Community Treatment Order Policy
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### Consultation Groups

| Approved by (Sponsor Group) | Quality Committee |
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<th>Name and Job Title of author:</th>
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<tbody>
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<td>Mason Fitzgerald</td>
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### Implementation Date :

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## Version Control Summary

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1.0 Introduction:

1.1 From 3 November 2008, the Mental Health Act 1983, as amended by the Mental Health Act 2007 (‘the Act’) introduced a scheme to provide treatment of mental disorder in a community setting. 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’

1.2 This policy should be read in conjunction with relevant chapters of the Code of Practice to the Mental Health Act (‘the Code’) which offers guidance on the operation of the Act. In particular, the five guiding principles set out in Chapter 1 of the Code should be considered when making decisions about a course of action under the Act.

2.0 Executive Summary:

2.1 This Trust-wide policy sets out procedural requirements, where these are explicit in the Act or Code but guidelines may be produced locally which, while complying with this policy, provide advice on more specific matters. Where appropriate, reference should be made to other Trust policies, namely the “Consent to Treatment Policy”, the “Advance Decision to Refuse Treatment Policy”, the ‘Responsible Clinician and Nominated Deputy Policy’, the Mental Capacity Act Policy’ and “Missing and Absent without Leave Policy”.

2.2 The purpose of this policy is to ensure that there is lawful and appropriate use of community treatment orders and that the legal rights of any patient subject to a community treatment order are upheld at all stages. There is no lower age limit for community treatment orders.

3.0 Criteria & Process for making a community treatment order:

3.1 The following criteria must be met in all cases before a community treatment order 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; this can also include a patient currently on section 17 leave from hospital. \(^1\) It is not applicable for patients on restriction orders.
- In the Responsible Clinician’s opinion, the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him or her to receive medical treatment.
- It is necessary for the patient’s health or safety or the protection of other people that such treatment should be received.

\(^1\) For a full list of eligible sections see Department of Health (2015) *Reference Guide to the Mental Health Act 1983 as amended by the Mental Health Act 2007*
Such treatment can be provided without the patient continuing to be detained in a hospital provided the patient is liable to being recalled to hospital for medical treatment

It is necessary that the Responsible Clinician should be able to recall the patient to

Taking account of the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case, appropriate medical treatment is available to the patient

3.2 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
- The patient must make him or herself available for examination by a Second Opinion Appointed Doctor if required

Other non-mandatory conditions may be set (see Para 5.4 onwards)

3.3 An Approved Mental Health Professional (AMHP) (who could be working in the same team as the Responsible Clinician) must agree in writing that the patient meets the criteria for a Community Treatment Order, a Community Treatment Order is appropriate and any conditions made are necessary or appropriate for one or more of the following reasons:

- to ensure the patient receives medical treatment;
- to prevent risk of harm to patient’s health or safety;
- to protect other persons.

If the Approved Mental Health Professional does not agree then the Community Treatment Order cannot be made. Faced with a disagreement, the Responsible Clinician should not attempt to seek an alternative view from another Approved Mental Health Professional as this would be deemed unlawful. Should circumstances change or further information come to light, further consideration could be given and ideally the original Approved Mental Health Professional should be consulted with an explanation clearly documented if this is not practicable.

3.4 An order is made by the Responsible Clinician completing Parts 1 & 3 with the Approved Mental Health Professional completing Part 2 of form CTO1. Once signed by the Responsible Clinician, the community treatment order automatically takes effect on the date and time specified on part 3 of the form, for a period of up to six months.

3.5 Although it must be given to the Hospital Managers as soon as practicable, there is no statutory form to record receipt of the Community Treatment Order. Therefore it is the responsibility of the Responsible Clinician to ensure that all completed community treatment orders are furnished to the local Mental Health Law Administration office as soon as is practicable after completion.

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

3 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.’

3.6 Once the CTO1 has been completed by the current Responsible Clinician, it is acceptable for a different Approved Clinician to assume the role of Responsible Clinician regarding the care and treatment of the patient in the community.

3.7 As there is no mechanism in the Mental Health Act for retrospectively amending or rectifying a defective form CTO1 once it has taken effect, it is essential that where practicable, any queries relating to the completion of the CTO1 is discussed with a Mental Health Law Administrator (or equivalent) before it is completed.

3.8 Once the Community Treatment Order is completed, the original statutory forms must be sent to the local Mental Health Law Administration office (who will forward to the relevant Mental Health Law Administration office if the patient is to be cared for in another locality).

