COMMUNITY TREATMENT ORDERS
FREQUENTLY ASKED QUESTIONS.

Q1: The patient was detained under s.3 and has been discharged from hospital on a Community Treatment Order. Has the s.3 come to an end?

A. The section continues, but the manager's authority to detain the patient in hospital is suspended, and for the duration of the CTO the patient is not a person who is liable to be detained. (s17D). The s3 must continue throughout the duration of the CTO; for this reason if the MHT decide to discharge the s3 for example on a discharge on a future date, with the intention that the RC should impose a CTO during the period of deferment, they have defeated their own purpose, since when the treatment section is discharged any CTO will also lapse with it. (See s17C.) It is the subsisting s.3 that provides the legal basis for recall.

Q2: Do all Community Treatment Orders have conditions attached to them?

A: Yes. The mandatory minimum conditions are that the patient must:

- make him or herself available for examination by the Responsible Clinician within the last two months of the CTO;

- if necessary, to make him or herself available to a second opinion doctor (SOAD) to enable completion of a certificate certifying that treatment should be given.(s17B3)

The Responsible Clinician can also attach conditions, with the agreement of the

Approved Mental Health Professional, for the following purposes:

- to ensure the patient receives treatment;

- to prevent any risk of harm to the patient's health and safety;

- to protect other persons.(s17B2)

Q3: Does the patient have to agree to become a CTO patient?

A: Although the discussions in Parliament before the passing of the Act seemed to suggest that the patient would have to agree to the imposition of a CTO, there is no requirement for this in the Act. However paragraph 25.14 of the Code of Practice comments that patients 'will need to be involved in decisions about the treatment to be provided in the community…. and be prepared to co-operate with the proposed treatment'.

Q4: When does a CTO patient need a certificate involving an examination by a SOAD? ('a Part 4A Certificate')

A: All CTO patients need a second opinion if they cannot or do not consent to treatment with medication, unless:

- Treatment is being given within the first month of the CTO, or the first three months since the treatment started, whichever is later;

- It is emergency treatment that is immediately necessary, given in the reasonable belief that the patient does not have capacity to consent, and given by force only if this is proportionate to the risk of harm to the patient, and the seriousness of that harm;

- It is immediately necessary to prevent serious deterioration or death and it is not irreversible or hazardous. (s64A- K).

The Part 4a Certificate should also deal with the treatment which the patient might need if s/he were to be recalled to hospital contents. Guidance is given in the Code of Practice Chapter 23.

Q5. Is it possible for a Tribunal to be satisfied that appropriate treatment is available if the SOAD requirements have not been complied with?

A. Yes. There is a serious backlog of SOAD referrals, and many CTO patients without capacity or who object are being treated beyond the one month cut-off point that usually applies.

There are several possible approaches to this issue, including:-

1. The legal framework within which treatment is delivered is not a matter for the Tribunal to determine. S. 72(c)(i) and (iv) requires the panel to find that there is mental disorder of a type and/or gravity that makes treatment appropriate, and that appropriate medical treatment is available. This relationship between a mental disorder and the treatment for a mental disorder that is both appropriate for it and available to the patient need not have anything to do with the checks and balances of the legal framework beyond s.72. This approach is consistent with the Code of Practice, paragraphs 6.7 and 6.8, which sites the disorder itself and the patient's subjective socio-cultural and religious issues as relevant to the meaning of the word appropriate, but not the engagement of a second opinion or any other legal issue (see also 6.10).

2. Alternatively, many RC's are treating under the emergency provisions in s.64, including the administration of depot medication. There is some support for this approach from the Care Quality Commission, which has published "Treatment under emergency powers for SCT patients awaiting second opinions", on its website (www.cqc.org.uk/guidanceforprofessionals):-

"The Commission takes the view that these 'emergency' provisions can extend to be used to ensure that a patient's medication levels do not drop below the therapeutic dose – i.e. it is not necessary to wait for a relapse to show before authorising treatment under these powers."

