Kent and Medway
NHS and Social Care Partnership Trust

Community Treatment Order (CTO) Policy
Section 17A
Mental Health Act 1983 (Amended 2007)

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Document Information

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REFERENCES

Mental Health Act 1983 Revised 2007
Mental Health Act 1983: Revised Code of Practice 2015
Supervised Community Treatment: A Guide for Practitioners NIMHE October 2008
Mental Health Act 2007 –Supervised Community Treatment (draft policy) CSIP
Supervised Community Treatment (briefing) – Jim Symington NIMHE National Lead for Legislation (London Implementation of the amended Mental Health Act) 16/7/2008

RELATED POLICIES

Consent to Treatment Policy
Mental Capacity Act Policy
Care Programme Approach (CPA) Policy
Absence Without Leave Policy
Section 117 Policy
Section 135 Policy
Section 132 Rights Policy

SUMMARY OF CHANGES

This document is a new policy written in line with the 2007 amendments to the Mental Health Act 1983 and the new Mental Health Code of Practice 2015, and replaces the existing Section 25A Supervised Discharge Order polices of East Kent and West Kent Partnership Trusts.

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1 INTRODUCTION

The 2007 amendments to the Mental Health Act 1983 (MHA) introduced Community Treatment Orders (CTOs). This policy sets out the legal framework for the operation of a CTO under Section 17A of the MHA.

This policy should be read in conjunction with relevant chapters of the MHA Code of Practice to the Mental Health Act ('the Code') which offers guidance on the operation of the Act. The relevant chapters of the Code are Chapter 29, Chapter 31 and Chapter 32.

2 OVERARCHING PRINCIPLES OF THE MENTAL HEALTH ACT

2.1 On 1 April 2015, the new Code of Practice of Practice to the MHA came into effect. It is essential that all those undertaking functions under the Act understand the five overarching Guiding Principles. The Guiding Principles must always be considered when making any decisions in relation to care, support or treatment provided under the MHA.

2.2 Although all Guiding Principles are of equal importance, the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

2.3 The five overarching Guiding Principles are:

a) Principle 1- Least restrictive option and maximising independence

If a patient can be treated safely and lawfully without detention under the 1983 Act, the patient should not be detained. Wherever possible, the focus should be on promoting the patient's recovery and independence.

b) Principle 2 - Empowerment and involvement

Patients should be fully involved in decisions about their treatment, care and support, and able to participate in decision-making as far as they can. Where appropriate, the views of the patient's family and carers should also be considered. A patient's views, wishes and feelings (including present, past and those expressed in advance) should be considered so far as they can be ascertained. With this in mind, the Code of Practice of Practice encourages professionals to support patients to develop advance statements of their feelings and wishes so that, during periods of wellness, they may express views about their future treatment and care.

c) Principle 3 - Respect and dignity

Not only should patients be treated with respect and dignity but these principles should also apply to the treatment of their families and carers.

d) Principle 4 - Purpose and effectiveness

Decisions about a patient's care should have clear therapeutic aim, promote recovery and be performed to current national and/or best practice guidelines.

e) Principle 5 - Efficiency and equity

The organisations involved in providing care and treatment to patients should work together to ensure that mental healthcare services are of high quality and equal priority is given to both physical health and social care services.

3 PURPOSE OF A CTO

3.1 "The purpose of a CTO is to allow suitable patients to be treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others - that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in particular, treating patients using the least restrictive option and maximising their

independence; and purpose and effectiveness should always be considered when considering CTOs" (MHA Code of Practice, paragraph 29.5)

3.2 There are various factors which should be taken into consideration when deciding whether to discharge a patient on to a CTO as opposed to using s.17 leave or Guardianship as an alternative framework. Further guidance on which legal framework would be most appropriate can be found in Chapter 31 of the MHA Code of Practice. The following charts provide a useful overview of the factors which need to be taken into account when deciding which framework is most appropriate for the patient:

Section 17 Leave or CTO?

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

- Trial Section 17 leave can be useful for clinical team to assess how the patient manages outside hospital before making decision to discharge.
- A decision to authorise Section 17 leave for more than 7 consecutive days on more than one occasion should be documented, including why discharge is not appropriate.

Guardianship or CTO?

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

4 THE CARE PLANNING PROCESS

4.1 CTO patients are entitled to after-care services under section 117 of the MHA (please refer to the Trust-wide Section 117 Policy for further information. The after-care arrangements should be drawn up as part of the normal care planning arrangements and in line with the Trust-wide CPA policy which can be accessed via this link.

4.2 The team developing the CPA after-care plan should include representatives of the inpatient and community mental health teams and should specify who will take responsibility for supplying elements of the care plan, including arrangements for assessment and review and timescales for provision of services. The aftercare package resulting from the care planning process should be discussed and agreed with the patient and their carers.

4.3 The care plan is required to cover how the various elements of the CTO will work for that patient and how carers will be involved (as per the Empowerment and Involvement principle).

4.4 The patient should have a discharge CPA meeting and be provided with a copy of their care plan before they are discharged from hospital onto the CTO.

5 PATIENT CONSENT

5.1 Patients do not need to give formal consent to a CTO; however patients should be involved in decisions about the treatment to be provided in the community and should be prepared to co-operate with the proposed treatment plan. As discussed in 29.17 of the Code of Practice, without consent a CTO is unlikely to be effective.

