## Policy: S24

### Community Treatment Order Policy

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<tr>
<th>Version:</th>
<th>S24/05</th>
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<tr>
<td>Ratified by:</td>
<td>Trust Management Team</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>13th May 2015</td>
</tr>
<tr>
<td>Title of originator/author:</td>
<td>Head of Mental Health Law &amp; Clinical Records</td>
</tr>
<tr>
<td>Title of responsible Director</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date issued:</td>
<td>13th May 2015</td>
</tr>
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<td>Review date:</td>
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</tr>
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<td>Target audience:</td>
<td>All clinical staff and Managers</td>
</tr>
<tr>
<td>Disclosure Status</td>
<td>(B) Can be disclosed to patients and the public</td>
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<tr>
<th>EIA / Sustainability</th>
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Other Related Procedure or Documents:
### Equality & Diversity statement

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.

### Sustainable Development Statement

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
## S24 - Community Treatment Order Policy

### Version Control Sheet

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<th>Date</th>
<th>Title of Author</th>
<th>Status</th>
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<tr>
<td>S24/01</td>
<td>Sept 08</td>
<td>Patient Services Manager</td>
<td>New policy developed</td>
<td>Specimen policy produced by the London Mental Health NHS Trusts &amp; Foundation Trusts Mental Health Act Leads. Amendments made to policy during Oct 08</td>
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<tr>
<td>S24/02</td>
<td>29.10.08</td>
<td>Patient Services Manager</td>
<td>Trust wide circulation for use</td>
<td>Note: This new Policy is a <strong>working draft document</strong>. Its Consultation period will end 12th December 2008. At end of consultation period – policy reviewed and minor changes to references were done. On 16/01/09 Policy was signed off and issued</td>
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<td>as working draft document <strong>effective from on 3rd Nov 08</strong></td>
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<tr>
<td>S24/03</td>
<td>12.05.11</td>
<td>Head of Mental Health Law &amp; Clinical</td>
<td>Policy re-formatted</td>
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<td>Aug 11</td>
<td>Head of Mental Health Law &amp; Clinical</td>
<td>Working document back to August</td>
<td>Section 135(2) appendix attached. Minor Amendments made further to SCT visit from CQC: 4.1 wording strengthened; 6.3 removed ‘once introduced’ changed MHAC to CQC. Present to 25th August Policy Review Group for approval – approved.</td>
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<td>S24/05</td>
<td>Feb 15</td>
<td>Head of Mental Health Law &amp; Clinical</td>
<td>Policy renamed and fully amended</td>
<td>Flowchart attached. Responsible Director changed as MHA/MCA now sits in Governance (Medical Directorate). References to 2015 MHA Code of Practice completed. Textual changes where Code has altered wording. Under Trustwide consultation ending 30.03.15. Approved at May 2015 TMT</td>
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<td>Records</td>
<td>to be compliant with new MHA Code of Practice</td>
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1. **FLOWCHART**

1. There are signs that the patient’s mental health is deteriorating or has breached CTO condition.

2. Community team keeps in touch with RC who reviews the case.

3. After review & discussion patient remains at home and CTO continues or conditions changed by RC using form CTO 2.

4. RC decides that treatment is needed urgently and completes recall notice (form CTO 3).

5. Patient informed about recall to hospital in writing through form CTO 3 then either 6. or 7. below occurs.

6. Patient agrees to return to hospital form CTO 4 completed on return.

7. Patient refuses to return team decide need assistance to convey him or her.

8. With help of ambulance/police (if necessary) or secure transport patient returned to hospital.

9. A copy of notice of recall (form CTO 3) is given to hospital managers and form CTO 4 completed.

10. Patient is detained in hospital for treatment for up to 72 hours.

11. Within the 72 hours if patient’s condition stabilises and patient discharged CTO continues. If conditions are varied RC completes form CTO 2. Patient may agree to remain in hospital on voluntary basis.

12. Patient still too unwell to return home within the 72 hours. RC and AMHP agree CTO must be revoked. The patient is then readmitted to hospital under original section and a new period of up to 6 months begins. Hospital Managers supplied with copy of form CTO 5 completed by the RC and AMHP.
2. INTRODUCTION

2.1 This policy sets out the legal framework for the operation of an order made under section 17A of the Act which is known as a ‘Community Treatment Order’ (‘CTO’). The title of this policy has been changed to reflect the fact that the previous term ‘Supervised Community Treatment’ is now redundant.

2.2 The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The term ‘patient’ is used throughout to reflect the language of the Code but terms such as ‘CTO patient’ or ‘service user’ may be preferred locally.

2.3 This policy should be read in conjunction with chapter 29 of the Mental Health Act 1983 Code of Practice (the Code) which offers guidance on the operation of the Act. The [new] principles set out in Chapter 1 of the Code in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs.

3. SCOPE & PURPOSE OF THIS POLICY

3.1 This Trust-wide policy sets out legal and procedural requirements, where these are explicit in the Act or Code. Where appropriate, reference should be made to the following Trust policy: P1 Missing Persons and Patients Absent Without Leave.

3.2 The purpose of this policy is to ensure that there is lawful and appropriate use of CTOs and that the legal rights of any patient subject to a CTO are upheld at all stages.

