Mental Health Act community treatments orders (CTO) – focused visits report

Published: 1 November 2022

Page last updated: 1 November 2022

This report looks at how community treatment orders have been used in 9 boroughs across London.

Contents

Introduction

Introduced as part of the Mental Health Act (MHA) in 2007, community treatment orders (CTOs) enable people detained under the MHA to be discharged into the community providing they meet certain conditions. This may include, for example, living in a certain place, attending appointments with mental health professionals, or not taking drugs and drinking alcohol. If they don't comply, they may be recalled to hospital under the MHA.

We were concerned that figures around the use of CTOs were not providing an accurate picture, and that CTOs were being used in an overly restrictive way.

Between February 2019 and November 2021, Mental Health Act Reviewers from the London region explored how CTOs were being used in 9 boroughs across London. This report details the findings of our review, and highlights key areas of concern including people being on CTOs for years, a lack of care planning and access to advocacy services, and the disproportionate use of CTOs for Black people.

In June 2022, the government published its proposed changes to CTOs as part of the draft Mental Health Bill. These changes are in line with some of our concerns. They include:

- increasing the number of decision makers before someone is put on a CTO
- requiring that CTOs provide a genuine therapeutic benefit to those who are subject to them
- increasing the frequency of review
- giving power to the mental health tribunal to review the conditions attached to a CTO.

As part of the reform bill, the government has stated that it wants to see a decrease in the overall use of CTOs, especially the disproportionate use of CTOs for Black people. While we welcome the government's objective to reduce the disproportionate use of CTOs for Black people and people from some ethnic minority groups, we are concerned about how this will be achieved.

As highlighted by our report, there are still a lot of mixed feelings across professional and user groups about the use of CTOs, with research not yet finding any tangible benefits of the power. While we recognise that CTOs may currently provide the least worst alternative for many patients, we echo the findings of the Independent Review of the MHA that, at a suitable point following implementation of the draft Bill's proposals, there should be a review of CTO powers.

We will continue to evaluate whether the opportunities provided by a revised MHA and a new code of practice improve the situation.

Summary

- Between 2019 and 2021, the CQC London Region Mental Health Act Reviewers carried out a series of focused visits to explore how community treatment orders (CTOs) were being used in 9 boroughs across London.
- We spoke with patients on a CTO, their relatives, carers and professionals. While some patients appreciated the benefits of being on a CTO, the majority were unhappy about being subject to its conditions. In contrast, carers and relatives supported the use of CTOs and saw them as key to helping their loved ones stay out of hospital.
- There were differing views among professionals, including responsible clinicians and approved mental health professionals (AMHPs), about the added value of CTOs. Some felt they played a key role in preventing long hospital admissions. However, others were unsure about how effective they were in supporting people in the community.
- While CTOs were generally used for shorter periods of time, some CTOs had been active for several years with the patient never having been recalled to hospital. In some cases, patients did not know how they could be taken off CTO.
- Most community mental health teams (CMHTs) closely supervised patients on CTOs. If a patient needed to be recalled to hospital, most boroughs told us that this would generally happen quickly, and was not affected by bed shortages.
- Family and patient involvement in CTOs, and support from advocacy services, varied. While we found good evidence of patient and family involvement in discharge planning, there was little or no uptake of the vast majority of independent mental health advocacy (IMHAs) services by patients on a CTO. We also found challenges around ensuring people were advised of their rights in the community.
- Most of the concerns we raised related to care planning, rights and assessments of capacity to consent to treatment. Issues included concerns around the oppressive implementation of CTOs, varying quality of care plans, timeliness of discussions around patient rights post discharge, and compliance with consent to treatment.

- The actions trusts took to address the issues we raised varied. Some trusts took a proactive approach to alerting staff to potential issues, for example by incorporating the actions identified into their regular training programmes. However, measures put forward by other trusts were often retrospective, such as audits, reviews and reminders. Not only were staff not responsive to these, but these types of measures added further steps into an already complex system of checks.
- There are some fundamental issues around the use of CTOs. While CTOs are more restrictive than life in the community, they are less restrictive than hospital admission and relatives see them as essential to preventing relapse. However, concerns remain, in particular around the disproportionate impact on Black British patients. The government's MHA reform bill sets out proposals for changes to CTOs. While we welcome the proposals for change, we will continue to evaluate whether these reforms will lead to improvements for patients, their families and carers.

Background

Between February 2019 and November 2021, CQC London Region Mental Health Act Reviewers carried out a series of focused visits to explore how CTOs were being used in 9 mental health NHS trusts across London. (References are to sections of the MHA unless otherwise stated.)

Why we carried out these visits

We were concerned that CTOs might be being used over restrictively or in ways other than intended by the MHA and might remain in place for many years.

We had concerns about the accuracy of the numbers of patients on a CTO recorded by NHS Digital, which in some cases appeared to be unrealistically high while in others no CTOs were recorded at all.

Methodology

Between February 2019 and November 2021, we visited 9 London boroughs, which equated to 1 per mental health trust. Each visit was announced and we requested data from the trust about the number of patients on a CTO in the borough, their ethnicity and the organisation of the trust, as well as the number of patients on a CTO recalled to hospital and those whose CTOs had been revoked. We also requested the trusts to organise focus groups of care co-ordinators, approved mental health professionals (AMHPs), inpatient and community consultant psychiatrists acting as responsible clinicians for patients on a CTO, managers of AMHP and community services and independent mental health advocates (IMHAs). In addition, we spoke with the MHA law lead (or equivalent) and examined the records of approximately 15 to 20 current patients on a CTO (figure 1).

Figure 1: Numbers of people we spoke with

London borough	Patients on a CTO	Carers and relatives	Care co-ordinators and AMHPs	RCs	Managers (see below)	IMHA	MHA law lead
London borough Barking and Dagenham	**Patients on a CTO** 1	**Carers and relatives** 0	**Care co-ordinators and AMHPs** Focus group	**RCs** 4	**Managers (see below)** 0	**IMHA** 0	**MHA law lead** 1
London borough Bromley	**Patients on a CTO** 8	**Carers and relatives** 5	**Care co-ordinators and AMHPs** 13	**RCs** 3	**Managers (see below)** 5	**IMHA** 2	**MHA law lead** 1

London borough	Patients on a CTO	Carers and relatives	Care co-ordinators and AMHPs	RCs	Managers (see below)	IMHA	MHA law lead
London borough Camden	**Patients on a CTO** 5	**Carers and relatives** 1	**Care co-ordinators and AMHPs** Focus group	**RCs** 5	**Managers (see below)** 4	**IMHA** 0	**MHA law lead** 1
London borough Croydon	**Patients on a CTO** 6	**Carers and relatives** 0	**Care co-ordinators and AMHPs** Focus group	**RCs** Focus group	**Managers (see below)** 0	**IMHA** 1	**MHA law lead** 2
London borough Ealing	**Patients on a CTO** 3	**Carers and relatives** 0	**Care co-ordinators and AMHPs** Focus group	**RCs** 1	**Managers (see below)** 0	**IMHA** 0	**MHA law lead** 1
London borough Haringey	**Patients on a CTO** 2	**Carers and relatives** 1	**Care co-ordinators and AMHPs** Focus group	**RCs** Focus group	**Managers (see below)** 0	**IMHA** 0	**MHA law lead** 1

London borough	Patients on a CTO	Carers and relatives	Care co-ordinators and AMHPs	RCs	Managers (see below)	IMHA	MHA law lead
London borough Hillingdon	**Patients on a CTO** 1	**Carers and relatives** 0	**Care co-ordinators and AMHPs** Focus group	**RCs** 4	**Managers (see below)** 0	**IMHA** 0	**MHA law lead** 1
London borough Tower Hamlets	**Patients on a CTO** 3	**Carers and relatives** 0	**Care co-ordinators and AMHPs** Focus group	**RCs** 2	**Managers (see below)** 0	**IMHA** 1	**MHA law lead** 1
London borough Wandsworth	**Patients on a CTO** 8	**Carers and relatives** 3	**Care co-ordinators and AMHPs** 15	**RCs** 4	**Managers (see below)** 0	**IMHA** 1	**MHA law lead** 1
London borough Total	**Patients on a CTO** 37	**Carers and relatives** 10	**Care co-ordinators and AMHPs** 28+	**RCs** 23+	**Managers (see below)** 10	**IMHA** 5	**MHA law lead** 10

At the end of the site visit we provided summary feedback to the MHA law leads and those managers wishing to attend. Following each visit, we submitted a report of our findings to the trust containing any action points. Each trust responded to CQC with a Provider Action Statement setting out the action they would take in response.

