Summary: These Practice Guidance notes are intended to help staff (Clinicians, Care Coordinators, Community and Inpatient Nursing Staff, Approved Mental Health Professionals & Mental Health Act Administrators) interpret and use Supervised Community Treatment provisions effectively and legally and promote best practice, taking into account Trust and local practice issues.

Keywords: SCT, CTO Guidance Procedure

Target Audience: Clinicians, Care Coordinators, Community and Inpatient Nursing Staff, Approved Mental Health Professionals & Mental Health Act Administrators

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Supervised Community Treatment Practice Guidance Notes
Supervised Community Treatment

Sections 17A – 17G Mental Health Act 1983 as amended by the Mental Health Act 2007

1. Introduction

1.1 These Practice Guidance Notes are intended to help clinicians within Southern Health NHS Foundation Trust (SHFT) interpret and use Supervised Community Treatment provisions effectively and legally taking into account local practice issues. No statement within the Practice Guidance Notes should be taken to contradict the primary documents (see para 1.3). Comments specific to Southern Health NHS Foundation Trust are made in italics throughout these guidance notes.

1.2 Supervised Community Treatment (SCT) is a provision introduced into the Mental Health Act 1983 by the 2007 amendments which allows certain patients to be discharged from hospital detention while remaining liable to recall to hospital for further treatment if necessary. This is achieved by means of a Community Treatment Order (CTO).

1.3 The primary documents relating to this provision are the Mental Health Act (MHA) (1983) as amended by the Mental Health Act (2007), the Code of Practice (CoP) Chapter 29, Chapter 25 of the Mental Health Act Reference Guide and these should be referred to at all times. The Code of Practice is a well written document with respect to SCT/CTO and should provide the guidance needed under most circumstances.

1.4 Copies of these documents and other useful documents can be found on SHFT MHA Website.

2. Purpose & Considerations for using SCT

2.1 SCT is not an ‘emergency power’ and therefore professionals – inpatient and community Approved Clinicians (AC) and Approved Mental Health Professionals (AMHPs) should always have time to consider the options, read the relevant parts of the Act and CoP and consult colleagues before embarking on SCT, or extending a CTO. It is imperative that SCT is implemented in a planned way in line with the principles of the Care Programme Approach (CPA).

2.2 It is intended that SCT may apply to patients currently detained in hospital (see 3.1 for eligibility). As well as enabling the earlier discharge from hospital of patients previously detained in hospital it is intended to help to prevent relapse and the harm that relapse might cause. The issue as to what part of the Act should most appropriately be used is addressed in Chapter 31 of the CoP.

2.3 There is no age limit for SCT, although the number of children and young people made subject to SCT is likely to be small (CoP 19 para 19.5). Those aged 16 and over are referred to as ‘adult community patients’ and those under 16 are referred to as ‘child community patients’.

2.4 Paras 27.18 – 27.21 CoP suggest that SCT should be considered for any detained patient who has had more than seven uninterrupted days of Section 17 leave and states “The requirement to consider SCT does not mean that the responsible clinician cannot use longer term leave if that is the more suitable option but the Responsible Clinician (RC) will need to show that both options have been considered and the decision and the reasons for it should...
be recorded in the patient’s notes” NB compliance with this requirement is included as a standard in the Trust’s MHA Audit programme.

2.5 In addition, the RC may need to consider placing a patient on a CTO if that patient has been on long-term section 17 leave and that patient’s detention has become due for renewal.

2.6 The responsible clinician may consider making a report under section 20 and renewing a patient’s detention whilst they are on leave. The responsible clinician may only do this if they are satisfied that the criteria in section 20 of the Act are met and particularly that a Community Treatment Order is not appropriate in the circumstances of the case (see CoP chapter 28 for guidance).

2.7 For patients on leave whilst under section 3, the detention can be renewed only if the criteria under section 20 are met:

i) P is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital;

ii) It is necessary for the health and safety of the patient or the protection of others that he should receive such treatment and that it cannot be provided unless he continues to be detained; and

iii) Appropriate medical treatment is available to him.