5.2 If the CTO is to be successful, it will be important that the patient understands and agrees to the conditions attached to the CTO. In considering whether to agree to a patient being discharged on to a CTO, the AMHP must be agree that the criteria is met and that the CTO is appropriate. The AMHP will consider whether a patient has the capacity to understand any conditions attached to the CTO. Please refer to the Trust-wide Mental Capacity Act Policy for further information.

6 CRITERIA FOR A CTO

6.1 A patient must be detained in hospital under Section 3, 37, 47, 48 or 51 at the time a CTO is made.

6.2 For a patient to be placed on a CTO, the following criteria must be satisfied:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment
- It is necessary for the patient's health or safety or for the protection of other persons that the patient should receive such treatment
- Treatment can be provided without continued detention in hospital subject to being recalled to hospital
- It is necessary that the RC should be able to recall the patient to hospital
- Appropriate medical treatment is available

6.3 The decision as to whether a CTO is the right option for any patient is taken by the RC and requires the agreement of an AMHP. The RC should consider the principles, in particular the least restrictive option and maximising independence principle.

6.4 Out of hours, the on call Consultant can, under delegated authority, act as the Responsible Clinician.

7 CONDITIONS TO BE INCLUDED IN A CTO

7.1 The CTO includes conditions with which the patient is required to comply.

7.2 Mandatory conditions (attached to all CTOs) are that:

- The patient must make themselves available for examination if the RC is considering extending the CTO (Section 20A) and

- The patient makes themselves available for examination if required by a Second Opinion Appointed Doctor (SOAD).

7.3 Any specific condition can be imposed provided that it is necessary or appropriate to ensure that the patient receives medical treatment for mental disorder, prevent a risk of harm to the patient's health or safety as a result of mental disorder and protect other people from a similar risk of harm. Conditions can be set for all of these purposes, but not for any other reason and the AMHPs agreement to the proposed conditions must be obtained before the CTO can be made. The conditions must not deprive the patient of their liberty and should:

- Be kept to a minimum number consistent with achieving their purpose
- restrict the patient's liberty as little as possible while being consistent with their care plan and recovery goal
- have a clear rationale, linked to one or more of the purposes described in paragraph 7.3 above and
- be clearly and precisely expressed, so that the patent can readily understand what is expected

7.4 The nature of the conditions will depend on the patients individual circumstances and should be stated clearly having regard to the least restrictive principle. The reasons for any specific condition should be explained to the patient and others as appropriate (for example, the patient's IMHA, family or carers).

8 THE CTO PLANNING & PROCEDURE PROCESS

8.1 The inpatient RC ***must***:

- Be satisfied that all relevant criteria have been met and must ensure that a Discharge CPA Meeting is held. The purpose of this meeting is to establish an after-care plan for the patient.

- Seek agreement from the RC who will be responsible for the patient in the community that a CTO is appropriate. To evidence that agreement has been sought, both the inpatient RC and the community RC must both write an entry on Rio progress notes to confirm that a conversation has taken place and that it is agreed that a CTO is appropriate for the patient. In the event that an agreement between the inpatient RC and the community RC cannot be reached as to the appropriateness of a CTO for a patient, the inpatient RC should escalate the case to the community Assistant Medical Director.

8.2 Prior to a referral being made to the AMHP Service for a CTO application, the AMHP Service will require the following:

- Discharge CPA Meeting to have been held and documented evidenced clearly in the patient's electronic record on Rio
- Evidence that agreement has been sought from the Responsible Clinician who will be responsible for the patient in the community
- Evidence that a Care Co-ordinator has been allocated
- Address details of where the patient will be residing upon discharge

8.3 The AMHP Service will require at least 3 days' notice to enable an AMHP to attend a meeting to agree to a patient being discharged on to a CTO.

8.4 For a CTO to be made effective, An AMHP on behalf of a Local Social Services Authority (LSSA) ***must***:

- Be in agreement that all criteria are met. If the AMHP does not agree then the CTO cannot be made. In the event that there is a disagreement with the AMHP, the Responsible Clinician should not attempt to seek an alternative view from another AMHP.

8.5 The CTO and the AMHPs agreement to the CTO and any specific conditions attached to the CTO must be put in writing using Form CTO1:

- The Responsible Clinician must complete Parts 1 & 3 of Form CTO1 and the AMHP must complete Part 2 of form CTO1. Once signed by the Responsible Clinician, the CTO automatically takes effect on the date and time specified on part 3 of the form, for a period of up to six months.

8.6 The in-patient Responsible Clinician must forward Form CTO1 to the Mental Health Act Administration Office as soon as possible after completion.

8.7 The chart at Appendix C shows the CTO planning and procedure process.

9 PATIENT INFORMATION

9.1 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, and the services which will be available for the patient in the community.

9.2 There is a duty on hospital managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing. At the point of the CTO application being made, the AMHP involved in making the application will be responsible for explaining to the patient what their Section 132 rights are. The local Mental Health Act Administration office must also write to the patient to inform them of their Section 132 rights upon receiving the completed CTO1. The Mental Health Act Office will also write to the patient's Nearest Relative, unless the patient objects to this.