4. DEFINITIONS

4.1 Community Treatment Order is an order made under section 17A of the Mental Health Act 1983 (as amended) which requires an unrestricted patient usually detained under section 3 or 37 to be discharged subject to certain conditions and liable to recall to hospital.

4.2 Responsible Clinician is the consultant psychiatrist (or other approved clinician) who is in charge of a CTO patient at any given point. When moving between the community and inpatient services, there will usually be a change in RC. Out of hours, there is a duty consultant who in

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2 Code of Practice (2015) para 29.5
emergencies may assume RC responsibility for patients within their designated service.

4.3 **Hospital Managers** is a term used in the Act for the detaining authority or the body responsible for use of compulsion i.e. the Trust Board. However, day to day responsibility for receipt and scrutiny of statutory documentation is delegated to senior managers or MHA Office staff and out of hours, to unit coordinators, the nurse in charge or equivalent.

5. **DUTIES**

5.1 **Chief Executive**

The Chief Executive is responsible for ensuring that the Trust has a policy in place for Community Treatment Orders and that systems exist for monitoring the effectiveness of its implementation.

5.2 **Accountable Director**

The Medical Director is responsible for writing, reviewing and updating the policy and for ensuring it is implemented to the required standards. The Medical Director is responsible for monitoring the use of Community Treatment Orders. The Medical Director is responsible for ensuring the trust provides staff training in the use of CTOs including appropriate recall to hospital and revocation where necessary.

5.3 **Managers**

Clinical Directors are responsible for ensuring compliance with this policy within their service lines and for ensuring that each CTO patient has an allocated Responsible Clinician whether in the community or an inpatient setting.

5.4 **Policy Author**

The Head of Mental Health Law is responsible for alerting the Medical Director through the Trust’s Clinical Effectiveness & Compliance Committee to any legislative or procedural changes which affect the accuracy of this policy. He/she will also update and amend this policy at intervals decided by that Committee.

5.5 **Specific Staff for Policy**

All responsible clinicians making CTOs, recalling patients to hospital, revoking a CTO with an AMHP, amending conditions or providing treatment must adhere to this policy.
5.6 All Staff

All staff involved in the treatment of or recall of CTO patients must adhere to this policy to ensure patients’ rights are upheld and all actions taken by staff are lawful.

6. SYSTEMS / DOCUMENTATION

Where Recorded:

6.1 All Statutory Documentation relating to use of CTOs will be held in a Trust MHA Office and a copy will be scanned onto the individual patient’s Rio record to be available to staff 24/7.

6.2 Recorded by:

The use of CTOs will be recorded on each individual Rio record by MHA Office staff. Reports on Trustwide usage and any exceptions to this policy will be made regularly to the Trust’s Clinical Effectiveness and Compliance Subcommittee by the Head of Mental Health Law & Clinical Records.

6.3 When recorded:

The use of CTOs will be recorded at the actual time and date they are implemented in an individual case.

7. CRITERIA & PROCESS FOR MAKING A CTO

7.1 There is no lower age limit for a CTO. The following criteria must be met in all cases before a CTO can be made by the patient’s Responsible Clinician (‘RC’):

- The patient must be currently liable to detention for treatment under section 3 or an unrestricted section under Part III of the Act, including a patient currently on section 17 leave from hospital. It is not applicable to patients on restriction orders.
- The RC must be satisfied that the risk of harm arising from the patient’s mental disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual.

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3 For a full list of eligible sections see Department of Health (2008) Reference Guide to the Mental Health Act 1983 para.15.9 / Table 15.1
4 Code of Practice (2015) para 29.16
• The RC’s decision to place a patient on a CTO should only ever be made on clinical grounds where the patient meets the criteria in section 17A of the Act.

7.2 The following conditions are mandatory in all cases:

• The patient must make him or herself available for examination to determine whether to extend the community treatment period\(^5\)
• The patient must make him or herself available for examination by a second opinion appointed doctor when requested\(^6\) However, this only applies if the RC is unable to certify that the patient has capacity and is consenting to treatment.

7.3 An AMHP (who could be working in the same team as the RC\(^7\)) must agree in writing that the patient meets the criteria for a CTO, a CTO is appropriate and any conditions made are necessary or appropriate for one or more of the following: to ensure the patient receives medical treatment, to prevent risk of harm to patient’s health or safety, to protect other persons. If the AMHP does not agree with the RC that the patient should be discharged onto a CTO, the CTO cannot be made. The RC should not approach another AMHP for an alternative view.

7.4 An order is made by the RC completing Parts 1 & 3 with the AMHP completing Part 2 of form CTO1. The AMHP should also meet with the patient before deciding whether to agree that the CTO should be made.

7.5 Although it must be given to the Hospital Managers as soon as practicable, there is no statutory form to record receipt of the order. When signed by the RC, the CTO automatically takes effect on the date and time specified for a period of up to six months.

7.6 As there is no mechanism for retrospectively amending or rectifying a defective form CTO1 once handed to the Hospital Managers, it is essential that where practicable, the form (or a copy of it) is seen by or at least discussed with a Mental Health Act/Law Administrator (or equivalent) before acting on it.

8. **CARE PLANNING & SCT:**

8.1 As patient is being discharged subject to an order under the Mental Health Act 1983, a care plan must be prepared and a care co-ordinator will need to be identified.

