journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Community Treatment Orders (CTO)

Ref: MHA-0010-v3.3

Status: Ratified

Document type: Policy

Contents

1 Introduction

The purpose of a Community Treatment Order (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 (Department of Health, 2015).

This policy supports the trust in the delivery of Our Journey to Change and our ambition to create safe and personalised care.

It helps us deliver our strategic goals as follows:

• This policy supports the trust to co-create a great experience for all patients, carers and families by ensuring that CTO's are used lawfully, focusing on minimising risks and providing safe treatment in the least restrictive way.

2 Why we need this policy

2.1 Purpose

This policy provides guidance about the use of CTOs, patients for whom they are suitable, and providing and managing care planning and support in the community.

This policy includes guidance on circumstances that might lead to recall to hospital.

2.2 Objectives

Following this policy will ensure that:

- CTOs are used lawfully;
- Patients are treated in the least restrictive way;
- The independence of patients is maximised;
- Practitioners receive guidance about care and treatment for patients on a CTO;
- Risks to patients, carers, staff, and others are minimised.

3 Scope

3.1 Who this policy applies to

- All trust staff

3.2 Roles and responsibilities

Role	Responsibility
The Trust	The Trust are defined as the 'hospital managers' for the purposes of the Mental Health Act. Hospital managers have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. They must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. As managers of what the Act terms 'responsible hospitals', hospital managers have equivalent responsibilities towards CTO patients, even if those patients are not actually being treated at one of their hospitals.
Ward and Team Managers	Each manager is responsible for ensuring that the policy is followed within their area of responsibility.
Local authorities	Each Local Authority Social Care / AMHP Lead is responsible for ensuring that the policy is adhered to within their area of accountability.

4 Policy

4.1 Who can be discharged using a CTO?

A CTO application can only be made if the patient is detained on one of the sections listed below:

- Section 3
- Section 37
- Section 45A
- Section 47
- Section 48

Patients detained under Part 3 of the MHA can only be discharged onto a CTO if they are NOT subject to restrictions under sections 41 or 49

The Responsible Clinician (RC) and an Approved Mental Health Professional (AMHP) must agree that the criteria below are met, and that a CTO is appropriate:

A.	The patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
B.	It is necessary for the patient's health or safety, or for the protection of other persons that they should receive such treatment;
C.	Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without their continuing detention in hospital;
D.	It is necessary that the RC should be able to exercise the power to recall the patient to hospital; and
E.	Appropriate medical treatment is available for the patient.

In terms of D above, the RC shall give particular consideration to what risk there would be of a deterioration of the patient's condition if they were not detained in hospital as a result, for example, of refusing or neglecting to receive medical treatment for mental disorder.

Some of those discharged onto a CTO will be known to mental health services and will have experienced cycles of relapse and re-admission.

Others may be patients who, during a period of detention in hospital, are identified as needing the support and structure which a CTO offers to help prevent relapse in the community and avoid further admissions under the MHA.

Patients of any age can be discharged onto a CTO; there is no upper or lower age limit.

A risk that the patient's condition will deteriorate is a significant concern, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The RC 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 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, and
- Evidence that recall may be necessary (rather than informal admission or reassessment under the Act).

MHA Code of Practice 29.16

4.2 Role of the AMHP

Where possible the AMHP should be attached to the MDT responsible for the patient's care and treatment in the community.

Responsibility for ensuring that an AMHP considers the case lies with the Local Social Services Authority (LSSA) which would become responsible under section 117 MHA 1983.

The AMHP must decide whether to agree with the patient's RC that the patient meets the criteria for a CTO, and (if so) whether a CTO is appropriate. Even if the criteria are met, this does not mean that the patient must be discharged onto a CTO. In making that decision, the AMHP should consider the wider social context for the patient. Relevant factors may include:

- Any support mechanisms the patient may have
- Potential impact on the rest of the patient's family and their need for support in providing care
- Employment issues

If the AMHP does not agree with the RC that the patient should go onto a CTO, or if they do not agree with the conditions attached to the CTO, then the CTO cannot be made. A record of the AMHP's decision and the full reasons for it should be recorded in the patient's clinical record.