9.3 Whilst a patient is under a CTO framework, they must be provided with their Section 132 Rights every three months by their Care Co-ordinator in accordance with the Section 132 Rights Policy which can be accessed here.

10 RIGHT TO ACCESS AN INDEPENDENT MENTAL HEALTH ADVOCATE (IMHA)

10.1 In addition to Section 132 rights being read to the patient upon discharge and at regular intervals thereafter in the community, the patient must also be informed of their right to access the independent mental health advocacy service. Information leaflets are available on i-connect or from the MHA Administration Offices.

11 THE ROLE OF THE CARE CO-ORDINATOR & MONITORING CTO PATIENTS

11.1 The care co-ordinator is responsible for co-ordinating the patient's care plan and seeing the patient regularly. The Care Coordinator will work closely with the RC and regularly update them on the progress the patient is making. The care coordinator must ensure they are including and updating other professionals involved with the patient's care and the patient's family or carers, where appropriate. The patient's family and or carers are an important link and all means should be made to encourage open and supportive communication and interventions between all parties.

11.2 The care coordinator is responsible for overseeing and updating the patients care plan with them. The plan should make it clear how often contact will be made and what will be the purpose of the care plan, the interventions and outcomes. The care plan must also have a clear crisis contingency plan that makes it clear if there are any relapse indicators, or changes that show the plan is no longer working. The plan should address how support and monitoring will be offered to reduce further deterioration and risk to reduce the possibility of recall being necessary. If recall is considered then an advanced care plan should be made to reduce any difficulties on readmission.

11.3 The KMPT Long Term Care Framework must be used to ensure that the case management of clients under CTO's are managed with due consideration of risk and are discussed and planned within the MDT and POD meetings in community teams.

12 RESPONDING TO CONCERNS RAISED BY THE PATIENT'S CARER

12.1 Particular and prompt attention should be paid to carers when they raise a concern that the patient is not complying with the conditions or that the patient's mental health appears to be deteriorating. Such concerns may prompt a review of how a CTO is working for the patient and whether criteria for recall to hospital might be met or whether more support in the community should be put in place.

13 RECALL OF PATIENTS TO HOSPITAL

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

13.2 The RC does not have to interview or examine the patient in person before deciding to recall them.

13.3 The RC has overall responsibility for co-ordinating the recall process and wherever possible the RC should give the patient oral reasons for the recall before it happens. The family and carers involved in providing support to the patient should also be informed where appropriate.

13.4 Out of hours, the on call Consultant will take on the responsibility of Responsible Clinician and can issue recall notices where required.

14 GROUNDS FOR RECALL

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

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

14.2 A patient may also be recalled to hospital if they break either of the mandatory conditions; however 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. The Responsible Clinician must consider whether the patient has a valid reason for failing to comply with either of the mandatory conditions before using the recall power.

15 PROCESS FOR RECALL

15.1 The responsible clinician has responsibility for coordinating the recall process and arranging an inpatient bed for the patient, unless it has been agreed that someone else

will do this. The professional who is arranging a bed for a CTO patient subject to recall must communicate clearly to CRHT the risks of the patient remaining in the community and provide estimated timescales for when the patient will be returning to hospital.

15.2 The RC should give the patient written notice of recall using Form CTO3. The hospital to which the patient is being recalled must be specified clearly on Form CTO3.

15.3 The recall notice is only effective once served on the patient and there are three ways of serving Form CTO3 to the patient as shown in the table below:

Method	Time when Notice becomes Effective
By delivering the CTO3 by hand to the patient	Notice deemed served ***straight away***
By delivering CTO3 by hand to the patient's usual or last known address	Notice deemed served at the ***start of the following day***
By sending the recall notice by pre-paid 1st class post to the patient's usual or last known address	Notice deemed served at the ***start of the second business day***

15.4 It is important that, wherever possible, Form CTO3 is handed to the patient personally. It will not usually be appropriate to post a notice of recall to the patient this should only be used as an option if the patient has failed to attend for medical examination (as per the mandatory conditions of the CTO) despite being requested to do so and when the need for the examination is not urgent.

15.5 The patient will be deemed to be Absent Without Leave (AWOL) if they do not attend hospital once the recall notice has become effective as shown in the table above (please refer to the Trust-wide Absence Without Leave Policy for further information

15.6 If the patient's whereabouts are known but access to the patient cannot be obtained because the patient is in a private residence, it may be necessary to consider whether a warrant issued under section 135(2) is needed. Please refer to the Section 135 Policy for further guidance.

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

15.8 The Responsible Clinician should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide appropriate treatment. The patient can be recalled to any hospital and 'Hospital' does not necessarily mean 'in-patient' unit; the patient may be recalled for treatment at a Community Mental Health Centre. When deciding where it is appropriate to recall the patient to (in-patient setting or out-patient setting), it will be important to consider risk and whether or not the patient will be compliant with any medication needed. If the patient is particularly risky or if it is likely that they will not consent to medication; then it is most likely to be more appropriate that the patient is recalled to hospital so that they can be treated appropriately in an in-patient setting.

15.9 In some instances, a patient may be recalled while already attending 'hospital' e.g. if they should attend hospital voluntarily or in compliance with the (compulsory) condition of a CTO but then refuse to accept 'necessary' treatment.