3.9 The Mental Health Law Administration office will ensure copies are available to the relevant care coordinator and clinical team. The care coordinator should also clearly document within the patient’s records that the provision of information to the patient regarding rights (including access to an Independent Mental Health Advocate) has been discussed with the patient. The trusts ‘rights template’ should be used for this purpose and is available on the patient’s electronic record in the Mental Health Act folder (see Para 6.2).

4.0 Care Planning and Community Treatment Orders:

4.1 A care plan should be prepared and, subject to the usual considerations of patient confidentiality, the following parties should be consulted if appropriate:

- The Patient
- The Nearest Relative
- Any carers
- Any advocate involved in the patient’s care
- An Attorney (authorised by Lasting Power of Attorney – Personal Welfare) or Court Appointed Deputy under the Mental Capacity Act 2005
- Members of the multi-disciplinary team involved in the patient’s care
- The patient’s GP. Where there is none, encouragement and help should be given to enable the patient to register with a practice.

Patients must be given the opportunity to be involved as far as is practicable with planning, developing and reviewing their own care and treatment in accordance with the Mental Health Act Code of Practice empowerment and involvement principle (see 1.2 above). Where practicable, all patients should be given a copy of their care plan that reflects the legal framework (the Community Treatment Order and related conditions) under which they are being treated.

4.2 In common with other Care Programme Approach arrangements, a care coordinator needs to be identified for patients subject to a community treatment order. Where appropriate, this could be the Responsible Clinician although this may be an exceptional arrangement.

4.3 To reflect the development of community based services and ensure best practice, any prospective Responsible Clinician should be involved at an early stage in determining whether supervised community treatment is appropriate and specifically any conditions to be attached to it. This will greatly assist in the delivery of seamless transfer of care from hospital to community and vice versa although the final decision to make the order rests with the current Responsible Clinician.
5.0 Conditions attached to a Community Treatment Order:

5.1 There are two conditions set out at 3.2 above which are mandatory in all cases. A Responsible Clinician may, with the agreement of the Approved Mental Health Professional, set other conditions which they think are necessary or appropriate to achieve one or more of the goals set out at 3.3 above.

5.2 Advice on setting other conditions is provided by the Code which the Responsible Clinician and Approved Mental Health Professional should always consider. It is important that the reason for any condition is explained to the patient and others, where appropriate and that this is recorded in the clinical records. In all cases, there should a link between the person’s mental disorder and any condition imposed on a community treatment order.

5.3 Where there is disagreement between the Responsible Clinician and Approved Mental Health Professional about the necessity or appropriateness of a particular condition or conditions, it would not be acceptable for an Responsible Clinician to use his or her right to significantly vary conditions (see 5.4 below) shortly after discharge to overcome a legitimate objection by an Approved Mental Health Professional.

5.4 Once an order has been made, the Responsible Clinician may subsequently vary the conditions of the community treatment order (using form CTO2) or suspend any of them where appropriate (e.g. to allow for a temporary absence of the patient) but must record, with reasons, any decision to suspend in the clinical records. In either case, the form CTO2 should be relayed to the Mental Health Law Administrator holding the community treatment order 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 Approved Mental Health Professional to vary or suspend conditions. The patient MUST be informed of the variation of conditions; this is the responsibility of the Responsible Clinician. The Mental Health Law Administration department are responsible for ensuring the Patient also receives a copy of CTO2 (and see 6.1 below).

6.0 Provision of Information on making an Order:

6.1 The Responsible Clinician should inform the patient and others who were consulted, of the decision to discharge a patient onto a community treatment order, including any conditions applied to the community treatment order and services available for the patient. This will normally include making a copy of the community treatment order documentation available to the patient.

6.2 The patient should be provided with information verbally by the care co-ordinator or other appropriate person. This will be recorded on the ‘rights template’, and stored in the electronic patients records. An information leaflet will be provided in writing to the patient by the Mental Health Law Administrator and to the nearest relative unless the patient objects.