The RC should not approach another AMHP for an alternative view.

4.3 Making a CTO

	Action:	Notes:
1.	RC completes Part 1 of form CTO1 and signs and dates.	
2.	RC may add additional conditions with agreement of AMHP.	Conditions must not amount to a deprivation of liberty or lead the patient to believe that medication can be given compulsorily in the community. See 4.3.2

3.	AMHP completes Part 2 of form CTO1 and signs and dates.	
4.	RC completes Part 3 of form CTO1 and signs and dates.	Date in Part 3 of form **must not** be earlier than date of AMHP signature, or CTO will be invalid.
5.	Form CTO1 forwarded to Mental Health Legislation Department	

Process 1 - Making a CTO

4.3.1 Conditions attached to the CTO

The CTO includes conditions with which the patient is expected to comply. There are two conditions which must be included in all cases and are printed on the CTO 1 Form. 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 appointed doctor (SOAD) to provide a part 4A certificate authorising treatment.

RCs may also, with the AMHP's 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, or
- Prevent a risk of harm to the patient's health or safety as a result of mental disorder, or
- Protect other people

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

Additional conditions must consider the patient's cultural needs and background.

The patient, and (subject to normal considerations of patient confidentiality) any others with an interest such as parent or carer, should be consulted and the patient's wishes and views should be entered on the electronic patient record.

The care plan should be signed and dated to indicate that the conditions have been communicated.

The conditions should:

- be kept to a minimum number consistent with achieving their purpose;
- restrict the patient's liberty as little as possible while being consistent with achieving their purpose;
- have a clear rationale, linked to one or more of the purposes in paragraph 5.1.2 above; and
- be clearly and precisely expressed, so that the patient can readily understand what is expected.

The conditions will depend on the patient's circumstances. They might include:

- when and where the patient is to receive treatment in the community;
- where the patient is to live;
- avoidance of known risk factors;
- avoidance of high-risk situations relevant to the patient's mental disorder.

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 record.

4.3.2 Inappropriate use of additional conditions

Additional conditions must not give rise to a deprivation of liberty. For example:

> ***Susan will reside at New Futures in Shoretown where she will be supervised at all times. She must not leave New Futures unsupervised or unescorted.***

would not be an appropriate additional condition.

A CTO cannot and does not authorise a deprivation of liberty.

The additional conditions must not lead the patient to believe that medication may, or will be, administered compulsorily in the community. For example:

Susan must take her medication.

It must be made clear to the patient that a refusal of medication **may** lead to recall if the recall criteria are met, and that, following recall, medication may be administered compulsorily in hospital.

Examples of acceptable additional conditions regarding medication could be:

Susan will attend Coast Road clinic every two weeks to receive her depot injection.

Or

Mark will allow members of the care team to visit his flat for the purpose of providing his medication or depot injection.

On attending the clinic or allowing access to the care team, medication cannot then forcibly be given.

4.4 Information for patients on a CTO and others

As soon as the decision is made to discharge a patient onto a CTO, the RC should inform the patient and others consulted of:

- The decision,
- The conditions to be applied to the CTO
- The services which will be available for the patient in the community, including the right to an IMHA.

See TEWV Section 132 Procedure for process for informing patients and their nearest relatives of their rights.

4.5 Monitoring CTO patients

It is important to maintain contact with a patient on a CTO and to monitor their mental health and wellbeing. Arrangements will vary depending on the patient's needs and circumstances. All those involved need to agree to the arrangements. Responsibilities should be clearly set out in the patient's care plan. For those subject to the CPA, the care co-ordinator would normally be responsible for co-creating the care plan, and for those not subject to the CPA the 'key-worker' will assume this responsibility. Co-creating the plan will mean working with the patient, responsible clinician (if they are different people), the team responsible for the patient's care, family, carers, and any others with an interest.

Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour because 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 treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if treatment is required that can only be given in a hospital.

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.

If the patient is not complying with CTO conditions the reasons for this need to be properly investigated. Recall to hospital may be considered if it is no longer safe and appropriate for the patient to remain in the community. Changes may also be needed to the patient's care or treatment plan.

If the CTO is felt to be failing to promote recovery and then consideration needs to be given to discharging the CTO and taking a different approach.

4.6 Varying and suspending conditions

The RC may vary or suspend the conditions of the CTO by completing form CTO2.

Any condition no longer required must be removed.

Although the RC has the power to change conditions, it is not acceptable for an RC to make significant changes shortly after discharge as a way of including a condition that the AMHP objected to.

It is important to discuss any proposed changes to the conditions with the patient and anyone else affected by the changes. The patient's views about the changes should be sought and considered before any change is made.

For further information see paragraphs 29.40-29.43 MHA CoP.

4.7 Responding to concerns raised by the patient's carer

It is important to pay attention 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.

4.8 Informal admission of CTO patients

A CTO patient who has the capacity to consent to hospital admission and does consent may be admitted informally.

If the admission is likely to be prolonged, consideration should be given to changing the RC from the community consultant to the inpatient consultant. This must be formally agreed and

clearly recorded so that everyone is aware of who the RC is. This is particularly important if the need to recall arises as only the RC can recall the patient.

A CTO patient who has agreed to hospital admission can be recalled if necessary, see 4.9 below. They cannot be held under S5(2) or S5(4).

4.9 Recall to hospital.

The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or 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.

The RC may recall a patient on a CTO to hospital 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 persons if the patient were not recalled.

A patient may also be recalled if they have failed to comply with either of the mandatory conditions attached to all CTOs – that the patient must make themselves available for medical examination:

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

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.

A patient on a CTO may agree to hospital admission as an informal patient. A patient who has agreed to an informal admission may still be recalled if they meet the criteria above.

The RC must be satisfied that the criteria are met before using the recall power. Any action must be in proportion 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 may resolve the problem and avert the need for recall.

It might be necessary to recall a patient whose condition was deteriorating despite compliance with treatment, if the risk cannot be managed otherwise.

For further information see paragraphs 29.45-29.51 MHA CoP.

4.10 Procedure for recall to hospital

	Action:	Notes
1	RC Completes form CTO3	RC must identify appropriate hospital and make sure they are ready to receive the patient and provide appropriate treatment before recalling.
2	Form CTO is served on patient.	

3	If patient does not return to hospital, they can be treated as AWOL	Recall must be to hospital, but treatment can be given on an outpatient basis if appropriate.
4	Patient returns to hospital.	
5	Staff complete form CTO4, and forward to MHL department.	Patient may be detained in hospital for up to 72 hours from the time they arrive at the hospital following recall. Patient must be allowed to leave at the end of the 72 hour period unless the CTO is revoked

Process 2 - Recalling a patient.

The RC has responsibility for coordinating the recall process.

The RC must complete a written notice of recall to hospital (Form CTO3), which is effective only when served on the patient. Wherever possible, the notice should be handed to the patient personally. If this is not possible, Form CTO3 can be served by delivery to the patient's usual or last known address.

Once the recall notice has been served, the patient can, if necessary be treated as absent without leave (AWOL) and taken and transported to hospital.

A notice of recall handed to the patient has immediate effect.

A notice of recall hand delivered to the patient's usual or last known address is deemed to be served (even though it may not actually be received by the patient) on the day after it is delivered. i.e., the notice is deemed to be served at one minute past midnight.

A notice of recall sent by first class post is deemed to be served on the second working day after posting.

If the patient's whereabouts are known, but access to the patient cannot be obtained it may be necessary to consider whether a warrant under section 135(2) is needed. See TEWV Inter-agency policy for the operation of sections 135 and 136 MHA 1983.

The patient should be transported to hospital in the least restrictive manner possible.

