COMMUNITY TREATMENT ORDER PROTOCOL

Document Reference	Prot509
Version Number	3.3
Author/Lead **Job Title**	Sara Johns, Mental Health Legislation Manager Michelle Nolan, Mental Health Act Clinical Manager John Heffernan, AMHP Team Manager (ERYC) John Thirkettle, Mental Health Operations Manager (Police) Jake Balla, Specialist Development Nurse, Mental Health, Quality and Patient Safety (YAS) Kirsten Bingham, AMHP Lead (Hull CC)
Director's Name on behalf of Humber Teaching NHS Foundation Trust	Dr Kwame Fofie Medical Director
Date Last Reviewed (this version)	17 April 2024
Date of Next Review	April 2027
Protocol Agreed by **Date Agreed**	Crisis Care Concordat – 08.04.24 AMHP Forum - 25.04.24 Mental Health Legislation Steering Group – 17 April 2024
Name of Ratifying Committee **Date Ratified**	Mental Health Legislation Steering Group 17 April 2024

VALIDITY – Policies should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.00	*July 2014*	*New Protocol. The compulsory powers contained within the Mental Health Act 1983 (the Act) make it possible in appropriate circumstances for some patients to continue to receive their care and treatment in the community. This protocol sets out the new legal framework for this approach.* *At present we do not have a protocol in relation to this and staff need a source of referral in relation to the process.*
2	*December 2016*	*To take into account changes as a result of the Mental Health Act Code of Practice 2015*
2.1	*February 2017*	*Minor amendments following observations from MHLC on 09/02/17 and CRMG on 09/02/17 with regards to recall*
2.2	*November 2017*	*Additional sentence added to 5.14 regarding the importance of reviewing at MDTs. Also replaced RRS with MHRS and changed Medical Director's name.*
2.3	*January 2018*	*Appendix 5 – (Additional Guidance for CTO recalls) added by Adrian Elsworth (Assistant Director) following action from an SI investigation*
3	*March 2021*	*Full review*
3.1	*May 2021*	*Added the need for 3 month follow up appointment with consultant after CTO discharge as per action form SI (Page 14)*
3.2	*July 2022*	*Minor amendments. Added process for notifying Bed Management Team of need to recall patient (page 10). Amendments to duties and responsibilities (page 6 & 7). Clarification of AMHP responsibilities (page 13 & 14). Approved at Mental Health Legislation Steering Group (20/07/22)*

3.3	*April 2024*	*Reviewed. Section 3.2 (page 5) clarified the sections where patients can be considered for a CTO.* *Page 8 – clarity that transfer of RC form should be completed electronically on EPR.* *Section 5.10 (page 12) and bottom of page 24 amended to ensure consideration for secure transport if police assistance isn't made available.* *Clarified that the telephone number for YAS to request an ambulance to transport people detained under the MHA has NOT changed (as have other YAS numbers) and remains* ***0300 3300 295.*** *Approved at Mental Health Legislation Steering Group (17 April 2024).*

Contents

1. INTRODUCTION

The compulsory powers contained within the Mental Health Act 1983 (The Act) make it possible in appropriate circumstances for some patients to continue to receive their care and treatment in the community. This protocol sets out the legal framework for this approach.

The name of the section that details these requirements and powers is a ***Community Treatment Order (CTO)*** – Section 17A Mental Health Act 1983.

Treatment of physical disorders are not covered under a Community Treatment Order; they are covered by the Mental Capacity Act 2005.

Documentation of any discussion, assessments and decisions in relation to the process must be clearly evident.

1.1. Guiding Principles

The following principles should be considered when making decisions about any course of action under the Mental Health Act 1983 as outlined in the Code of Practice: Mental Health Act revised 2015 (COP 1.1):

Least Restrictive option and maximising independence

- Where it is possible to treat a patient safely and lawfully without detaining them under the Act the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement

- Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professions should explain the reasons for this.

Respect and dignity

- Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness

- Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity

- Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2. SCOPE

This protocol should be read in conjunction with relevant chapters of the Code of Practice 2015 which offers guidance on the operation of the Act. Chapter 29 focuses on CTO. The five guiding

principles set out in Chapter 1 of the Code should be considered when making decisions about any course of action under the Act.

This Trust-wide procedure sets out procedural requirements, where these are explicit in the Act or Code, but guidelines may be produced locally which, while complying with this protocol, provide advice on more specific matters. Where appropriate, reference should be made to other Trust policies (e.g. ECT).

The purpose of this protocol is to ensure that there is lawful and appropriate use of CTO and that the legal rights of any patient subject to a CTO are upheld at all stages. There is no lower age limit for CTO.

3. PROTOCOL STATEMENT

3.1. Purpose of a Community Treatment Order (CTO)

A CTO is designed to prevent unnecessary repeated re-admission to hospital. *"The purpose of 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"* (Code of Practice, 29.5).

CTO provides a framework for the management of patient care in the community and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if necessary.

3.2. Who should be considered for a Community Treatment Order?

CTOs may be made only in respect of patients who are liable to be detained in hospital for treatment on the basis of one of the orders and directions set out in the table below. CTOs may not be made in respect of patients detained in hospital on the basis of an application for admission for assessment under section 2 or 4, nor restricted patients (MHA Reference Guide 26.9).

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

As above, only patients who are detained in hospital for treatment under Section 3 of the Act, or are unrestricted Part 3 patients and meet all the following criteria, can be considered for CTO:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
- Treatment can be provided without the patient having to remain in hospital;
- It is necessary that the RC should be able to recall the patient to hospital should they be non-compliant and there is a risk of deterioration;
- Where Section 17 Leave is likely to exceed seven days.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive in partnership with the Local Social Services Authorities (LSSA), Humberside Police and YAS has responsibility to ensure that policies, protocols and processes of a multi-agency perspective are in place for the Trust staff to understand regarding the implementation of Community Treatment Orders.

Executive Director of Nursing, Allied Health and Social Care Professionals
Caldicott Guardian and Chief Operating Officer
Executive Director of Nursing, Allied Health and Social Care Professionals
Caldicott Guardian and Chief Operating Officer have responsibility for ensuring the appropriate training and education to support implementation.
Medical Director,

It is the responsibility of the Medical Director to oversee the working of this protocol in cooperation with the clinical teams and Responsible Clinicians. They hold the responsibility to monitor the compliance to the policy through the Mental Health Legislation Committee.

Responsible Clinicians (RC)

The RC will determine with the Approved Mental Health Professional whether a patient meets the criteria for CTO and that it is a suitable treatment option for them. The RC is also responsible for:

- Setting the conditions of the CTO
- Varying the conditions
- Suspending the conditions
- Recalling a patient to hospital
- Authorising treatment.

The Consultant Psychiatrist who is covering for an absent RC will de facto become that patient's RC for the duration of their absence, during the day, and the duty Consultant, out of hours, with all the responsibility that that entails.

Approved Mental Health Professionals (AMHPs)

The AMHP must decide whether to agree with the patient's RC that the patient meets the criteria for CTO, and, if so, whether CTO is appropriate. Even if the criteria for CTO are met, it does not mean that the patient must be discharged onto CTO. In making that decision, the AMHP will consider the wider social context for the patient. Relevant factors may include any support networks the patient might have, the potential impact on the rest of the patient's family, and employment issues.
The AMHP will consider how the patient's social and cultural background may influence the family environment in which they will be living and the support structures potentially available, but no assumptions are to be made simply on the basis of the patient's ethnicity, or social or cultural background.

The Act does not specify who this AMHP will be. It may be an AMHP who is already involved in the patient's care and treatment as part of the multi- disciplinary team or it can be an AMHP acting on behalf of any willing Local Authority (LA). The LAs should agree with each other and with the Trust what arrangements are likely to be the most convenient and appropriate for the patient. However; if no other LA is willing, then the responsibility for ensuring that an AMHP considers the case will lie with the LA which would become responsible under section 117 for the patient's after-care if the patient were discharged. If the AMHP does not agree with the RC that the patient is to go onto CTO, then CTO cannot go ahead. A record of the AMHP's

decision and the full reasons for it must be kept in the patient's notes. It would not be appropriate for the RC to approach another AMHP for an alternative view.