15.10 Once the CTO3 has been served to the patient, the RC must then send a copy of the CT03 to the Mental Health Act Administrators Office where the recall is intended to take place.

15.11 Where the police have detained someone under s136 and upon checking on Rio it is established that they are subject to a CTO, the AMHP and the doctor sould continue their assessment in accordance with the requirements of s136. If they conclude that the person needs to be admitted to hospital at this stage the recall process needs to be commenced.

The Responsible Clinician should issue a CTO3, it takes effect upon being hand delivered to the patient.

16 EFFECT OF RECALL

16.1 The patient may be detained for up to 72 hours commencing from the time the patient is first detained following recall. The start of the detention period is recorded using Form CT04.

16.2 Once a patient has been admitted following recall, the inpatient consultant will become the Responsible Clinician for the patient.

16.3 Upon admission, the Nurse in Charge of the ward should inform the AMHP Service of the patient's arrival.

16.4 As soon as practicable, the patient should be given information verbally and in writing about their rights following their arrival after the recall notice, including their right to access the independent mental health advocacy service. The patient's carer and/or Nearest Relative should also be informed, unless the patient objects to this.

16.5 The patient may be medically treated in the same way that they were under the terms of the original Section (i.e. with or without consent, subject to the Consent to Treatment provisions under Part IV of the MHA - please refer to the Consent to Treatment Policy for further guidance).

16.6 If the use of the recall power is not appropriate or necessary because a patient with capacity agrees to come into hospital on an informal basis or to attend for treatment in a community setting, there is no statutory reason why that should not happen. To avoid confusion or failure to adhere to the intended legal authority, it is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in the clinical records. Admitting staff must follow the Informal Patients' Policy and ensure that the Consent to Informal Admission Agreement is signed by the patient prior to the patient being admitted as an in-patient on an informal basis and uploaded to Rio.

16.7 If an informal community patient wishes to leave the ward and following a risk assessment it is deemed inappropriate for the patient to leave, a decision to formally recall the patient should be made and form CTO3 served to give authority to detain. Form CTO3 can be handed to the patient whist they are an informal in-patient on the ward. The holding powers under section 5(2) or section 5(4) cannot be used as an alternative to recall in this situation Out of hours, the on call Consultant will take on the responsibility of Responsible Clinician and can sign the CTO3.

16.8 Staff may consider using common law to restrict the movement and maintain the safety of a patient who has capacity whilst awaiting the completion of a CTO3. Reasons for doing this must be clearly recorded in the patient's records and this incident must be recorded on Datix. If the patient lacks capacity, the MCA may be used to authorise a restriction of the patient's movement, however this must be a proportionate response to the level of risk posed and such an incident must also be recorded on Datix. Please refer to the MCA policy for more information.

16.9 A recalled patient may be transferred to another hospital if necessary by completing Form CTO6. The responsible hospital remains the hospital to which the patient was recalled. The Nurse in Charge must inform the AMHP Service if a recalled CTO patient is transferred in this way.

16.10 The patient can be transferred to units within the hospital specified on the CTO3 during the recall period.

16.11 Following arrival after the recall notice, the Responsible Clinician and clinical team should consider the circumstances of the recall and in particular, whether a CTO remains the right option for the patient. The Responsible Clinician may allow the patient to leave the hospital at any time before the expiry of the 72 hour recall period, to recommence their CTO, if this is deemed appropriate.

16.12 During the 72 hour period, subject to an AMHP's agreement, the RC may revoke the patient's CTO.

17 REVOKING A CTO OR RETURN TO THE COMMUNITY

17.1 If the patient requires in-patient treatment for longer than 72 hours after arrival at hospital, the RC should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under their original section (for example, a Section 3 or a Section 37) prior to being placed on a CTO and a new period of detention will begin for up to 6 months.

17.2 The RC must contact the AMHP Service to arrange to meet with an AMHP to discuss revoking the CTO.

17.3 A CTO may be revoked if, following their respective assessments:

- The RC considers that the patient again needs to be admitted to hospital for medical treatment under the Act **AND**
- An AMHP agrees that the criteria are met and that revocation is appropriate.

Process for Revoking a CTO

17.4 The CTO can only be revoked with the AMHP's agreement and by completing Form CTO5. In the event of disagreement between the AMHP and the RC, It is not appropriate for a Responsible Clinician to approach another AMHP for an alternative view.

17.5 If the AMHP does not agree that the CTO should be revoked, their decision and the reasons for it must be fully documented on Rio, and the patient must be discharged from hospital by the end of the 72 hours and the CTO continues.

17.6 Where the AMHP agrees, the Responsible Clinician may revoke the CTO by completing Parts 1 & 3 of Form CTO5 and the AMHP completing Part 2 of form CTO5. The revocation takes effect immediately once signed. The completed form must be forwarded to the Mental Health Act Administration office as soon as possible.

17.7 The patient must be informed of their rights following revocation and this must be evidenced by the completion of the s.132 rights form, a copy of which should be placed in the patient's clinical file; the original must be sent to the Mental Health Act Administration office. The patient must also be informed of their right to access the IMHA service, even if the patient declined this during the recall period.