The RC must identify an appropriate hospital (which can be any hospital, not just the responsible hospital named on the CTO) and ensure that the hospital is ready to receive the patient and to provide appropriate treatment. A copy of the notice of recall should be sent to the managers of the hospital to which the patient is being recalled.

Recall must be to hospital, but treatment may be given on an outpatient basis if appropriate.

On recall to hospital, the RC will generally remain the community RC. This is to ensure continuity of care, particularly where the recall is only for a short period of time. If the CTO is revoked the inpatient consultant will generally take over as RC. This is not a hard and fast rule – there may be times where it makes sense for the patient to have an inpatient RC even though the CTO has not been revoked, for example where a patient on a CTO agrees to a prolonged inpatient admission.

When the patient arrives at the hospital after recall, Form CTO4 must be completed and sent to the relevant MHL department. The patient may be detained in hospital for up to 72 hours from the time they arrive at the hospital, and may be given treatment under Part IV of the MHA (see section 4.17.4 below).

The patient must be given verbal and written information about their rights following recall. See TEWV Section 132 and 132A Mental Health Act 1983 Procedure.

During the 72 period the patient remains a CTO patient, even if they remain in hospital for one or more nights. The RC may end the recall and allow the patient to leave the hospital at any time within the 72 hour period.

There is no power to grant leave under section 17 to a recalled patient as the patient is not at that point 'liable to be detained'.

Once the 72-hour period has passed the patient must be allowed to leave if the RC has not revoked the CTO (see section 4.11 below)

On leaving hospital the patient will remain on a CTO as before.

Section 5(2) cannot be used to extend the 72 hours

For further information see paragraphs 29.52-29.62 MHA CoP.

4.11 Revoking the CTO

	Action:	Notes:
1	RC completes part 1 form CTO5 and signs and dates.	CTO can only be revoked at any time within the 72-hour recall period. If more than 72 hours have passed since the patient was recalled, the CTO cannot be revoked.
2	AMHP completes part 2 of form CTO5 and signs and dates.	
3	RC completes part 3 form CTO 5 and signs and dates.	Date in Part 3 of form **must not** be earlier than date of AMHP signature, or CTO will be invalid
4	Form CTO5 forwarded to Mental Health Legislation Office	

Process 3 - Revoking a CTO

If the patient needs inpatient treatment for longer than 72 hours after arrival at the hospital, the RC should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under the MHA. The RC and an AMHP should reassess the patient before revoking the CTO.

The CTO may be revoked if:

- The RC considers that the patient again needs to be admitted to hospital for medical treatment under the Act, or
- An AMHP agrees with that assessment, and also believes that it is appropriate to revoke the 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.

The AMHP 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.

MHA CoP 29.66

If the AMHP does not agree that the CTO should be revoked, the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient therefore remains on a CTO.

A record of the AMHP's decision and the full reasons for it should be kept in the patient's notes.

It would not be appropriate for the responsible clinician to approach another AMHP for an alternative view.

If the AMHP agrees, the CTO may be revoked by completing form CTO 5. Parts 1 and 3 are completed by the RC and part 2 by the AMHP. The form must then be forwarded to the relevant MHL department. The revocation takes effect immediately once the form has been signed by the AMHP and RC and forwarded to the MHL department.

The RC or AMHP must ensure that the patient is given oral reasons for revoking the CTO before it is revoked.

On revocation of the CTO the inpatient AC will become the RC. It is essential that the inpatient AC is involved in the discussions and decision around revoking the CTO.

On revocation, the patient is detained again under the powers of the MHA exactly as before going onto a CTO except that:

- It is a new detention period of 6 months for the purpose of review;
- It is a new detention period for the purpose of application to the tribunal;

Written reasons for the revocation should be given to the patient and (where appropriate) their nearest relative.

The hospital managers have a duty to ensure that a patient whose CTO is revoked is referred to the Tribunal without delay. The MHL department are responsible for performing this duty. The patient also has the right to apply to the Tribunal.

For further information see paragraphs 29.63-29.68 MHA CoP.