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

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5 The Code, paras. 29.27 – 29.31
6 It is held that such an action may be in breach of the Public Law Principle of ‘Propriety of Purpose’ which requires that a statutory power can only be exercised for a legitimate purpose which Parliament intended.
• Appeals to the First Tier Tribunal (Mental Health) and the Hospital Managers;
• Recall, Revocation or Discharge of the Community Treatment Order by the Responsible Clinician;
• Discharge (excluding discharge from recall to hospital) where permitted, by nearest relative (subject to 72 hours’ notice requirement), discharge by the First Tier Tribunal (Mental Health) or Hospital Managers;
• Access to Independent Mental Health Advocacy services;
• The Role of the Care Quality Commission;
• Treatment rights while subject to community treatment order in the community.

7.0 Recall from community treatment order:

7.1 Where a change of Responsible Clinician 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 current Responsible Clinician as soon as practicable.

7.2 Where a patient breaches a condition of their Community Treatment Order, refuses necessary treatment which indicates risk of relapse or engages in high-risk behaviour as a result of mental disorder, the Responsible Clinician may review the conditions of the Community Treatment Order. Having done so, if he or she believes the criteria for recall is met, the Responsible Clinician may recall the patient to hospital.

7.3 To ensure compliance with the Mental Health Act and the Code of Practice, recall should only be considered if:

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

Or

• The patient has broken one of the two mandatory conditions outlined at 3.2 above unless they have a valid reason and have been given opportunity to comply with the condition before recall is considered. Other conditions which have been breached may not lead to recall if the breaking of the conditions do not satisfy the criteria under 7.3

7.4 The Responsible Clinician 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 sent by first-class post or delivered by hand to the patient’s usual or last known address. If access cannot be gained to the patient, consideration could 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.

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7 Independent Mental Health Advocacy services under the Act are introduced from April 2009.
8 The Code paras. 29.45 - 29.51
<table>
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<th>Appropriate Method of Serving form CTO3</th>
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<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>
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<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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<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</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>
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Table 1. Appropriate Method by which to Serve a Notice of Recall

7.5 The Responsible Clinician should ensure that the hospital to which the patient is recalled is ready to receive him or her and to provide treatment although this may be given on an out-patient basis, if appropriate. 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.9

7.6 If the hospital is under the management of the same organisation as the patient’s detaining hospital immediately before making the community treatment order, a copy of the completed form CTO3 will provide authority for detention. It is the responsibility of the admitting nurse or team leader to complete form CTO4 recording the date and time of the patient’s arrival at the hospital or out-patient setting following recall to hospital. This is the record of when the 72 hour detention period under recall began.

7.7 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

7.8 As soon as practicable, the patient should be given information verbally and in writing about their rights following their arrival after the recall notice, and the impact if any, on their treatment rights which are set out in a separate section

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9 In London see, Mental Health Project Team, Territorial Policing Headquarters, Metropolitan Police (2011) Operational Guidance for Police Officers and Staff responding to Incidents involving someone with a Mental Illness, 1st January 2011 (published under Freedom of Information Act Scheme at http://www.met.police.uk/foi/pdfs/policies/mental_health_policy.pdf)

The provision of supervised community treatment rights must be recorded in the same manner used for other detained patients.

7.9 Following arrival after the recall notice, the Responsible Clinician and clinical team should consider the circumstances of the recall and in particular, whether supervised community treatment 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 Responsible Clinician may allow the patient to leave the hospital at any time before the expiry of the 72 hour recall period, to recommence their Community Treatment Order, if this is deemed appropriate.

7.10 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. 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.

7.11 However recall is permissible in relation to an existing inpatient. If the informal community patient wishes to leave the ward and following a risk assessment it is deemed inappropriate for the patient to leave, a decision to formally recall the patient should be made and form CTO3 served to give authority to detain.

7.12 The holding power under section 5(2) or section 5(4) must not by virtue of section 5(6), be used as an alternative to recall in this situation. Local Procedures need to be established to ensure recall notices can be served outside of office hours (please refer to the Trusts ‘Responsible Clinician and Nominated Deputy Policy’ for further guidance regarding cover arrangements in the absence of the ‘regular’ Responsible Clinician).

8.0 Revocation of community treatment order or return to Community:

8.1 If in-patient treatment is required for longer than 72 hours from arrival in hospital, the Responsible Clinician should consider revoking the community treatment order.

8.2 To revoke a community treatment order, the Responsible Clinician must consider that the patient now needs to be admitted to hospital for treatment under the Act. An Approved Mental Health Professional, having considered the wider social context for the patients, must also agree with the Responsible Clinician’s assessment, before the community treatment order may be revoked. This need not be an Approved Mental Health Professional already involved in the patient’s care and treatment.

