COMMUNITY TREATMENT ORDER POLICY MENTAL HEALTH ACT 2007 SECTION 17A

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(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

Community Treatment Orders (Section 17A) were introduced in 2008, by the Mental Health Act 2007, and replaced Supervised Discharge (Section 25A).

A CTO allows some patients who are compulsorily detained in hospital for treatment, who no longer need to remain in hospital to receive that treatment, to be discharged, subject to conditions which ensure that they continue to receive further treatment in the community. A CTO lasts for 6 months initially, is renewable for a further 6 month period and for annual periods thereafter. Application for a CTO is made by the 'Responsible Clinician' (RC) and requires the agreement of an 'Approved Mental Health Professional' (AMHP). When a CTO ends (unless it ends by being 'revoked') a patient is discharged from both the Community Treatment Order and the original hospital application.

CTO also modifies Section 17 in that a Responsible Clinician may not grant or extend leave of absence under Section 17 for more than seven days, unless they first consider whether the patient should be dealt with under Section 17A instead.

"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." (Mental Health Act Code of Practice 29.5).

2 Introduction

This policy provides guidance on both legal requirements and best practice in the use of Community Treatment Orders for patients with severe and enduring mental disorders. It sets standards that staff using CTO are expected to adhere to locally.

3 Definitions

AC **Approved Clinician:** A senior mental health professional who has been approved to act as *Responsible Clinician* for patients subject to the *MHA*.

AMHP **Approved Mental Health Professional:** A mental health professional who has been approved under the *MHA* to act on behalf of the *LSSA* in assessing patients for compulsion under the *MHA*.

Care Co-ordinator: The member of the patient's care team who takes responsibility for arranging the patients care plan under *CPA*.

CPA **Care Programme Approach:** The system under which care is provided for patients in contact with mental health services.

Code of Practice: The Code of Practice that guides all staff in mental health services on discharging duties under the *MHA*.

CTO **Community Treatment Order:** order under section 17a *MHA* requiring a patient to receive treatment in the community.

IMHA **Independent Mental Health Advocate:** a service that provides information and support to patients subject to the *MHA*, to help them understand and exercise their rights and understand the powers they are subject to.

LSSA **Local Social Services Authority:** the local council that provides social services in conjunction with the NHS.

MCA **Mental Capacity Act 2005:** the law that provides a framework for decision making on behalf of people who lack capacity to make decisions for themselves and provides protection for vulnerable adults.

MHA **Mental health Act 1983 as amended by the Mental Health Act 2007:** the law that regulates the admission to hospital and treatment of mentally disordered persons whose liberties need to be restricted.

MHARM **Mental Health Act Review Managers:** The non-executive directors of the Trust and lay persons appointed for the purpose of reviewing the detention of patients subject to the MHA.

RC **Responsible Clinician:** an *Approved Clinician* who is in charge of the treatment of a patient subject to the *MHA*.

SOAD **Second Opinion Appointed Doctor:** a doctor appointed by the Care Quality Commission to review treatment of patients subject to compulsory treatment under the *MHA*.

MHT **Mental Health Tribunal:** an independent panel to which patients subject to compulsion under the MHA can appeal against compulsion.

Nearest Relative The patient's representative, defined by section 26 of the Mental Health Act and given specific powers that protect the rights of a detained patient.

4 Scope

This policy applies to patients of all ages who are detained in hospital for treatment under the Mental Health Act sections 3, 37, 45A, 47 and 48, provided there is no restriction order.

The policy applies to all staff who are involved in planning the discharge or providing care in the community for the above patients.

5 Purpose

The purpose of this policy is to provide good practice guidance on the use of Community Treatment Orders, specifically to assist in the planning, application and review of CTOs, including identifying appropriate patients, setting conditions for patients and compliance with legal processes for application, recall of patients, revocation and renewal of orders. This policy does not supplant the official guidance on Supervised Community Treatment and all professionals are required to have regard to the Mental Health Act Code of Practice and are advised to be familiar with the NIMHE SCT Guide for Practitioners.