4.12 Reviewing CTOs

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

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 being on a CTO must be discharged without delay.

4.13 Extending CTOs

A patient's CTO may be extended by the RC. This must be done before the period of CTO expires.

All decisions should be taken in line with the least restrictive option and maximum independence principle.

The RC must examine their patient within the last two months leading up to the day on which the patient's CTO is due to expire and decide whether the criteria for extending the CTO under section 20A of the MHA are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment.

The RC should also consult the wider multi-disciplinary team (MDT). Where appropriate this should include:

- The patient,
- Nearest relative,
- IMHA and / or other representative,
- Family and carers,
- Local authority and clinical commissioning group responsible for the patient's aftercare, and
- Any other key service providers.

Consultation should take place during a care programme approach (CPA) meeting, or a formal review meeting for those not subject to the CPA, and before the RC decides whether or not to extend the CTO.

When deciding whether to extend the CTO the RC, 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.

Where RCs are satisfied that the criteria are met, they must submit a report to the hospital managers on form CTO7. The extension takes effect immediately once the form has been signed by the AMHP and RC and forwarded to the MHL department. It is then received by a MHL Officer who completes part 4.

Before the RC can submit that report they must obtain the written agreement of the AMHP. The RC must ensure that the AMHP is given enough notice to interview the patient if appropriate.

This does not have to be the AMHP who originally agreed that the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. It can be an AMHP acting on behalf of any willing local 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.

MHA CoP 32.16

If the criteria for extending the CTO are not met, the patient should be discharged by the RC rather than waiting for the CTO to expire. Where an AMHP does not agree to extension, the RC may choose whether to discharge the patient or allow the CTO to continue until it expires.

	Action:	**Notes:**
1	RC completes Part 1 of form CTO7 and signs and dates.	
2	AMHP completes Part 2 of form CTO7 and signs and dates.	
3	RC completes Part 3 of form CTO7 and signs and dates.	Date in Part 3 of form **must not** be earlier than date of AMHP signature, or CTO will be invalid.

4	Form CTO7 forwarded to Mental Health Legislation Office	

Process 4 - Extending a CTO

4.14 Deprivation of liberty while on a CTO

A CTO cannot authorise a deprivation of liberty. If a patient on a CTO is cared for in a care home or other provision, such as Independent Supported Living, and the care regime in place amounts to a deprivation of liberty, the care home or ISL provider must obtain an authorisation under the Deprivation of Liberty Safeguards (DoLS) or a Court of Protection Order.

Similarly, a patient subject to a CTO who requires admission to an acute hospital for physical healthcare may also require an authorisation under DoLS.

A DoLS authorisation under the Mental Capacity Act 2005 (MCA) can exist alongside a CTO, provided there is no conflict with the conditions of the CTO and the placement in which the DoLS is authorised.

4.15 Transfer

4.15.1 Transfer of patient who has been recalled to hospital

A patient who has been recalled to hospital can be transferred to another hospital within the 72-hour period allowed for in the recall.

If the hospital is managed by the same organisation (i.e., within TEWV) there are no statutory requirements for the transfer.

If the hospital is managed by a different organisation (i.e., other than by TEWV) then Form CTO6 must be completed to authorise the transfer. Form CTO6 can be completed by a MHL Officer, or any other person authorised to do this on behalf of the Hospital Managers.

4.15.2 Transfer or patient who has not been recalled to hospital

Responsibility for a CTO patient who has not been recalled to hospital can be transferred at any time.

If the new responsible hospital is managed by the same organisation (i.e., within TEWV) there are no statutory requirements for the transfer.

If the new responsible hospital is managed by a different organisation (i.e., other than by TEWV) then Form CTO10 must be completed to authorise the transfer. Form CTO10 can

be completed by a MHL Officer, or any other person authorised to do this on behalf of the Hospital Managers.

4.16 Discharge from CTO

Patients should not remain subject to a CTO once it is no longer necessary, i.e., if the answer to any of the following questions is “no”.