We would like to thank the MHA law leads for organising the visits and the patients on a CTO, their carers' and relatives and the care co-ordinators, AMHPs, responsible clinicians, managers and IMHAs who gave up their time to speak with us.

Figure 2: London boroughs and CTO numbers

London borough visited	Number of patients on a CTO
London borough visited Barking and Dagenham	**Number of patients on a CTO** 37
London borough visited Bromley	**Number of patients on a CTO** 30
London borough visited Camden	**Number of patients on a CTO** 95
London borough visited Croydon	**Number of patients on a CTO** 68
London borough visited Ealing	**Number of patients on a CTO** 29
London borough visited Haringey	**Number of patients on a CTO** 26
London borough visited Hillingdon	**Number of patients on a CTO** 18
London borough visited Tower Hamlets	**Number of patients on a CTO** 64
London borough visited Wandsworth	**Number of patients on a CTO** 35

Ethnicity

The government recognised in the MHA white paper that around 5,000 new CTOs are made annually, far more than was originally anticipated. In addition, CTOs are disproportionally used for Black people. NHS Digital's annual report on the use of the MHA stated that in 2020/21 Black or Black people were now over 10 times more likely to be given a CTO than White people. This over-representation was reflected in our findings – in most boroughs, Black people accounted for approximately 50% of patients on CTOs. This is despite the proportion of people from ethnic minority groups living in the borough being lower. The highest percentages relate to the boroughs of Haringey, Croydon, and Tower Hamlets, with Black people and people from ethnic minority groups comprising 69%, 66% and 66% of all CTOs (figure 3).

Please note: Our ethnicity figures are approximate and are included to show only that our findings were generally consistent with the national picture. There is no recent ethnicity per head of population data available about some London boroughs and in some trust data we received, Black ethnicity was used to refer to either Black African, Black Caribbean, Black mixed and Black other census categories.

Figure 3: Ethnicity

London borough	Number of patients on a CTO	Number of Black patients on a CTO	Percentage
London borough Barking and Dagenham	**Number of patients on a CTO** 37	**Number of Black patients on a CTO** 19	**Percentage** 51%
London borough Bromley	**Number of patients on a CTO** 30	**Number of Black patients on a CTO** 15	**Percentage** 50%
London borough Camden	**Number of patients on a CTO** 95	**Number of Black patients on a CTO** 49	**Percentage** 52%
London borough Croydon	**Number of patients on a CTO** 68	**Number of Black patients on a CTO** 45	**Percentage** 66%
London borough Ealing	**Number of patients on a CTO** 29	**Number of Black patients on a CTO** 15	**Percentage** 52%

London borough	Number of patients on a CTO	Number of Black patients on a CTO	Percentage
London borough Haringey	**Number of patients on a CTO** 26	**Number of Black patients on a CTO** 18	**Percentage** 69%
London borough Hillingdon	**Number of patients on a CTO** 18	**Number of Black patients on a CTO** 8	**Percentage** 44%
London borough Tower Hamlets	**Number of patients on a CTO** 64	**Number of Black patients on a CTO** 42	**Percentage** 66%
London borough Wandsworth	**Number of patients on a CTO** 35	**Number of Black patients on a CTO** 22	**Percentage** 63%

MHA law leads told us that some trusts were monitoring the ethnicity of patients on a CTO. In addition, some trusts are involved in the development of Patient and Carer Race Equality Frameworks (PCREFs). These are designed to eliminate racial disparity in the access to, experience of and outcomes of ethnic minority groups in relation to mental health services.

How CTOs work: summary of the law

Community treatment orders (CTOs) were introduced into law by the Mental Health Act 2007. CTOs allow some patients who have previously been detained in hospital for treatment to live in the community while still being subject to powers under the MHA, provided certain criteria set by the responsible clinician are met. This includes, for example, living in a certain place, attending appointments with mental health professionals, or not taking drugs and drinking alcohol. If they don't comply, they may be recalled to hospital under the MHA. An approved mental health professional (AMHP) needs to agree that a CTO is appropriate.

Any conditions added by the responsible clinician must be necessary or appropriate for ensuring that the patient receives medical treatment or to prevent risk of harm to the patient or others. Patients on a CTO may be recalled to hospital for treatment should their mental health relapse or to prevent risk of harm. After recall, they may live in the community subject to their CTO or, if they need to be treated as an inpatient, their responsible clinician may revoke the CTO and the patient will become detained for treatment in hospital once again. The MHA does not specify how long a CTO may last.

A CTO is less restrictive than detention in hospital, but more restrictive than living in the community without being subject to the MHA. While a patient on a CTO with capacity to consent to treatment may not receive compulsory treatment in the community, they may be recalled to hospital if they meet the criteria and receive compulsory treatment there. As a result, a CTO is coercive in the sense that patients on a CTO in the community will understand that if they do not accept treatment, for example depot medicine, then the depot medicine may be administered in hospital without any other legal procedure being required.

On the other hand, CTOs are designed to respond to relapse and any associated risk of harm before the situation becomes critical, maintaining stable mental health outside hospital and promoting recovery. As a result, CTOs are consistent with the two principles of the least restrictive option and maximising independence and purpose and effectiveness.

What people told us

What patients on a CTO told us

Of the 37 patients on a CTO we spoke with, the vast majority were, as we expected, unhappy about being subject to a CTO. However, 7 patients were more positive and appreciated the benefits of taking medicine regularly, staying well and remaining out of hospital, as well as being admitted quickly if they became unwell. Out of the patients we spoke with, 29 said they had regular contact with their care co-ordinator and community responsible clinician and understood how to appeal against their CTO (although not all had done so). Some (approximately 14) said they were aware of their rights as a patient on a CTO, while only 7 understood they were entitled to access an IMHA. However, of the 37 patients on a CTO we spoke with, no one said they knew what needed to happen for them to come off the CTO. Examples of what patients on a CTO told us included:

"I have been on a CTO for over 2 years. I had been discharged for a year previously and I was fine until I came into contact with the police and they delivered me back to psychiatric services. You cannot escape if you are mixed race. I have had too many appointments. They are always wanting to see me and this has made me suicidal. I want to be discharged and to have nothing to do with services and not to take medication because I am not mentally ill. I have no faith in the system and no faith in tribunals. All White panels, and especially White judges, will never take my word against that of the treating team."

"I have been on a CTO for between 2 and 3 years. I have never been recalled to hospital. My care co-ordinator advised me of my rights over the phone. I had a tribunal about 2 months ago. I see my responsible clinician and care co-ordinator at the depot clinic or community mental health team base every 3 weeks. I have Clopixol depot, but would prefer tablets. At the tribunal, my responsible clinician said I need to remain on the CTO."

"I am really well at the moment and working full-time. The CTO helps as I need to go to hospital when I have a manic episode as I tend to run away. I see the community mental health team fortnightly for my depot. I am accepting of the CTO as I just want to get on with my life."

"Being on a CTO is not too bad. I live in supported accommodation and have not had to return to hospital. Being on a CTO makes it easier to get help and support. I am on depot medication and feel very well at present."

What carers and relatives told us

We spoke with 10 carers and relatives of patients currently on a CTO. While some were unhappy about the restrictions imposed by the CTO on the patient, all the carers and relatives we spoke with saw the CTO as 'essential' in breaking the cycle of not taking their medicine and subsequent relapse, followed by lengthy hospital admissions. None of the carers or relatives believed that the patient would take their medicine in the community in the absence of the CTO framework. One relative described her daughter as "the best she's been" due to the CTO. Several carers and relatives said the CMHTs were helpful and effective. Some had been able to participate in meetings virtually during the COVID-19 pandemic.

However, some carers and relatives said the community teams were unhelpful. One relative told us, "There is a total lack of respect for the family from the community team". Some carers and relatives found it very difficult to speak with doctors or members of the CMHT. In some cases, the patient refused to allow the team to speak with family members. Another family member complained that in the past 15 months, his brother had only been seen twice by his responsible clinician, which he felt was not enough. He said he was invited to a care programme approach meeting for his brother, but the responsible clinician did not listen to what he had to say. While one relative thought a CTO was the only effective option for their relative, they considered it did not last long enough and was not restrictive enough, as after their relative was discharged it took 2 years before he was re-detained and they felt that unless the CTO was permanent and continuous, their relative would never fully recover.

What care co-ordinators told us

All the care co-ordinators we spoke with told us they were involved in the CTO planning process before the patient's discharge from hospital. In 5 boroughs, care co-ordinators requested patients be placed on CTOs where this was considered appropriate. All care co-ordinators felt that the community responsible clinicians knew their patients who were on a CTO well and that this was helpful in the delivery of care.