6 Roles and Responsibilities

6.1 Responsible Clinician

6.1.1 Consulting with the patient, relatives and friends and any professionals concerned with the patient's care, including the patient's GP, in considering the need for a Community Treatment Order.
6.1.2 Consulting with an AMHP to consider whether the criteria for CTO are met and the power of recall and proposed conditions are necessary and appropriate.
6.1.3 Ensuring the record of consultation form (Appendix B) is completed.
6.1.4 Making a Community Treatment Order, if the criteria are met (with agreement of an AMHP) under Section 17A (Form CTO1).
6.1.5 Setting conditions for CTO.
6.1.6 Varying or temporarily suspending conditions (Form CTO2).
6.1.7 Within one month of the start of the CTO to review prescribed medication with the patient and either complete a certificate of capacity and consent (CTO 12) or request a Second Opinion Approved Doctor Certificate from the Care Quality Commission if the patient lacks mental capacity to or refuses to consent.
6.1.8 Deciding whether to make a report extending CTO (with agreement of an AMHP) under Section 20A (Form CT07).
6.1.9 Deciding whether to exercise the power to recall under Section 17E (Form CTO3).
6.1.10 Revoking CTO (with the agreement of an AMHP) (Form CTO5).
6.1.11 Deciding whether to confirm CTO following patient's return from AWOL (Form CTO8).
6.1.12 'Barring' Nearest Relative discharge (Form M2).
6.1.13 Authorising reassignment of responsibility for CTO patient being transferred from Scotland to England (CTO9).

6.2 Approved Mental Health Professional

6.2.1 In consultation with the RC, considering whether the criteria for a CTO are met under Section 17A and the CTO is appropriate and necessary.
6.2.2 Consult with the nearest relative and any other relatives or carers as agreed with the RC.
6.2.3 Considering whether the conditions for CTO are appropriate and necessary.
6.2.4 Providing a written report in support of the CTO at the time the order is made.
6.2.5 In consultation with the RC, considering whether the criteria for revocation of CTO are met, and that revocation is appropriate.
6.2.6 In consultation with the RC considering whether the criteria for extension of CTO are met, and that it is appropriate to extend the CTO.
6.2.7 Where any of the above are considered appropriate to provide signed agreement on appropriate forms.

6.3 Second Opinion Appointed Doctor

6.3.1 Deciding whether to give a Part 4A certificate authorising treatment (CTO11).

6.4 Mental Health Act Administrator

6.4.1 Receiving and scrutinising all relevant forms.

6.4.2 Referring CTOs back to the RC where the CTO contains errors, omissions or inadequate evidence that the criteria are met
6.4.3 Referring the CTO to the Hospital Managers (MHARMs) for review, if there are unresolved queries in respect of validity of the order.
6.4.4 Informing the Nearest Relative of CTO (if patient does not object).
6.4.5 Giving patient's information about the availability of independent mental health advocacy.
6.4.6 Giving Nearest Relative (if patient does not object) information about the availability of independent mental health advocacy.
6.4.7 Authorising transfer of recalled patients to another hospital (Form CT06).
6.4.8 Informing the patient of the extension of CTO.
6.4.9 Receiving Nearest Relative's request for discharge.
6.4.10 Informing Nearest Relative of discharge from CTO (unless patient objects).
6.4.11 Authorising reassignment of responsibility for a CTO patient (Form CT10).
6.4.12 Monitoring all time periods related to CTO.

6.5 Inpatient Nursing Staff

6.5.1 Considering the appropriateness of a CTO during care planning and discharge planning.
6.5.2 Supporting the RC and AMHP in ensuring that appropriate consultation takes place before the CTO is made (see 6.1.1).
6.5.3 Arranging a discharge planning meeting to implement the CTO.
6.5.3 Ensuring that the Section 132 Information for Patient form (Appendix C) is completed and submitted with the CTO.
6.5.4 Recording start time of the recall when a recalled patient arrives at the hospital (Form CTO4).
6.5.5 Recording time of the patients release from hospital when recall is ended.
6.4.6 Recording time of patient's admission following transfer (Form CTO6).

6.6 Care Coordinators

6.6.1 Preparing a care plan under CPA before the CTO is made.
6.6.2 Coordinating patients care under CPA.
6.6.3 Liaison with the Responsible Clinician to review patient's treatment in the community.
6.6.4 Monitoring for the need for recall and revocation.
6.6.5 Providing information to the patient about the CTO and care plan, including the conditions and his/her rights to an IMHA and to appeal.

6.7 Mental Health Act Review Managers

6.7.1 Reviewing CTOs referred by the MHA Manager because of unresolved doubts about the validity of the order.
6.7.2 Considering patient appeals for discharge from CTO (This responsibility is reserved to the Non-Executive Directors).
6.7.3 Reviewing the CTO at every renewal.

7 Policy detail/Course of Action

7.1 Considering a Community Treatment Order

7.1.1 A CTO should be considered for those patients who are detained in hospital for treatment and who have a history of non-compliance, relapse and re-admission cycles and who may benefit from the support and structure offered by CTO.