Following feedback from the First-Tier Tribunal, consultants should pay particular attention to the criteria of whether

‘It remains necessary for the health and safety of the patient or the protection of others that the patient should receive such treatment and that it cannot be provided unless the patient remains liable to be detained.’

The question that will be asked by the Tribunal is whether hospital treatment constitutes a significant part of the patient’s treatment plan. If the consultant considers that hospital treatment no longer forms a significant part of the patient’s treatment plan, the consultant must either:

i) Place the patient on a CTO; or

ii) Discharge the patient from section.

For note, the Tribunal appears to be interpreting this test quite strictly. For example, treatment or circumstances that cause treatment to fall outside of this test include:

- Treatment delivered entirely under the auspices of the patient’s community mental health team;
- There appears to be no interplay or joint working between the inpatient and community care team.

2.8 It is unlawful to recall the patient to hospital solely in order to renew the authority for their detention.

3. Eligible Patients: (CoP Chapter 29)

3.1 SCT applies to patients being discharged from a hospital detention for the purpose of treatment. Most patients eligible for detention under SCT within the Trust will have been
detained under section 3 but a small number will have been detained under other orders such as Hospital Orders (section 37 or 51), a Hospital Direction (section 45A), or a Transfer Direction without restrictions (section 47 or 48).

3.2 SCT cannot be used for patients detained under section 2 of the Act or patients subject to restrictions under sections 41 and 49 of the Act.

3.3 SCT is only an option for patients who meet key criteria as laid out in Chapter 31 of the CoP.

4. **Responsible Clinician for Patients subject to SCT: Refer to Allocation of RC Protocol – Appendix 1**

4.1 The Responsible Clinician (RC) is the clinician with overall responsibility for the patient’s care and should be a clinician who has the expertise to manage the assessment and treatment of a patient discharged under a CTO.

4.2 The RC’s role whilst the patient is subject to a detaining order in hospital is to assess the appropriateness of SCT for the patient in consultation with other professionals involved in the patient’s care, including an AMHP and the Nearest Relative. The assessment should be based on factors such as risk, past history, home circumstances and previous concordance with treatment. SCT may also be suggested as an option by the Tribunal when a patient makes an application for discharge.

4.3 The RC can change and should change to reflect the patient’s need appropriate to their circumstances. Any change should occur as a result of discussion and forward planning through the CPA process. Where the In-Patient Consultant and the Community Consultant for an individual is not the same person then the RC should change at the point that the patient is discharged into the community.

4.4 The local MHA Administrator (MHAA) should be informed when care is transferred and a Notification of Change of RC form should be passed to the MHAA – see Appendix 1. If the CPA identifies that the patient’s needs are best met through, Community Teams on discharge RC responsibility will be transferred directly to the relevant Approved Clinician (AC). A Notification of Change of Responsible Clinician for a patient subject to Supervised Community Treatment Form must be completed – Appendix 2.

4.5 At any point it must be clear who the RC is and arrangements will need to be made in each area to clarify who ‘covers’ that individual when they are not available for example out-of-hours and when they are on leave.

4.6 Quick Summary:

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<td>Community RC</td>
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In all instances, the transferring RC should i) discuss and confirm the allocation with the receiving RC and ii) inform their local MHA Administration team in writing using a Notification of Change of RC form that the allocation has taken place.
5. **Approved Mental Health Professionals (AMHPs): (CoP 29.22 – 29.33)**

5.1 The AMHP is a professional approved by a local Social Services Authority (LSSA) to carry out a variety of functions within the Act.

5.2 The AMHP’s role is to independently assess the patient to decide whether the patient meets the criteria for SCT and, if so, whether SCT is appropriate. The AMHP may be a professional already involved in the care of the patient but does not have to be so.

5.3 To reach an informed decision the AMHP requires sufficient time, preferably two weeks in order to consider

- The wider social context for the patient
- Relevant clinical history
- Relevant factors such as any support networks the patient may have
- The potential impact on the patient’s family
- Employment issues
- How the patient’s social and cultural background may influence the family environment and the support structures that are potentially available.