Most CMHTs closely supervised their CTOs and reviewed their use regularly. Patients on depot medicine were seen consistently out of necessity. The majority of patients on a CTO remained in the community longer as a result, sometimes with no recalls to hospital. While contact in the community between care co-ordinators and patients on a CTO was generally regular, in some cases high caseloads could be a barrier to achieving this. Care co-ordinators and responsible clinician often carried out joint reviews. We were told that it was often difficult for patients to show that they no longer needed to be subject to a CTO.

In most cases, each geographical team, recovery team or sub-team was responsible for recalling patients on a CTO. There was often a centralised AMHP team who care co-ordinators could ask for advice. However, in 2 boroughs, it was felt that care co-ordinators needed more training on the CTO recall process as many did not fully understand it.

While care co-ordinators from 7 boroughs reported that bed management issues did not delay CTO recalls (even if there were acute bed shortages in the trust), in 2 boroughs we were told that the trust did not prioritise the allocation of beds to patients being recalled from CTOs. This could cause significant delays, which could be exacerbated if a section 135(2) warrant needed to be obtained and police assistance was required. (A section 135(2) warrant, which enables the police to remove a CTO patient from their home to hospital, is used if the patient does not respond to the serving of the recall notice or absconds.) On the other hand, 4 boroughs reported minor delays due to police involvement. The presence of a police liaison officer was identified by 1 borough as being useful in resolving any operational issues.

How quickly patients on a CTO could be recalled to hospital was critical in determining whether or not care co-ordinators considered CTOs were effective as compared with MHA assessments. In boroughs where recall delays were minimal, CTOs were preferred. However, where there were significant delays in recalls, detention under sections 2 or 3 was considered to be more effective.

Care co-ordinators from 2 boroughs acknowledged the disproportionately high number of Black British patients on CTOs. Some felt this was because these patients were the most reluctant to accept services, whereas others thought Black British patients with a lower risk history were disproportionately preferred for CTOs over patients from a White ethnic background.

In 1 borough, there was some uncertainty among care co-ordinators as to the trust's policy on how often patients on a CTO should be reminded of their rights, while in another, one care co-ordinator was unsure about the availability of leaflets. Elsewhere, care co-ordinators were clear about the importance of regularly advising patients who were on a CTO of their rights.

What responsible clinicians told us

In several boroughs, we were told that CTOs had become much less used over recent years, although often from a high initial number. There was sometimes a focus on selecting well-known patients only for CTOs, with newly diagnosed or unknown patients being refused. The responsible clinicians we spoke with often took the view that CTOs worked very well for a relatively small number of patients and usually for a short period of time. This includes patients with a diagnosis of Autistic Spectrum Disorder, patients with minimal insight into their conditions and those likely to comply with treatment in response to the responsible clinician's power of recall to hospital. Generally, responsible clinician's felt that a patient should not be on CTO for more than 2 years. We found that those who had been on CTOs longer were often older people. Overall, the responsible clinicians we spoke with told us that they did not like or want long-term CTOs and preferred collaboration to compulsion.

Communication between community and inpatient responsible clinicians was reported to be generally very good, although we were informed of examples where this had broken down. In 1 borough before the COVID-19 pandemic, responsible clinicians treated patients both when they were in hospital and in the community. We heard how this enhanced the consistency of care for patients on a CTO. Some responsible clinicians found the inpatient/community divide unhelpful as community responsible clinicians felt patients could appear on CTOs without consultation or too soon. This could lead to community responsible clinicians discharging patients from CTOs within 6 months or less of their leaving hospital. Community responsible clinicians generally saw patients who were on a CTO in the first month and then every 3 months, with more frequent care co-ordinator contact in between.

Many community responsible clinicians felt that the power of recall was not effective as patients could wait a long time for a bed and if a section 135(2) warrant and police involvement was needed, it could take a long time for recall to be actioned. Some community responsible clinicians stated they were not involved in decision-making once a patient had been recalled to hospital. Responsible clinicians from 4 boroughs specifically identified very limited bed availability as delaying CTO recalls and in some cases told us this was becoming worse over time. By contrast, responsible clinicians from 3 boroughs denied any bed management issues and said admissions to hospital following CTO recalls took place quickly. We were informed that in some boroughs, patients on a CTO who were recalled to hospital chose to restart taking their medicine and remain in hospital informally.

The Devon Partnership case

In 2 boroughs, responsible clinicians had taken action following the case of Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin).

In this case, the High Court decided that the section 12 requirement that a medical practitioner must have “personally examined” a patient before completing a medical recommendation and the section 11 requirement that an AMHP must have “personally seen” a patient before making an application, in relation to sections 2, 3, 4 and 7 (detention and guardianship), required the physical attendance of the person in question on the patient.

It has been argued that the same requirements for personal examination in the Devon judgment should apply to the creation and extension (renewal) of CTOs, even though the statutory wording is different. Thus, a CTO created following a section 3 which failed to meet the Devon requirements should be regarded as invalid and a CTO extension that could not be redeemed by a re-examination in person within the current period should also be regarded as invalid. Trusts have therefore been advised to err on the side of caution (see, for example, Evans, Stephen, 2021, The Devon decision and remote examination: where to go from here?).

In the 2 boroughs in question, it emerged that a significant number of patients on a CTO had not been "personally examined" by a responsible clinician at the time of their CTO extension and a number of patients were discharged from CTO as a result. They relapsed and were all subsequently admitted on section, which showed the benefits of their being subject to a CTO.

However, others have argued that the scope of the judgment is restricted to civil detention sections and therefore responsible clinicians do not need to see a patient in person either to create a CTO or extend a CTO. Nor does an AMHP need to see the patient as part of the process (see, for example, Auburn, Jonathan & McCann, Lucy, 2021, Community Treatment Orders: does seeing patients remotely suffice?).

All the responsible clinicians we spoke with showed a thorough understanding of the MHA as it applies to CTOs, especially about consent to treatment certification under Part 4A and Part IV. However, while most responsible clinicians proactively reviewed whether or not a CTO should be extended before its expiry, responsible clinicians in 1 borough routinely left CTOs to lapse rather than actively discharging them.

Responsible clinicians from 4 boroughs complained that patients on a CTO who were assessed as lacking capacity to consent to treatment in the community were waiting up to several months for second opinion appointed doctors (SOADs) visits. . This generally preceded the COVID-19 pandemic, during which SOAD interviews with patients on a CTO were carried out by telephone. (It has been argued that there is no requirement in the MHA for a SOAD to "personally examine" the patient. Section 119(2) states that the SOAD "may" visit and examine a patient, suggesting SOAD certificates are not affected by the judgment in Devon Partnership, although others disagree.)

In our response to the MHA Reform Bill, the CQC has called for a reduction in the time before a statutory Second Opinion Appointed Doctor (SOAD) is required to certify medication, and we welcome proposals to achieve this.

Overall, some responsible clinicians did not consider that CTOs added value to a patient's care or prevent further hospital admissions, while others felt CTOs had a role in preventing additional lengthy hospital admissions through promoting improved medication compliance in the community, as a less restrictive alternative to detention in hospital.

What AMHPs told us

Three of the boroughs we visited told us there was a section 75 National Health Service Act 2006 partnership agreement in place between the trust and the borough. This meant that local authority and trust staff were integrated into the CMHTs. Two such agreements had recently ended or were due to end at the time of our visits.

In nearly all boroughs, there was a centralised approved mental health professional (AMHP) service that provided AMHPs for making, extending and revoking CTOs. AMHPs told us that they were involved in the care planning process of patients before their discharge from hospital to a CTO, they felt able to challenge the appropriateness of CTOs and gave careful consideration to any proposed conditions in relation to risk and the principle of the least restrictive option and maximising independence. We were told that there were generally good working relationships between the community teams and the AMHP services which enabled CTOs to run efficiently.

In some boroughs, we were told that there was an established referral process in place which all the AMHPs agreed worked well in practice, with CTO referrals being passed to the AMHP service in adequate time and with a rationale for the proposed CTO. However, elsewhere up to 50% of referrals were passed to the AMHP very late, such as the day before discharge, allowing little time for them to consider the whether the CTO was appropriate. At times AMHPs felt as though the decision to complete a CTO application had already been made and the AMHP role was seen as perfunctory or simply rubber stamping. In 1 borough, the ward or CMHT would sometimes request a section 3 MHA assessment in order to be able to place the patient on a CTO, even if the patient was ready for discharge. We were told that the AMHP service refused to comply with these requests.