\(^5\) Form CTO1 contains a statement to this effect: ‘The patient is to make himself or herself available for examination under section 20A, as requested.’

\(^6\) Form CTO1 contains a statement to this effect: ‘If it is proposed to give a certificate under Part 4A of the Act in the patient’s case, the patient is to make himself or herself available for examination to enable the certificate to be given, as requested.’

8.2 The patient should have a discharge CPA meeting and a copy of the care plan before they are discharged from hospital onto the CTO.8

8.3 It will be important to maintain contact with a patient on a CTO and to monitor closely their mental health and wellbeing after they leave hospital. When monitoring and review suggests that the CTO is failing to promote recovery then consideration needs to be given to discharging the CTO and taking a different approach.9

8.4 In addition to the statutory requirements in the Act for review of CTOs it is good practice to review the patient’s progress on their CTO as part of all reviews of the CPA care plan or its equivalent.10

9. CONDITIONS ATTACHED TO A CTO:

9.1 There are two conditions set out at 7.2 above which are mandatory in all cases.

9.2 The RC may, with the AMHP’s agreement and following discussions with the patient, set other conditions which are identified as being necessary or appropriate to: ensure that the patient receives medical treatment for mental disorder, prevent a risk of harm to the patient’s health or safety as a result of mental disorder and protect other people from a similar risk. Conditions may be set for any or all of these purposes but not for any other reason.11

9.3 Conditions should be stated clearly having regard to the least restriction principle and may include: where and when the patient is to receive treatment in the community, where the patient is to live and avoidance of known risk factors or high-risk situations relevant to the patient’s mental disorder.12

9.4 The RC may vary the conditions of the CTO (using form CTO2) or suspend any of them where appropriate (e.g. to allow temporary absence of patient) but must record, with reasons, any decision to suspend in the clinical records. In either case, a decision to vary or suspend should be relayed to the Mental Health Act/Law Administrator (or equivalent) holding the CTO documentation to enable them to update their records. Any condition no longer required must be removed. It is not necessary to seek the agreement of an AMHP to vary or suspend conditions.

9.5 Failure to comply with a condition (apart from those at 7.2 above) does not in itself trigger recall.

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8 Code of Practice (2015) see paras 34.13-34.14 & 34.19
9 Code of Practice (2015) see paras 29.38-29.39
10 Code of Practice (2015) see chapter 34
11 Code of Practice (2015) para 29.29
12 Code of Practice (2015) para 29.32
10. **PROVISION OF INFORMATION ON MAKING AN ORDER:**

10.1 As soon as the decision is made to discharge a patient onto a CTO, the RC should inform the patient and others consulted of the decision, the conditions to be applied and the services which will be available for the patient in the community including the continuing right to an IMHA.

10.2 There is a duty on the Hospital Managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving information both orally and in writing and must be done as soon as practicable after the patient goes onto the CTO. In WLMHT an Information leaflet will routinely be provided in writing to the patient by the Mental Health Act/Law Administrator (or equivalent) and to the nearest relative unless the patient objects.

10.3 Information in writing given to the patient (and where copied to the nearest relative) will include reference to their rights and the following matters:

- Appeals to the First-tier Tribunal (Mental Health)
- Recall, Revocation or Discharge by RC
- Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours notice requirement), MHRT or Hospital Managers
- Independent Mental Health Advocacy Services
- The Role of the Care Quality Commission
- Treatment rights while subject to CTO in the community

11. **RECALL FROM CTO:**

11.1 Where a change of RC on recall is anticipated, best practice requires that they should be made aware of and involved in any of the following actions required of the RC as soon as practicable.

11.2 The RC may recall a CTO patient to hospital for treatment if:

- The patient needs to receive treatment for mental disorder in hospital (either as an in-patient or out-patient) or
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

11.3 Where a patient breaches a condition of their CTO or refuses necessary treatment they should always be given the opportunity to comply with the condition before recall is considered unless there is a risk of harm to their health or safety or to others.

11.4 The RC must be satisfied that the criteria are met before using the recall power. Any action should proportionate to the level of risk and whether recalling the patient to hospital is justified in all the circumstances e.g, if they might agree to admission to hospital on a voluntary basis.

11.5 The RC must complete a written notice of recall to hospital (form CTO3) which is effective only when served on the patient. Where possible, this
notice should be handed to the patient personally, or otherwise be delivered by hand to the patient’s usual or last known address. If access cannot be gained to the patient, consideration should be given to obtaining a warrant under section 135(2) of the Act. Table 1 below summarises the reasons for and effect of each method of Serving a Notice of Recall. First class post can also be used in limited circumstances.

11.6 The RC should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide appropriate. Whilst recall must be to a hospital, the required treatment may be given on an outpatient basis, if appropriate.

11.7 Conveyance to that hospital should be in the least restrictive manner possible. Reference should be made to any policies agreed locally with the police and any guidance provided by a police force.13

11.8 If the hospital is under the management of the same organisation as the patient’s detaining hospital immediately before making the CTO, a copy of the completed form CTO3 will provide authority for detention. Form CTO6 is not required for transfers within the same organisation but the receiving hospital must complete form CTO4 recording the date and time of the patient’s initial recall to hospital.