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, it is necessary in the interests of the patient’s health and safety or for the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the RC to be able to exercise the power to recall the patient to hospital, if that is needed? (The longer the patient has been on a CTO without the need for recall, the more important it will become to question whether this criterion is still satisfied?

CTO patients may be discharged in the same way as detained patients, by the Tribunal, the hospital managers, or the nearest relative.

The RC may discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for a CTO.

A patient’s CTO should not simply be allowed to lapse.

The reasons for discharge should be explained to the patient.

For further information see paragraphs 29.75-29.77 MHA CoP

4.17 Medical treatment

4.17.1 Prescription charges

Under the National Health Service (Charges for Drugs and Appliances) Regulations 2015, a patient on a CTO must not be charged medication they need for treatment of their mental disorder.

4.17.2 Medical treatment of patients who have not been recalled to hospital.

Part 4A of the MHA sets out rules for treatment of patients on CTOs who have not been recalled to hospital.

Part 4A rules also apply to CTO patients who have consented to informal admission or who have consented to remain in hospital following recall

The rules for Part 4A patients differ depending on whether or not the patient has the capacity to consent or refuse the treatment in question.

Unless explicitly stated, references to a person who lacks capacity to consent or refuse treatment in this section includes patients under the age of 16 who lack the competence to consent or refuse treatment.

Part 4A patients who have the capacity to consent to or refuse a treatment, may not be given that treatment unless they consent. **There are no exceptions to this rule, not even in emergencies.**

The effect is that treatment can only be given without their consent if they are recalled to hospital.

	**Refusal to consent to treatment in itself does not justify a recall to hospital and fuller consideration of the patient's presentation and circumstances is required when considering whether a recall to hospital is warranted.** **25.26 MHA CoP**

For part 4A patients, aged 18 or over, who lack the capacity to consent to or refuse a treatment, it may be given if someone who has lasting power of attorney or a Court of Protection appointed deputy consents on their behalf. Similarly, it may be given in the case of those aged 16 and over if a deputy consents to the treatment on their behalf.

Part 4A patients who lack capacity to consent to or refuse a treatment may also be given it, without anyone's consent by or under the direction of the approved clinician in charge of the treatment, unless:

- In the case of a patient aged 18 or over, the treatment would be contrary to a valid and applicable advance decision made by the patient
- In the case of a patient aged 18 or over, the treatment would be against the decision of someone with the authority under the MCA 2005 to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection)
- In the case of a patient aged 16 or over, the treatment would be against the decision of a deputy who has authority to refuse it on the patient's behalf, or force needs to be used in order to administer the treatment and the patient objects to the treatment.

	**For further information see paragraphs 24.14 to 24.23 MHA CoP**

	**Some treatments can only be given if an appropriate treatment certificate has been completed. See section 4.17.5 below**

4.17.3 Emergency treatment under section 64G for CTO patients not recalled to hospital.

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.

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 and does not entail significant physical hazard, or
- 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.

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

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

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

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

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.

4.17.4 Medical treatment of patients who have been recalled to hospital

Part 4 of the MHA deals mainly with the treatment of people who are liable to be detained in hospital, this includes patients who have been recalled from CTOs.

Unless section 58 or section 58A apply, section 63 of the MHA (treatment not requiring consent) means that patients who have been recalled on a CTO can be given medical treatment for mental disorder whether they:

- Consent to it, or
- Have not consented to it

	**The treatment must be given by, or under the direction of the approved clinician in charge of the treatment in question.**

	**If sections 58 or 58A apply, recalled CTO patients may be given the treatment only if the rules in those sections apply. See section 4.17.5 below**

4.17.5 Treatment requiring a treatment certificate.

There are specific rules regarding the certification of certain treatment given to CTO patients under Part 4A of the MHA:

- 'Section 58 type treatment' – treatment to which section 58 would apply if the patient were detained. i.e., medication for the treatment of mental disorder after an initial 3-month period.
- 'Section 58A type treatment' – ECT and medication given as part of ECT.