Divisional Clinical Leads, Modern Matrons, Team Leaders, and Charge Nurses

Divisional Clinical Leads, Modern Matrons, Team Leaders, and Charge Nurses are responsible for implementing operational systems within their respective areas to ensure adherence to the principles and standards of the protocol.

5. PROCEDURES

5.1. Assessment for CTO

- A patient's suitability for CTO is initially assessed by the multi-disciplinary team within the inpatient unit.

  Any decision should be documented with a rationale regarding the suitability/non suitability for a CTO. If it is decided that a CTO is the most appropriate course of action a pre discharge meeting/S117 meeting must be arranged and must include:
  - Locality Approved Mental Health Professional (AMHP), (CTO's should be referred to the relevant LA AMHP Service and an AMHP will be allocated);
  - Community Consultant;
  - Community Care Coordinator.

  This is to ensure there is discussion regarding any conditions that are placed on the CTO. If unable to attend content of discussion and agreement should be documented in the patient record.

  Both the RC (inpatient) and the Approved Mental Health Professional (AMHP) have to agree that a CTO can be implemented in order for CTO application to be made. They must also agree on the content of all the specified conditions included in the order (COP 29.25).

  The AMHP should meet with the patient before deciding whether to agree that the CTO should be made (COP 29.22). The AMHP needs time to meet the patient, review their progress and speak to significant people (friends / family), which requires time.

- If the AMHP does not agree with the rationale for this decision it must be recorded in the patient's notes (COP 29.25).
- Where this occurs the RC should not approach another AHMP for their opinion (COP 29.25).
- CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it.
- Every effort must be made to ensure the patient/carer understands the purpose of the CTO. Prompt attention should be paid to carers when they raise a concern that the patient is not complying with the conditions or the patient's mental health is deteriorating. This may prompt a review of the patient's care (COP 29.44).
- In assessing the patient's suitability for CTO, the RC must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others and that appropriate treatment is, or would be, available for the patient in the community. Under the Act, medical treatment covers nursing, psychological intervention, specialist mental health habilitation, rehabilitation and care (Section 145).
- In making their decision the RC must assess what risk there would be of the patient's condition deteriorating after discharge, for example as a result of refusing or neglecting to receive treatment.
- The RC must be satisfied that the risk of harm to self and others arising from the patient's disorder is sufficiently serious to justify the power to recall the patient for treatment should they deteriorate.
- Patients do not have to consent formally to CTO. However, patients will need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

- A Mental Health Tribunal may recommend that an RC should consider whether a patient should go on CTO. In this event the RC should carry out an assessment of the patient's suitability in the normal way.
- If the RC and AMHP agree that the patient should be discharged onto a CTO, they should complete the relevant statutory form (CTO1) and send it to the hospital managers via the Mental Health Act administrator (this can be submitted electronically (see Electronic MHA Forms SOP). The RC must specify on the form the date that the Community Treatment Order (CTO) comes into force or is implemented.
- There should be discussion between the Inpatient and Community RC prior to the making of the CTO to ensure a smooth transition for the patient.
- At the point of the patient going onto the CTO the RC should decide whether the patient has the capacity to consent to the treatment; this must be recorded on the capacity to consent to treatment form (Z48) in CDC format in clinical charts. If the patient has capacity to consent to treatment and has done so then the RC named on the CTO1 should complete form CTO12 (Certificate that the patient has the capacity to consent to treatment). The Community RC should arrange to see the patient within a month after discharge from inpatient Unit, or sooner, and assess them again for capacity to consent to the treatment; this must be recorded on the capacity to consent to treatment form (Z48) in CDC format in clinical charts. If the patient still has capacity a fresh CTO12 should be completed.
- If the patient lacks capacity, or refuses consent, a SOAD request should be made by the inpatient RC on discharge (or within 24 hours of discharge – this is a Trust standard). This is to avoid a delay in a SOAD visiting the patient.
- Any form of certification for treatment must be done within one month of discharge (unless patient is still within 3 months of first being treated). If there is a delay the community responsible clinician can complete an emergency treatment form using Section 64G.

Once the SOAD has reached a view about the patient (they do not have to see the patient) they may complete a form CTO11. Both forms CTO11 and CTO12 should be shared with the patients General Practitioner (GP). A copy of these will be sent to the GP by the mental health legislation department.

A Transfer of RC form (Z11) should also be completed on the Electronic Patient Record by the inpatient RC and the receiving community RC.

5.2. Conditions to be attached to the Community Treatment Order

The following two conditions are mandatory:

- Patients must make themselves available for examination when needed for consideration of an extension to the CTO.
- Patients must make themselves available to allow a Second Opinion Appointed Doctor (SOAD) to provide a Part 4A certificate authorising treatment.

Responsible clinicians may also, with the AMHP's agreement, set other conditions which they think are 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;
- protect other people.

Conditions should restrict the patient as little as possible and be clearly documented so that the patient can readily understand what is expected.

Following the Supreme Court Judgment of ***Welsh Ministers v PJ [2018] UKSC 66*** the Court declared that there is no power to impose conditions in a Community Treatment Order which have the effect of objectively depriving a patient of his or her liberty.
For the full judgment (17 December 2018), see following link:
https://www.supremecourt.uk/cases/docs/uksc-2018-0037-judgment.pdf

5.3. Varying and Suspended Conditions

The RC has the power to vary conditions of the patient's CTO or suspend any part of them. This does not need the agreement of an AMHP. However good practice dictates the RC should have discussed any changes to a recently agreed CTO with the AMHP and Care Programme Approach (CPA) care coordinator. This is done using form CTO2.

5.4. Care Planning and CTO

A care plan **must** be prepared and include details of who is responsible for the care and treatment of a patient subject to a CTO. This should be done before discharge.

The care plan must include:

- A statement of the patient's needs for future treatment in the community and any conditions.
- In cases of dual diagnosis or physical health problems, disability or sensory impairment, plans for the treatment of the patient's other conditions should be co-ordinated to provide integrated care wherever possible.
- Details of crisis support.
- Details of day care services, training and equipment, where appropriate.
- Personal support, counselling and advocacy.
- Carer and family support.
- Particular cultural requirements, such as linguistic or religious factors that may affect a patient's needs.
- Risk and relapse plan.
- Current risk assessment.

The following parties should be informed, subject to the usual considerations of patient confidentiality:

- The Nearest Relative – who should be informed of their rights by the inpatient team.
- Any carers/family/relevant others.
- An Attorney (authorised by Lasting Power of Attorney – Personal Welfare) or Court Appointed Deputy under the Mental Capacity Act 2005.
- Members of the multi-disciplinary team involved in the patient's care.
- The patient's GP. Where there is none, engagement and help should be given to enable the patient to register with a GP practice.

5.5. Provision of information

The RC should inform the patient and others who were consulted, of the decision to discharge a patient onto CTO, including any conditions applied to the CTO and services available for the patient. This will include **making a copy of the CTO documentation available to the patient** and any professionals who were consulted as part of the process.

A copy of the CTO paperwork should also be sent to the patient's GP. This is done by mental health legislation department.

The hospital managers will ensure that the patient is provided with information verbally by the care co-ordinator or other appropriate person. This will be recorded on a rights form (Z05). The Care Coordinator is also responsible for completing the Section Rights Care Plan in CDC format in the MHA & Legal tab in clinical charts. An information leaflet will be provided to the patient by the Mental Health Act Administrator and to the Nearest Relative, unless the patient objects.

The Domestic Violence Crime and Victims Act (2004) place a number of duties on Hospital Managers in relation to certain unrestricted Part 3 patients (see COP 37.34).