We were informed that a lack of support in the community following discharge onto a CTO, such as housing issues, the social environment and inappropriate placements, could disadvantage patients on a CTO.

Care co-ordinators in some boroughs told us that AMHPs reported delays in obtaining section 135(2) warrants, arranging police assistance and obtaining a bed. Sometimes a bed was arranged but was lost by the time the other factors were in place. AMHPs had experienced delays of up to six weeks while arranging a recall on behalf of the responsible clinician.

Overall, AMHPs had differing views about whether CTOs were effective in maintaining patients in the community and whether or not CTO recalls were quicker than setting up a MHA assessment. Sometimes it appeared to AMHPs that CTOs were being used due to a lack of resources or a lack of alternative ways to improve engagement with patients. Some AMHPs considered that CTOs did not reduce admissions and was merely being used as a safety net.

What managers of community services told us

We spoke with groups of managers independently of the other focus groups in 2 of the boroughs we visited. The managers included CMHT managers, assertive outreach team managers, AMHP leads and team managers and service managers for the boroughs we visited.

The managers with we spoke had very good oversight of the CTO process and were confident that the right patients were subject to CTOs. CTOs were mainly used for people with a long history of mental illness, with a history of risk, non-engagement and non-compliance. CTOs provided long-term mental stability for these patients and prevented revolving door admissions. The power of recall enabled early intervention to reduce risk. We were told that CTOs could be effective in these cases.

Managers' views of CTO trends in the 2 boroughs differed, with 1 group stating numbers of CTOs had increased in recent years and the other saying numbers had decreased due to changes in the medical team. They said responsible clinicians differed in their views of the effectiveness of CTOs with some arguing they could lead to oppressive practice, while others felt they were appropriate in some cases.

Both groups of managers said there was good communication between inpatient and community teams and that CMHTs were involved in CTO planning discussions. Requests for CTOs often came from community teams as the patients were well known to them. AMHPs were invited to pre-discharge planning meetings.

The managers we spoke with had different views about CTO recall delays. Some felt that police not being available could contribute to delays, while others felt this had improved and delays were not significant. In 1 borough, relationships with the police were reported to be excellent, although high-risk patients might wait longer due to the higher level of police response needed and the availability of specialist beds.

The managers in 1 borough acknowledged that there were issues with keeping patients informed about their rights following discharge from hospital onto their CTO, but the trust was in the process of reviewing the system in place for monitoring the documentation of rights discussions.

What MHA law leads (or equivalent) told us

In all boroughs, the MHA law lead oversaw the legality of CTOs and the MHA administration team was responsible for sending out reminders to responsible clinicians and CMHTs about CTO expiries, extensions, consent to treatment certificates, discussions of rights, Mental Health Tribunals and Hospital Managers' hearings. In some cases, clinicians were unresponsive and MHA administrators spent a considerable amount of time following up requests.

One of the biggest challenges we heard about was making sure that CTO consent to treatment certificates were in place in a timely manner following patients on a CTO' discharge from hospital, although 1 borough told us this was not an issue. Another borough had developed an electronic dashboard for monitoring these, although relied heavily on locum responsible clinician across the trust, which affected compliance with CTO consent to treatment certificates.

We were informed that CTO numbers and the ethnicity of patients on a CTO often reflected the demographics of the borough. In 1 borough, we were told that patients from Black British census groups were consistently overrepresented among patients on a CTO by a factor of 6 to 7 based on the population data, which was reported to the trust board and shared across London trusts.

We were interested to note that in 1 trust there were more patients on CTOs than detained patients, despite being informed that the general trend across the boroughs we visited was a reduction in the numbers of CTOs.

Most boroughs could call on a pool of skilled and ethnically diverse hospital managers for panel hearings, although we were told that most patients who were on a CTO did not attend hospital managers' hearings, with paper hearings held instead in three boroughs for CTO extensions. In one borough, we were informed that CTO extensions tended to be completed at the last minute.

MHA governance meetings were held in every trust bi-monthly or quarterly and CTO data and trends reported to the trust board.

Out of the MHA law leads we spoke with, 5 acknowledged that there were issues in the recording of rights on the patient electronic system and recognised that this was more challenging with community patients than with inpatients. However, we were informed that 1 MHA administration team was developing a new policy for CMHTs to give rights advice every 3 months, while another had made good progress with rights compliance by developing an electronic dashboard that pulled data through from the electronic patient record. This was monitored in MHA governance meetings and passed down to team managers, with a target for discussions of rights to be held every quarter.

Several MHA law leads reiterated that they were experiencing SOAD delays of several months for patients in the community who were on a CTO.

What IMHAs told us

Patients on a CTO are entitled to access the services of an independent mental health advocate (IMHA) (MHA Code of Practice paragraph 6.8) and there is a duty on the hospital managers to provide patients on a CTO with information about advocacy services (MHA Code of Practice paragraph 6.17).

The MHA Reform Bill proposes a duty on hospitals to notify advocacy providers about qualifying patients and arrange for advocates to visit them. It also extends the statutory duty to provide information rights to patients who have been conditionally discharged.

The majority of IMHA services we spoke with told us that there was very little uptake of their service by patients on a CTO. In 1 borough, statistics from the previous year showed no referrals at all. Some IMHAs suggested that staff were often not aware of how patients could access the service or that the IMHA service was not promoted well by CMHTs to patients on a CTO. Others pointed out that it could be difficult to engage with patients once they were discharged from hospital. Where IMHAs were contacted by patients on a CTO, this was usually because the patient had already been in contact with the IMHA service as an inpatient. Some patients who did contact the IMHA service reported difficulty in accessing community services, such as housing support and day services.

The IMHAs we spoke with were keen to raise awareness of their service among nurses in depot clinics and care co-ordinators. Patients on a CTO who lacked capacity also needed to be referred. In some cases, it was not clear that the letter sent out by the MHA administration team to patients at the start of their CTO included the contact details of the IMHA service. We were also told that since IMHA work was episodic rather than open-ended, patients on a CTO would have to contact an IMHA again if they needed help with a different issue. As a result, it was not possible for IMHAs to continue to support patients on a CTO in these circumstances unless the patient took the initiative.

What we were told about CTO recall delays

Professionals we spoke with told us that CTO recalls and admissions to hospital varied from between 1 and 6 weeks. Data about such delays for one of the boroughs we visited over 1 year revealed that of 16 recalls involving 8 patients on a CTO, 8 recalled patients (50%) were admitted to hospital the same day as they were recalled and 2 the day after, representing minimal delays, despite the much longer ones reported by staff and managers. In total, 2 patients were admitted after 6 days, 1 after 13 days, 1 after 14 days and 1 after 15 days, where section 135(2) MHA warrants and police attendance was needed. In one of these section 135(2) warrant cases, initial delay in securing police attendance led to the bed no longer being available, so a second recall was issued to another unit where a bed was available. A further section 135(2) warrant was needed.

Activities

This work was carried out before discussion of MHA Reform Bill proposed changes to CTOs, which are in line with some of our concerns. We will continue to monitor whether the opportunities provided by a revised MHA improve the situation. At a suitable point following implementation of the draft Bill's proposals, there should be a review of CTO powers.

As part of our review we looked at a sample of electronic patient records. In total, we looked at 159 CTO patient records, approximately 15 to 20 records per borough we visited.

Discharge from hospital

In all the boroughs we visited, we found very good evidence that patients were involved in the discharge planning process. Patients, family members, community psychiatrists and care co-ordinators were involved in pre-discharge meetings. Most patients received section 17 leave to their placements before discharge, which was important to show that the patient was ready for discharge onto the CTO. In all the records we looked at, we found evidence that the hospital managers had written to the patient to give them information about their CTO, including the legal grounds and any conditions made by the responsible clinicians (although in one case these were not routinely uploaded onto the electronic patient record).

The MHA Reform Bill may bring changes in the area but the CQC has emphasised the ongoing need for adequately resourced community support for discharged patients, and outreach to minority groups is one important factor in addressing health inequalities.

Making the CTO

In all the boroughs we visited, we found that the aims of patient care and treatment were clearly set out under the CTO framework and the responsible clinician had recorded the clinical rationale for the use of the CTO at the point of discharge. The responsible clinician had also recorded how the CTO criteria were met and why a less restrictive option was not appropriate, with reference to the patient's relapse history and the risks associated with relapse. However, in the vast majority of cases in all the boroughs we visited, the responsible clinician had not included an explicit explanation as to why they needed to use the power of recall, as required by the MHA Code of Practice paragraph 29.16.