8.3 If the Approved Mental Health Professional does not agree that the community treatment order should be revoked, their decision and the reasons for it must be fully documented in the clinical records, and the patient must be discharged from hospital by the end of the 72 hours and the Community Treatment Order continues. (Alternatively, the Patient could be discharged from the Community Treatment Order altogether, in which case original section the patient was subject to immediately before the Community Treatment Order began would be discharged also.) It is not appropriate for a Responsible Clinician to approach another Approved Mental Health Professional for an alternative view.

11 This position is confirmed by s17E(4), The Act
8.4 Where the Approved Mental Health Professional agrees, the Responsible Clinician may revoke the community treatment order by completing Parts 1 & 3 and the Approved Mental Health Professional completing Part 2 of form CTO5. The revocation takes effect immediately once signed. The form must be forwarded to the Mental Health Law Administrator as soon as practicable.

8.5 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 community treatment order 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.

8.6 The patient must be informed of their rights following revocation and this must be evidenced by the completion of the rights form, a copy of which should be placed in the clinical file, the original being sent to the mental health act office. This should also be documented in the progress notes of the patient’s electronic records.

8.7 On revocation, form CTO5 must be copied to the Managers of the Hospital to which the patient was recalled, if the patient was transferred during the period of recall.

8.8 A flow chart detailing recall and revocation can be found at appendix 1

9.0 Extending the Community Treatment Period:

9.1 A Community Treatment Order can be extended following examination of the patient by the Responsible Clinician within the last two months of the current period of the Community Treatment Order. The Responsible Clinician must determine that the conditions for extension are met. These mirror the criteria and mandatory conditions described at 3.1-3.2 above with the additional requirement that the Responsible Clinician must also consult at least one other person who has been professionally concerned with the patient’s medical treatment. If the Responsible Clinician is not a registered medical practitioner, this policy dictates that the person with whom the Responsible Clinician consults, must be a registered medical practitioner.

9.2 As when making the original Community Treatment Order, the Responsible Clinician must obtain the written agreement of an Approved Mental Health Professional that the conditions for extending the community treatment order are met and where they are met, that extension is appropriate. This need not be the Approved Mental Health Professional who originally signed form CTO1.

9.3 The Responsible Clinician completes part 1, the Approved Mental Health Professional completes Part 2 of form CTO7 and then the Responsible Clinician completes and signs part 3, 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 Law Administrator (or other authorised person) who completes Part 4.

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12 The Act, s20A(6)
9.4 Once received, the Hospital 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 continued Community Treatment Order. 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.

9.5 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 community treatment order period – see also 15.0 below.

9.6 Where the criteria for extending a community treatment order are not met and consequently, the Responsible Clinician 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 Responsible Clinician rather than waiting for the current Community Treatment Order to expire. This does not apply to a case where an Approved Mental Health Professional does not agree to extension. In such a case, the Responsible Clinician may choose to exercise his or her right of discharge or may allow the Community Treatment Order to lapse.

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

10.0 Discharge from Compulsion under the Act:

10.1 ‘Discharge’ for a Community Treatment Order patient, regardless of who orders it, means complete release from liability to compulsion under the Act in hospital or in the community. It is not the same as ‘recall’ or ‘revocation’ which are described at 7.0 and 8.0 above nor the process of ‘discharge subject to being liable to recall’ which follows the making of a community treatment order.

10.2 The Responsible Clinician can discharge a patient from a community treatment order at any time in writing by completing the local discharge from liability to detention form under section 23 of the Act and providing it to the Managers of the responsible hospital. There is no statutory form for this purpose nor a statutory requirement to consult with any other person.

10.3 A Part II community treatment patient’s nearest relative (there is no available power in relation to Part III community treatment order 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.

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13 The Code, paras. 38.11 - 38.12
14 The Code, para. 38.25
15 S17A(1), The Act
16 An order for discharge is made under s23(2)(a) if a Community Treatment Order has been revoked or s23(2)(c) if a Community Treatment Order is still in force
10.4 Within the permitted 72 hours, the Responsible Clinician may sign a report barring discharge under section 25 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'. Where a report is made, the nearest relative will be advised by the Mental Health Law Administration office of their right to apply to the First Tier Tribunal (Mental Health). If a Tribunal application is not made, Mental Health Law Administration may arrange a review by the Hospital Managers.