5.4 “If the AMHP does not agree with the responsible clinician that the patient should go onto SCT, then SCT cannot go ahead. A record of the AMHP’s decision and the full reasons for it should be kept with the patient’s notes. It would not be appropriate for the responsible clinician to approach another AMHP for an alternative view” (CoP para 29.25).

NB - The record of the AMHP assessment and outcome should be recorded on the AMHP Assessment form – see Appendix 3

6. **The Care Co-ordinator**

6.1 The Care Co-Ordinator (CC) is responsible for making the arrangements for the SOAD visit and liaising with the patient and the SOAD to confirm a time, date and venue of the visit. CCs must remind the patient of the time and date of the SOAD’s appointment the day before the visit.

6.2 Where the patient lacks capacity to consent to their treatment, the CC is required to make suitable arrangements to facilitate the attendance of the patient which may include the CC meeting the patient and bringing them to the location of the visit.

6.3 Where a patient deemed incapable does not attend, this will be treated as a failure by the CC to make suitable arrangements for the visit, the SOAD will advise the RC and CC that the visit has not been completed because the patient did not attend and that they will be required to submit a new electronic second opinion request form to facilitate a further SOAD visit.

6.4 The CC is responsible for providing the patient with information in accordance with s132, see CoP paras 4.9 – 4.30 and information concerning their right to access Independent Mental Health Advocacy (IMHA) services, see CoP para 6.15 – 6.20 A record of the provision of this information should be made on part 1 & 2 of the Trust’s s132/IMHA form, a copy of which should be retained in the patient’s notes and a copy sent to the MHAA. The CC should repeat s132/IMHA rights every 3 months.

6.5 Responsibilities for monitoring should be laid out and agreed in the care plan. The care plan will normally be co-ordinated by the CC who will need to ensure that appropriate action is
taken if the patient becomes unwell, engages in high-risk behaviour as a result of their mental disorder or withdraws consent to or refuses treatment.

7. **Making the CTO – The Process: (CoP 29.27 – 29.33)**

*See Appendix 4. Process Flowchart*

7.1 Good planning in line with the principles of CPA is essential. The patient, the patient’s Nearest Relative, the patient’s carers, the patient’s Advocate, and the multidisciplinary team should be involved where practicable.

If the RC is to change at the point of discharge from hospital, for example where there are different in-patient and community ACs, then they should both be involved at this point. It is important that the patient’s General Practitioner is also involved in the planning for SCT.

7.2 *The Trust’s position in line with the CoP para 29.20, is that a pre-discharge CPA review is essential for any patient being discharged on SCT. The RC in the In-patient unit and the AC in the community must be involved and should attend.*

7.3 In the pre-discharge CPA meeting, discussions with the patient should include

- that it is a condition of their CTO that they make themselves available to meet the SOAD and the consequences of not attending (non-consenting patients only)
- the preferred venue for the meeting with the SOAD, and for future Managers’ Hearings for the extension of the CTO and Tribunal hearings (i.e. Community Treatment Team base or hospital)

7.4 It is the responsibility of the RC to discuss the mandatory and discretionary conditions of the order with the patient and to inform the patient of the consequences of not complying with the conditions.

7.5 The MHAA should be informed of the CPA in which SCT is to be considered, in order to provide the relevant paperwork which is required at the inception of a CTO (CTO 1, SOAD visit request form, (non-consenting patients only) s132/IMHA Information form, change of responsible clinician form and SCT patient information leaflet).

7.6 If the RC and the AMHP are in agreement that the patient should be discharged onto a SCT then they complete the relevant Statutory Form CTO1 and send it to the MHAA in the detaining hospital, to be formally accepted on behalf of the Hospital Managers.

7.7 The CTO1 form must specify the date on which the CTO is to be activated, which can be a short while after the date on which the form is signed to allow arrangements to be made for discharge. The CTO1 form should be sent to the MHAA before part 3 has been signed to allow the MHAA to scrutinise, as amendments cannot be made to the form after the order has been activated by the completion of part 3.