The MHA Reform Bill proposes a narrowing of criteria for making a CTO (so that there must now be risk of 'serious' harm to the patient or others unless 'necessary' treatment be provided) and a new requirement to consult with the community clinician before making a CTO or varying conditions.

Discretionary CTO conditions

In 2 boroughs, we found that discretionary CTO conditions were person-centred and proportionate to the documented risks. Conditions appeared to have a clear purpose and took account of the principle of the least restrictive option and maximising independence.

Elsewhere, we found 2 CTO1 forms containing a discretionary condition that the patient must reside at a specified residential home. It appeared that these patients might lack capacity to agree to living at the home for the purposes of receiving care and treatment for mental disorder. We advised the trust to review these cases for potential deprivation of liberty.

We found 20 CTOs with a discretionary condition that the patient must reside at a specified address. The therapeutic purpose of this condition was not addressed in the patient's care plan and we could not readily find justification for the restriction in the patient's progress notes. We also found 5 CTOs with a condition that the patient must live wherever the clinical team decided. We took the view that this type of condition did not strongly show a clear purpose or have regard to the principle of the least restrictive option and maximising independence.

In 1 borough, most CTO1 forms contained a discretionary treatment condition stating that the patient "must take medication as prescribed". We considered that this wording did not make it clear enough that medicine cannot be forced on patients who are subject to a CTO in the community, and that recall to hospital has to be justified with evidence that a person's mental state has deteriorated and there is corresponding increased risk (MHA Code of Practice paragraphs 29.35, 29.46 and 29.49). The letter sent to all patients on a CTO following the creation of the CTO stated: "Should you breach a condition, the responsible clinician has the power to recall you to hospital". We suggested that the letter should be clearer on this point. In some cases, a patient was recalled "due to non-compliance with medication", with no justification in terms of relapse or risk.

Discretionary conditions relating to the misuse of illicit drugs and alcohol on the CTO1 were relatively common, for example:

> "... He must refrain from illicit substances including cannabinoids and provide regular random urine drug tests as required by the treating team in the community. If the conditions are not met and his mental state deteriorates, he would be liable to recall to hospital under the provisions of the CTO. Alcohol consumption will need to be negotiated with the community team as appropriate...."

However, the MHA only allows patients on a CTO to be recalled to hospital to receive treatment for mental disorder (MHA Code of Practice paragraph 29.46). Discretionary conditions must be necessary or appropriate to ensure that the patient receives medical treatment for mental disorder and/or to prevent a risk of harm to the patient's health or safety as a result of mental disorder and/or to protect other people from a similar risk of harm (MHA Code of Practice paragraph 29.28). We suggested that conditions relating to alcohol and illicit substances should form part of the patient's CTO care plan rather than be included as unenforceable conditions of the CTO.

The MHA Reform Bill proposals state that conditions applied through CTO must be 'necessary' and not just 'appropriate' and that a Tribunal can recommend conditions of CTO be reconsidered.

Oppressive implementation of CTOs

Occasionally, CTOs appeared to have been put in place in oppressive ways. In one case, a community mental health nurse appeared seriously to pressurise a CTO patient into taking depot medicine at home when the patient was clearly objecting, with no legal grounds to do so. Another CTO patient was described as taking their medicine, but requiring staff "insistence".

Information sharing

While we found evidence in the progress notes that professionals occasionally sought permission from patients to share information in specific circumstances, we noted that care plans in some boroughs did not state patients' general preferences on information sharing with their Nearest Relatives under the MHA, other family members or other agencies (MHA Code of Practice paragraphs 4.32 and 10.5).

The MHA Reform Bill proposes replacing the 'Nearest Relative' role with a 'Nominated Person', so that patients can choose who undertakes this role. The CQC welcomes this because it would give patients more autonomy.

Support and contact in the community

Patients on a CTO were well supported in the community in all the boroughs we visited and received regular contact from their care co-ordinators and, in some cases, jointly from both their care co-ordinators and community responsible clinicians. In all cases there was prompt follow up following the start of the CTO, but in 1 borough we found that meetings with the patient's community responsible clinician was much less frequent after this initial contact.

Care planning

We identified both positive and negative aspects of care plans and risk assessments for patients on a CTO in the boroughs we visited. Many care plans were of good quality, comprehensive and up to date. The best were well written, supported the CTO conditions and included the patient's views, as well as specifying those responsible for providing community follow up. These care plans also detailed patients wider social needs, such as housing, finances and employment.

We were told that care co-ordinators co-developed care plans with patients in the community and that patients were given copies of their care plans. However, some patients had no care plan in their records at the start of their CTO, with one being completed approximately 2 years later.

A substantial number had not been updated since their last detention in hospital, which in some cases was months before our visit. In these cases, it was not clear how the patient was being supported in the community and there was no mention of an aftercare plan. Some care plans did not reference the fact that the patient was on a CTO. Some were poorly written, being either generic, very brief or containing out of date information. It was often unclear exactly how up to date the content was.

The care plans we reviewed did not always contain details of the patient's views or preferences. Care plans often did not address the wider social needs of the patient and it was often not clear whether patients were in receipt of aftercare services funded under section 117. In some cases, we could not find details of any involvement from external agencies in the care plan.

Discussions of rights

In 53 records, we found that there had not been a timely verbal discussion of rights between the community team and the CTO patient following their discharge from hospital (section 132A MHA, MHA CoP 4.9, 4.10 and 4.28). In some boroughs, there was significant variation in where staff recorded discussions of rights in the electronic patient record. In one borough, it was relatively common for the patient record not to state whether or not the patient had understood their rights. This was despite the fact that the electronic form for documenting rights included a prompt for this purpose.

The MHA Reform Bill proposes additional statutory duties for services to inform patients of their rights, including to provide information about making complaints (including to CQC), as well as to provide information to patients who have been conditionally discharged.

Independent mental health advocacy services

In the majority of boroughs, although care co-ordinators told us that patients on a CTO were told about the local independent mental health advocacy (IMHA) service both verbally and in writing, we found there was low uptake (and in one borough zero uptake) of the advocacy service. In 1 borough, the care co-ordinators we spoke with in our focus group did not know which organisation provided IMHA services in the borough.

Consent to treatment

In one borough, we were able to locate assessments of capacity to consent to treatment completed within 1 month of the start of the CTO that related to the consent certificate (CTO12 form) or the SOAD request made at the same time, as required by Part 4A MHA (MHA Code of Practice paragraphs 25.28 and 25.29). In one case, there were several subsequent CTO12s completed and all were accompanied by assessments of capacity.

Several assessments of capacity contained detailed reasons for the responsible clinicians decision and had clear evidence of the discussion between the responsible clinician and the patient. In all but one case, we found that the community responsible clinician had completed a CTO12 certificate or requested a SOAD within the specified 1 month timeframe following the CTO patient's discharge from hospital.

However, in the remaining boroughs, compliance with consent to treatment was often relatively poor. In a significant number of cases (over 40 records), we could not find a detailed assessment of the patient's capacity to consent to treatment within the 1 month timeframe following the CTO patient’s discharge from hospital. As a result, there were often delays in the community responsible clinician issue of a CTO12 certificate or the submission of a SOAD request.

Of the records we looked at, several mentioned the patient's capacity. However, there was often no evidence about why the patient lacked capacity to consent to treatment. In some cases, the assessment of capacity had been completed incorrectly or not fully completed, even where the trust had developed an embedded form in the electronic patient record for that purpose. In other cases, the assessment of capacity was documented in the progress notes or not documented at all.

We found several cases where the community responsible clinician had completed a CTO12 certificate but had not personally met the patient to assess their capacity and views on treatment. One community responsible clinician wrote in the progress notes: "CTO12 completed - unable to contact the patient. Read discussions between patient and staff which indicate she had capacity and is consenting to treatment and will review this when I meet the patient." However, there was no evidence of the responsible clinician reviewing the decision.

Another responsible clinician wrote that the patient "disagrees with her diagnosis and treatment but is agreeing to take medication. Form CTO12 completed." A further community responsible clinician completed a CTO12 certificate 2 months late in July 2021. The responsible clinician did not see or speak with the patient and did not carry out an assessment of capacity but merely stated: "We think the patient agrees." In another case, the community responsible clinician completed a CTO12 certificate within 1 month but the accompanying assessment of capacity to consent to treatment stated that the patient lacked capacity to consent to treatment. The responsible clinician who completed the CTO12 (instead of requesting a SOAD) had not seen the patient or spoken with them.