17.8 Upon receipt of Form CTO5, the Mental Health Act Administration office must make a referral to the First-tier Mental Health Review Tribunal and write to the patient's Nearest Relative to inform them of the revocation, provided the patient does not object to this.

17.9 A flowchart showing recall and revocation procedures can be found at Appendix D.

18 EXTENDING THE CTO

18.1 A CTO expires at the end of six months. A CTO can be extended for a further six month period and subsequent annual periods.

18.2 Within the last two months of the detention period, the RC must consider either renewal or discharge. This decision making process must involve a CPA meeting so that the RC may examine the patient. The patient must be given the opportunity to invite an IMHA to his/her CPA meeting. The RC will then take the responsibility to contact the appropriate AMHP Service if the decision is to renew the CTO.

18.3 The criteria for extending a CTO are same as when a person is discharged on a CTO (please refer to Paragraph 7 – criteria for CTO).

18.4 The RC must consult at least one other person who has been professionally involved in the patient's medical treatment. This person must not be the AMHP who is completing the CTO extension report with the RC.

18.5 An AMHP must confirm in writing that the criteria are met and it is appropriate to extend the CTO. This need not be the same AMHP who completed Form CTO1.

18.6 The report (and the AMHP's statement of agreement) must be made using Form CTO7. The Responsible Clinician completes Part 1, the AMHP completes Part 2 of form CTO7 and then the Responsible Clinician completes and signs Part 3.

18.7 The AMHP will then complete a Rio Progress Note and provide a full written report following the CTO renewal assessment.

18.8 The completed Form CTO7 must be sent to the Mental Health Act Administration Office as soon as possible. Upon receipt of the completed Form CTO7, the Mental Health Act Administration Office will write to the patient to inform them of their Section 132 rights. The Mental Health Act Office will also write to the patient's Nearest Relative, unless the patient objects to this.

19 PATIENTS ABSENT WITHOUT LEAVE

19.1 If a patient does not comply with a recall notice or absents themselves during recall they are considered as absent without leave (AWOL) in the same way as if detained under Section 2 or 3.

19.2 CTO patients who are deemed AWOL may be taken into custody under section 18 of the MHA and returned to the hospital to which they have been recalled by an AMHP, a Police Officer, a member of staff (of the hospital to which they have been recalled).

19.3 A CTO patient cannot be taken back into custody after their CTO has ceased to be in force or six months have elapsed since the patient was first absent without leave, whichever is the later date.

19.4 If a CTO patient is absent without leave for **more than 28 days**, they must be re-examined by the Responsible Clinician on their return to establish whether they still meet the criteria for community treatment (Section 21B MHA). If this does not happen, the CTO will expire automatically at the end of the week starting with the day of their arrival back to hospital. The Responsible Clinician must submit their report using CT08, following consultation with both an AMHP and another professional who has been professionally concerned with the patient. A report is not required if the community treatment order is revoked instead. If a CTO8 is completed after the Community Treatment Order would have expired, it automatically extends the patients Community Treatment Order from when it would otherwise have expired in the normal way.

19.5 If a CTO patient returns to hospital **within 28 days** BUT the deadline for their extension report has approached and the extension report has not yet been made, i.e. at any point during the week which ends on the day their CTO is due to expire, the patient's CTO is treated as not expiring until the end of the week starting with the day on which they returned to hospital. The Responsible Clinician therefore has a week to submit an

extension report using Form CTO7. An AMHP is required to also agree that the criteria are met and it is appropriate. The Responsible Clinician must also consult with another professional who has been professionally concerned with the care of the patient.

20 CTO PATIENTS WHO ARE IMPRISONED

20.1 Detention in prison, remanded or otherwise detained in custody by any court in the UK of less than six months' duration will allow a CTO to continue or to be extended in accordance with the provisions set out in section 22 of the MHA.

20.2 CTO patients who are imprisoned or who are in custody are treated as being AWOL. If the patient had already been recalled to hospital when first imprisoned and the patient's CTO would otherwise have expired, or is about to expire whilst the patient is in prison or custody, it will not in fact expire until the end of the week (7 days) starting with the day of the patient's return to hospital.

20.3 If the patient was not subject to recall when first imprisoned, then the CTO will not expire until the end of the week (7 days) starting with the day of the patient's release from custody.

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

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

20.6 Detention in custody for a period of more than six months will automatically bring a CTO to an end.

21 REASSIGNMENT OF RESPONSIBILITY FOR CTO PATIENTS

21.1 Responsibility for a CTO patient may be transferred from the managers of one hospital to another, by reassigning responsibility for the patient in accordance with regulations made under section 19A MHA. This situation may arise for example when a patient who has been detained in hospital outside of Kent is then placed on a CTO and resides in Kent.

21.2 The managers of the responsible hospital may authorise this using form CTO10. They may only do so if the managers of the new hospital agree to the assignment and specify a date on which it is to take place.

21.3 Once responsibility is assigned, the new hospital becomes the responsible hospital. The underlying authority for the patient's detention is treated as if it had always specified the new responsible hospital as the one in which the patient was detained when first discharged onto the CTO.

21.4 A change of responsible hospital does not change the date on which the CTO is due to expire.

21.5 If responsibility for a CTO patient is assigned to KMPT on Form CTO10, the MHA Office will notify the patient of the reassignment of responsibility in writing. Unless the patient has requested otherwise, the MHA Office will also inform the Nearest Relative of this transfer.