Depending on the facts, this supports the position that "emergency" is to be construed considerably more widely than under the old common law doctrine of

necessity.

Q6. In what circumstances may a CTO patient be recalled to hospital?

A.
The RC may recall a CTO patient to hospital if either

1. the RC considers that
(a) The patient requires treatment in hospital for his mental disorder; and
(b) there would be a risk of harm to the health or safety of the patient or to other person if the patient were not recalled to hospital for that purpose. (s17E(1)

OR

2. the patient has failed to comply with one of the mandatory conditions set out in s17B(3) (i.e. failing to make himself available for examination by the RC or SOAD). (s17E(2)).

Can you recall a CTO patient who is already an informal patient in hospital?
Yes. See s17E(4) and Q. 18 below

Q7. Does the Responsible Clinician have to see the patient before recall for breach of the conditions on the CTO?

A. If the patient has refused to cooperate with the mandatory conditions (under s 17B (3)) of examination by the R.C. or the SOAD, s/he can be recalled. The purpose of recall is to establish the patient's mental condition so that the RC can decide whether or not to exercise his powers to continue the CTO or to revoke it. However there is no power to recall the patient for breach of one of the non-mandatory conditions, unless the RC considers that there has been a decline in the patient's mental state which would justify his recall under s17E(1). Therefore the RC's decision to recall the patient on such grounds must be based on a recent medical examination.

Q8. How does recall take place?

A. The RC exercises the power of recall by notice in writing to the patient (s17E(5), which is sufficient authority for the Managers of the hospital to detain the patient. (s17 E(6)).

Q9. What is the CTO patient's status when recalled to hospital by the RC?

A. The RC should examine the patient and make a decision within 72 hours, after which the authority to further detain the patient expires. (s17F(6)
The RC must choose whether to:

EITHER

1. Revoke the CTO if the s3 conditions are met (i.e. mental disorder of a nature or degree to make liability to detention for treatment appropriate, and it is necessary for the health or safety of the patient or for the protection of others

that he should be so detained). The RC must confirm his view in writing on Form CTO5, contained in the Mental Health Regulations 1983. On the same form, the AMHP must state that they agree with the RC's opinion and that it is appropriate to revoke the order. The patient then becomes a patient detained on the original treatment order and the Managers' power to detain which had been suspended by the CTO is reactivated.

OR

2. The RC can choose to 'release' the patient; but NB s17F (7) provides that a patient who is released under this section remains a community patient and subject to the CTO (presumably under the same conditions as before recall).

Q10. Can the recalled patient be compelled to accept treatment in the first 72 hours?

A. S62A and Paras. 24.28 to 24.31 Code of Practice govern the powers to treat a recalled patient. The power to treat is dependent on how long the patient has been discharged from hospital on the s3, whether the proposed treatment is already explicitly authorised for administration on recall on a part 4A certificate (SOAD certificate); provisions also exist for RC to treat in the absence of specific authority to treat on recall if he considers that discontinuing existing treatment would cause the patient serious suffering. However the provisions are complicated, and care needs to be taken to ensure that the rules are applied correctly in each case.

Q11. Is there a right to review of the revocation of a CTO order?

A. S.68 (1) (d) imposes a duty on the Hospital Managers to refer to the MHT (FTT) the case of a patient who has been re-admitted to hospital for treatment following the revocation of a CTO under s17F. The reference must take place 'as soon as possible' (s68 (7). In addition the patient or Nearest Relative may apply (see below).

Q12. If a patient is recalled and his/her case is referred to the Tribunal, what happens to that referral if the patient is discharged from the hospital on another CTO before the hearing?

This situation is dealt with in Guidance issued by the Deputy Chamber President Judge Hinchliffe on 01 08 10, the full text of which is appended to these FAQs.

The effect of this Guidance is that, contrary to previous practice, the Tribunal will now treat these referrals as lapsing at the point when the patient is put back on a CTO. Detailed legal reasoning for this approach is given in the Guidance and will not be repeated here. In practical terms, this approach relieves the Tribunal and witnesses of the expense and time of continuing hearings which are often unpopular with the patient, who may feel coerced to attend a hearing which s/he has not requested, at a point just after s/he has been discharged from hospital.