7.8 All CTO’s must have a treatment certificate in place within one month of the CTO being in place. See guidance flowchart Appendix 5

7.9 If the patient still requires medical treatment after the first month on a CTO, and they have capacity and are consenting to the treatment, the responsible clinician must complete a CTO12 Form and a SHFT Record of Assessment for Consent to Treatment – CTO Patient Form – Appendix 6

7.9.1 If the patient still requires medical treatment after the first month on a CTO, but lacks capacity to consent to the treatment it must be authorised by a SOAD on statutory form CTO11. The
RC should submit an electronic SOAD visit request to the CQC and complete a SHFT Record of Assessment for Consent to Treatment – CTO Patient Form. Appendix 6 also see Appendix 7 - Process Flowchart - Patients subject to CTO who are incapable of Consenting to their Treatment

If there is a delay in obtaining a CTO11 certificate, treatment can be provided under the Emergency Treatment provision of section 64G – ECT (form at Appendix 7) and 64G – Medication (form at Appendix 8)

NB – For Treatment on Recall please see 13.4 of this policy

7.10 The Care Co-Ordinator (CC) is responsible for making the arrangements for the SOAD visit and liaising with the patient and the SOAD to confirm a time, date and venue of the visit. CCs must remind the patient of the time and date of the SOAD's appointment the day before the visit.

7.11 Where the patient lacks capacity to consent to their treatment, the CC is required to make suitable arrangements to facilitate the attendance of the patient which may include the CC meeting the patient and bringing them to the location of the visit.

7.12 Where a patient deemed incapable does not attend, this will be treated as a failure by the CC to make suitable arrangements for the visit, the SOAD will advise the RC and CC that the visit has not been completed because the patient did not attend and that they will be required to submit a new electronic second opinion request form to facilitate a further SOAD visit.

7.13 The General Practitioner (GP) will also be informed by the MHAA that any potential change in the prescribed psychotropic medication will need to be discussed with the RC in order for the RC to issue a new CTO12 certificate or make arrangements for the new medication to be approved by a SOAD. The MHA Administrator will provide the GP with a copy of the treatment certificate CTO11 or CTO12 listing the approved medication.

7.14 The CTO must include the conditions discussed and agreed in the CPA meeting, that the patient is required to comply with while on SCT. There are two conditions that are mandatory. Patients must make themselves available for medical examinations by RC for consideration of extension of the CTO and an incapacitated patient must make themselves available for medical examination by a SOAD to provide a part 4A certificate authorising treatment.

7.15 The conditions imposed in or by a CTO must not amount to a deprivation of liberty i.e. i) continuous supervision control of a patient and ii) the patient not being free to leave. This includes both the legal conditions i.e. the conditions written on the CTO and the factual conditions of the CTO i.e. the actual circumstances resulting from the CTO. The CTO will be invalid if the legal conditions amount to a deprivation of liberty; if the factual circumstances amount to a deprivation of liberty then either:

- P must consent to the deprivation (if he/she has the capacity to do so), or
- A DoLS authorisation must be applied for if P lacks capacity.

7.16 Other conditions may be set to ensure that the patient receives medical treatment for their mental disorder, to prevent a risk of harm to the patient’s health or safety or to protect other people but not for any other reason. All conditions must be agreed by both the inpatient RC and community AC and the AMHP.

7.17 A letter detailing the conditions will be given to the patient by the MHAA. A copy of this letter will also be sent to the GP and the Nearest Relative. The latter will be sent providing the patient consents.
7.18 *It is good practice for the RC to consult with an AMHP should there be any subsequent variation to the conditions of the Community Treatment Order. Variations to the CTO should be recorded on a CTO2 which should be passed to the MHA Administrator for distribution.*

7.19 The detaining hospital has a duty to inform the Nearest Relative (unless the patient or relative have asked for this information not to be given) if practicable at least 7 days before the date of discharge from the hospital.