7.1.2 The key factor in deciding to use a CTO will be a significant risk that the patient's condition will deteriorate if s/he does not comply with aftercare and that the consequent risk of harm would justify his/her recall to hospital (see also Code of Practice 29.8-29.18).

7.1.3 Patients do not have to formally agree to CTO but will need to be prepared to co-operate with the proposed care plan.

7.1.4 The criteria for making a CTO are that the patient is detained under Section 3 of the Act or under an unrestricted Part III order, and:

a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment.
b) It is necessary for the patient's health or safety, or for the safety of other persons, that the patient should receive such treatment.
c) Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital.
d) It is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital.
e) Appropriate medical treatment is available for the patient.

7.1.5 The critical element of these criteria is the need for the power to recall and this will usually relate to a known pattern of non-compliance and relapse, associated with significant risk of harm to the patient or others, in particular when rapid relapse requires a prompt response or disengagement from services impedes contact.

7.1.6 The RC must state clearly why the power of recall is needed on Form CTO 1.

7.2 Making a CTO

7.2.1 **Before making a CTO the Responsible Clinician must**:

- Consider if a CTO is right for the patient, taking into account the alternative options, the guiding principles of the Act (see Code of Practice Chapter 1) and the patients care needs and associated risks.
- Consult with the patient and any carers or relatives who are involved, provided the patient consents. If the patient refuses his/her consent the RC must consider whether potential risks to carers, relatives or others justify consultation without consent or reconsider whether discharge from hospital is appropriate.
- **NB.** The RC can delegate consultation to other practitioners, but must ensure that appropriate consultation has been completed and recorded.
- Discuss the proposed treatment plan with an AMHP, the care team and all professionals who will be concerned with the patient's care on discharge and ensure that a care plan under CPA is agreed and completed.
- **It is essential that named professionals are identified for all key roles following discharge (in particular the RC and Care Co-ordinator), that they are consulted and agree to take on the role, and that their details are included in the care plan (see also 7.2.5).**

- Seek the agreement of an Approved Mental Health Professional that the criteria are met, a CTO is appropriate and that the specified conditions are appropriate.

7.2.2 All CTOs include two **mandatory conditions**:

- That the patient makes her/himself available for examination by the Responsible Clinician to consider extension of the order, and
- That the patient makes him/herself available for examination by a Second Opinion Appointed Doctor (SOAD) for a Part 4A Certificate.

7.2.3 The CTO may include further **discretionary conditions** for the purpose of

- ensuring that the patient receives treatment,
- preventing a risk of harm to his/her health or safety or
- protecting the safety of others.

NB: **Mandatory** in this context means they must be included in every CTO; **Discretionary** means the RC may include them i n the CTO.

7.2.4 The RC must have regard to the guiding principles set out in the MHA Code of Practice when setting such further conditions and conditions should be kept to a minimum necessary to ensure the patient receives the required treatment. In practice the CTO is a contract between the patient and the care team and in order for it to be effective it will require the patient's acceptance of the conditions, although his/her formal agreement is not required.

7.2.5 Whenever the conditions are changed a new form must be completed by the RC (Form CTO 2).

7.2.6 The completed Community Treatment Order must be submitted to the Mental Health Act Administrator and **must include the record of consultation form (Appendix B) and a copy of the patient's care plan, including details of who has responsibility for prescribing medication and for the patient's physical health.**

7.2.7 The MHA Manager will scrutinise the completed form CTO 1, record of consultation and care plan and refer the forms back to the RC if there are any errors, omissions or concerns about the evidence to support the legal criteria.

7.2.8 If concerns about the validity of the CTO remain unresolved, the MHA Manager will refer the CTO to the Hospital Managers for review and confirmation or discharge.

7.2.9 On making the order the RC must consider whether the patient is consenting to the proposed medication, as the power to continue to treat the patient under the CTO after 1 month is dependent on his/her consent, or the approval of a Second Opinion Appointed Doctor. Where the patient has, or is likely to, refuse consent, or lacks the capacity to give consent, the RC must immediately request a SOAD. The one month period is extended if the three months treatment allowed by Part 4 of the Act has not yet ended.

7.2.10 If a different RC takes over the care of the patient on discharge, the in-patient RC who has made the order will remain the RC for the patient until formally transferred to the Community Psychiatrist. **The Care Co-ordinator must ensure that all care plan documentation is updated to reflect the changes.**

7.3 Provision of information to Patients

7.3.1 The patient must be given a copy of the CTO (Form CTO 1) and their care plan – this will normally be posted to them by the Mental Health Act Manager on acceptance of the order.