In some cases, we could not find a record of the date when SOAD requests had been made. Sometimes the responsible clinician requested a SOAD but did not complete a section 64C certificate to authorise continued treatment in the meantime, meaning that treatment was unlawful until the SOAD completed a CTO11 Part 4A certificate, often several months later. We were informed that there were lengthy delays in the appointment of a SOAD by the CQC once the request was made. Delays in submitting a SOAD request and lengthy waits for the SOAD review had caused an increased use of emergency treatment authorisation certificates.

In 10 cases we found that the patient's capacity to consent to treatment had not been reviewed in the community for over a year. We found that 2 patients had been assessed as lacking capacity to give valid consent to treatment, yet there was a CTO12 certificate in place. We also found several conflicting statements from the assessing responsible clinician about capacity to consent to treatment which had created confusion over the validity of the certification in place.

In 5 cases, we found that the inpatient responsible clinician had completed a CTO12 certificate at the point the patient was discharged from hospital, but the community responsible clinician had not re-assessed the patient's capacity to consent to treatment within 1 month of the start of the CTO. The community responsible clinician had not completed a new CTO12 certificate although this should have occurred following a permanent change of responsible clinician.

Duration of CTOs

We did not analyse data on the duration of the CTOs that were in place at the time of our visits. However, in general, most patients had been subject to CTOs for shorter periods than we had expected. In 1 borough, for example, which was typical of those we visited, of the 35 CTOs in place at the time of our visit in July 2021, only 1 CTO had started in 2017, 1 in 2018, 6 in 2019 and 7 in 2020, with the vast majority (20 CTOs) having started in 2021, the year of our visit.

Recall and revocation

In the majority of cases we found that CTO recall and revocation processes had been followed correctly. As a less restrictive option, community staff often attempted to engage with the patient before using the power of recall. There were generally no significant delays between the point of recall and the patient's admission to hospital although delays did occur due to the need to obtain section 135(2) warrants and police involvement (see above).

In most cases, evidence of the relevant authority to treat the patient during the recall process was in the electronic patient record. We often found supporting evidence from the AMHP involved when the CTO revocation had taken place. Revocations occurred within the 72 hour period following the patient's recall to hospital.

In one case, a patient was unlawfully made subject to 2 consecutive recall periods without any indication he had been informed of his status or rights. In a second case, a section 135(2) warrant had been obtained from the magistrate 4 days before the patient was served the recall notice. A further CTO patient was admitted informally and was not subject to the recall process but a CTO4 form was incorrectly completed. In another case, a section 5(2) holding power had been unlawfully used to extend the CTO recall period. In another case, a patient was recalled to hospital then immediately given extensive unescorted leave.

In one trust, they had developed their own artificial “statutory” form to document the annulment of a patient's recall following the issue of a statutory CTO3 recall notice. We respectfully advised against making attempts to imitate statutory paperwork. We found 4 cases where the artificial statutory form had been used. In 1 case, the patient had been recalled to hospital, treated as an outpatient with medication and had returned home within the 72 hour recall period. We advised that in such circumstances the recall had taken effect and should be documented in the usual way (see MHA CoP paras. 29.61 and 29.62).

Assessments of capacity to consent to treatment following recall to hospital

In most cases, assessments of capacity to consent to treatment for CTO recall and revocation were completed in a timely way. However, we found over 10 cases where the patient's capacity to consent to treatment during the CTO recall period or following revocation of the CTO was not documented, not fully evidenced or completed late. Section 62 urgent treatment forms, T2 consent certificates and SOAD requests had also not been completed in these cases. Where SOADs had been requested, we also could not find the date of the request. In these cases, it was unclear under what authorisation treatment was being given.

In one case, a CTO patient was recalled to hospital but an assessment of capacity was only completed 14 days later when a section 62 form was completed and a SOAD requested. The patient was given some medication during this period which was not covered by his CTO11 Part 4A certificate and was therefore unlawful. In two other cases, the patient was correctly recalled, and his CTO revoked, but although a T2 certificate was completed, there was no assessment of capacity to consent to treatment in the electronic patient record.

Expiry of CTOs

Some CTOs had been active for several years with the patient never having been recalled to hospital. In many cases, we found that the responsible clinician had provided evidence for the clinical reasons why it was necessary to extend the CTO period. We found that the majority of CTOs had not been left to expire but had been proactively rescinded by the community responsible clinician following a multidisciplinary team discussion where the ongoing need for the CTO was discussed. However, in 2 cases, the CTO had ended in an unplanned way due to administrative errors. In 1, there had been an error in the CTO extension paperwork, which meant the patient was no longer subject to a CTO. In the second, the CTO had unintentionally lapsed, despite entries by the clinical team on the patient's record which suggested that the CTO should be extended. In 3 cases in 2 different boroughs, we found that the CTOs had simply been allowed to lapse, contrary to MHA Code of Practice paragraph 29.76.

Other areas

In all the boroughs we visited, the statutory CTO paperwork was available to view and in good order. In the vast majority of cases, we found good quality reports written by the assessing AMHP about the creation, extension and revocation of CTOs. The reports covered the patient's medical and social background and explained why the use of the CTO framework was justified. Several patients had exercised their right to challenge their CTO by appealing to the Mental Health Tribunal or Hospital Managers' panel. All the MHA administration teams had good oversight of the use of CTOs in the boroughs we visited.

Second opinion appointed doctor (SOAD) visits

Since we were told about delays of up to several months for SOADs visiting patients on a CTO in the community, we asked the MHA Operations Manager of the Second Opinion Appointed Doctor Service at CQC for the latest data. We were told that there was an initial period in 2020, when SOADs were working remotely rather than making arrangements to meet with patients in person, where second opinions awaiting appointment went down to less than 50 nationally. However, this was said to have increased since the beginning of 2021 and now stands back at pre-pandemic levels. This reflects SOADs returning to previous commitments and a general reduction of available SOADs to carry out this work.

In 2021, the average time nationally for a CTO second opinion to be carried out was 24 working days with a range of 2 working days to 104 working days. At the time of writing, there are currently 142 CTO second opinions awaiting appointment nationally with the earliest dating back to mid-November 2021.

Action points

This section outlines the number and type of action points raised across the 9 London boroughs.

Care plans did not address the wider social needs of the patient and/or had not been updated since the patient's discharge from hospital and/or did not include patient views and/or did not reference section 117 funding arrangements and/or were poorly written or very brief or patients had no care plan or no care plan review had taken place.

This action point was raised in 7 of the 9 boroughs we looked at.

Consent to treatment – no assessment of capacity relating to informal admission following recall.

This action point was raised in 1 of the 9 boroughs we looked at.

Consent to treatment – no assessments of capacity completed before the expiry of the first month following a patient's discharge from detention onto a CTO.

This action point was raised in 5 of the 9 boroughs we looked at.

Consent to treatment – no CTO12 Part 4A consent certificate or SOAD request completed before the expiry of the first month following a patient's discharge from detention onto a CTO.

This action point was raised in 2 of the 9 boroughs we looked at.

Consent to treatment – no assessments of capacity completed before the expiry of the first month following a patient's discharge from detention onto a CTO and no assessments of capacity following CTO recall or revocation. In both cases, assessments of capacity were missing and/or completed late or very brief or incomplete. Sometimes the responsible clinician had completed the assessment of capacity without seeing the patient.

This action point was raised in 2 of the 9 boroughs we looked at.

Consent to treatment – assessments of capacity lacked detail and patient views.

This action point was raised in 1 of the 9 boroughs we looked at.

Consent to treatment – the responsible clinician had completed a CTO12 Part 4A consent certificate without personally meeting the patient.

This action point was raised in 1 of the 9 boroughs we looked at.

Consent to treatment – the patient's capacity had not been reviewed for over a year and some assessments of capacity lacked detail.

This action point was raised in 1 of the 9 boroughs we looked at.

Consent to treatment – no new assessment of capacity or CTO12 Part 4A consent certificate following a permanent change of responsible clinician.

This action point was raised in 1 of the 9 boroughs we looked at.

Discretionary CTO condition – coercive. Misleading condition and letter to patients on a CTO, suggesting treatment can be forced on capable patients on a CTO in the community.

This action point was raised in 1 of the 9 boroughs we looked at.

Discretionary CTO condition - patient must reside at a specified residential home. Patients may lack capacity to consent. Potential deprivation of liberty.

This action point was raised in 1 of the 9 boroughs we looked at.

Discretionary CTO condition – patient must live at a specified address or wherever the clinical team decides. No clear purpose or justification or regard to the principle of the least restrictive option and maximising independence.

This action point was raised in 4 of the 9 boroughs we looked at.