Information in writing given to the patient must be provided in a language and format that the patient can understand taking into account any cultural, ethnic or disability issues (and if it is appropriate this can be copied to the nearest relative).

This information will include reference to their rights and the following matters:

- Appeals to the Mental Health Review Tribunal (MHRT).
- Recall, revocation or discharge by RC.
- Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours' notice requirement), MHRT or hospital Managers.
- Independent Mental Health Advocacy Services.

5.6. Monitoring CTO Patients

- It is Important to maintain close contact with patients on a CTO to enable monitoring of their mental health. The type and scope of these arrangements will depend on the patient's individual needs and circumstances including cultural, disability, ethnic or gender needs.
- Respective responsibilities should be set out in the patient's care plan. The CPA Care Co-ordinator will be responsible for co-ordinating the care plan in consultation with the RC.
- Appropriate action will need to be taken if the patient becomes unwell. If the patient refuses crucial treatment an urgent review of the situation will be needed. Recalling the patient to hospital will be an option if risk justifies this or there is no safe alternative that is acceptable to the patient and RC.
- If the patient is not compliant with any condition of the CTO, the reasons for this need to be properly investigated. A recall to hospital may be needed if it is no longer safe and appropriate for the patient to remain in the Community.

5.7. Procedure for recall to hospital (Please see Appendix 5 for additional Guidance)

- An RC need not examine the patient before issuing a notice of recall (CTO3). They can act on reports received which provide an account of the patient's current behaviour and situation.
- Failure to meet a condition should not necessarily result in an automatic recall. Equally even if the patient is fully compliant with any of the conditions, recall can still be made if the patient's health deteriorates significantly to an extent necessitating hospital treatment.
- The local agreement is that the care coordinator will coordinate the process although the RC has overall responsibility for the recall process.
- To start this process off, the community team responsible should send an email to the bed management email address stating that they wish to recall the patient. This information should include the patient's name, NHS number, Responsible Clinician and brief details of the reason for recall, including whether the reason for recall is due to a breach of one of the two mandatory conditions (see 5.2). The Bed Management Team will then follow this up with an email acknowledging this and/or ringing back for further discussion.
- Once a hospital has been identified the RC must complete a CTO3. A hospital must be identified at the time the CTO3 is completed. Where possible a copy of the CTO3 should be handed to the patient or in exceptional circumstances posted by first class post (See Code of Practice paragraph 29.55). The patient has to be recalled to the hospital which is named on the CTO3 and it would be unlawful to take them to a different hospital.
- However, the patient would not have to be recalled as an inpatient so in theory, and depending on the circumstances, they could be recalled to the hospital on the CTO3, assessed and released if appropriate. If the patient was to be transferred under the original CTO3 the hospital managers would have to accept the patient before transfer was carried out. If this was done and the correct procedures followed the original CTO3 would still be valid and detention would be lawful at the second hospital.
- Please note that if a situation were to arise whereby the original hospital named on the CTO3 would not accept the patient, even for assessment, then a fresh CTO3 would need to be completed naming the hospital that is to assess and/or treat them. If this was not done then their conveyance to and detention at the alternative hospital would not be lawful.

- Please note that the CTO3 cannot be served electronically; the recall form must continue to be served in hard copy. Electronic communication can, however, be used as an additional means of providing the patient with the information, if that is their preference.
- The notice of recall (CTO3) that is handed to the patient is effective immediately. If the patient is unavailable or simply refuses to accept it, the CTO3 should be delivered by hand to the patient's usual or last known address. The notice of recall is then deemed to be served the day after it is delivered – that is the day (which does not have to be a working day) beginning immediately after midnight following delivery.
- If the patient's whereabouts are known but access to the patient cannot be obtained, consideration should be given to obtaining a warrant issued under Section 135(2) (see Section 135 protocol).
- Prior to obtaining a Section 135(2) Warrant, a decision must be made and agreed between the RC, Care Co-ordinator as to who should apply for the Warrant and execute it (see protocol 508 Section 135 for the process to follow).
- If the hospital is under the management of the same organisation as the patient's detaining hospital immediately before making the CTO, a copy of the completed form CTO3 will provide authority for detention. The receiving unit must complete form CTO4 recording the date and time of the patient's arrival.
- Transfer after recall, to a hospital managed by another organisation requires that arrangements for the transfer are properly in place and that form CTO6 is completed to provide authority to transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to – see Appendix 1 (flow chart). CTO6 is not needed for transfers within Humber Teaching NHS Foundation Trust.
- As soon as practicable, the patient shall be given information, verbally and in writing about their rights following recall and the impact, if any upon their treatment rights which are set out in a separate section below. The provision of CTO rights must be recorded in the same manner used for other detained patients. This information must be translated/provided in a format and language that the patient can understand. Nursing staff should also complete the Section Rights Care Plan in CDC format in the MHA & Legal tab in clinical charts to ensure regular repeating of rights as necessary.

5.8. Patient agreeing to come back into hospital

If recall is not appropriate or necessary because a patient with capacity agrees to come into hospital on an informal basis or to attend for treatment in a community setting, there is no statutory reason why that should not happen. Recall is permissible in relation to an existing inpatient. It is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in their health and social care records.

In the event a patient agrees to come into hospital on an informal basis and then deteriorates once admitted recall should be considered. The use of Section 5 (holding powers) is not allowed in these occasions.

5.9. Emergency Recall Procedure

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

- The RC has legal responsibility for co-ordinating the recall process but this is facilitated by the CPA Care Co-coordinator or the Mental Health Response Service (MHRS). Assistance may be requested from the police in terms of accessing a warrant/transport. Out of hours, this defaults to the on-call Approved Clinician (AC).
- All on-call ACs should ensure when carrying out on-call duties that they have in their possession, or ready access to, the form CT03 – Notice of Recall to Hospital
- The team/clinician requesting the recall must liaise with the on-call AC stating both the rationale for recall and associated risks and, where practicable, make available the current care plan and a copy of the CTO1 – Community Treatment Order. Copies of all CTO1's will be scanned into the Trust IT system by the mental health legislation department.

5.10. Conveying patient back to hospital

- The decision how to convey a patient back to hospital is made by the RC in consultation with the care coordinator/team/MHRS following an appropriate risk assessment. If the care coordinator cannot facilitate a safe transfer to the recalled unit an ambulance must be contacted to support transfer. It would be dependent on the nature of the risks involved as to whether an ambulance was able to mitigate those risks.
- If risks to staff are high, it is advisable for staff to go in pairs or seek assistance from the police. If police assistance required staff must reiterate to them that they have authority to assist and convey patient into hospital as the patient is now subject to Section 18 (AWOL) once recall notice is served.
    - The police will only support transfer when there is significant risk. Contact the police via normal route and clearly explain the associated risks and reason for the request. The police **do not** have to attend; the only reason will be if there is significant risk to the service user or others.
- CTO care co must make attempts first to convey the patient to the unit before contacting the police.
- The patient should be conveyed in the least restrictive manner, which may require assistance from the ambulance service or there might need to be some consideration for secure transport – if appropriate the patient may be accompanied by a relative, carer, etc. A CTO patient who has been recalled can be conveyed by any officer on the staff of the hospital to which the patient is recalled, any police officer, any AMHP or any other person authorised in writing by the RC or managers of the hospital. (COP 17.35)
- Guidance in chapter 17 of the COP regarding conveyance of patients to hospital applies except that an AMHP will not necessarily be involved in the conveyance.
- The RC should ensure that the hospital is ready to receive the patient and provide treatment. The hospital need not be the hospital that the patient was detained in prior to going out on CTO or under the same management (see Code of Practice chapter 29).