<table>
<thead>
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<th>Patient’s Circumstances</th>
<th>Appropriate Method of Serving form CTO3</th>
<th>Notice effective</th>
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<tbody>
<tr>
<td>Patient can be approached in person and may be at or in hospital already</td>
<td>Deliver form by hand personally</td>
<td>Effective Immediately</td>
</tr>
<tr>
<td>Need for recall is urgent but not possible to hand notice to patient personally as their whereabouts are unknown, patient is unavailable or refuses to accept the notice</td>
<td>Deliver form by hand to patient’s usual or last known address. If appropriate, consider whether s135(2) warrant should be sought see appendix 1flowchart</td>
<td>Notice deemed to be served after midnight on the day it was delivered. It does not matter whether it is a working day, a weekend or a holiday. It does not matter whether it is actually received by the patient or not</td>
</tr>
<tr>
<td>Patient not available in person e.g. has failed to attend requested appointment to see Second Opinion Appointed Doctor but situation is not urgent</td>
<td>Deliver form by 1st class mail to address where patient is believed to be</td>
<td>Served on the 2nd working day after posting (e.g. posted Friday effective from Tuesday)</td>
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Table 1. Appropriate Method by which to Serve a Notice of Recall

11.9 Transfer after recall, to a hospital managed by another organisation requires that arrangements for the transfer are properly in place and that form CTO6 is completed to provide authority to transfer. A copy of the previously completed CTO4 should be provided to the receiving hospital to ensure time limits are adhered to.⑩

11.10 As soon as practicable, the patient shall be given information verbally and in writing about their rights following recall and the impact, if any on their treatment rights which are set out in a separate section below. The provision of SCT rights must be recorded in the same manner used for other detained patients.

11.11 Following recall, the RC and clinical team will consider the circumstances of the recall and in particular, whether SCT remains the right option for the patient. They must consult the patient and (subject to usual considerations about involving a nearest relative) any other carer, to decide whether a variation in the conditions or change in the care plan – or both – is appropriate. The RC may allow the patient to go on leave outside the hospital at any time during the 72 hour recall period.

11.12 If recall is not appropriate or necessary because a patient with capacity agrees to come into hospital on an Informal basis or to attend for treatment in a community setting, there is no statutory reason why that should not happen. Recall is permissible in relation to an existing inpatient⑪. To avoid confusion or failure to adhere to the intended statutory scheme, it is essential that the circumstances surrounding the admission and confirmation that the patient gave valid consent are properly recorded in the clinical records.

12. REVOCATION OF CTO OR RETURN TO COMMUNITY:

12.1 Having assessed the patient following recall, the RC must determine what should happen next. During this maximum 72 hour period from arrival in hospital, the patient remains a CTO patient even if they remain for one or more nights. The RC may allow the patient to leave the hospital at any time within this period. Once this period ends, the patient must be allowed to leave if the RC has not revoked the CTO. Although not specifically covered by the legislative scheme, the Code acknowledges that there is no impediment to a patient agreeing to remain in hospital on a voluntary basis where they have the capacity to choose to do so for a brief period.⑫ Section 5(2) holding powers cannot be used for a CTO patient

⑪ This position is confirmed by s17E(4), The Act
⑫ Code of Practice (2015) para 29.49 ‘does not explicitly mention capacity but for all Informal admissions to WLMHT capacity to consent to admission must be considered"
12.2 To revoke a CTO, the RC must consider that the patient now needs to be admitted to hospital for treatment under the Act. An AMHP must also agree with the RC’s assessment. This need not be an AMHP already involved in the patient’s care and treatment.

12.3 If the AMHP does not agree that the CTO should be revoked, their decision and the reasons for it must be fully documented in the clinical records, the patient must be discharged from hospital at the end of the 72 hours and the CTO continues. It is not appropriate for an RC to approach another AMHP for an alternative view.

12.4 Where the AMHP agrees, the RC may revoke the CTO by completing Parts 1 & 3 and the AMHP completing Part 2 of form CTO5. The revocation takes effect immediately once signed. The form must be forwarded to the Mental Health Act/Law Administrator or equivalent as soon as practicable. The RC or AMHP must give the patient (or arrange for the patient to be given) oral reasons for revoking the CTO before it is revoked.

12.5 The effect of completing form CTO5 is that the patient reverts to being detained under whichever section of the Act they were subject to immediately before the CTO was made. However, in all cases they are subject to a new period of detention of up to six months beginning with the day of revocation.

12.6 On revocation, form CTO5 must be copied to the managers of the hospital to which the patient was recalled (via MHA Office) if the patient was transferred during the period of recall. The Hospital Managers have certain duties in this situation including referring the patient to the Tribunal without delay.

12.7 It is the responsibility of the Hospital Managers to ensure that no patient is detained following recall for longer than 72 hours unless the CTO is revoked. Through the MHA Offices, the statutory documentation will be checked to monitor the patient’s length of stay following the time of detention after recall. Where this period is exceeded, this will be reported as with all other MHA exceptions through the Trust’s Clinical Effectiveness & Compliance Committee.