7.20 The CC is responsible for providing the patient with information in accordance with s132, see CoP paras 4.9 – 4.30 and information concerning their right to access Independent Mental Health Advocacy (IMHA) services, see CoP para 6.15 – 6.20 A record of the provision of this information should be made on part 1 & 2 of the Trust’s s132/IMHA form, a copy of which should be retained in the patient’s notes and a copy sent to the MHAA. The CC should repeat s132/IMHA rights every 3 months.

8. **Monitoring SCT Patients (CoP 29.36– 29.43)**

8.1 Responsibilities for monitoring should be laid out and agreed in the care plan. The care plan will normally be co-ordinated by the CC who will need to ensure that appropriate action is taken if the patient becomes unwell, engages in high-risk behaviour as a result of their mental disorder or withdraws consent to or refuses treatment.

8.2 The RC will need to consider with the patient what the next steps in their care plan should be. The RC can vary or suspend any of the conditions of the CTO and does not need to agree this with the AMHP although it would be good practice to obtain this agreement where conditions had only recently been agreed with the AMHP. Variations in the conditions must be recorded on the statutory form CTO2 and sent to the MHAA of the responsible hospital. The RC will need to consider recall to hospital if it is no longer safe and appropriate for the patient to remain in the community.

8.3 The RC should remove conditions if the patient’s mental health has improved and the conditions are no longer required or relevant. The changes in conditions should be recorded on statutory form CTO2, a copy of this form should be retained in the patient’s notes and the original should be sent to the MHAA as soon as possible.

9. **Extension and Expiry of CTOs (CoP 32.2 – 32.16)**

9.1 CTOs expire at the end of the six months starting on the day that the order was formally accepted on behalf of the Hospital Managers. They can be extended for a further six months and then for a year at a time. The RC should be mindful of the expiry date of the order. However, a prompt will be sent by the MHAA 8 weeks prior to the expiry date, which will be copied to the appropriate Community Team Leader.

9.2 Within the last two months before the CTO is due to expire the RC must examine the patient in order to determine if the patient meets the criteria for extension. The RC can recall the patient to hospital to carry out this examination as “making himself available for examination” is one of the mandatory conditions of a CTO. The criteria for extension are the same as those for making the CTO in the first place.

9.3 If the RC’s proposal is to extend the CTO a CPA meeting should be arranged with all professionals present, including an AMHP, no later than 3 weeks before the expiry of the order. The timing of the CPA is crucial in order to allow arrangements to be made for a Managers Hearing to consider the extension and to allow time for the preparation of reports.
9.4 The RC is required to make a report on statutory form CTO7 and must consult with one or more persons who have been professionally concerned with the patient’s medical treatment. An AMHP will also need to provide a statement in the report confirming that the criteria for SCT are still met and that it is appropriate to extend the CTO.

9.5 The CTO7 report should be completed in a chronological order in line with regulations i.e. RC to complete part 1 but should not complete Part 3 until the AMHP has completed part 2. This report is sent to the Mental Health Act Administrator of the responsible hospital to be formally accepted on behalf of the Hospital Managers and for a Managers Hearing to be arranged. It is essential that the Managers Hearing should be in advance of the expiry date.

9.6 Renewal of detention and extension of CTOs is dealt with in Chapter 32 of the CoP.

10. **Emergency Assessment under Section 136 for Patients Subject to SCT**

There may be occasions when a patient under a CTO is arrested on s.136 by Police. In this event, professionals should adhere to established processes which address requirements of s.136 as per Code of Practice. Good practice would indicate that the RC for the CTO of the patient would make himself available to provide an assessment under s.136 at the place of safety and should consider the use of recall as one possible means of disposal. Where the RC may not be available to provide an assessment, he should liaise with the doctor assessing to agree the most suitable outcome. Out of hours the assessing doctor should follow the standard s.136 procedure. On completion of a medical assessment a CTO3 can be used to facilitate recall if this is felt to be the most suitable outcome. Providing the doctor acting in the capacity of RC is an Approved Clinician.