5.11. On arrival at hospital – first 72 hours

- Inpatient clinical Team to assess patient's condition.
- CTO4 to be completed by admitting nurse.
- Mental Health Legislation Department to be contacted.
- Provide treatment and determine next steps.
- At this point the patient may be well enough to return to the community once treatment has been given or require a longer period of assessment/treatment in hospital.
- The patient may be detained in hospital for a maximum of 72 hours after recall to allow the RC to determine what should happen next. During this period the patient remains on CTO even if they remain in hospital for one or more nights.
- The RC may allow the patient to leave the hospital at any time during the 72 hour period. Once 72 hours from the time of admission has elapsed, the patient must be allowed to leave if the RC has not revoked the CTO. On leaving the hospital, the patient remains on a Community Treatment Order as before.
- An outcome of recall to be completed by nursing/medical staff – form Z29.

5.12. Hospital Manager's Responsibilities

- It is the responsibility of the Hospital Managers to ensure that no patient is detained longer than 72 hours without the CTO being revoked. Mental Health Act Administrators are required to monitor the length of detention under recall in order to ensure that the 72 hours period is not exceeded.
- The Mental Health Act Administrators will ensure that arrangements are in place to cover any necessary transfers of responsibility between locality RCs and hospital RCs.
- If a patient's CTO is revoked and they are detained in a hospital other than the one which was the responsible hospital at the time of recall – the Hospital Managers of the new hospital must send a copy of the revocation form to the area Mental Health Act Administrator.

5.13. Revoking the CTO

- If the patient requires inpatient treatment for longer than 72 hours, the RC should consider revoking the CTO.
- The responsible clinician and an AMHP should reassess the patient before revoking their CTO (29.63)
- In order for the CTO to be revoked the following criteria must apply:
    - The RC considers that the patient needs to be admitted to hospital for treatment under the Act.
    - The AMHP agrees with that assessment and the revoking of the CTO.
    - If the AMHP does not agree that the CTO should be revoked then the patient cannot be detained in hospital after the maximum period of 72 hours.
- Once agreed that a CTO should be revoked, the RC and AMHP must complete the relevant statutory forms (CTO 5) and forward them to the Mental Health Legislation Department. The patient is then detained under the Act exactly as before going onto the CTO, except that a new detention period begins for the purpose of review and applications to the Tribunal.
- Mental Health Act Administrators have a duty to refer patients whose CTO's have been revoked to the Mental Health Act Tribunal.
- A transfer of RC form to be completed (Z11) as responsibility will transfer over to the inpatient RC. This will not apply to on call consultants.
- The decision to revoke should be made by the inpatient RC in consultation with the community RC.

5.14. Review of CTO

- It is a statutory requirement under the Act for a CTO to be reviewed. It is good practice to do this as part of the CPA care review process.
- Reviews of CTO's should cover whether the CTO is meeting the treatment needs and as to whether the patient continues to satisfy the criteria for a CTO. Where they do not, they must be discharged without delay.
- There is an expectation that all patients subject to Community Treatment Orders will be regularly reviewed at MDT meetings, which includes discussions around timescales for planned medical reviews, and actions to be considered following medication changes and when family voice concerns/distress.

5.15. Extending the Community Treatment Order

- A CTO can be extended following examination (in person) of the patient by the RC - for the purpose of determining the need for extension of the CTO - within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met. These conditions mirror the criteria and mandatory conditions described in paragraphs 5 and 6.2 above with the additional requirement that the RC must also consult one or more persons who have been professionally concerned with the patient's medical treatment.
- Reminders for extensions will be sent out six weeks prior to expiry from the mental health legislation department.
- The RC completes and signs Parts 1 and 3, the AMHP completes Part 2 of form CTO7 addressing the report to the relevant Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital's internal mail system. It is then received by a Mental Health Act Administrator (or other authorised person) who completes Part 4.
- Before responsible clinicians can submit that report they must obtain the written agreement of an approved mental health professional (AMHP). Responsible clinicians should ensure that the AMHP is given enough notice to be able to interview the patient **if appropriate** (MHA COP 32.15), however there is no legal requirement for the AMHP to see the patient.
- The AMHP must agree that the conditions for extending the CTO are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1. It may (but need not) be an AMHP who is already involved in the patient's care and treatment (MHA COP 32.16).

- The RC must also consult a second professional who is someone who has been professionally concerned with the patient but who is a different discipline to the RC. They cannot be the AMHP who is also completing the CTO7.
- Once received, the Managers must undertake a review of the report provided on form CTO7. Where practicable, this should be done before the new period of extension takes effect but the completed form CTO7 provides lawful authority for the patient's continued CTO. If not heard before the current period expires this must be recorded on Datix by the mental health legislation department. Such reports will be dealt with in the same way as reports made to renew detention under the Act although it may be appropriate to arrange the Managers' review at a more convenient location than the hospital in which the patient was originally detained.
- Recall powers can be used if patient unwilling to attend for an outpatient review to look at extension.
- Extension periods for CTO mirror the renewal scheme for Section 3 patients: the initial CTO lasts for up to six months, if extended lasts for a further six months and thereafter, up to one year on each extension. The new period of CTO is calculated from the day after the date on which the current order would have otherwise come to an end if it had lapsed.

5.16. Discharge from CTO

- CTO patients can be discharged by the Tribunal, hospital Managers, and/or nearest relative. The RC can also discharge a CTO at any time. A Community Treatment Order should not be simply allowed to lapse. If discharge is by the RC or hospital managers a Section 23 form must be completed. The original form to be sent through to mental health legislation with a copy being kept in the patient's case notes.
- The reasons for discharge should be explained to the patient.
- Once discharged the patient remains subject to after care services under Section 117.
- The patient must be discharged if any of the four essential criteria no longer apply.
- For any patient discharged from a CTO an appointment with the Consultant must be arranged to occur **within the 3 month period** following the discharge; this was identified as good practice as part of a recent Serious Investigation.
- A nearest relative's request for discharge must be made in writing with 72 hours' notice.
- The patient's General Practitioner (GP) must be advised of any discharge.

5.17. Decision to use CTO or section 17 Leave

- Section 17 (relating to leave of absence from hospital) of the Act is amended so that when considering granting longer term leave, an RC must consider whether CTO is the more appropriate way of managing the patient in the community. This applies to S17 leave for more than seven consecutive days (or where leave is extended so the total leave granted exceeds seven consecutive days).
- These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for CTO. An RC may still legitimately authorise longer-term leave where it is the more suitable option but must prove that he/she has considered whether CTO is more appropriate.
- The RC must record in the patient's health and social care records that he/she has considered whether longer-term leave or CTO is appropriate with reasons when authorising or reviewing such leave. This question should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, S17 leave forms will carry a tick box statement to the effect that CTO has been considered where appropriate.
- The Code sets out a table of pointers for CTO or longer-term leave of absence which may be of assistance to RCs and is replicated overleaf. A further table contrasting CTO and guardianship can also be found in the Code at Para. 31.7.

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

5.18. Advance Decisions/Advance Statements (MCA 2005 s24)

- Even where clinicians may lawfully treat a patient under the Mental Health Act 1983 they should seek where practicable to comply with the patient's wishes where expressed as an Advanced Decision (COP 17.8). The patient must be recalled/revoked. It does not apply to ECT.
- Patients cannot be given treatment in the community which goes against any Advance Decision.

Definitions

- **Advance decision**: A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.
- **Advance statement**: A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Please refer to Trust Guidance on Advance Decisions/Advance Statements.

5.19. Community Treatment Orders – Children and Young People

- There is no lower age limit for CTO (COP 19.113).
- Parents or those with parental responsibility may not consent on a child's behalf to treatment for a mental disorder or refuse it while the child is on a CTO. However, the clinician giving the treatment should consult with the parents or those with parental responsibility about the particular treatment (subject to normal considerations of patient confidentiality) (COP 19.114).
- If a parent (or person with parental responsibility) is unhappy with a particular treatment and the child/young person is deemed not competent to consent (or young person lacks capacity to consent), a review should take place to consider whether treatment/care plan/CTO are still appropriate.
- Robust arrangements for any subsequent transition to Adult Services should be undertaken.