7.3.2 The Responsible Clinician must ensure that the patient understands the effect of the order, the conditions attached and how treatment under the order will be provided. **Patients must not be told that any refusal of medication or breach of other discretionary conditions will result in recall.**

7.3.3 The patient must also be given information about his/her rights of appeal and to support from an Independent Mental Health Advocate. An information leaflet on CTO is available for this purpose. The section 132 Information for patients form (Appendix C) must be completed to show that this has been done and submitted to the MHA office with the CTO.

7.3.4 The patient must be reminded of his/her right to an IMHA and appeal periodically, at minimum at every CPA or CTO review, and at any time the CTO and the associated conditions or restrictions are discussed. Every time such information is given it should be recorded on the patient's clinical record and the Section 132 continuation form (appendix C).

7.3.4 With the patient's agreement a copy of the CPA plan will be given to the patient's GP and Nearest Relative. The RC must ensure that the GP has been notified of the CTO and that no medication for mental disorder must be prescribed, unless included on the certificate, CTO 11 or 12. This can be done by letter.

7.4 Medical Treatment for mental disorder

7.4.1 The rules for treating CTO patients are very complex and some aspects differ significantly from the normal rules for medical treatment (e.g. the need for a certificate even for consenting patients). RCs for CTO patients are advised to read the appropriate section of the Reference Guide to the Mental Health Act in addition to this policy.

7.4.2 One month after the start of treatment under a CTO, (unless the three month period of first treatment under section 3 has not yet expired), either a SOAD certificate (CTO 11) or the patient's consent (CTO12) is required for medication to continue.

7.4.3 If the patient withholds consent to medication, this can only be given in an emergency until the CTO 11 is completed. The RC must ensure that a CTO 11 is requested at the earliest opportunity to ensure that treatment is not interrupted.

7.4.4 A patient who lacks capacity to consent may be treated unless he/she objects. Such treatment must be administered under the direction of an AC.

7.4.5 Emergency Treatment may be given if it is immediately necessary to save the patient's life, prevent serious deterioration, alleviate serious suffering or prevent the patient being a danger to others and it is the least intrusive way available. Any force used must be proportionate to the danger.

7.4.6 If a patient refuses treatment they cannot be forced to receive it in the community and the RC must consider if the criteria for recall to hospital are met.

7.4.7 The RC may delegate prescribing medication to someone else (e.g. the GP**), however the GP must not prescribe any medication for mental disorder that is not included in the certificate.**

7.4.8 Whenever medication is changed a new Form CTO 11 or CTO 12 is required.

7.5 Effect of the CTO

7.5.1 The preceding section 3 continues in the background although the CTO suspends the liability of the patient to be detained in hospital and the requirement to take medication.

7.5.2 The patient becomes liable to be recalled to hospital if he/she breaches the mandatory conditions or needs to receive treatment for mental disorder in hospital and is at risk of harm to him/her or others if not recalled.

7.5.3 If the CTO is revoked the patient reverts to being liable to be detained under section 3 for up to 6 months.

7.6 Recall to hospital

7.6.1 The RC may recall a CTO patient to hospital if the patient is in breach of either of the **mandatory conditions**.

NB: The breach of **discretionary conditions** in itself is not sufficient ground for recall.

7.6.2 In all other cases the RC may order recall if s/he believes that

- the patient needs to receive treatment for mental disorder in hospital and
- there would be a risk of harm to the health or safety of the patient, or to other persons, if the patient was not recalled.

7.6.3 A copy of the recall notice must be sent to the hospital and the RC or care coordinator must liaise with the inpatient team to inform them of the purpose and objective of the recall and to agree a treatment plan.

7.6 4 The RC must complete Form CTO 3 to recall the patient. If possible the CTO 3 should be taken direct to the patient and the recall will take effect immediately. The patient should be encouraged to go to the hospital immediately.

7.6.5 Alternatively the recall notice can be delivered by hand or posted to the patient's last known address. If delivered to the patient's last known address by hand the recall takes effect the following day and if posted by first class post on the second business day after posting.

7.6.6 The RC must agree with the patient's care team which professional(s) will take responsibility for delivering the recall notice and co-ordinating the patient's return to hospital.

7.6.7 When the patient arrives at the hospital on recall, the person receiving the patient must complete Form CTO 4, including the time of arrival, and send it to the MH Act Office

7.6.8 On recall the patient can be detained for up to 72 hours to facilitate treatment. Recalled patients are subject to Part 4 of the Act and may be treated without their consent, in accordance with a Part 4a Certificate. (See paragraph 7.7.6 for treatment without a SOAD certificate).