11. **Recall to Hospital: (CoP 29.52 – 29.62)**

11.1 The recall power provides a means to respond to the patient’s deteriorating mental health before the situation leads to the patient or other people being harmed. *See Appendix 8 - SCT Recall Procedures Flowchart*

11.2 Criteria for Recall

11.2.1 The RC or out of hours on call AC acting as RC, may recall a patient on SCT to hospital if the patient needs to receive treatment for mental disorder as an in- patient or out-patient and there would be a risk of harm to the patient or others if the patient were not recalled. The RC can also recall a patient to hospital if they break one of the mandatory conditions although the patient must be given the opportunity to comply before recall is considered.

11.2.2 RC must be satisfied that the criteria are met before using the recall power and that the action proposed is proportionate to the level of risk, for example it may be appropriate to monitor the situation in the community or the patient can agree to voluntary admission to hospital without recall. It is good practice that the possibilities that might arise should a patient deteriorate are dealt with within the Crisis and Contingency plan within the CPA care plan.

11.3 Co-ordination of Recall

11.3.1 The possibility of recall should be addressed in the care plan for the patient on SCT. The care plan should address the issues of why, when and how the patient could be recalled to hospital and should identify the wishes of the patient as far as is possible. Discussions within a CPA setting should also include the nomination of a person who would take the lead in organising and arranging the conveyance of the patient to hospital in the event of a recall.
11.3.2 The RC is responsible for co-ordinating the recall process, which starts when the RC completes a written notice of recall, Statutory Form CTO3. The recall is effective only when served on the patient. If the notice of recall cannot be personally served on the patient there are other provisions which must be followed (see CoP 29.55- 29.58). Once the notice of recall is served the patient can be considered absent without leave and taken and conveyed to hospital accordingly (see policy CP24 – Service Users Missing/Absent Without Leave) although the least restrictive manner of conveyance should be used. This should be guided by a risk assessment. It may be that the use of Section 135(2) may need to be considered. Guidance on the Conveyance of Detained Patients is contained within Chapter -17 of the CoP, particularly CoP paras 17.30 – 17.32. Copies of CTO3 should be forwarded to the receiving hospital, the MHAA at both the receiving hospital and the home unit if different and a copy retained in the patient’s notes. A further copy can be used for the individual or agency conveying the patient for example the care co-ordinator, the police or ambulance service.

11.3.3 The RC should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide treatment which can be on an out-patient basis. The hospital need not be the same hospital as the patient’s responsible hospital (i.e. the hospital in which they were detained prior to discharge to SCT). The RC needs to complete statutory form CTO3 and send it to the Hospital where the patient is to be admitted.

11.3.4 The RC should inform the AAT or HHT of a potential out of hours recall and the need for identification of a bed within SHFT. The identification of a bed would normally fall to the bed management arrangements as identified in the Trust Admissions Transfer and Discharge Policies. In order to minimise the difficulties that might arise where the patient is admitted to a hospital other than their ‘home’ hospital, staff responsible for bed management must be particularly sensitive to the need to admit the patient to their ‘home’ hospital wherever possible.

12. Effect of Recall & Assessment following Recall – CoP -29.61 – 29-68

12.1 The 72 hour period starts on the patient’s arrival in hospital and the Nurse in Charge will need to document this by completing statutory form CTO4, this document and form CTO3 should be delivered to the MHAA as soon as possible. The ward staff will need to inform the Community RC of the patient’s arrival on the ward, the duty AMHP Coordinator as well as the clinical team looking after the patient for his period in hospital.

NB A patient subject to Supervised Community Treatment may agree to informal admission and should be treated as an informal patient. However if the patient’s health deteriorates to the extent that to allow them to leave would pose a risk to their health and/or safety or the protection of others, consideration should be given to serving a formal recall notice on them under s17E (form CTO3 ) so that they can be prevented from leaving hospital whilst a full assessment can be undertaken. Section 5 holding powers cannot be used in these circumstances the RC must be contacted immediately to initiate the formal recall process. In the event of such an emergency staff should take steps to prevent harm and under the power of common law, the doctrine of necessity and duty of care, should prevent the patient from leaving the clinical area until the RC is able to review the patient.