5.20. Consent to treatment guidelines

- The rules on treating community treatment order patients for mental disorder (unless recalled to hospital) are set out in Part 4A of the 1983 Act. They differ depending on whether the patient has the capacity, or (in the case of a child under 16), the competence, to consent to

the treatment. (For the purposes of these explanatory notes, “capacity” will be used to include competence.)

- In brief, patients who have the capacity to consent to treatment may not be treated unless they do, in fact, consent.
- If the patient consents to the treatment in question, the approved clinician in charge of the treatment will satisfy the certificate requirement by issuing their own Part 4A certificate (CTO12) stating that the patient consents to the treatment and has the capacity to do so. This new approved clinician’s Part 4A certificate is now sufficient to meet the certificate requirement so long as the patient continues to consent and has capacity to do so. But it is still possible to meet the certificate requirement by means of a Part 4A SOAD certificate instead. The certificate does not give authority to treat purely authorisation whilst subject to a CTO.
- This rule does not apply to electroconvulsive therapy for patients under 18. That is because, unless it is an emergency, treatments covered by section 58A may not be given to any patient under 18 (whether or not they are otherwise subject to the 1983 Act) without the approval of a SOAD.
- Section 64F of the 1983 Act makes it clear that a supervised community treatment patient who has consented to treatment may at any time withdraw that consent. This section also sets out what happens if a patient who has consented to treatment subsequently loses the capacity to do so. In both cases, the patient will be treated as having withdrawn consent to the treatment in question. This, in turn, means that any approved clinician’s Part 4A certificate relating to the treatment would no longer be valid and a SOAD’s Part 4A certificate would be required instead.
- However, section 64F provides that treatment may continue whilst a new certificate is being sought, if the approved clinician thinks that stopping the treatment would cause serious suffering to the patient. This might allow treatment to continue in the case of a patient who has lost capacity to consent, but it does not allow treatment to continue against the wishes of a patient who still has capacity to consent, unless the patient were recalled to hospital. That is because there is no legal authority to give the treatment even if a SOAD’s Part 4A certificate has been obtained.
- In general, supervised community treatment patients recalled to hospital are subject to the same rules as detained patients, although section 62A provides that a new certificate under section 58 or 58A is not required if the treatment has already been expressly approved by a SOAD on a Part 4A certificate (CTO11).
- This section extends the exception in section 62A to approved clinicians’ Part 4A certificates. In other words, a new certificate under section 58 or 58A is not required if the treatment in question is already covered by an approved clinician’s Part 4A certificate, provided that the patient continues to consent to the treatment (and still has the capacity to do so).
- Section 62A also provides that, even if the treatment has not been expressly approved by a SOAD’s Part 4A certificate, it may be continued while a new SOAD certificate is sought, if the approved clinician in charge thinks stopping the treatment would cause the patient serious suffering.
- The medical treatment of a CTO patient who is admitted informally is governed by part 4A i.e. either a CTO12 if patient consenting or CTO11 if not.
- If a patient CTO is revoked the patient is once again detained in hospital and treatment can only be given on the authority of a part 4A certificate until a section 58 certificate (T3) has been obtained.
- Emergency treatment can be prescribed by the RC.

6. EQUALITY AND DIVERSITY

The core Mental Health Act policies, protocols and procedures have been impact assessed. Where individuals are being detained or receiving treatment under the terms of the Act it is vital that no community group is treated less favourably.

Where peoples' legal status is affected we have a clear duty to inform them of their rights regardless of their language or communication difficulties. DVDs in 28 languages other than English are available on the rights of detained patients. When people with physical impairments are detained clinical staff should identify this need as soon as possible to enable the Trust to access appropriate support e.g. BSL interpreter, Independent Mental Health Advocates.

Where religious belief is important to patients this will be respected and the Trust chaplain will support access to relevant faith leaders and information. Clinical settings, wherever possible, should be able to accommodate individual prayer/meditation space with appropriate access facilities.

7. IMPLEMENTATION

This protocol will be disseminated by the method described in the Documents Control Policy.

All other stake holders, partners and services to be made aware of the protocol via Mental Health Legislation Steering Group members and distributed via their internal systems

The implementation of this protocol requires no additional financial resource.

8. MONITORING AND AUDIT

This protocol will be monitored via untoward incidents or PALS and Complaints that arise as a result of the use of the protocol and reported to Humber Teaching NHS Foundation Trust which will then be processed at the Operation Risk Management Group and dealt with.

The Mental Health Legislation Committee receive a quarterly report including data pertaining to the adherence of the Mental Health Act, and an assurance report, which meets the monitoring requirements of the Mental Health Act Code of practice (2015). The Mental Health Legislation Committee will identify additional actions/scrutiny as required to achieve satisfactory assurance on behalf of the organisation.

Regular audits are to be built into the Trust audit programme and the Mental Health Legislation Team will lead on this however audits may be completed by other clinicians. A specific tool will be devised for this purpose in order to monitor, check, observe, assess, inspect and authenticate that everything is working according to this element from the policy.

The Mental Health Legislation Team will feed back any subsequent recommendations through the Mental Health Legislation Steering Group in order for action plans to be implemented and disseminated through the care groups.

Divisional Managers and Clinical Leads will be responsible for ensuring that any system or practice changes are implemented and for lessons learnt to be shared to all clinicians working to this policy.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Jones. R. (2015) Mental Health Act Manual (Twenty-Sixth Edition). London. Sweet & Maxwell.

Department of Health (2015). Mental Health Act Code of Practice. London TSO.

Mental Capacity Act 2005.

National Institute for Mental Health in England. Supervised Community Treatment: A Guide for Practitioners. October 2008.

National Institute for Clinical Excellence (NICE) (2011). Clinical Guidance 136 – Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.

Surrey and Borders Partnership NHS Foundation Trust S17A Community Treatment Order Policy

10. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Mental Health Act Policy
Missing Patient Procedure and Section 18 Absence without Leave
Section 135 Warrant to Search for and Remove Patients Protocol
Inpatient Search Policy
Consent to Treatment under the MHA SOP
Electronic MHA Forms SOP

Appendix 1 – Community Treatment Order Pathway

COMMUNITY TREATMENT ORDER PATHWAY

WHO CAN BE DISCHARGED ONTO CTO?

Only patients detained for treatment under Section 3 of the Act, or unrestricted Part 3 patients can be considered for CTO.

CTO CRITERIA

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
- Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital;
- It is necessary that the RC should be able to exercise the power under Section 17E(1) of the Act to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

MAKING THE CTO

Once the RC and the AMHP agree that the patient should be discharged onto CTO a pre discharge meeting/S117 meeting must be arranged and must include:

- Locality Approved Mental Health Professional (AMHP),
- Community Consultant;
- Community Care Coordinator.

This is to ensure there is discussion regarding any conditions that are placed on the CTO. If unable to attend content of discussion and agreement should be documented in the patient record.

the RC must complete the Form CTO1, Section 17A. Once this form is completed in its entirety the CTO is active as soon as the patient leaves hospital.

CONDITIONS

The CTO must include conditions, which the patient is required to comply with while on CTO. There are two mandatory conditions, the patient must make themselves available when either of the following applies:

- When needed for consideration of extension of the CTO; and
- If necessary, to allow a SOAD to provide a Part 4A certificate authorising treatment. The above conditions are written on the Form CTO1 form under Section 17B(2).

Other conditions

The RC with the AMHP's agreement can set other conditions, which they think are necessary or appropriate to:

- Ensure that the patient receives medical treatment/nursing care for mental disorder;
- Prevent a risk or harm to the patient's health or safety;
- Protect other people.

VARIATION AND SUSPENSION OF CONDITIONS

The RC can vary or suspend any conditions, without the agreement of the AMHP at any time during the period of the CTO. Any variation or suspension of conditions must be completed on Form CTO2. The COP 29.40 gives recommendations regarding the variation of conditions.