21.6 If a CTO patient is being transferred within the same hospital, for example, from one CMHT to another, there is no need to complete Form CTO10. If a patient is being transferred from one CMHT to another CMHT, a discussion should take place between the relevant RCs or Care Co-ordinators and a note should be made on Rio to confirm agreement of the transfer. If there is a disagreement regarding the transfer, this issue should be raised with the Community AMD.

22 DISCHARGE OF CTO PATIENTS

22.1 This section and the sections below apply to CTO patients under Part 2 MHA only (not Part 3 patients), except where otherwise stated.

22.2 Discharge here means discharge from both CTO and the underlying authority for detention whether Part 2 or Part 3 as applicable meaning that the patient can no longer be recalled to hospital or required to stay in hospital.

Discharge by Nearest Relative

22.3 The Nearest Relative (NR) may discharge a patient from their CTO in the same way that they can discharge a patient detained under section 3.

22.4 The NR must give managers of the responsible hospital 72 hours written notice.

22.5 The RC may make a written report barring discharge using form M2 certifying that the patient, if discharged, would be likely to act in a manner dangerous to other persons or his or herself. This is the sole reason for preventing discharge and there is no requirement for the risk of dangerousness to be immediate risk. Paragraph 32.23 of the Code of Practice states:

> 'The dangerousness question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others' general need for protection.'

22.6 The NR cannot discharge from a specific recall to hospital.

Discharge by Responsible Clinician

22.7 The RC may discharge CTO patients (including unrestricted Part 3 MHA) at any time by making a written order under section 23 of the MHA. Please see Appendix E for the RC's Section 23 Discharge Form.

Discharge by Hospital Managers

22.8 Hospital Managers may discharge CTO patients (including unrestricted Part 3 MHA) at any time by making a written order.

22.9 Hospital Managers cannot discharge from a specific recall to hospital.

Discharge by the First-tier Mental Health Review Tribunal

22.10 The First-tier Mental Health Review Tribunal may discharge CTO patients (including Part 3 MHA) at any time by making a written order.

22.11 The First-tier Mental Health Review Tribunal cannot discharge from a specific recall to hospital.

23 CONSENT TO TREATMENT AND CTO PATIENTS

23.1 Please refer to the Trust-wide Consent to Treatment Policy which can be accessed here.

24 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

24.1 All clinical and other professional staff, with responsibilities for persons detained under the MHA 1983 should be familiar with this policy.

24.2 Training will be held on a regular basis in line with Trust guidelines.

25 STAKEHOLDER, CARER AND USER INVOLVEMENT

25.1 Clinicians, Consultants/Medical Staff and Nursing Staff
25.2 CTO Working Group
25.3 Mental Health Act Good Practice Group
25.4 Mental Health Act Managers' Committee
25.5 Mental Health Act Administrators
25.6 AMHP Service

26 RECORD KEEPING

26.1 A service user's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council 2006, the Royal College of Psychiatrists 2009 and Nursing and Midwifery Council 2009 Standards and NHS Record Keeping - NHS Code of Practice for Record Keeping 2006).

26.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money and manage risks (Information Governance Toolkit, Essential Standards). **Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record, RiO.**

26.3 For full details of the specific information needed to ensure compliance with this policy see the Data Entry Guide.

27 EQUALITY IMPACT ASSESSMENT

27.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." In effect to undertake equality impact assessments on all policies/guidelines and practices. This obligation has been increased to include equality and human rights with regard to disability age and gender. See Equality Assessment at Appendix A.

28 HUMAN RIGHTS

28.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that requirements of the Human Rights Act are properly upheld.

29 KEY PERFORMANCE INDICATORS

What should be achieved	How will it be achieved	Who will undertake the work	When will work be complete and/or evidence available	What evidence will be available to demonstrate achievement
Full compliance with	Continuous	MHA Administrators;	Ongoing.	Accurate and timely

the statutory provisions of the 2007 Amendments to the MHA 1983	monitoring of the use of Section 17A.	Group Practice Group.	Quarterly reports to Groups and Trust Board.	completion of paperwork.

30 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non compliance
All paperwork relating to Section 17A.	Quarterly reports to the Trust Board.	MHA Administrators; members of Good Practice Group; Trust Board.	Quarterly reports and ad hoc as required.	Statistical returns and ad hoc as required	Advise relevant Manager. In-house training to raise awareness.
CTO review dates	Renewal Dates appear on Red Board	Red Board Meeting	Daily	Minutes of Red Board Meeting	Locality AMPH will manage the review of those cases in collaboration with RC and MHA admin. Sis arising will be considered MHLOG.

31 EXCEPTIONS

31.1 This Policy applies only to those persons detained under Section 17A of the 2007 Amendments to the Mental Health Act 1983.