7.6.9 A patient who does not comply with the recall is absent without leave and can be detained and returned to hospital by any officer on the staff of the hospital, any person authorised by the managers of the hospital, any police constable or any AMHP (MHA Section 138). If the patient is in a private dwelling a warrant under section 135.2 of the MHA may be needed.

7.6.10 A patient does not have to be readmitted as an inpatient on recall and will normally remain under the care of their RC in the community.

7.6.11 A patient may agree to stay in hospital on a voluntary basis.

NB: The holding powers under section 5 do not apply to CTO patients who are admitted informally. If there is a possibility that the patient may need to be prevented from leaving the hospital the RC should consider the need to use the power of recall.

7.6.12 A patient may be discharged following treatment provided there are no concerns for his/her health, according to the treatment provided.

7.6.13 During the period of a patient's recall to hospital the RC must consider whether the patient's response to recall and treatment is sufficient to allow him/her to return to the community and if not consider the need to revoke the order.

7.7 Revocation of the CTO

7.7.1 If the RC considers revocation of the CTO is necessary he/she must request an AMHP to assess the patient. This should if possible be done by an AMHP who has been involved with the patient previously.

7.7.2 Whenever possible the RC and AMHP should assess the patient together and must in any case discuss the patient and consult with other members of the care team before deciding on revocation.

7.7.3 If the AMHP and RC agree on the need for compulsory readmission they will complete Form CTO5 and the patient will revert to the legal status he/she was under at the time the CTO was made (usually section 3).

7.7.4 On revocation a new 6 month detention period will start from that day.

7.7.5 On revocation of the CTO the MHA Manager will refer the patient to the Mental Health Tribunal.

7.7.6 The patient will again become liable to receive treatment under Part 4 of the Act. There will however not be a new three month period during which treatment can be given without his/her consent. Treatment may be given under

any previous SOAD certificate which has not expired. A new certificate T2 must be completed as soon as possible.

7.7.7 Patients who have been recalled to hospital or whose CTO has been revoked may be given treatment which would require a Part 4 certificate without such a certificate only under the following circumstances:

- It is authorised in the CTO 11 for use on recall, or
- It was authorised prior to recall in the CTO 11 or CTO 12 and needs to be given to avoid serious suffering to the patient, pending a new certificate, or
- It is permitted under Part 4 being immediately necessary, or
- It is less than one month since the CTO was made (except for ECT).

7.8 Renewal of the CTO

7.8.1 After the initial 6 month period a CTO can be extended for a further period of 6 months and subsequently for a year.

7.8.2 The Mental Health Act Office will inform the RC two months prior to expiry of the CTO that the order needs to be reviewed.

7.8.3 During the two months before the order expires; the RC must examine the patient to assess whether he/she meets the criteria for extension. A patient who does not attend the review appointment may be recalled for this purpose.

7.8.4 The criteria for extension of the CTO are the same as for making the initial order (see paragraph 7.1.4). In deciding whether these conditions are met the RC must consult with other professionals concerned with the patient's treatment.

7.8.5 If the RC thinks that the CTO should be extended he/she must seek the agreement of an AMHP and complete Form CTO 7. The AMHP should if possible be one who has previous knowledge of the patient.

7.8.6 CTOs are a significant interference with the patient's rights and the justification for continuing restrictions must carefully considered by the RC, in particular whether the power of recall continues to be necessary.

7.8.6 A CTO must always be reviewed and if it is no longer deemed necessary should be discharged and not allowed to lapse.

7.8.7 All CTO renewals will be referred to a Mental Health Act Review Managers hearing. The MHA Manager will inform the patient that the CTO has been extended.

8 Consultation

This policy is a revision of an existing approved policy with only minor changes reflecting changes in national guidance and practice. It has been circulated within the Mental Health and Learning Disabilities division and discussed in professional forums. It has been circulated to the Clinical Standards Group prior to approval.

9 Training

This CTO Policy has a mandatory training requirement which is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis.

Following ratification specific training on CTO and this policy will be provided to professional groups within the MH & LD division. Ongoing training will be provided through the MHA mandatory training programme.

10 Monitoring Compliance and Effectiveness

Community Treatment Orders are governed by statutory processes and forms. Every Community Treatment Order and subsequent actions and changes are recorded on statutory forms which are scrutinised by the Mental Health Act Office. This scrutiny will ensure that the law and policy are being complied with.

There is an annual data return on the use of Supervised Community Treatment which the NHS makes to the Department of Health.