12.2 The patient must be assessed by the clinical team to determine the next steps and whether the care plan needs to be changed. The patient may be detained in hospital for up to 72 hours to allow the RC to determine what should happen next and to implement treatment.

12.3 During this period the patient remains a SCT patient. The RC can allow the patient to leave at any point within the 72 hour period and on leaving the hospital the patient will remain on SCT as before. However, once 72 hours have elapsed the RC must allow the patient to leave hospital unless the CTO has been revoked or the patient agrees to stay as an informal patient.
If the patient is discharged back to the community on SCT the SHFT CTO Recall Record of Assessment Form should be completed and sent to the MHAA.

The MHAA should be informed if the patient is admitted as a voluntary patient or if the patient agrees to remain in hospital informally following recall.

12.3.1 The patient remains on SCT when initially admitted the RC should not change within the initial 72 hour period, particularly as the patient will remain on SCT if then discharged from hospital. Where the patient is admitted under a different consultant or to a different out-of-area hospital, it remains most appropriate, for the sake of continuity of care, that the RC is not changed. In these circumstances the RC will have a duty to communicate in a timely manner with the clinical team managing the patient in the hospital and to assist in reviewing the care plan. In order to minimise potential difficulties, good practice would be for bed management to consider admitting the patient to their ‘home’ hospital wherever possible.

12.4 The rules on treatment when recalled are dealt with in CoP 25.33 – 25.36. Also see Appendix 9 CQC Guidance Note - Administration of medicine and the MHA 1983 - Part C.

12.5 A certificate for treatment on Recall is not required if the CTO is less than one month old.

12.6 A certificate is not needed under either section 58 or 58A if a part 4A certificate (CTO12) consent certificate has been issued and the patient is consenting.

12.7 A certificate is not needed under either section 58 or 58A if the treatment in question is explicitly authorized for administration on recall on the patient’s SOAD issued part 4A certificate (CTO11).

12.8 Treatment that was already being given on the basis of a part 4A certificate may be continued, even though it is not authorized for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. It may only be continued pending compliance with section 58 or 58A.

13. Revoking the CTO: (CoP 29.63 – 29.68)

13.1 If a patient is likely to need admission for more than 72 hours following recall then the RC should consider revoking the CTO. See Appendix 10 - SCT Revocation Procedures Flowchart. The RC should consult with an AMHP for consideration of the revocation and allow the AMHP to independently assess the appropriateness of the revocation. The AMHP can be involved in the patient’s care plan but does not need to be so and does not need to be the AMHP who agreed to the original CTO. The RC and AMHP must complete the appropriate statutory form, CTO5, for the revocation to take place and then send it to the MHAA of the hospital where the patient is accommodated.

13.2 When the CTO is revoked the patient is detained under the part of the Act that they were detained on before going onto SCT. A new period of detention of six months begins from the date of the revocation, for the purposes of review and applications to the tribunal.

13.3 Revocation of the CTO automatically leads to the patient being referred to the Tribunal Service by the MHAA on behalf of the Hospital Managers. Upon revocation treatment is provided under Part 4 of the Act and a new Consent to Treatment or Second Opinion will be required immediately. See Appendix 9 - CQC Guidance Note - Administration of medicine for mental disorder and the MHA 1983 – Part D.

13.4 Within SHFT there will be a change of RC at the point where the CTO is revoked, if the inpatient and community consultant is not one and the same person. If the patient is to be
treated in a different out-of-area hospital then a change of RC should also take place. The guiding principle is that the RC should be the clinician in overall charge of the patient’s treatment at that time.