APPENDIX A EQUALITY ASSESSMENT

EIA Screening form					
	1	**2**	**3**	**4**	**5**
	Which of the 3 parts does it apply to (if any) 1.Eliminating discrimination? 2.Promoting equal opportunities? 3.Promoting good relations?	Is there evidence or reason to believe that some groups could be differently affected? Which groups are affected?	How much evidence do you have? 0-2 None or little 3-4 Some 5-6 Substantial	Is there a public concern that the function/policy is being carried out in a discriminatory way? 0-2 None or little 3-4 Some 5-6 Substantial	Priority (add columns 3 & 4)
Age	N/A	N/A	N/A	N/A	Low
Disability	2	No	N/A	0	Low
Gender	N/A	N/A	N/A	N/A	Low
Race	N/A	N/A	N/A	N/A	Low
Religion Belief	N/A	N/A	N/A	N/A	Low
Sexual orientation	N/A	N/A	N/A	N/A	Low

Conclusions	
If the policy, procedure or practice affects any group differently, can this be legally justified?	**N/A**
Does the policy/ strategy include opportunities to promote equality?	**Yes –** The policy enables some mentally ill patients to live and work in the community
Is there a need to gather more information than is currently available to assess the impact of the policy, procedure or practice	**No** (If yes, state what information is needed and how this might be collected)
Is it possible to easily modify this policy, procedure or practice to address any issues highlighted above? Please give details of how and when this could implemented	**No:** The policy applies legal principles.

Considering these questions and information presented in the previous sections you must make a decision as to whether a full impact assessment must be completed. A full impact assessment will include further/extensive consultation with the groups/stakeholders that have been identified

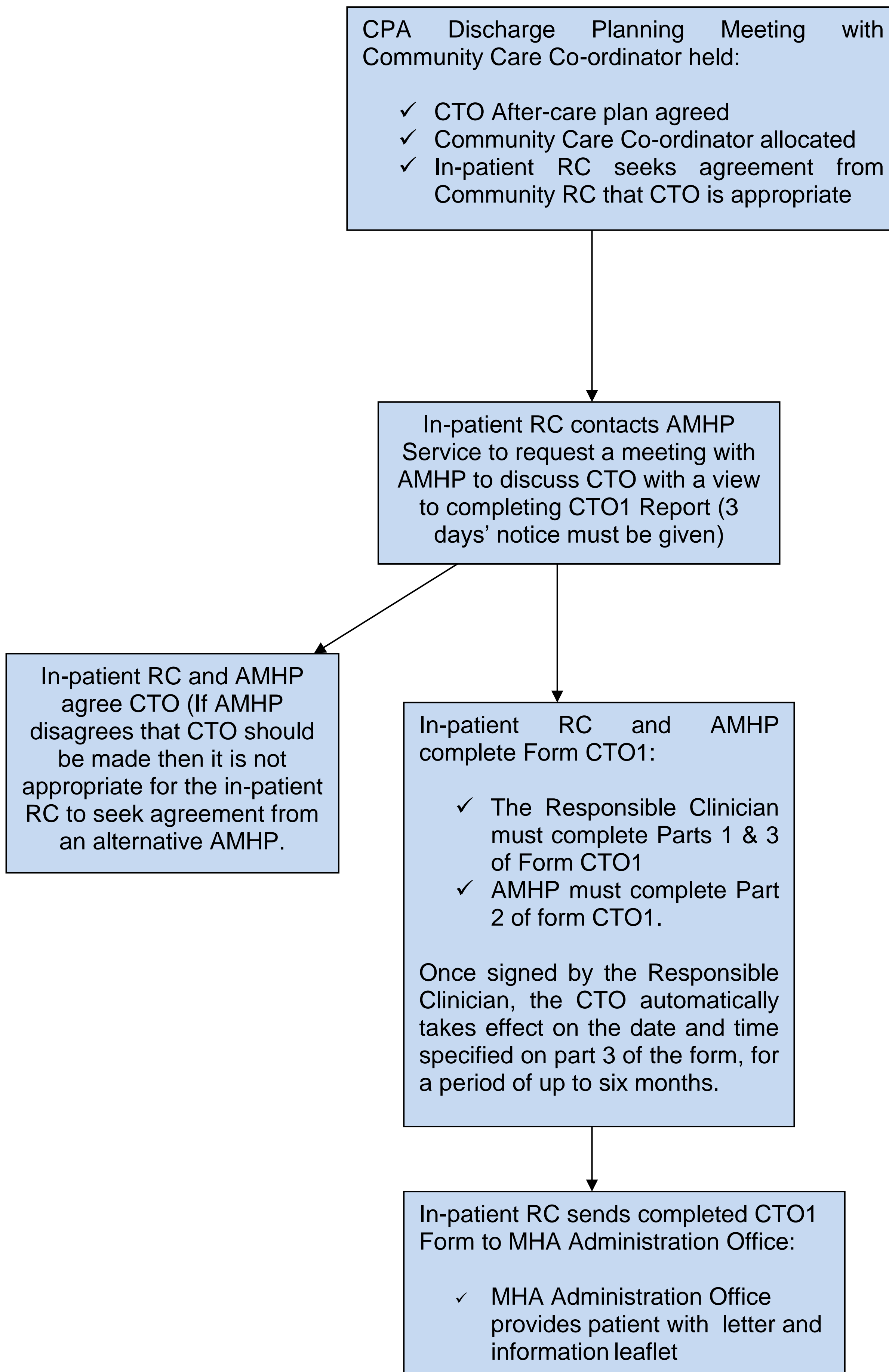
Conclusions

Based on your answers to the questions in this screening, what is the relative priority of this policy, procedure or practice for full assessment?	**1** ☒ Low* **2** ☐ Rewrite within next review date **3** ☐ Withdrawn and re-write * Low priority policies, procedures and practices do not have to undergo full assessment.
If you identified this policy, procedure or practice as a 2 or 3 rating, why was this?	☐ It is a major policy, procedure or practice, in terms of its scale or significance for Trust activities. ☐ High relevance to equality, equal opportunities or good inter-group relations/likely to have a significant impact on people from diverse groups. ☐ Possible/actual negative impact identified. ☐ Insufficient information/evidence to make a Judgement. ☐ Other_______________________________________
Please indicate the date a full assessment is proposed to commence:	