RECALL TO HOSPITAL

The RC may recall a patient on a CTO to hospital if they fail to comply with the conditions of their CTO, or if the patient requires treatment. The RC must complete a Form CTO3, Section 17E and the recall lasts only for 72 hours. The COP gives guidance on recall, paragraph

29.52 onwards.

If a patient is recalled to hospital, Form CTO4 must be completed by clinical staff once the patient has been recalled and this should be sent to Mental Health Act Administrator.

If the CTO is not revoked

If the CTO is not revoked after 72 hours the patient is free to leave hospital and continues on the CTO as before, complying with the conditions set, e.g. being monitored in the community by the Care Co-ordinator or a member of the team.

Revoking the CTO

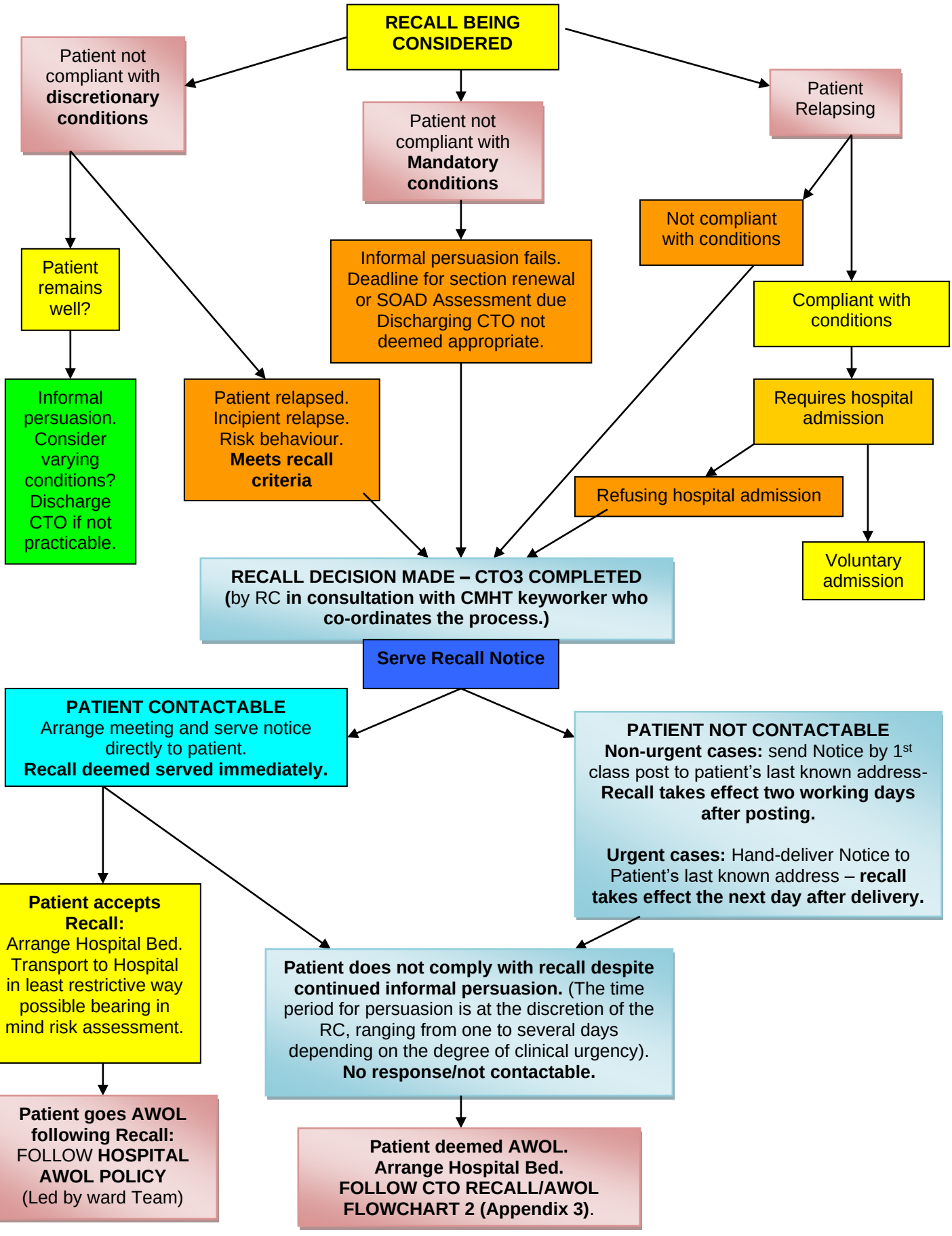
If the patient requires longer than 72 hours in hospital, the RC must consider revoking the CTO. The CTO can also be revoked if the patient no longer meets the criteria. To revoke the CTO, Form CTO5 must be completed.

After revoking a CTO

If the CTO is revoked the patient is automatically placed back on their original detaining Section in hospital. The patient's Section 3 then starts again. The patient, once their CTO is revoked, is then referred automatically to the First Tier Tribunal.

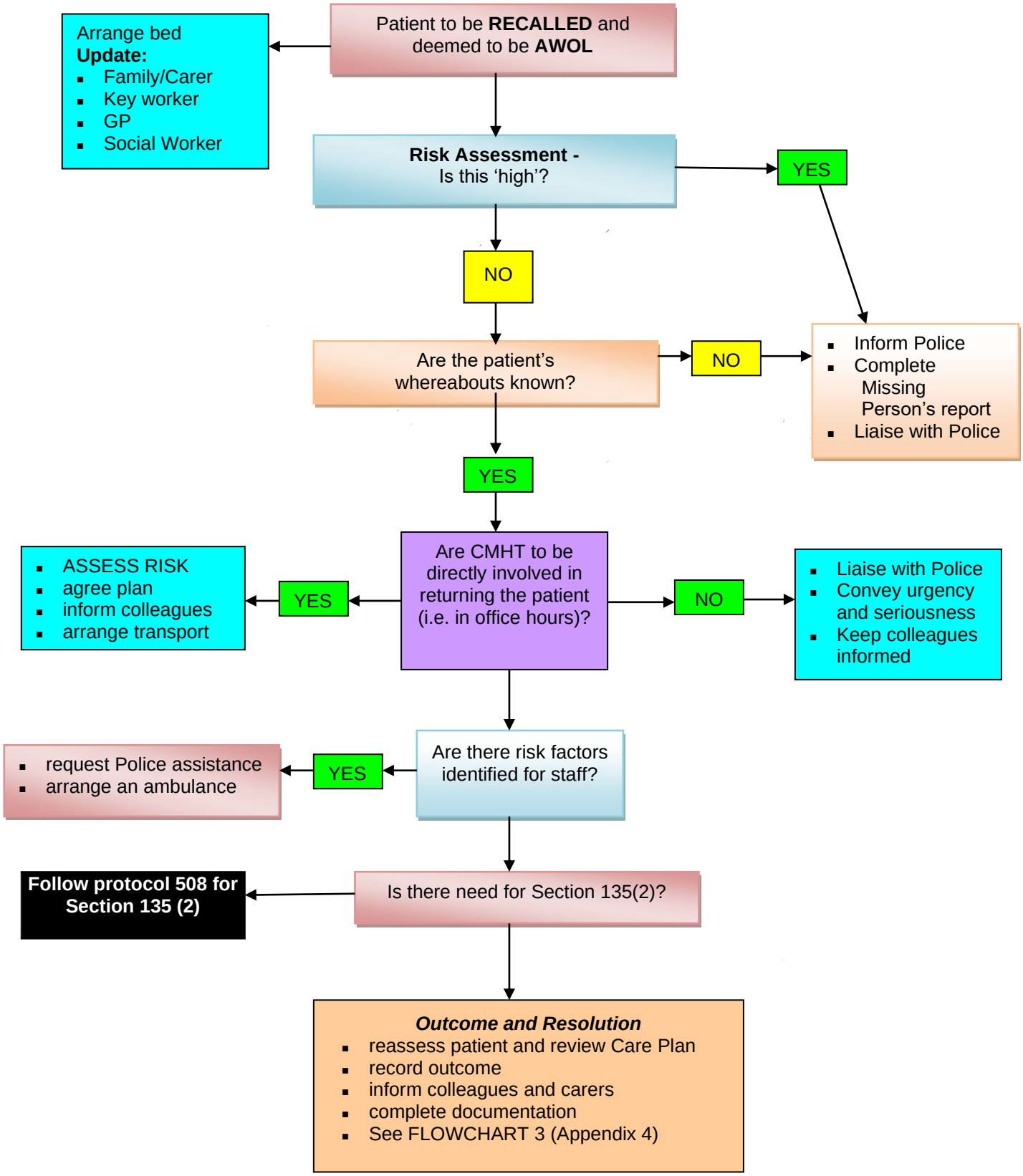
Appendix 2 – Summary of Action (Pre-Recall) Flowchart 1