14. Review and Discharge of SCT (CoP 32.17 – 32.19)

14.1 A CTO should not simply be allowed to lapse. It is good practice for SCT to be reviewed as part of the care plan review under CPA to see if the SCT is still meeting the patient’s needs. If the criteria for SCT are no longer met then the CTO must be discharged without delay. If Guardianship is considered a better option for a patient on SCT then the relevant application needs to be made.

14.2 Patients subject to SCT can be discharged from SCT in the same way as other detained patients, by the Tribunal, the Hospital Managers, the Nearest Relative (for Part 2 patients only) or the RC.

14.3 When discharging a patient from a CTO the RC should complete SHFT’s Section 23 Order for Discharge Form and send it to the MHAA as per current practice.

14.4 The reasons for discharge of the CTO should be explained to the patient and the clinical team should ensure that the patient continues to receive after-care services under section 117 of the Act as appropriate.

15. Dispute Resolution

15.1 It is possible given the complexity and multiple sites of SHFT that disputes might arise over who should take responsibility for various parts of the CTO process.

15.2 It would be good practice for disagreements to be resolved between the professionals concerned but if this proves impossible then the issue should be taken to the relevant senior managers to resolve. Out of hours the issue should be raised with the manager on-call.

16. Primary Documents

Mental Health Act 1983 as amended by the Mental Health Act 2007 Mental Health Act Code of Practice 2015 Mental Health Act Reference Guide 2015

17. Useful References

SHFT Mental Health Act Website. http://www.southernhealth.nhs.uk/search/?q=mha&radio=

CSIP ‘SCT Frequently Asked Questions’ on CSIP and Trust Mental Health Act Websites’

CSIP ‘Background Guidance to the MHA’

18. CTO Statutory Forms

<table>
<thead>
<tr>
<th>CTO 1</th>
<th>Section17 A Community Treatment Order, incorporating the conditions</th>
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<tbody>
<tr>
<td>CTO 2</td>
<td>Section 17B Variation of conditions of a CTO</td>
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<td>CTO 3</td>
<td>Section 17E Notice of Recall to Hospital</td>
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<td>CTO 4</td>
<td>Section 17E Record of patient’s detention in hospital after recall</td>
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<td>CTO 5</td>
<td>Section 17F(4) Revocation of CTO</td>
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<td>CTO 6</td>
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<td>CTO 7</td>
<td>Section 20A Report extending the Community treatment period</td>
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<td>CTO 8</td>
<td>Section 21B Authority for extension of Community treatment period after Absence without Leave for more than 28 days</td>
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<td>CTO 9</td>
<td>Regulation 16(4) and (5) Community patients transferred to England</td>
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<tr>
<td>CTO 10</td>
<td>Section 19A Authority for assignment of responsibility for community patient to hospital under different managers</td>
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<tr>
<td>CTO11</td>
<td>Section64C(4) Certificate of appropriateness of Treatment to be given to community patient</td>
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<tr>
<td>CTO12</td>
<td>Section 64C(4A) – certificate that the community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate)</td>
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19. Appendices

**Appendix 1**
Allocation of RC Protocol

**Appendix 2**
Notification of Change of Responsible Clinician for a patient subject to Supervised Community Treatment – Form

**Appendix 3**
Hampshire County Council Supervised Community Treatment assessment Pro forma

**Appendix 4**
Setting up a new Community Treatment Order - Process Flowchart

**Appendix 5**
Community Treatment Order - Guidance for Treatment

**Appendix 6**
Record of Assessment for Consent to Treatment – CTO Patient Form

**Appendix 7**
Second Opinion Appointed Doctor (SOAD) Visits for Non Capacitated Patients subject to CTO – Process Flowchart

**Appendix 8**
S64G Emergency Treatment (ECT) - Form

**Appendix 9**
S64G Emergency Treatment (Not ECT) - Form

**Appendix 10**
SCT Recall Procedures - Flowchart

**Appendix 11**
CQC Guidance Note – the administration of medicine for mental disorder and the MHA 1983

**Appendix 12**
SCT Revocation Procedures - Flowchart

**Appendix 13**
Supervised Community Treatment Recall Procedure - Flowcharts