Practice in the application of CTO will be audited against the standards set by this policy 3 yearly and the outcome reported to the Mental Health Act Scrutiny Committee

11 Links to other Organisational Documents

- Treatment under Part IV Mental Health Act 1983
- Clinical Risk Assessment and Management Policy (MH&LD)
- Policy on Aftercare - Section 117 Mental Health Act 1983
- Giving Information to Detained Patients Policy – Section 132 Mental Health Act 1983
- IW NHS Trust Intranet Community Treatment Orders
- Standard Operational Procedure for Community Treatment Orders (CTO) – Recall
- Standard Operational Procedure for Applications to Court for Warrants under Section 135.2 Mental Health Act 1983

12 References

- Department of Health (2015). Code of Practice to the Mental Health Act 1983. TSO
- Department of Health (2008). Reference Guide to the Mental Health Act 1983. TSO
- Jones, R. (2019). The Mental Health Act Manual, 22nd Edition. Sweet and Maxwell.
- National Institute for Mental Health (2008). Supervised Community Treatment: A Guide for Practitioners. NIMHE

13 Appendices

Appendix A

CTO Progress Checklist
Community Treatment Order: Process Checklist

Step	Required Actions	Tick to confirm
Consider CTO if	Patient detained under sections 3, 37, 45A, 47 or 48 • Has a history of non-compliance, relapse and re-admission, **and** • is considered at high risk of relapse and re-admission, **and** • is likely to cooperate with the framework of CTO	
RC must discuss Community Treatment Order	With • The patient • The inpatient care team • The care coordinator and the community care team • The Approved Clinician who will act as community RC • The patient's GP • The patient's family, friends and/or carers • An Approved Mental Health Professional	
Discharge Planning Meeting	Before the CTO is made a named Care Coordinator and community RC must be identified to support the CTO. DPM confirms: • Consultation with all above (record on consultation record) • Transfer of clinical responsibility to named RC • Name Care Coordinator • Details of CPA care plan • Conditions to be imposed on the patient • The reason why the power of recall is necessary • That the patient has been advised of and understands his/her rights. • Patient's consent to treatment: Form CTO 12, or • If patient refuses consent or lacks mental capacity to consent to treatment a referral for SOAD is required to complete certificate for treatment Form CTO 11	
RC makes the CTO	• RC completes Form CTO 1, Part 1 • AMHP completes Part 2 • A CPA care plan must be completed • RC completes Part 3 • Form CTO 1, record of consultation and CPA passed to MHA Office	
Treatment under CTO	• All treatment requires a certificate (Forms CTO11 or CTO12) and can normally only be given with the patient's agreement. • Treatment cannot be given by force.	

Considering Recall	CTO patients can be recalled to hospital if: • They breach either of the **mandatory conditions**, **Or** • If the patient needs treatment for a mental disorder in hospital, **And** • There would be a risk of harm to health or safety of the patient or to other persons, if the patient were not recalled. RC completes Form 3, setting out the grounds for recall. RC sends copy of CTO 2 to the Hospital	
Effecting Recall	• The community treatment team will normally deliver the recall notice Form CTO 3 direct to the patient and take the patient to hospital, with Police support if required. • The recall notice can also be delivered to the patient's home, in which case it takes effect the next day, • Posted by first class post, in which case it takes effect on the second business day after posting.	
Following Recall	• The patient can be treated in hospital as if s/he is a detained inpatient, provided the proposed treatment is included in the certificate, or if discontinuing treatment would cause the patient suffering. • The patient must be released from recall within 72 hours, unless the CTO is revoked.	
Revocation of the CTO	Following recall of a CTO patient the RC can revoke the CTO if: • The patient needs to be detained in hospital for treatment of mental disorder (i.e. the conditions set out in section 3 (2) are met, **and** • An AMHP agrees – ideally this should be an AMHP who is part of the patient's community care team. The RC completes Form CTO5 with an AMHP. The patient returns to the detained status before the CTO was made.	
Review / Extension of the CTO	• CTO patients must be reviewed at regular intervals to ensure that the Care Plan continues to meet their needs and they are complying with the CTO and whenever it is proposed to transfer any of the key roles (care co-ordinator, RC) to another professional. • A named AMHP will remain in contact with the care team and attend reviews wherever possible. • A formal review must be held within the 2 months before expiry of the CTO to consider the need and appropriateness for its continuation.	
Discharging the CTO	The RC may discharge the patient from CTO at any time following review and agreement by the care team.	

Appendix B

CTO Consultation Checklist

MENTAL HEALTH ACT
Community Treatment Order (CTO) Consultation and Paperwork Checklist

NHS Isle of Wight NHS Trust

PATIENT'S NAME	DOB	IW NO

Consultation

Please Note: when considering a CTO, it is the RC's responsibility to consult with the Patient and all interested parties.