10.5 If the Responsible Clinician does not sign such a report, discharge from compulsion by the nearest relative takes effect after 72 hours or at a point after that which the nearest relative may have specified. Where a patient has been recalled to hospital, only the Responsible Clinician can discharge him/her during the period of 72 hours following recall. There is no power of discharge available to the nearest relative, Hospital Managers or First Tier Tribunal (Mental Health) to discharge specifically from a recall period; only the Community Treatment Order as a whole.

10.6 The First Tier Tribunal (Mental Health) can discharge a community treatment order patient other than during the 72 hour period of recall of such a patient. If following recall, a patient’s Community Treatment Order is revoked, the Mental Health Law Administration office will refer the patient’s case to the First Tier Tribunal (Mental Health) as soon as possible. All circumstances where there is a duty to refer a case to the First Tier Tribunal (Mental Health) are set out in section 68 of the Act.

10.7 An application for discharge can be made once by a patient to the First Tier Tribunal (Mental Health) during any period of their community treatment order. Any withdrawn application is disregarded and does not interfere with this right. The First Tier Tribunal (Mental Health) cannot vary conditions on a Community Treatment Order imposed by the Responsible Clinician and although it can make a recommendation, cannot oblige an Responsible Clinician to make a Community Treatment Order for a detained patient. The First Tier Tribunal (Mental Health) application rights of both patients and their nearest relatives are set out in section 66 of the Act.

10.8 It may be appropriate for the First Tier Tribunal (Mental Health) 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.

10.9 If a patient is detained in another hospital under section 3 or equivalent, (other than by their Community Treatment Order being revoked) this will automatically discharge the existing Community Treatment Order and its underlying section. A Community Treatment Order can only be recommenced by starting a fresh assessment again; Detention under section 2 will not affect a current community treatment order.\(^\text{17}\) Detention in prison or elsewhere of less than six months' duration will allow a Community Treatment Order to continue or to be extended in accordance with the provisions set out in section 22 of the Mental Health Act. Detention in custody for a period of more than six months will automatically bring the Community Treatment Order to an end.

11.0 **Transfer between Hospitals and Jurisdictions**

\(^\text{17}\) Admission under section 2 should not normally be considered as a legitimate alternative to recall or revocation of a community treatment order.
11.1 Paragraphs 7.5-7.6 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.

11.2 The responsible hospital for a patient subject to a Community Treatment Order 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’.

11.3 Assignment of responsibility for community patients between hospitals within the same organisation requires no statutory paperwork but the Managers of the hospital must write to the patient informing him or her of the assignment either before or soon after it takes place and must give the name and address of the responsible hospital even if it is part of the same organisation. This function is the responsibility of the Mental Health Law Administration office in the locality from which the patient is being transferred.

11.4 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 Community Treatment Order.

11.5 In the case of any transfer or reassignment of responsibility, the Code requires that the needs and interests of the patient are considered to ensure compatibility with the patient’s rights to privacy and family life under Article 8 of the European Convention on Human Rights.

11.6 Once a Community Treatment Order 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.

11.7 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 community treatment order, form CTO9 is completed by the Responsible Clinician (Part 1) and an Approved Mental Health Professional (Part 2). As when making a new community treatment order, any conditions must be specified on form CTO9 and have the written agreement of an Approved Mental Health Professional.

12.0 Decision to use a community treatment order or section 17 Leave:

12.1 Section 17 (relating to leave of absence from hospital) of the Act states that when considering granting longer term leave, a Responsible Clinician must consider whether a community treatment order might be the more appropriate way of managing the patient in the community. This applies to section 17 leave being considered for more than 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days).

12.2 These provisions do not affect leave arrangements for restricted patients or patients whose legal status makes them ineligible for a community treatment order.

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18 *The Act*, s19A
19 *The Code*, para 37.18
order. The Responsible Clinician may still legitimately authorise longer-term leave where it is the more suitable option but must document that he/she has considered whether a community treatment order is more appropriate.

12.3 This issue should be reconsidered whenever an ongoing period of longer-term leave is reviewed. Additionally, s17 leave forms provide a space for the Responsible Clinician to record their reasons, if applicable, that a community treatment order has been considered where appropriate and why the use of section 17 was preferred.