This, of course, does not prevent the patient making an application if they wish to contest the new CTO, and it does not apply to other time-triggered references arising under

section 68 which do not lapse. Indeed, if one referral lapses and another doesn't then the surviving referral will still go ahead.

The situation is distinguished from the position where a patient on a s3 is placed on a CTO before the hearing, in which case the law as set out in the case of AA still applies (again see the Guidance below for fuller reasoning) and the hearing will go ahead (albeit on the CTO criteria).

Q13. When does a CTO patient have a right to apply to the Tribunal?

A. By s.66 (i)(ca) when a CTO is first imposed, the patient may apply in the 'relevant period' i.e. in the first six months after detention counting from the date of the imposition of the original s3 (or s2 if used).
When a CTO patient has been recalled to hospital and the CTO has been revoked, the patient may apply to the Tribunal within six months from the date of revocation (s66(i) (cb)). The Secretary of State has the right under s67 to refer any patient's case to the MHT at any time, including that of a CTO patient. The NR also has a right of appeal under s69.

Q14. Can a NR discharge a CTO patient?

A. The Nearest Relative may apply to discharge a CTO patient in any period in which the patient would have a right to apply. The Responsible Clinician has a right under s25 to bar the discharge (in the same way as a patient on a treatment section); the grounds for refusing discharge by the Tribunal on hearing the NR's application are that ' the patient, if discharged , would be likely to act in manner dangerous to other persons or to himself'.

Q15. What are the powers of the MHT when hearing a CTO patient application or reference?

The MHT's powers are set out at s72 (1) (c). They have a mandatory duty to discharge the CTO patient (the 'community patient') if not satisfied that:

(i) he is then suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or

(ii) that it is necessary for his health or safety or for the protection of others that he should receive such treatment; or
(iii) that appropriate medical treatment is available for him; or

(iv) in the case of an application by a nearest relative, that the patient if discharged would be likely to act in a manner dangerous to himself or others.
The Tribunal has no power to vary the conditions imposed by the RC; it must simply confirm or discharge the CTO.

Q16. The patient refuses to see the medical member for an examination before the hearing; what should happen now? Is it sufficient for the medical member to read the notes and speak to the CPN or other member of the community team familiar with the patient?

A. The Tribunal has published 'Process Guidance' concerning this situation, setting out best practice to be adopted by the hearing panel. The FTT (HESC) Rule 34 states that the Medical Member must 'so far as practicable' 'examine the patient and take such other steps as that member considers necessary to form an opinion of the patient's medical condition'. Taking the above steps will probably be sufficient to satisfy the requirements under this Rule, but the panel must determine as a preliminary issue whether the Rule has been complied with.

Q17: What if the patient refuses to see the Medical Member, and does not attend the hearing?

A: Again the Tribunal's Process Guidance deals with this situation, which engages Rule 39 as well as Rule 34, which permits a hearing to take place in a party's absence provided that certain conditions are satisfied, which must be determined by the panel before the hearing begins. If the panel is not satisfied that all necessary steps have been taken, or that reasonable steps have been taken to tell the patient about the hearing and the patient has chosen not to come, or that it is in the interests of justice to proceed, then the panel should adjourn and give directions specific to its concerns, in order that these will have been addressed in time for the next hearing.

Q. 18 What if a CTO patient is not recalled under the CTO (i.e. under the procedure under s17E) but brought back into hospital under another provision, for instance s.2, or as an informal patient?

A. The CTO remains in place and runs concurrently to a s2 order, or the patient's stay in hospital as an informal patient. This is because S17C provides that the CTO will only come to an end if it expires or is revoked, or discharged or, under s17C (c) if:

> 'the application for admission for treatment in respect of the patient ceases to have effect'.

As this section makes no reference to an application for admission for assessment, it is implicit that the imposition of an assessment section, or an informal admission, does not affect the CTO. This view is reinforced by s17E(4) which clearly envisages a situation in which the patient is already in hospital but can then be recalled from his/her CTO.