The Patient's Views		
Have you made sure that the patient understands what a CTO involves and discussed any fears they may have?	Yes: ☐	No: ☐
Have the conditions been fully discussed with the patient?	Yes: ☐	No: ☐
Have the patient's rights to an IMHA and appeal been explained?	Yes: ☐	No: ☐
Does the patient agree to the CTO?	Yes: ☐	No: ☐
Will the objections undermine the effectiveness of the CTO?	Yes: ☐	No: ☐
Have the patient's views been fully recorded?	Yes: ☐	No: ☐
Comments		
The Nearest Relative views		
Nearest Relative Name & Address:		
Does the patient have carers or a family network which may support them in the community?	Yes: ☐	No: ☐
Have you explained to the family exactly what a CTO is and asked for their views?	Yes: ☐	No: ☐
Have you taken these views into account as far as possible?	Yes: ☐	No: ☐
If the family/carers are against the use of a CTO, will this undermine its effectiveness for the patient?	Yes: ☐	No: ☐
Have their views been recorded?	Yes: ☐	No: ☐
Comments:		

Consultation continued

The following information **must** be provided to the MHA admin office when a new CTO is made in order for the MHA administrator to process the CTO. **Please provide the following details: -**

Please state the following Key Persons			
Who is the Community RC?		Has the Community RC been consulted prior to the CTO being made? Yes: ☐ No: ☐	
Who is the Care Coordinator?		Has the Care Coordinator been consulted prior to the CTO being made? Yes: ☐ No: ☐	
Who is the AMHP that will support revoke & renewals?		Has this AMHP been consulted prior to the CTO being made? Yes: ☐ No: ☐	
Who is the GP?	Has the GP been consulted prior to the CTO being made?	Yes: ☐	No: ☐
	Has a copy of the Care Plan been sent to the GP?	Yes: ☐	No: ☐
	Does the Care plan include details of who is responsible for: prescribing medication?	Yes: ☐	No: ☐
	the patient's physical health?	Yes: ☐	No: ☐

Where has this consultation been recorded (e.g. patients notes/PARIS/SWIFT)

Accompanied documents

The following documents **must** be forwarded to the MHA admin office when a new CTO is made in order for the MHA administrator to process the CTO. If you have not provided the documents, **please state why you have not done so and when they will be made available.**

Key documents attached			
	Yes	No	If No state why and when will the document be available to the MHA admin office
132 rights paperwork (included in the pack)			
Care Plan (provided by the patients Care Coordinator)			
AMHP's assessment report			
Section 117 checklist (included in the pack)			

Appendix C Section 132 Information for patients Form

ISLE OF WIGHT NHS TRUST
RECORD OF INFORMATION GIVEN TO DETAINED PATIENTS & RECORD OF PATIENT'S AGREEMENT TO INFORM THEIR NEAREST RELATIVE OF THEIR BEING SUBJECT CTO
(Section 132 of the Mental Health Act 1983, as amended by the Mental Health Act 2007)

Patient's full name:	**Date:**
RC:	**Community RC:**

INFORMATION GIVEN TO DETAINED PATIENT

	The information given must include informing the patient:
• **Given** • **(Please tick)**	• of the provisions of the CTO, and the effect of those provisions; • of the rights (if any) of their nearest relative to discharge them (and what can happen if their responsible clinician does not agree with that decision); • of the effect of the community treatment order, including the conditions which they are required to keep to and the circumstances in which their RC may recall them to hospital. • of the reasons for their CTO; • of the maximum length of the CTO; • that their CTO may be ended at any time if it is no longer required or the criteria for it are no longer met; • that they will not automatically be discharged when the current period of CTO ends • that their CTO will not automatically be renewed or extended when the current period of CTO ends. • of the role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved • of the nature purpose and likely effects of any treatment which is planned • of the right of the RC and the hospital managers to discharge them • of their right to ask the hospital managers to discharge them; • of their rights to apply to the Tribunal; about the role of the Tribunal; and how to apply to the Tribunal • of the rights (if any) of their nearest relative to apply to the Tribunal on their behalf; • that CTO orders that are revoked, - that their cases will be referred automatically to the Tribunal. • how to contact Mental Health Act administration to help process appeal applications and access to legal solicitors • how to make a complaint to the Commission, and about the Trusts own complaints system and how to use it • the right to an Independent Mental Health Advocate (IMHA) (except for patients on S4, 5(4), 5(2) & 135/136) • How to access the MHA Code of Practice

• Patient understood initial explanation given? **Yes** ☐ **No, (please comment below)** ☐

If no, further attempts <u>MUST</u> be made and documented until staff are satisfied the patient understands.

