted to that other hospital at the time when the patient was originally admitted in pursuance of that application.

In any case of a patient being revoked, section 20 shall have the effect as if the patient had been admitted to hospital in pursuance of the application for admission for treatment on the day on which the order is revoked. The detention will last for six months and the RC will be able to renew the detention order, if appropriate, two months prior to the last day of the detention order.

Where the CTO patient has been recalled to a hospital which is not the responsible hospital, the RC/Mental Health Act Department must furnish the managers of that hospital with a copy of the order.

48. MEDICAL TREATMENT FOR MENTAL DISORDER – ON REVOCATION OF A CTO

Upon revocation of the CTO, the patient would be detained on the treatment order they were on directly before the CTO was applied. As such the patient will be subject to Part 4 of the Act as far as medical treatment for mental disorder is concerned. The period of time spent receiving treatment on section 2 and section 3 and CTO will count as being continuous. In order to treat patients under Part 4 of the Act, new certificates will be needed within 1 week of the CTO being revoked.

49. DUTY TO INFORM NEAREST RELATIVE

The Mental Health Act Department on behalf of the hospital managers will inform the nearest relative that a detained patient is to be discharged from hospital, unless that patient or the relative has asked that such information should not be given. This duty applies equally where patients are to be discharged from hospital by means of a CTO.

50. EXTENSION OF COMMUNITY TREATMENT ORDER PERIOD

Within two months ending on the day on which the CTO would cease to be in force, it shall be the duty of the RC to examine the patient and, if it appears to him that the conditions are satisfied and that the AMHP has agreed in writing, the RC must furnish the managers of the responsible hospital a report on the prescribed Form CP3. However, before providing the report the RC must consult one or more other persons who have been professionally involved with the patient's medical treatment.

The report, duly furnished, would extend the CTO for the prescribed period. Unless the hospital managers discharge the patient under section 23, the care coordinator as delegated by the hospital managers would inform the community patient of the renewal.

51. CONSULTATION BY RC PRIOR TO EXTENSION OF COMMUNITY TREATMENT

ORDER PERIOD

Before furnishing the above CTO Form CP3 to the hospital managers, the RC must consult one or more other persons who have been professionally concerned with the patient's medical treatment. The RC will need to complete Part 3 of Form CP3 with details such as the name and profession of the person consulted. Ideally, it may be the care coordinator, an Occupational Therapist, a Community Psychiatric Nurse (CPN) or a chartered psychologist who has been professionally concerned with the patient's medical treatment.

52. HOW CAN A COMMUNITY PATIENT BE DISCHARGED FROM CTO?

A community patient ought to be discharged from a CTO if the patient no longer meets the criteria for CTO. Such a patient can be discharged from CTO in the following ways:

- Discharge by the RC at any time using Form CP8;
- By the hospital managers under section 23 of the Act using Form CP8;
- For Part 2 patients following application by their Nearest Relative (NR) giving 72 hours' notice;
- By the MHRT;
- Following the patient's reception under guardianship.

53. EFFECT OF EXPIRY OF A COMMUNITY TREATMENT ORDER

A patient will be absolutely discharged from CTO and liability to be recalled to hospital and the application for admission for treatment will similarly cease to have any effect when the CTO expires.

54. SAFEGUARDS FOR CTO PATIENTS

Patients on CTO will be entitled to similar safeguards to patients detained in hospital including nearest relative rights and the right to apply to an MHRT. Patients on a CTO will also have their treatment (if it involves giving medicines) reviewed and certified by a second opinion appointed doctor or an AC after three months from when medication was first given or one month from discharge from hospital onto CTO, whichever is later. CTO patients will have their case reviewed regularly and will be discharged when they no longer meet the criteria.

55. MONITORING

Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The statutory Form CP6 must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the Form CP6, is carefully monitored.

The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a CTO is appropriate.

56. TRAINING

The Health Board will provide ongoing training for staff who are involved with the care and treatment of patient's subject to Community Treatment Orders. Details of training available can be found by contacting the Mental Health Act Department or checking their intranet page on CaV Web.

57. IMPLEMENTATION

This document will be widely disseminated to staff across Cardiff and Vale University Health Board. It will be published on the organisations intranet site and referred to during training relevant to the Act.

58. RESPONSIBILITIES

58.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

58.2 Chief Operating Officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

58.3 Community Team Managers/Service Managers

It is the responsibility of all clinical managers to:

- Ensure that this procedure is brought to the attention of all their staff, and that they understand and adhere to the guidance/procedure contained within.
- Ensure that all staff involved in the care and treatment of CTO patients have received adequate training and are competent to carry out these guidelines.

59. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Domestic Violence, Crime and Victims Act 2004
Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008

60. APPENDICIES

Appendix A – Treatment with medication for patient's subject to a Community Treatment Order.

Appendix A

TREATMENT WITH MEDICATION FOR PATIENTS SUBJECT TO A COMMUNITY TREATMENT ORDER

Has it been 3 months since medication first administered when patient was detained in hospital for assessment or treatment **OR** **Has it been 1 month since CTO commenced?**

Yes

Is the patient capable of consent?

- Capable and consenting → Treatment can only be given once certified by the AC on Form CO8.
- Capable and refusing → No authority to treat in the community - consider recall to hospital
- Not capable to consent → Is force required to administer treatment?
  - No → Emergency treatment can be given under emergency treatment powers s.64D pending certification on form CO7 by SOAD
  - Yes → Emergency treatment can be given under emergency treatment powers only if immediately necessary and the use of force is proportionate under s.64G

No

Treatment can be given by direction of RC under Section 63, MHA

KEY:

s.63, MHA	Treatment not requiring consent
s.64B, MHA	Adult community patients
s.64D, MHA	Adult community patients lacking capacity
s.64G, MHA	Emergency treatment for patients lacking capacity or competence
CO7	Certificate of appropriateness of treatment to be given to a community patient (Part 4A certificate)
CO8	Certificate of consent to treatment for community patient (Approved Clinician Part 4A certificate)