IMHA service. Staff unaware of contact details of IMHA service and/or lack of referrals of patients on a CTO lacking capacity by staff and/or lack of CTO patient referrals.

This action point was raised in 2 of the 9 boroughs we looked at.

Information sharing. Care plans did not state patients' preferences on information sharing.

This action point was raised in 3 of the 9 boroughs we looked at.

Lapsed CTOs. CTOs being unintentionally or deliberately allowed to lapse rather than proactively discharged.

This action point was raised in 3 of the 9 boroughs we looked at.

Power of recall – lack of explicit explanation as to why this was needed.CTO1 and/or CTO7 forms.

This action point was raised in 4 of the 9 boroughs we looked at.

Recall to hospital. Two consecutive recall periods or capacity to consent to treatment during recall period not documented and/or no section 62 urgent treatment form and/or no date given for SOAD requests.

This action point was raised in 3 of the 9 boroughs we looked at.

Rights. No discussion of rights between community team and patient following discharge onto CTO.

This action point was raised in 7 of the 9 boroughs we looked at.

Section 135(2) warrant. Warrant obtained before serving of CTO recall notice.

This action point was raised in 1 of the 9 boroughs we looked at.

Total action points raised: 50

Provider action statements

When we raise issues with providers, we ask them to respond with provider action statements to show they have an action plan to resolve the issue.

The majority of action points raised related to care planning, rights and assessments of capacity to consent to treatment. Actions around assessments of capacity related either to the start of a CTO or following recall to hospital and revocation or both. While the measures that trusts told us they would take to address the issues raised in the action points, such as audits, reviews and reminders, all addressed the concerns we raised, they often did so retrospectively, adding further steps to what were often already highly complex pre-existing systems of checks.

The process of legal checks, often made the responsibility of a small MHA administration team, occurred after the errors had been made and relied on someone having the time and knowledge to identify the error. Spot checks often replaced routine checks of issues such as care planning. The more time-consuming the checking system, the less likely it would be reliably completed, and the more likely errors would fail to be caught be it.

By contrast, some trusts chose to incorporate the actions identified into their regular training programmes, such as CTO training for community staff or section 12(2) and approved clinician refresher training for responsible clinicians. This has the added advantage not only of alerting staff to potential issues but also proactively ensuring that the relevant professionals took responsibility for carrying out their own duties correctly first time round, in turn reducing the need for complex reminder systems. Process flow charts could also be helpful.

A combination of regular audit and training on an ongoing basis ensured that standards would not deteriorate over time. Where the responses to technical MHA actions were written by managers (or were so attributed), with no obvious involvement from the MHA law lead, the responses showed generally less understanding of CTOs and of the action being raised.

Care planning

Two trusts had excellent care plans and we identified no actions. Two responded by arranging training for staff. Two trusts said they would contact the relevant community teams and ask them to check that all their care plans met the appropriate standards. One trust said they would introduce a new care planning process for all community teams based on the practice in the best CMHTs. One trust said they would invite the care co-ordinator to the care planning approach (CPA) discharge meeting within 2 weeks of the start of the CTO to show that the care plan was complete. One trust told us it was piloting the Dialog Plus care planning system, which it hoped would lead to better co-production in care planning in the longer term. Another trust informed us about its "Perfect Ward" application that hosts audit tools used to monitor quality and performance on inpatient wards and community settings, including care plans.

Four trusts added care planning to their monthly audits or created new ones, some involving input from a modern matron or senior manager. One trust said it would add care planning to the agenda for supervision meetings. One trust said it would make sure care plans could be properly documented on the electronic patient record and monitored, while another trust told us it had created a new decision tree and flow chart for care planning. Three trusts told us that the MHA administration team would send reminders to staff, while another trust said it would remind community teams of the CPA policy. A further trust said it would remind care co-ordinators of the trust's care planning standards.

Rights

As indicated above, many of the professionals we spoke with acknowledged the problems associated with regularly advising patients on a CTO of their section 132 rights in the community. However, 2 trusts showed excellent practice and documentation about how patients on a CTO were advised of their rights under the MHA and we identified no actions. Two trusts said they would include section 132 rights for patients on a CTO in their training, with 1 trust organising a targeted briefing for relevant staff by the MHA law lead. One trust said it would create a new form on the electronic patient record that could be monitored by the MHA administration team. One trust gave community teams 3 months to make sure all rights advice was up to date. One trust, which was in the process of reviewing its CTO policy, told us it would revise its guidance on section 132. A further trust said they would add rights advice to their decision tree and flow chart for community teams.

Five trusts said they would audit section 132 rights for patients on a CTO, either regularly or quarterly. In 3 cases, we were told the audit would be carried out by the MHA administration team. In 4 trusts, we were informed that care co-ordinators would be reminded to advise patients on a CTO of their rights, in 1 case by their managers, but in the rest by the MHA administration team. However, comments included in the Provider Action Statements, such as "the local MHA office will continue to routinely remind staff of the need to provide patients with information about their rights" suggested that staff were not particularly responsive to these reminders. Some of the responses to the actions we raised also appeared to place a considerable burden on the MHA administration team.

This example from a provider action statement effectively places the responsibility for advising patients on a CTO of their rights on the MHA team, when in fact the responsibility lies with the community team:

> "On commencement of a CTO, the MHL Office will email the care co-ordinator, attach a CTO rights leaflet, inform them that the patient is now on a CTO and remind them to read and explain CTO rights to the patient, if they have not done so already."

Assessments of capacity to consent to treatment

We identified action points around assessments of capacity to consent to treatment, either following the start of the patient's CTO or following CTO recall or revocation, in all 9 boroughs we visited.

Capacity to consent to treatment on recall and revocation – the law

The capacity and consent to treatment arrangements for CTO patient in the community are referred to as Part 4A. If a CTO patient in the community is assessed to lack capacity, the community responsible clinician must request a SOAD who must certify that the patient's treatment is appropriate using a CTO11 certificate. If the community responsible clinician assesses the CTO patient to have capacity, then the responsible clinician can complete a CTO12 consent certificate. The MHA allows a period of 1 month following the CTO patient's discharge from detention in hospital for this to take place. If the SOAD does not assess the patient past the end of the 1 month period, the community responsible clinician can continue to treat the CTO patient provided a section 64 urgent treatment certificate has been completed (MHA Code of Practice paragraph 25.31). Patients on a CTO who have capacity to consent to treatment may not be compulsorily treated in the community, even in emergencies. Treatment can be given without their consent only if they are recalled to hospital (MHA Code of Practice 24.17).

After a CTO patient has been recalled to hospital and their CTO revoked, the arrangements for capacity and consent to treatment are identical to those for detained patients under Part IV, since following the CTO being revoked, the patient becomes detained in hospital and subject to section 3 or 37 as they were before discharge onto their CTO. The patient will either be subject to a T2 consent certificate completed by the inpatient responsible clinician or a T3 certificate completed by a SOAD.

There are certain exceptions (see MHA Code of Practice paragraph 25.33). During the 72 hour recall period, treatment will need to be authorised by an urgent treatment certificate or Part 4A certificate which allows the treatment the patient was receiving to continue in the community. If the CTO patient agrees to come into hospital as an informal CTO patient instead of going through the CTO recall and revocation process, they will continue to be subject to Part 4A while in hospital (provided they are not recalled and their CTO revoked, in which case they will become subject to Part IV).

Capacity to consent to treatment on recall and revocation - responses

All the trusts responded to our findings by telling us that responsible clinicians would be reminded of their responsibilities to complete assessments of capacity to consent to treatment and to document these in the appropriate place, usually on a particular form in the electronic patient record. In all cases, these reminders (and in 2 trusts, 3 reminders to each responsible clinician, to be given at different times) were to be issued by the MHA administration team. However, there was little evidence that consultant psychiatrists were responsive to the reminders they were already receiving.

Some trusts told us they were introducing stronger measures, such as the medical director and mental health law lead jointly writing to all responsible clinicians to set out clearly the requirements and expectations on responsible clinicians in relation to patients on a CTO. In another, we were informed that breaches would be recorded as incidents by the CMHT Operational Lead with responses expected within 48 hours and the results to be discussed in Directorate Management Team meetings. Another trust informed us of its robust escalation process.

Only 1 trust told us they would organise training for responsible clinicians including these specific issues. In total, 7 trusts stated they would audit consent to treatment. One trust said they would remind all responsible clinicians where assessments of capacity for patients on a CTO should be documented. Other trusts said they would update their policies or procedures, add the issues to meeting agendas or re-design the forms on their electronic patient record system. Some trusts understood this action to relate to capacity more generally, rather than specifically to the law relating to patients on a CTO under the MHA both in the community and following recall to hospital. We were informed that this issue would come under the remit of the Mental Capacity Act 2005 (MCA) lead rather than the MHA law lead and form part of MCA training. We did not consider that this would improve practice in relation to CTOs.