APPENDIX B ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
CAMHS	Child and Adolescent Mental Health Service
CoP	Code of Practice (Mental Health Act 1983:Revised 2007)
CTO	Community Treatment Order
CPA	Care Programme Approach
IMHA	Independent Mental Health Advocate
KMPT	Kent and Medway NHS and Social Care Partnership Trust
LSSA	Local Social Services Authorities
MCA	Mental Capacity Act 2005
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
RC	Responsible Clinician
S	Section
SCT	Supervised Community Treatment
SOAD	Second Opinion Appointed Doctor
Part 2 SCT patient	A patient who was detained on the basis of an application for admission for treatment (section 3) immediately before becoming an SCT patient.
Part 3 SCT patient	A patient who was detained on the basis of an unrestricted hospital order, hospital direction or transfer direction immediately before becoming an SCT patient.
Responsible hospital	The hospital whose managers have responsibilities in relation to the SCT patient in question. Initially, at least, this will be the hospital in which the patient was liable to be detained immediately before becoming an SCT patient.

APPENDIX C THE CTO PLANNING & PROCEDURE PROCESS



APPENDIX D RECALL & REVOCATION PROCEDURES FLOWCHART

The grounds for recall are met:

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

There would be a risk of harm to the health and safety of the patient or to other persons if the patient were not recalled

↓

RC or other delegated professional contacts CRHT to arrange a bed for patient who is to be recalled.

RC should ensure oral reasons for the recall are given before it happens. The family and carers involved in providing support to the patient should also be informed.

RC completes Form CTO3 specifying the hospital to which to patient is to be recalled to. A copy of Form CTO3 is to be sent to local MHA office.

→

Form CTO3 is served to the patient using one of the methods specified in paragraph 15.4 of this policy.

↓

Once CTO3 is 'deemed' served, patient can be treated as AWOL

↓

If the patient refuses to return, is in a private residence and will not allow entry to health care professionals, it may be necessary to obtain a section 135(2) warrant (see paragraph 15.7)

If the patient is not in a private residence, he or she can be returned to hospital by a member of staff under s.18 of the Mental Health Act (although it may still be appropriate to seek the assistance of the police and/or the ambulance service).

The patient must be transported in the lease restrictive manner and may be accompanied by a friend, relative or carer.

↓

As soon as the patient arrives to hospital:

- ✓ Form CTO4 to be completed (to start recording 72 hour recall period)
- ✓ Form CTO4 to be sent to MHA Office
- ✓ Patient Section 132 Rights to be read
- ✓ AMHP Service to be informed that patient has arrived at hospital

→

If the patient requires in-patient treatment for longer than 72 hours after arrival at hospital, the RC should consider revoking the CTO:

- ✓ RC must contact AMHP service to discuss revocation of CTO
- ✓ AMHP must agree to the revocation
- ✓ Form CTO5 must be completed and sent to the MHA Office
- ✓ Patient Section 132 Rights to be read
- ✓ MHA Office must automatically refer patient to Tribunal
- ✓ Patient will be detained on previous section prior to CTO and a new period of detention of 6 months will begin

↓

At any time during the 72 hour recall period, the patient can be released back into the community on his/her CTO if in-patient treatment is no longer required. The CTO will continue as before.

APPENDIX E RESPONSIBLE CLINICIAN SECTION 23 DISCHARGE FORM

Kent & Medway NHS & Social Care Partnership Trust

Mental Health Act 1983
Discharge of Community Treatment Order
(Section 17A)

To be completed by the Responsible Clinician

Full name & Address of Responsible Clinician ……………………………………………………

……………………………………………………….

……………………………………………………….

Confirm that I am the Responsible Clinician of:

Full name & Address Of patient ………………………………………………………..

………………………………………………………..

………………………………………………………..

Hereby direct that the above named patient shall cease to be subject to after-care under Section 17A Community Treatment Order as from date below.

The following people have been consulted about the discharge of this order, and I have taken account of the views they expressed.

Name & Address Designation of those consulted …………………………………………………………

…………………………………………………………..

…………………………………………………………..

…………………………………………………………..

…………………………………………………………..

…………………………………………………………..

……………………………………………………………

……………………………………………………………

Signed ……………………………………………… **Date** ………………………………
(Responsible Clinician)

APPENDIX F EASY READ IMHA LEAFLET

Easy Read-IMHA.pdf

APPENDIX G EASY READ CTO LEAFLET

Easy Read -
Community-Treatmen

APPENDIX G EASY READ NEAREST REALTIVE LEAFLET (FOR PATIENTS)

Easy Read - NR.pdf