SUMMARY OF ACTION TO BE TAKEN WHEN RECALLING A PATIENT SUBJECT TO A CTO, PRIOR TO PATIENT BEING DEEMED AWOL (PRE-RECALL) – FLOWCHART 1

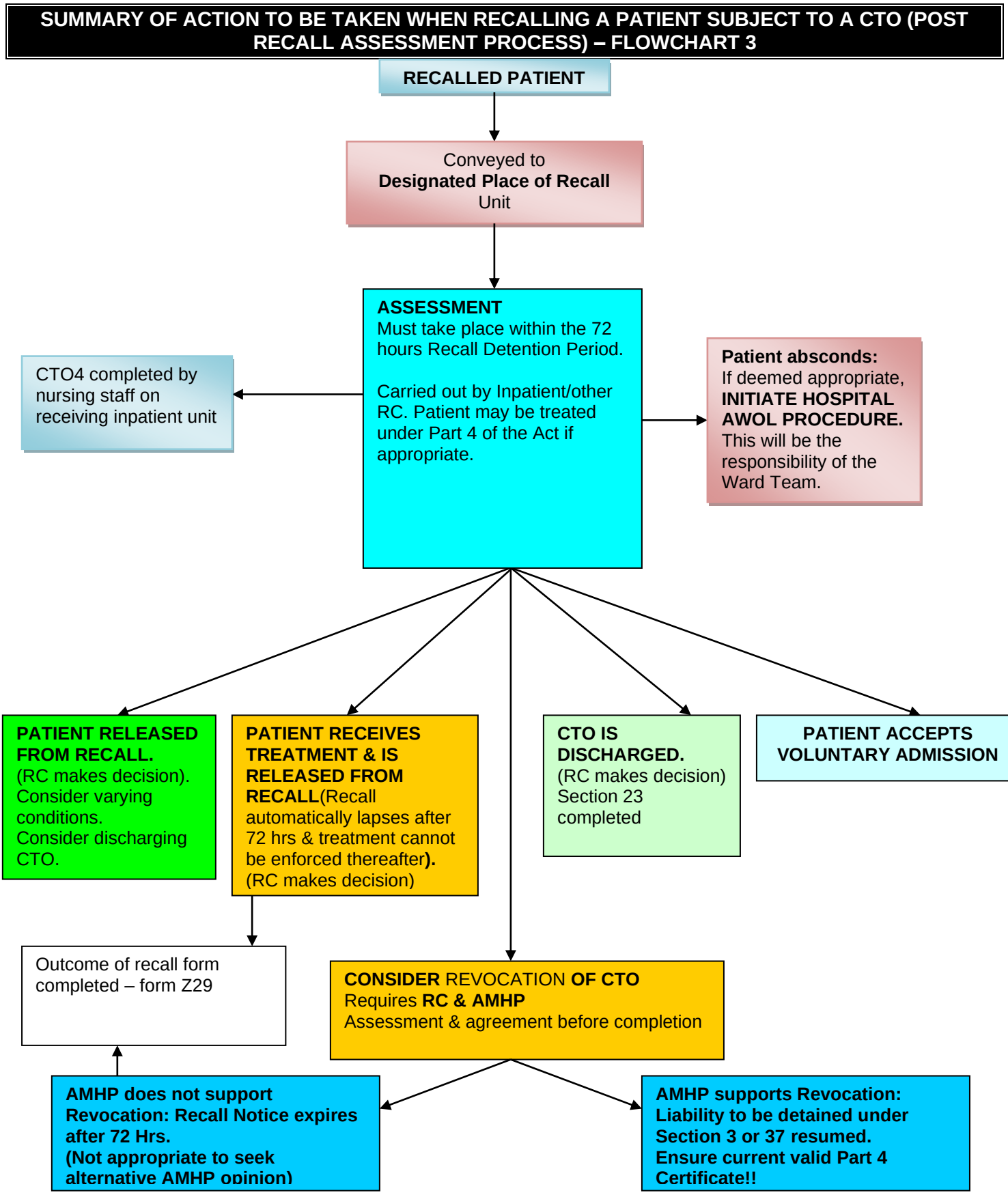


Appendix 3 – Summary of Action (Reporting a Patient AWOL) – Flowchart 2

SUMMARY OF ACTION TO BE TAKEN WHEN RECALLING A PATIENT SUBJECT TO A CTO, AND REPORTING THEM AWOL – FLOWCHART 2



Appendix 4 – Summary of Action (Post-Recall Assessment Process) – Flowchart 3



Appendix 5 – Additional Guidance for CTO recalls

The only person who can recall a CTO patient is the Responsible Clinician (RC). That is, the Approved Clinician (AC) in charge of that CTO patient. In the majority of cases the decision surrounds either a failure to comply with one of their mandatory conditions associated with the CTO or a need to receive medical treatment for their mental disorder in a hospital and that, if they were not recalled to hospital to receive treatment, there would be a risk of harm to their health or safety, or to other people.

The recall must be in writing, form CTO3 (handed directly to the patient preferably, put through their letter box, or in exceptional circumstances posted, first class, to their last known address). Recall does not have to be to the same hospital, or group of hospitals, as manage the CTO. The responsible clinician must send a copy of the form to the managers of the hospital to which the patient is recalled as soon as reasonably practicable. If that is not the responsible hospital, the responsible clinician must also tell those managers the name and address of the responsible hospital. Service users may be recalled to any hospital, not just their responsible hospital. In practice, service users should not be recalled to any hospital unless it has been established that the hospital can accept them – hospital managers are not obliged to accept service users just because a responsible clinician has issued a recall notice.

Service users recalled to hospital do not have to be admitted as inpatients; they could be recalled for outpatient treatment instead.

Service users may be recalled even if they are already in hospital at the time. This can happen, for example, if a service user attends hospital either voluntarily or to comply with a condition of their CTO, but then refuses to accept the treatment the responsible clinician thinks is needed. If the service user, or someone else, would be at risk if the patient does not have that treatment, the service user can be formally recalled to allow the treatment to be given without the service user's consent.

Once the recall notice has been served, the service user can, if necessary, be treated as absent without leave and taken to hospital. Community patients who are AWOL may be taken into custody and returned to the hospital they were recalled by an AMHP, a police officer, or a member of staff of the hospital to which they have been recalled. The timescales for bringing a service user into hospital following recall must be adhered to.

Where CTO patients are at any time absent from the hospital to which they have been recalled, or to which they have been transferred while recalled, they are considered to be AWOL. They may be taken into custody under section 18 and taken to the hospital by any AMHP, police officer, or any other constable.

When a recall has been arranged:

In respect of the engaged service user, liaise with Mental Health Crisis Intervention Team (MHCIT) around suitable location to recall. If a bed is available on a treatment unit this unit should be named on the CTO3 and the service user taken to the allocated treatment unit.