13. **EXTENDING THE COMMUNITY TREATMENT PERIOD:**

13.1 A CTO can be extended following examination of the patient by the RC within the last two months of the current period of the CTO. The RC must determine that the conditions for extension are met. These mirror the criteria and mandatory conditions described at 7.1-7.2 above with the additional requirement that the RC must also consult one or more other person who has been professionally concerned with the patient’s medical treatment.

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17 Code of Practice (2015) para 29.68
18 The Act, s20A(6)
13.2 As when making the original CTO order, the RC must obtain the written agreement of an AMHP that the conditions for extending SCT are met and where they are met, that extension is appropriate. This need not be the AMHP who originally signed form CTO1 but where the RC is not a registered medical practitioner, they should consult a doctor.  

13.3 The RC completes and signs Parts 1 & 3, the AMHP completes Part 2 of form CTO7 addressing the report to the relevant Hospital Managers. The completed report will be effective once it has been sent or delivered to the Managers or put into the hospital's internal mail system. It is then received by a Mental Health Act/Law Administrator (or other authorised person) who completes Part 4.

13.4 Once received, the Managers must undertake a review of the report provided on form CTO7. Where practicable, this should be done before the new period of extension takes effect but the completed form CTO7 itself provides lawful authority for the patient’s CTO to continue. Such reports will be dealt with in the same way as reports made to renew detention under the Act although it may be appropriate to arrange the Managers’ review at a more convenient location than the hospital in which the patient was originally detained.

13.5 The Code sets out questions that a Panel of Managers should address in the order given whenever they review a report made using form CTO7:  

Is the patient still suffering from mental disorder?  
- If so, is the disorder of a nature or degree that makes it appropriate for the patient to receive medical treatment?  
- If so, is it necessary in the interests of the patient’s health or safety or the protection of other persons that the patient should receive such treatment?  
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed? (For example, if a patient has been on a CTO for an extended period without the need to exercise the power to recall, it may not be appropriate to continue on a CTO)  
- Is appropriate medical treatment available for the patient?

13.6 The Code then requires that if three or more members of the panel (being a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is “no”, the patient should be discharged.

13.7 Where the answer to all these questions is “yes”, but the RC has made a report under section 25 barring discharge by the nearest relative (discussed further below) the following question must then be addressed:

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19 Although this is not an explicit requirement of the Act currently, this is a safeguard against potential future challenges to the validity of ‘medical evidence’.  
20 Code of Practice (2015) para 38.18
• Would the patient, if discharged, be likely to act in a manner that is dangerous to other people or to him or herself?

13.8 Where three or more members of the panel (being a majority) disagree with the RC and conclude that the answer is “no”, they should usually discharge the patient. However, they retain a residual discretion not to discharge in such cases, so should always go on to consider whether there are exceptional reasons why the patient should not be discharged.

13.9 Special provisions for extending the community treatment period apply to patients who have been unlawfully at large (‘absent without leave’) which are set out in sections 21A & 21B of the Act. After an absence of more than 28 days, form CTO8 must be completed to extend the CTO period.

13.10 Where the criteria for extending a CTO are not met and consequently, the RC does not plan to make a report to the Managers using form CTO7 (or where applicable, form CTO8) the patient should be discharged by the RC rather than waiting for the current CTO to lapse.

13.11 Extension periods for CTOs mirror the renewal scheme for section 3 patients: the initial CTO lasts for up to six months, if extended lasts for a further six months and thereafter, up to one year on each extension. The new period of a CTO is calculated from the day after the date on which the current order would have otherwise come to an end if it had lapsed.

14. DISCHARGE FROM LIABILITY TO DETENTION:

14.1 ‘Discharge’ for a CTO patient, regardless of who orders it, means complete release from liability to detention under the Act in hospital or in the community. It is not the same as ‘recall’ or ‘revocation’ which are described at 7 and 8 above nor the process of ‘discharge subject to…being liable to recall’21 which follows the making of a CTO order.

14.2 The RC can discharge a patient from a CTO at any time in writing by completing the local discharge from liability to detention form under section 23 of the Act22 and providing it to the Managers of the responsible hospital. There is no statutory form for this purpose nor statutory requirement to consult with any other person.

14.3 A Part II CTO patient’s nearest relative (there is no available power in relation to Part III CTO patients) can order their discharge in the same way as they can for section 2 or 3 patients. An order must be put in writing giving at least 72 hours notice but need not be in any specific form. To assist this process, a standard letter will be made available where required, an illustrative example of which may be found at paragraph 29.23 of the Code.

21 S17A(1), The Act
22 An order for discharge is made under s23(2)(a) if the CTO has been revoked or s23(2)(c) if CTO is still in force
14.4 Within the permitted 72 hours, the RC may sign a report barring discharge under s25 of the Act. In doing so he or she has concluded that ‘the patient, if discharged, would be likely to act in a manner that is dangerous to other people or to him or herself’. A review by the Managers will then be arranged which will include consideration of the key question of dangerousness (see 13.7 above). Where a report is made, the nearest relative must be advised of their right to apply to the Tribunal.

14.5 If the RC does not sign such a report, discharge by the nearest relative takes effect after 72 hours or at a point shortly after that which they have specified. Where a patient has been recalled to hospital, only the RC can discharge him/her during the period of 72 hours following recall. During the same period, there is no power of discharge available to the nearest relative, Hospital Managers or Tribunal.