In the case of a CTO patient who lacks capacity (or competence, if under 16) to consent to treatment, a SOAD must certify that the treatment is appropriate (CTO11).

In the case of a part 4A patient who has capacity (or, if under 16, is competent) to consent to the treatment and has consented, the approved clinician in charge of the patient's treatment must certify that the patient has capacity/competence and has consented (CTO12).

In the case of patients aged under 18, regardless of capacity to consent, ECT can only be authorised by a part 4A certificate (i.e., not by a part 4A consent certificate).

A treatment certificate is not 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)
- if the criteria under section 64G are met for emergency treatment in the community of patients lacking capacity or competence, or
- it is immediately necessary, and the patient has capacity to consent to it and has consented, or their donee or deputy or the Court of Protection has consented on the patient's behalf.

4.17.6 CTO patients recalled to hospital – exceptions to the need for treatment certificates

Generally, CTO patients recalled to hospital are subject to sections 58 and 58A in the same way as other detained patients. But there are exceptions, as follows:

- a certificate under section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became a CTO patient
- a certificate is not needed under either section 58 or 58A if a part 4A certificate or part 4A consent certificate has been issued (i.e. if a CTO 11 or CTO12 has been completed)
- a certificate is not needed under either section 58 or 58A if the treatment in question is explicitly authorised for administration on recall on the patient's SOAD issued part 4A certificate, and

- treatment that was already being given on the basis of a part 4A certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. It may only be continued pending compliance with section 58 or 58A (as applicable) – in other words while steps are taken to obtain a new certificate.

The exceptions to the requirement to have a certificate under section 58 or 58A continue to apply if the patient's CTO is revoked, but only while steps are taken to comply with section 58 (where relevant).

Responsible clinicians should ensure that steps are in hand to obtain a new SOAD certificate under section 58 or 58A, if one is needed as soon as they revoke a CTO.

4.17.7 Urgent cases where certificates are not required (sections 62, 64B, 64C and 64E)

Sections 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary (section 62). In the same way, a part 4A certificate is not required in urgent cases where the treatment is immediately necessary (sections 64B, 64C and 64E).

This applies only if the treatment in question 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 and does not entail significant physical hazard, or
- 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.

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

	These are strict tests. It is not enough for there to be an urgent need for treatment or that the clinicians involved believe the treatment is necessary or beneficial.

	Urgent treatment under these sections can continue only for as long as it remains immediately necessary. **If it is no longer immediately necessary, the normal requirements for certificates apply.**

5 Definitions

Term	Definition
Approved Clinician (AC)	A suitably experienced and qualified professional from either a medical, psychological, nursing, social work or occupational therapy background that has been approved by a regional panel as having Approved Clinician status.
AC in charge of an element of treatment:	Where for example, the RC is not a Registered Medical Practitioner and there are prescribing issues there may be an AC in charge of that element of treatment who is not the RC in overall charge of the case.
Approved Mental Health Professional (AMHP)	A practitioner who has undertaken additional recognised professional training and is approved and authorised by the Local Authority and, where the AMHP is a Social Worker, registered with the General Social Care Council. The role of AMHP is to carry out legal functions in relation to the MHA which includes making an application for compulsion and supporting an application for SCT. Other professional groups may become AMHPs.