Only one location can be named on the CTO3. If the first place is no longer available a further CTO3 must be completed.

If no treatment bed available location of recall needs to be **Miranda House.**

When service users cannot be located or they have disengaged, location of recall needs to be **Miranda House.**

At all times CTO recalls will be allocated to specific units however the guidance has been written to support those times when a bed is not readily available.

Once a CTO3 has been completed and the service user has arrived at the hospital a CTO4 must be completed to acknowledge receipt of the service user and paperwork and to begin the 72-hour period.

Delays in admitting the CTO recall require escalation to senior managers and a Datix is required to be completed.

Miranda House
Following recall of service user to Miranda House all attempts must be made to admit onto Avondale. Once admitted to Avondale as with any other admission the patient's care is the responsibility of the nursing staff within the unit.

However if this is not possible the service user should be placed in the Section 136 (S136) suite for immediate assessment by a medic within Miranda House. If the S136 suite is in use consider other rooms within the unit to support safe assessment.

If the decision following assessment is to revoke the CTO to the parent section then the patient needs to be admitted to a suitable bed before this can happen. MHRS to locate a suitable bed, preferably within HFT units but if there is no capacity an out of area bed can be located.

As with all bed management decisions the lounge on Avondale can be utilised for a short period for the revocation to take place. This would then enable a transfer to an out of area bed to take place. A service user cannot be transferred on recall until recorded as accepted and detained under recall using form CTO4. A CTO 6 can then be used to transfer a service user under recall to a hospital under different managers.

MHRS to liaise with all areas in Miranda House and care coordinator to support the care of the service user while at Miranda House if unable to be admitted to Avondale.

Any ongoing medication needs will require discussion as part of the referral and communication with MHRS when a recall is considered. Emergency medication needs will be addressed either through MHRS or a ward within Miranda House.

Support with more challenging presentations will be managed initially by MHRS however with support from the other staff teams at Miranda until such a time a transfer to a unit is required.

Transport
If the care coordinator cannot facilitate a safe transfer to the recalled unit an ambulance must be contacted to support transfer. If the risks of such a decision are high consideration to police assistance can be explored. The police will only support transfer when there is significant risk. Contact the police via normal route and clearly explain the associated risks and reason for the request. The police **do not** have to attend; the only reason will be if there is significant risk to the service user or others. There might need to be some consideration for secure transport if police support isn't made available.

Out of area transfers following the decision to revoke the CTO need to follow the normal procedure and all out of area paperwork completed.

RC responsibility
It has been agreed and should be clarified before a recall occurs which psychiatrist will be involved in the assessment post recall. Within hours this should be the RC who has completed the CTO3, if this is unrealistic and the recall is likely to lead to a full revoke of the CTO discussions should occur between community consultants and their inpatient colleagues. Out of hours this will be the on-call psychiatrist.

CTO recall process for Care Coordinators
Once the Responsible Clinician (RC) has assessed that recall criteria has been met a hospital to provide treatment must be identified. The RC or care coordinator is to liaise with MHRS. The RC will then complete the notice of recall to hospital form CTO3.

The Role of Care Coordinator

Serving the notice

- The care co-ordinator will be responsible for serving the CTO 3 form to the client (original to go to Hospital Managers, duplicate copy goes to client). Make a copy for file and information. This duplicate form must be sent or delivered to client's last known address. If handed to client the notice takes immediate effect. **If not handed to patient, the notice does not come into effect until immediately after midnight the same day. If posted, first class should be used and notice does not come into effect until the second business day after posting.**

Obtaining the warrant

- To cover the eventuality that the client refuses to leave his/her property and to make themselves available for treatment, a Warrant to Search and Remove Patient Mental Health Act 1983, Section 135(2) must be obtained.
- Please follow process for gaining warrants via the Trust's Section 135 Warrant to Search for and Remove Patients Protocol.

Police and ambulance assistance

- Once warrant is issued, careful coordination is required to ensure least restrictive actions for client and efficient use of police and ambulance time.
- Phone police on **101** number and explain that a warrant has been issued and you will be requesting assistance. Police also to be made aware that client is AWOL and under Mental Health Act 1983 Section 18 can be conveyed to hospital if located outside of their home. (You must be able to provide details of any risk.) A log number will be issued.
- Identify whereabouts of client. If at home call police back, citing log number and requesting assistance to remove client from their home.
- Police have signed up to the Humber CTO recall policy however ambulance assistance may also be required.
- Phone ambulance on **0300 3300 295** and explain warrant, required needs and any risk. Urgent response can be obtained within 30 minutes however S135 does not automatically receive a Cat 2 ambulance call as a S136 does. Therefore the ambulance would be booked as a HCP call, and would most likely receive a 2 hour response time (dependent on current demand levels).

Things that may cause problems

- Once a client has been served with recall notice (CTO 3) they can be removed from their home under Warrant 135(2) by police. If this warrant is executed, a copy of the form **must** be left in the client's home and it is the responsibility of the care coordinator to secure the premises.
- **If client avoiding recall** – They are now classed as Absent Without Leave (AWOL). If they are in a public place they can be conveyed by the police under Section 18 of the Act and the local trust policy.
- The hospital to which the client is conveyed **must** be the one stated on the CTO 3 form.
- If in attendance when client is being recalled, ensure case notes, medication and drug card are available and taken in a secure bag to receiving hospital.

Responsibilities of professionals on arrival at hospital

- It is good practice for a member of staff to travel to the receiving unit to handover medication, drug card and case notes.
- Receiving nurse to complete CTO 4 and Z29 forms outcome of recall form and checklist number 18 which is in two parts: Community (to be completed by care coordinator) and Inpatient to be completed by receiving nurse. CTO 3 form is sent to Hospital Managers.
- Copies of **all** forms related to CTO recall to be placed in the patient's file.

Appendix 6 – Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** Community Treatment Order Protocol
2. **EIA Reviewer (name, job title, base and contact details):** Michelle Nolan, Mental Health Act Clinical Manager
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** Protocol

Main Aims of the Document, Process or Service

This protocol should be read in conjunction with relevant chapters of the Code of Practice 2015 which offers guidance on the operation of the Act. Chapter 29 focuses on CTO. The five guiding principles set out in Chapter 1 of the Code should be considered when making decisions about any course of action under the Act.

This Trust-wide procedure sets out procedural requirements, where these are explicit in the Act or Code, but guidelines may be produced locally which, while complying with this protocol, provide advice on more specific matters. Where appropriate, reference should be made to other Trust policies (e.g. ECT).

The purpose of this protocol is to ensure that there is lawful and appropriate use of CTO and that the legal rights of any patient subject to a CTO are upheld at all stages. There is no lower age limit for CTO.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This Protocol is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	This Protocol is consistent in its approach regardless of disability. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Men/Male Women/Female	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender related preferences, needs or requirements.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Marriage/Civil Partnership		Low	The Protocol applies to all irrespective of relationship status.
Pregnancy/ Maternity		Low	This Protocol is consistent in its approach regardless of pregnancy/maternity status however consideration would be given to an appropriate hospital in the event of the need to recall.
Race	Colour Nationality Ethnic/national origins	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to race or ethnicity. This protocol is consistent in its approach regardless of race. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This protocol is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people. Specific guidance is given in relation to gender and trans. As a guiding principle, everyone will be treated as an individual and gender should not be a barrier.

Summary

The Protocol is specifically aimed at the protection of all service users subject to a Community Treatment Order under the Mental Health Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.

It is felt that this protocol and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs. Any audit/monitoring outcomes of related policy would continue to inform any changes to the Equality Impact Assessment in relation to any of the equality target group characteristics and impact of use of CTO recall. There are statutory requirements and obligations built into existing related legislation (MHA 1983) and its supplementary Code of Practice as well as local systems in place for assurance of the monitoring of compliance with these requirements and reporting through related committees.
EIA Reviewer: Michelle Nolan

Date completed: 03.04.24	Signature: M Nolan.