14.6 The Hospital Managers have the power to discharge an CTO patient exercisable by 3 or more members of a panel (being a majority) on agreement that one of the criteria for a CTO or its extension is no longer met and consequently, the CTO is no longer appropriate or necessary. Where a patient’s CTO has been revoked, the review will be essentially the same as that for any patient liable to detention under the Act.

14.7 The Tribunal can discharge a CTO patient except during the 72 hour period of recall of such a patient. If following recall, a patient’s CTO is revoked, the Mental Health Act/Law Administrator (or equivalent) must refer the patient’s case to the Tribunal as soon as possible. All circumstances where there is a duty to refer a case to the Tribunal are set out in section 68 of the Act.

14.8 An application for discharge can be made once by a patient to the Tribunal during any period of a CTO. Any withdrawn application is disregarded and does not interfere with this right. The Tribunal cannot vary conditions on a CTO imposed by the RC and although it can make a recommendation, cannot oblige an RC to make a CTO order for a detained patient. The Tribunal application rights of both patients and their nearest relatives are set out in section 66 of the Act.

14.9 It may be appropriate for the Tribunal hearing to be held in an alternative setting such as a community facility by prior discussion and agreement if there are practical reasons for doing so.

14.10 If a Part II patient (i.e. liable to recall to underlying section 3) is detained in another hospital under section 3 or equivalent, other than by their CTO being revoked, this will automatically discharge the existing CTO and its underlying section 3. A CTO can only be recommenced by starting a fresh assessment again. This does not affect Part III patients (i.e. liable to recall to underlying section 37 or equivalent). Detention under section 2 will not

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23 Advice should be sought from the MHA Office who are responsible for referrals to the Tribunal on behalf of the Hospital Managers (The Trust Board)
affect a current CTO. Detention in prison or elsewhere of less than six months’ duration will allow a CTO to continue or to be extended in accordance with the provisions set out at 9.9 above. Detention in custody for a period of more than six months will automatically bring the CTO to an end in all cases.

15. TRANSFER BETWEEN HOSPITALS AND JURISDICTIONS

15.1 Paragraphs 11.6 11.-7 above describe the process for the physical transfer of a patient between hospitals following recall which requires the completion of form CTO6 where the hospitals are managed by different organisations. It does not necessarily mean that there is a transfer of the patient’s responsible hospital.

15.2 The responsible hospital for a patient subject to a CTO in the community (who may have been recalled to hospital) may be assigned to another hospital managed by a different organisation, with their agreement on completion of form CTO10. This process does not include the physical transfer of a patient which is dealt with above. It is referred to as an ‘assignment of responsibility for community patients’.

15.3 Assignment of responsibility for community patients between hospitals within the same Organisation requires no statutory paperwork but the Managers of the receiving hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give their name and address even if part of the same Organisation.

15.4 In any case, the new hospital becomes the responsible hospital and as such is treated as if it were the detaining authority when the patient was originally detained in hospital (and is now subject to recall to) prior to going onto a CTO.

15.5 Once a CTO has been revoked, transfer between hospitals under different managers is the same as for any other patient who is currently liable to detention using form H4.

15.6 Where a community patient under broadly equivalent legislation in Scotland, the Isle of Man or any of the Channel Islands is removed to England, their arrival in England is recorded using form M1 (date of reception of a patient in England) and where they are to be treated as if they were subject to a CTO, form CTO9 is completed by the RC (Part 1) and an AMHP (Part 2). As when making a new CTO, any conditions must be specified on form CTO9 and have the written agreement of an AMHP.

24 Admission under section 2 should not normally be considered as a legitimate alternative to recall or revocation of a CTO but its appropriateness as a temporary alternative might be argued where a patient has been admitted for assessment under s2 to an out of area hospital without their knowledge that he or she was subject to a CTO. The least restrictive option in that situation might be to briefly continue with s2 rather than revoking the CTO if discharge back to CTO is imminent.

25 The Act, s19A
16  DECISION TO USE CTO OR SECTION 17 LEAVE:

16.1 Section 17 (relating to leave of absence from hospital) of the Act is amended so that when considering granting longer term leave, an RC must consider whether SCT is the more appropriate way of managing the patient in the community. This applies to s17 leave for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).

16.2 These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for a CTO. An RC may still legitimately authorise longer-term leave where it is the more suitable option but must prove that he/she has considered whether a CTO is more appropriate.

16.3 The RC must record in the clinical records that he/she has considered whether longer-term leave or CTO is appropriate with reasons when authorising or reviewing such leave. This question should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, s17 leave forms will carry a tick-box statement to the effect that SCT has been considered where appropriate.