Code of Practice (CoP)	The Code of Practice (2015) to the Mental Health Act 1983
Hospital	The policy document refers to hospital with regards to sites for recall of patients. A hospital is defined within the meaning of the Mental Health Act and MHA CoP when referring to sites to which patients can be recalled.
Independent Mental Health Advocate (IMHA)	Under Section 130A SCT patients are entitled to the services of an IMHA.
Mental Health Act 1983 (MHA)	Refers to the Mental Health Act (1983) as amended by the Mental Health Act (2007) and the Patients in the Community Act (1995)
Mental Health Tribunal	The First–tier Tribunal (Mental Health) hears applications and references for people detained under the MHA or living in the community following the making of a conditional discharge, or a community treatment or guardianship order. The Tribunal is an independent judicial body. The Tribunal may recommend that the RC considers whether to make a CTO for patients detained under Section 3 of the MHA or equivalent unrestricted Part III provisions. The Tribunal has the power to discharge a patient from a CTO.
Patient	The MHA and MHA CoP make reference to 'Patient' when describing Service User, Client or Customer of Mental Health Services. This policy document will use the terminology Patient to minimise any confusion with legislative guidance.
Recall to hospital	A Patient can be recalled to hospital when evidence of relapse or high-risk behaviour relating to mental disorder indicates risk to the patient or to other people. The purpose of recall is to provide short-term treatment or consider revocation of the CTO.
Revocation of CTO	The CTO may be revoked by the RC if the patient needs to be detained in hospital for medical treatment under the MHA and an AMHP agrees with that assessment.
Reference Guide	The Reference Guide to the Mental Health Act 1983.
Regulations	The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008

Responsible Clinician (RC)	The approved clinician with overall responsibility for a patient's case. Certain decisions (such as placing a patient on a CTO) can only be taken by the RC.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Care Quality Commission who gives a second opinion on whether certain types of medical treatment should be given.

6 Related documents

- Consent to examination and treatment policy
- S17 Leave for Detained Patients Policy
- Time Away from the ward policy
- Missing Persons Policy
- Section 132 procedure
- IMHA procedure
- Associate Hospital Managers policy
- Deprivation of Liberty Policy
- Deprivation of Liberty Safeguards Procedure
- Human Rights, Equality, Diversity, and Inclusion Policy

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- The content of this policy is covered in mandatory MHL training.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training

Staff with professional registration	e-learning	3 hours	2 yearly
Staff without professional registration	e-learning	3 hours	2 yearly

8 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Compliance with requirements of legislation	Frequency = Each quarter Method = Report identifying issues will be produced by the MHL department Responsible = MHL Department	Mental Health Legislation Committee

9 References

- Department of Health. (2015). *Mental Health Act 1983: Code of Practice.* TSO.
- Department of Health. (2015). *Reference Guide to the Mental Health Act 1983.* TSO.

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	27 February 2024
Next review date	27 February 2027
This document replaces	MHA-0010-v3.2 Community Treatment Order (CTO) Policy
This document was approved by	Mental Health Legislation Committee
This document was approved	27 February 2024
This document was ratified by	Management Group
This document was ratified	20 March 2024
An equality analysis was completed on this policy on	26 January 2024
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
3	01 Feb 2017	Full review	Withdrawn
3	24 Mar 2020	Extended review date from 01 Feb 2020 to 01 June 2020	Withdrawn
3	01 Apr 2020	Extended review date to 30 Sept 2020	Withdrawn
3.1	10 Feb 2021	3 yearly review. Updated template. Minor grammatical changes made.	Withdrawn
3.2	18 Oct 2023	Minor wording change In section 4.3.1 “electronic care record” to “electronic patient record”	Withdrawn

3.3	20 Mar 2024	3 yearly review – no major changes. Template updated Flow charts changed to tables for accessibility Terminology amended to reflect changes to ‘care-coordinator’ in 4.5 and 4.13	Published

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Mental Health Legislation
Title	Community Treatment Order (CTO) Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	Ensure the Trust acts lawfully and follows best practice when using CTO's
Start date of Equality Analysis Screening	18/12/2023
End date of Equality Analysis Screening	20/01/2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Benefits patients, staff and the Trust by giving guidance on how CTO's should be applied and used lawfully.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO**

	• **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	N/A
Describe any positive impacts / Human Rights Implications	Ensuring patients' rights are protected by acting lawfully and following best practice.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Mental Health Act Mental Health Act Code of Practice
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	The Trust's Equality, Diversity and Human Rights Team were contacted.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	
Are supporting documents referenced?	Y	
6. Training		

Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	Approved 26/01/2024
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	
Does the document identify whether it is private or public?	Y	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	Y	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	