Conclusions

The future for CTOs

The draft Mental Health bill sets out a series of proposals to reform CTOs. These include:

- strengthening the requirement for evidence and justification for use
- increasing the number of decision makers before someone is put on a CTO
- introducing a time limit and increasing the frequency of review
- requiring that CTOs provide a genuine therapeutic benefit to those who are subject to them.

There is a proposal that recall from a CTO, should require continued therapeutic benefit to the patient and a substantial likelihood of serious harm, for example. Through the consultation which preceded the Bill, stakeholders were broadly supportive of the government's proposals, but others raised concerns or practical considerations around the implementation of the proposals. No detail is provided as to how CTOs might come to affect Black people less disproportionately. There was also no agreement about limiting the duration of a CTO to 2 years.

The government concluded that stakeholders remain divided on the use of CTOs, but agree on the need for change. However, there are vastly differing views as to what change may be needed. Many of these are identical to the arguments put forward before the introduction of CTOs. This is also reflected in the wide variation in the numbers of CTOs implemented by different responsible clinicians. The government hopes that its proposals will reduce the number of CTOs and their disproportionate use for Black people and people from some ethnic minority groups, but we are yet to see any detail about how this will be achieved. Reference is also made to the use of clearer guidance in a new Code of Practice and strong governance around the use of CTOs.

CQC anticipates that Government will keep the use of CTO under review over 5 years from the implementation of such changes, to see whether overall usage and overrepresentation of Black people and people from ethnic minority groups decreases.

CTOs in practice

The fundamental paradoxes around the use of CTOs remain. To have credibility as a less restrictive alternative to detention, CTOs must be as short as possible, yet for those patients for whom they provide a stable life in the community, they should arguably be without limit of time. However, it is almost impossible for patients or their legal representatives to show that their CTO should be discharged. If the patient has been repeatedly recalled to hospital, it can be argued that the CTO is effective, providing speedy access to treatment when their mental state deteriorates. If they are never recalled to hospital, it can also be argued that the CTO is effective, since the CTO patient complying with taking medicine in the community is successfully preventing hospital admission.

The patients we spoke with often resented having to take depot medicine in the community, the number of appointments with the community team and the continuing contact with mental health services. However, their relatives saw the CTO as essential for maintaining the patient's health in the community and avoiding long hospital admissions.

Responsible clinicians, while often expressing their distaste for the compulsion associated with CTOs, found them useful in some cases. AMHPs and care co-ordinators, despite the fact that CTO recall was sometimes delayed, often appreciated that patients on a CTO could be brought into hospital relatively quickly, using a process understood by everyone involved.

In the meantime, the disproportionate impact of CTOs (and detention generally) on Black British patients both across the London region and elsewhere remains unexplained and unaddressed and in need of urgent attention. We will continue to evaluate whether the opportunities provided by a revised MHA and a new code of practice improve the situation.

Recommendations

Unlawful, discriminatory or poor practice

- Providers should monitor, investigate and take steps to reduce the disproportionately high number of Black British patients currently on CTOs. Any disproportionate impact of longer-term CTOs on any patient group or demographic, such as older patients, should be investigated.
- Providers should take steps to prevent any oppressive implementation of CTOs, such as through the forcible and unlawful medication of patients on a CTO in the community who is clearly objecting.
- Providers should take steps to prevent any unlawful coercion associated with CTOs. All patients on a CTO and community mental health team (CMHT) staff should understand that patients who are on a CTO and have capacity to consent to treatment can never be compulsorily treated in the community. This can only happen if they are recalled to hospital.
- Providers should review all CTOs regularly against the legal criteria and discharge any that are no longer necessary or appropriate, in accordance with the principle of the least restrictive option and maximising independence.
- Providers should ensure that all patients on a CTO understand what they need to do to be discharged from their CTO.

Independent mental health advocacy (IMHA) services

- Providers should address the very low or non-existent take up of IMHA services by patients on a CTO in the community. Patients on a CTO should be given information about the IMHA role as it relates to them and be provided with the contact details for the IMHA service as part of their regular rights advice. The letter sent out by the MHA administration team to patients at the start of their CTO should include the contact details of the IMHA service.

Rights

- Providers must ensure that patients on a CTO are informed of how the MHA applies to them, including the essential legal and factual grounds for their CTO, both verbally and in writing as soon as practicable after the start of their CTO and regularly thereafter (see MHA Code of Practice, paragraphs 4.28 to 4.30). This information must also be given to patients on a CTO at the time they are recalled to hospital. Community team staff should understand the trust policy around rights advice for patients on a CTO.
- Providers should ensure that staff record the date and time of every discussion of a patient's rights, whether the CTO patient understood their rights and the name and role of the staff member providing the rights advice, as well as the details of any interpreter involved, consistently in the patient's electronic care record.

Care planning

- Providers should ensure that CTO care plans are accurate, comprehensive and up to date. Care plans should support the CTO conditions and include the patient's views, as well as specifying those responsible for providing community follow up. They should make reference to the wider social needs of patients on a CTO, such as housing, finances and employment, the involvement of external agencies and specify the aftercare services being provided under section 117.
- Providers should ensure that all patients on a CTO receive copies of their current care plans.

Information sharing

- Providers should ensure that discussions about information sharing with patients on a CTO are incorporated routinely into patient care plans.

Assessments of capacity to consent to treatment

- Providers should ensure that assessments of capacity to consent to treatment relating to the consent certificate (CTO12 form) or the SOAD request are completed at the same time, within 1 month of the start of the CTO as required by Part 4A MHA. These should contain the reasons for the responsible clinician's decision and document the discussion between the responsible clinician and the patient. The capacity of patients on a CTO should be regularly reassessed and the certification updated or a SOAD requested. The dates of SOAD requests should be documented. New assessments of capacity should be carried out following any permanent change of responsible clinician and new CTO12 certificates completed.

- Providers should make sure that assessments of capacity to consent to treatment for CTO recall and authorising treatment during the recall period and subsequent to any revocation of the patient's CTO are fully documented, including the reasons for the responsible clinician's decision.

Making the CTO

- Providers should ensure that in addition to explaining the clinical rationale for the CTO, responsible clinicians explicitly set out in the CTO1 form why they need to use the power of recall to provide treatment for the patient in the community.
- Providers should make sure that AMHPs are involved at an early stage whenever they are needed to agree a decision about a CTO, so they are able to fully consider and contribute to the making, revocation or extension (renewal) of CTOs.
- Providers should ensure that particular and prompt attention is paid to carers and relatives when they raise concerns about a patient subject to a CTO. Their concerns may prompt a review of how the CTO is working for that patient and whether the criteria for recall might be met or whether more support in the community should be put in place.

CTO conditions

- Providers should ensure that discretionary CTO conditions have a clear rationale. Conditions must be necessary or appropriate to ensure the patient receives medical treatment for mental disorder and/or to prevent a risk of harm to the patient's health or safety as a result of mental disorder and/or to protect other people from a similar risk of harm. Conditions should restrict the patient's liberty as little as possible while being consistent with their care plan and recovery goals. Conditions must not deprive the patient of their liberty.

CTO recall

- Providers should ensure that where there are delays between a CTO recall taking place (the completion of the CTO3 form by the responsible clinician) and the patient's admission to hospital due to an absence of beds, an escalation protocol exists to resolve such situations and minimise delays.
- Providers should organise training and regular refresher training for care co-ordinators on the CTO recall process. Training on CTOs should form part of refresher training for responsible clinicians, section 12 doctors and approved clinicians.

Multi-agency collaboration

- Providers should take steps to foster close collaboration with local agencies, such as the police and ambulance services, with the aim of promoting operational effectiveness.

Ending or extending (renewing) a CTO

- Providers should ensure that CTOs are always ended or extended (renewed) in a planned way, following discussion in advance between the responsible clinician and the community team, and are never simply allowed to lapse.

Tribunal appeals and discharges

- Providers must make sure that patients on a CTO are informed of their right to apply for discharge to the Mental Health Tribunal and the Hospital Managers' panel, as well as their Nearest Relative's right to apply for discharge. Should patients on a CTO wish to apply for discharge, they should be supported to do so.

NHS Digital

- NHS Digital should closely monitor and regularly update published data about the number of patients subject to CTOs in NHS trusts to ensure accuracy.

Print this document