16.4 A CTO (section 17A) is used where it is necessary for the patient’s health or safety or for the protection of others to continue to receive treatment after their discharge from hospital. It seeks to prevent the ‘revolving door’ scenario and the harm which could arise from relapse. It is a more structured system than leave of absence and has more safeguards for patients. A key feature of the CTO framework is that it is suitable only where there is no reason to think that the patient will need further treatment as a detained in-patient for the time being, but where the responsible clinician needs to be able to recall the patient to hospital if necessary.26

16.5 The Code sets out a table of pointers for longer-term leave of absence or a CTO which may be of assistance to RCs and is replicated below. (A further table contrasting CTOs and guardianship can also be found in the Code at Para. 31.7)

26 Code of Practice (2015) para 31.6 see also chapter 29
<table>
<thead>
<tr>
<th>Factors suggesting longer-term leave</th>
<th>Factors suggesting SCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Discharge from hospital is for a specific purpose or a fixed period.</td>
<td></td>
</tr>
<tr>
<td>● The patient’s discharge from hospital is deliberately on a “trial” basis.</td>
<td></td>
</tr>
<tr>
<td>● The patient is likely to need further in-patient treatment without their consent or compliance.</td>
<td></td>
</tr>
<tr>
<td>● There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a CTO.</td>
<td></td>
</tr>
<tr>
<td>● There is confidence that the patient is ready for discharge from hospital on an indefinite basis.</td>
<td></td>
</tr>
<tr>
<td>● There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given.</td>
<td></td>
</tr>
<tr>
<td>● The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary.</td>
<td></td>
</tr>
<tr>
<td>● The risk of arrangements in the community breaking down or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify a CTO, but not to the extent that it is very likely to happen</td>
<td></td>
</tr>
</tbody>
</table>

**CTO or longer-term leave of absence: relevant factors to consider**

17. **TREATMENT ON RECALL (PART 4 OF THE ACT):**

17.1 For most patients liable to detention under the Act other than CTO patients, the administration of medication for the treatment of mental disorder after three months is authorised by a valid consent certificate (form T2) or second opinion certificate (form T3). The former is only valid as long as the patient is able and willing to give consent, the latter permits specified medication to be given even in the absence of consent or lack of capacity to consent.

17.2 When a patient on a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients.²⁷ If treatment does not include psychotropic medication or

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²⁷ Mental Health Act 1983, Sections 57, 58, 58A and 63,
Electroconvulsive Therapy (‘ECT’) and a patient with capacity consents to it, it may be given under the direction of the RC.

17.3 If a Second Opinion Appointed Doctor (‘SOAD’) has approved any treatment (on form CTO11) in the event of the patient’s recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the SOAD has indicated otherwise, the certificate will authorise treatment (other than ECT) whether the patient has or does not have capacity to refuse it.

17.4 On recall, treatment that was already being given as described on form CTO11, may continue to be given if the approved clinician in charge of the treatment considers that stopping it would cause the patient serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

17.5 It may be necessary on recall, to rely on a certificate that was issued while a patient was detained prior to going onto a CTO if it remains technically valid. A new certificate should be obtained as soon as possible.28

18. TREATMENT WHILE IN THE COMMUNITY (PART 4A OF THE ACT):

18.1 The treatment of CTO patients who have not been recalled to hospital, including patients who are in hospital on a voluntary basis not having been recalled, is dealt with under Part 4A of the Act. The Code refers to them for convenience as ‘Part 4A patients’ and provides detailed guidance on their treatment in chapters 24 and 25.

18.2 There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria set out at 7.1-7.2 above.

18.3 The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 (‘MCA’)29 including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give a CTO patient any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient.

28 Code of Practice (2015) 25.33
18.4 The MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is ‘Gillick competent’ in accordance with a landmark ruling of the House of Lords\textsuperscript{30}. This is sometimes referred to as ‘Fraser competency’ acknowledging the Law Lord who set out the principles to be applied in determining such competency.

18.5 Part 4A patients over the age of sixteen, who lack capacity may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient’s behalf. If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under MCA until the CTO patient is detained in hospital when Part 4 rules applies.\textsuperscript{31}

18.6 If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in section 64G which reflect the similar scheme in the MCA\textsuperscript{32} The alternative mechanism is via recall to hospital but the recall criteria apply equally to patients lacking capacity.

18.7 In an emergency, treatment for Part 4A patients who have not been recalled can be given by anyone (it need not be an Approved Clinician or the RC) but only if the treatment is immediately necessary to:

- Save the patient’s life
- Prevent a serious deterioration of the patient’s condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;
- alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard. Form 64(G) (emergency treatment for patient under CTO in community) is available on the Exchange MHA pages for completion in these circumstances.

For ECT (or medication administered as part of ECT), only the first two categories apply.

\textsuperscript{30}Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL)
\textsuperscript{32}See conditions set out in section 6 Mental Capacity Act 2005
18.8 In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting SCT patient without first recalling them to hospital.

18.9 In non-emergency situations (excluding ECT for which reference should be made to paragraphs 25.19-25.25 of the Code and WLMHT Trust Policy E1 Electro-convulsive Therapy Policy) a patient may lack capacity and object to treatment but where physical force is not required he or she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO.

18.10 After the first month either the RC must certify that the patient has the capacity/competency to consent and does consent (form CTO12), OR a SOAD must certify that such treatment is appropriate on a Part 4A certificate (form CTO11). The SOAD certifies the appropriateness of treatment and any conditions attached to it not necessarily whether a patient has or lacks capacity or is refusing.\(^3\)

18.11 The SOAD will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply. See paragraph 17.3 above.

18.12 Form CTO11 should be kept with the original CTO and detention papers but a copy must be kept in the clinical records which will be a scanned copy where the primary record is electronic.