Q. 19 What if a notice of recall is served on the patient (under s17E (5)) but s/he ignores it?

A. S.17E(6) provides that a recall notice reinstates the power of the Hospital Managers to detain the patient. If the patient refuses to come back to hospital s/he is absent without leave from the hospital, triggering all the powers held by the Hospital Managers under s.18. A warrant under s135 (2) can be issued to gain access to the patient in their home if necessary.

15.9.10

REFERENCES MADE UNDER SECTION 68(7) Mental Health Act 1983 (as amended)

THIS Guidance relates to references made by Hospital Managers under section 68(7), after a patient's Community Treatment Order (CTO) has been revoked under section 17F(4). It is frequently the case that, by the time the reference is listed for hearing, the patient is living back in the community on a new CTO. The patient is then often reluctant to return to take any part in the tribunal process, particularly if this means returning to a hospital for a hearing.

This situation is not the same as that of a patient who has a hearing pending, based on their detention under s.3, and who is then discharged on a CTO. In such a situation the application or referral does not lapse and the panel will consider the case under section 72(1)(c). But where the only reason for a referral was the recall to hospital from a CTO and the subsequent revocation of the CTO (a section 68(7) referral) then, in logic, that reason completely disappears if the patient returns back to the community under a new CTO.

It is, of course, important that the safeguards provided by the obligation to refer under section 68(1)(c) remain. But if the section 68(7) reference lapses so that section 68(3)(c) does not apply, then both the obligation to refer a community patient in the usual way, and the date when that obligation arises, remain entirely unaffected by the recall, CTO revocation, and the subsequent second discharge back onto a CTO.

To set up unnecessary hearings in such cases is expensive in terms of the costs to public funds of both tribunal panels and legal representation, and also in terms of the commitments of the very busy professional witnesses who would normally attend to give evidence. It can also cause distress to patients who do not wish to participate in a hearing. Consequently, this approach relieves the Tribunal and witnesses of the expense and time of continuing hearings which are often unpopular with the patient who may feel coerced to attend a hearing which s/he has not requested, at a point just after s/he has been discharged from hospital.

The recent comprehensive Upper Tribunal decision of KF,MO and FF v Birmingham and Solihull NHS Mental Health Foundation Trust (2010) UKUT 185(AAC) was silent on section 68(7) references. However, these decisions made it plain that referrals generally survive changes in status – not least because, periodically, a patient is entitled to an independent review of their circumstances under the Act and these periodic reviews should not be de-railed by changes in status. But a 68(7) referral is triggered not by the passage of time but by the revocation of the CTO.

Therefore, after careful consideration of the overriding objective, and to enable the tribunal to deal with its cases proportionately, I have decided that following a reference under section 68(7), if the patient is subsequently placed on a new CTO, the 68(7) reference will be treated as having lapsed, and no further action will be taken by the tribunal in relation to it.[1] As I have said above, this does not prevent the patient making an application if they

[1] There are similarities with how the tribunal treats a reference made by a conditionally discharged restricted patient who is recalled to hospital, resulting in a reference being made pursuant to section 75(1)(a). If, before the reference is determined by the tribunal, the patient is conditionally discharged again, then the reference lapses.

wish to contest the new CTO, and it does not apply to other time-triggered references arising under section 68 which do not lapse, pursuant to the UT decision of *KF*. Indeed, if one referral lapses and another doesn't then it must be made clear to all parties that the surviving referral will still go ahead.

Accordingly, if a CTO patient is recalled and the CTO is revoked under section 17F, Hospital Managers must continue to refer cases to the tribunal pursuant to section 68(7) - but must then notify the tribunal immediately if the patient is placed on a new CTO.

Following such notification the referral will be treated as having lapsed, the parties should be notified, and the file will be closed unless there are other outstanding references or applications, in which case consideration will be given to the management, consolidation and listing of any continuing proceedings.

Mark Hinchliffe, Deputy Chamber President.