• Comments

• PATIENT'S AGREEMENT TO INFORM THEIR NEAREST RELATIVE OF THEIR SUBJECT TO CTO

• Nearest Relative identified by AMHP:

Unless the patient objects, the nearest relative has the right to be told of their admission to Section and the effects of that Section. Please indicate whether the patient objects to their nearest relative being informed: **Please tick**

The patient has no objections to their nearest relative being informed of their admission to Section ☐
The patient DOES OBJECT to their nearest relative being informed of their admission to Section ☐
Comments

• CONSULTATION WITH OTHERS

GP: Comment	Date
Care Co-ordinator: Comment	Date
Community RC: Comment	Date
Others: Comment	Date
Completed by:	
Signature:	**Date:**

NOTES:
The information should be given at the discharge planning meeting when the CTO is made and thereafter on the following occasions:

- at every CPA review
- At renewal of the CTO,
- When patient gives consent to treatment,
- At review of medication.
- Whenever the conditions and restrictions associated with the CTO are discussed
- Whenever the patient questions any aspect of the CTO.

However these minimum requirements do not prevent the nurse from using their professional judgement to decide how frequently the rights need to be re-read for each individual patient. For patients who have a good understanding of their rights it may not be necessary to re-new their rights at such frequent intervals.

While this patient is detained under the above-mentioned Section of the Mental Health Act he / she has been given information, both verbally and in writing, to explain his / her rights on the following occasions:				
Date	**Time**	**Explanation given by:** *(legible name)*	**Leaflet number given to patient**	**Patient understands?** **Yes / No / Comments / Reason for reading**

Appendix D

Letter to GP notification of CTO

Sevenacres
St Mary's Hospital
NEWPORT
Isle of Wight
PO30 5TG
Tel: 01983 534048
Fax: 01983 534020
(secure email) Name@nhs.net

Date

Address

Dear Colleague

Patient's Name – COMMUNITY TREATMENT ORDER, SECTION 17A MHA

I write to inform you that *Name and Date of Birth* was made subject to a Community Treatment Order (Section 17a of the Mental Health Act) on *date*.

Name will be the Community Responsible Clinician and in charge of the medical treatment for the patient's mental disorder whilst they are subject to Section 17a Mental Health Act. Any request for changes to the patient's psychiatric medication must be made via the Responsible Clinician so that the necessary legal treatment certificates can be made.

The patient is required to comply with the following mandatory conditions:

- **They must make themselves available for medical examination by their Responsible Clinician when extension of the CTO is being considered;**
- **They must make themselves available for medical examination, if necessary, to allow a Second Opinion Appointed Doctor (SOAD) to provide a Part 4A certificate authorising treatment.**

The patient is also subject to the following conditions:

- ***Insert as appropriate*.**

Whilst the patient is subject to Section 17a they are also subject to the power of recall (under Section 17e of the Mental Health Act) by the Responsible Clinician to receive medical treatment, if it is considered there would be a risk of harm to the patient's health or safety, or to other people.

Yours sincerely

Name, Job Title

Appendix E

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Community Treatment Order Policy Mental Health Act 2007 Section 17a**

Totals	**WTE**	**Recurring £**	**Non - Recurring £**
Manpower Costs			
Training Staff			
Equipment & Provision of resources			

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**

Totals:		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc.		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix F

Equality Impact Assessment (EIA) Screening Tool

Document Title:	**Community Treatment Order Policy Mental Health Act 2007 Section 17a**
Purpose of document	**Guidance of staff on application of relevant legislation**
Target Audience	**Professional staff in Mental Health Services**
Person or Committee undertaken the Equality Impact Assessment	**Stephen Ward, MHA and MCA Lead**

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men			
	Women			
Race	Asian or Asian British People			
	Black or Black British People			
	Chinese people			
	People of Mixed Race			
	White people (including Irish people)			
	People with Physical	*Yes*	*Yes*	*This policy applies only to those with mental disorders, as*

	Disabilities, Learning Disabilities or Mental Health Issues			*defined by the MHA 1983. The provision is designed to ensure safe and effective care for patients with the highest risks in the community. They may object to the imposition of restrictions under the power of section 17A.*
Sexual Orientation	Transgender			
	Lesbian, Gay men and bisexual			
Age	Children			
	Older People (60+)			
	Younger People (17 to 25 yrs)			
Faith Group				
Pregnancy & Maternity				
Equal Opportunities and/or improved relations				

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)		Yes	
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
No. Safeguards are built into the provision: strict criteria to who can be put on a CTO and rights of appeal.
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
The policy supports the application of legislation to protect persons with severe and enduring mental disorders and the public.

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	