18.13 The arrangements surrounding the SOAD’s examination will be complicated by the fact that the patient is in the community so an appropriate person should be asked to confirm arrangements with the SOAD and coordinate the process. This will normally be their care coordinator.

18.14 Other than in exceptional circumstances, SOAD examinations will be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit a CTO patient in a hostel or home, the SOAD will always be accompanied by an appropriate member of the care team.

19. **TRAINING:**

19.1.1 Detailed training for all relevant Trust staff was provided as part of the Implementation Plan in the run up to the amended Mental Health Act. This is now supported by attendance at mandatory Mental Health Law Update courses which include reference to key processes surrounding CTOs. Additional training may be commissioned by other committees as determined by current Governance arrangements for MHA/MCA.

\(^3\) Code of Practice (2015) para 25.32
19.2 Mental Health Act (‘MHA’) Managers (including any NEDs who sit on MHA Panels) will be offered refresher training on CTOs periodically to ensure that they are aware of any policy changes and relevant case-law.

20. MONITORING & REVIEW:

20.1 The Care Quality Commission have overall responsibility for monitoring all uses of CTOs. This work is routinely included in their published monitoring and visiting programmes. There is a requirement to report any deaths while subject to a CTO to CQC which is already operational.

20.2 The Trust’s Clinical Effectiveness & Compliance Committee (CECC) receives regular reports on all uses of the MHA including reviews of CTOs.

20.3 Local monitoring in relation to police assistance following recall will be undertaken through police liaison forums in each Borough. Any resulting recommendations will be relayed initially through the relevant CSU’s Clinical Effectiveness & Compliance Meeting which reports in turn to the Trustwide Committee.

20.4 All uses of the Act, including CTOs are reported annually through the Korner KP90 reporting route. Comparative data may be published which will be used to assist in monitoring any emerging trends.

21. FRAUD STATEMENT

(N/A)

22. REFERENCES (EXTERNAL DOCUMENTS)

This policy should be read in conjunction with the following:


23. SUPPORTING DOCUMENTS (TRUST DOCUMENTS)

- Policy C7 Consent to Examination & Treatment
- Policy P1 Missing Persons and Patients Absent Without Leave.

24. GLOSSARY OF TERMS / ACRONYMS

CTO – Community Treatment Order
CQC – Care Quality Commission
MHA – Mental Health Act 1983
MCA – Mental Capacity Act 2005
RC – Responsible Clinician (in charge of detained patient or CTO patient)
SOAD – Second Opinion Appointed Doctor (via Care Quality Commission)

25. APPENDICES

Appendix 1 – Procedure for CTO recall using section 135(2)
Appendix 2 – Monitoring Template
Appendix 3 – Illustrative standard letter for nearest relatives to discharge a CTO or section 2 or 3
APPENDIX 1

Procedure for CTO Recall Sec 135 (2)

Recall Letter issued to patient by Doctor
Care Co-ordinator & Team Informed by Doctor
Care Co-ordinator / Team Liaise with Police to complete Police Risk Assessment

Family Assessment as to needs of children & Vulnerable Adults

Guidance to complete Risk Assessment can be sourced via AMHP Leads

For Advice Contact Lead Social Worker or AMHP

Sec 135 (2) Warrant Required
Care Co-ordinator / Team Liaise with Police / family to assess if warrant for sec 135 (2) required

Sec 135 (2) Warrant Approved & Received
Care co-ordinator to arrange via Court

No Sec 135 (2) Warrant Required
Care co-ordinator

If Required Notify Police

Arrange date to return to hospital with Bed Manager

Care Co-ordinator

Arranged Rendezvous with Senior Police Officer
Police Receive Warrant

Access Gained or No response
Team Arrive at Address
Patient Compliant

Reassess Risk and Consider Alternatives
- Withdraw
- Reschedule
- Request Additional Support

Use of Reasonable Force Justified via Warrant
Access Gained Locksmith or Police Entry

Patient Admitted to Designated Ward

Use of Police Vehicle if Required
Patient to Hospital
APPENDIX 2

Illustrative standard letter for nearest relatives to use to discharge a patient

To the managers of [insert name and address of hospital in which the patient is detained, or (for a patient on a community treatment order) the responsible hospital.]

Order for discharge under section 23 of the Mental Health Act 1983
My name is [give your name] and my address is [give your address]
[Complete A, B or C below]

A. To the best of my knowledge and belief, I am the nearest relative (within the meaning of the Mental Health Act 1983) of [name of patient].

or

B. I have been authorised to exercise the functions of the nearest relative of [name of patient] by the county court.

or

C. I have been authorised to exercise the functions of the nearest relative of [name of patient] by that person’s nearest relative.

I give you notice of my intention to discharge the person named above, and I order their discharge from [say when you want the patient discharged from detention or a community treatment order].

[Please note: you must leave at least 72 hours between when the hospital managers get this letter and when you want the patient discharged.]

The time when:
• the notice is received by the hospital manager or an authorised person; or

• if the notice is sent by pre-paid post, the day service is deemed to have taken place [for first class post, service is deemed on the second business day following posting, and for second class post, service is deemed on the fourth business day following posting; or

• the notice is put into the internal mail system; and

• the time when you want the patient discharged.]

Signed ......................................................... Date ................................