12.4 The Code sets out a table of pointers for a community treatment order or longer-term leave of absence which may be of assistance to Responsible Clinician’s and is replicated below. (A further table contrasting a community treatment order and guardianship can also be found in the Code at Para. 31.7)

<table>
<thead>
<tr>
<th>Factors suggesting longer-term leave</th>
<th>Factors suggesting a community treatment order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge from hospital is for a specific purpose or a fixed period.</td>
<td>There is confidence that the patient is ready for discharge from hospital on an indefinite basis.</td>
</tr>
<tr>
<td>The patient’s discharge from hospital is deliberately on a “trial” basis.</td>
<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>
</tr>
<tr>
<td>The patient is likely to need further in-patient treatment without their consent or compliance.</td>
<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>
</tr>
<tr>
<td>There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a community treatment order.</td>
<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 community treatment order, but not to the extent that it is very likely to happen.</td>
</tr>
</tbody>
</table>

Table 2: a community treatment order or longer-term leave of absence: relevant factors to consider

13.0 Treatment on Recall or Revocation (Part IV of the Act):

13.1 For patients liable to detention under the Act other than community treatment 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

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20 Reproduced from the Code, para. 31.7
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.

13.2 When a patient subject to a community treatment order is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients. If treatment does not include psychotropic medication or Electroconvulsive Therapy ('ECT') and a patient with capacity consents to it, it may be given under the direction of the Responsible Clinician.

13.3 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 Second Opinion Appointed Doctor has indicated otherwise, the certificate will authorise treatment (other than Electro Convulsive Therapy) whether the patient has or does not have capacity to refuse it.

13.4 On recall, treatment that was already being given as described on form CTO11 (but not authorised for administration on recall), may continue to be given if the Approved Clinician in charge of the treatment considers that stopping it would cause the patient serious suffering. Otherwise, the criteria under section 62 may need to be considered.

13.5 Following revocation of the Community Treatment Order, steps must be taken at the earliest opportunity to obtain fresh authorisation certificated by forms T2 or T3, with section 62 criteria being considered in the meantime where necessary.

13.6 Practitioners should not rely on a certificate that was issued while a patient was detained prior to going onto supervised community treatment even if it remains technically valid. A new certificate should be obtained as necessary.

14.0 Treatment while in the Community (Part 4A of the Act):

14.1 The treatment of community treatment order 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.

14.2 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 7.3 above. It is the responsibility of the Approved Clinician in charge of the treatment to undertake an assessment of the patient’s capacity and whether they consent to treatment or not at the point of making the Community Treatment Order. This must be documented clearly in the patient’s notes and reviewed on a regular basis; at least during each CPA meeting, upon extension of the order or upon any change in treatment. A change in Approved Clinician in charge will also require a fresh assessment of capacity and consent.

14.3 The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 (‘MCA’) including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney.

21 Sections 57, 58, 58A and 63, The Act
22 The Code, para. 25.84
(personal welfare) or a court appointed deputy. It should be noted that the Mental Capacity Act may not generally be used to give community treatment patients any treatment for mental disorder (if they lack capacity) other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the Mental Capacity Act for the provision of treatments for physical problems for a community treatment patient.

14.4 The Mental Capacity Act 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 Lords23. This is sometimes referred to as ‘Fraser competency’ acknowledging the Law Lord who set out the principles to be applied in determining such competency.

14.5 Part 4A patients over the age of sixteen, who lack capacity, may be given specified treatments on the authority of an attorney24 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 the Mental Capacity Act.25

14.6 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 of the Act, which reflect the similar scheme in the Mental Capacity Act26. This is that the person believes that the patient lacks capacity, the treatment is immediately necessary (see below) and that any force used is a proportionate response to the likelihood of harm being suffered. The alternative mechanism is via recall to hospital but the recall criteria set out at 7.3 above apply equally to patients lacking capacity.

14.7 In an emergency, treatment for Part 4A patients who have not been recalled and who lack capacity, can be given by anyone (it need not be an Approved Clinician or the Responsible Clinician) 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.

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

23 Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL)
24 Young people aged 16 and 17 do not have the power, under the Mental Capacity Act to make a lasting power of attorney nor make valid and applicable advanced decisions to refuse treatment.
25 See Chapter 9 of The Code
26 See conditions set out in section 6 Mental Capacity Act 2005
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 Mental Capacity Act. These are the only exceptional circumstances in which force can be used to treat an objecting supervised community treatment patient, who doesn’t have capacity, without first recalling them to hospital.

In non-emergency situations (excluding Electro Convulsive Therapy for which reference should be made to paragraphs 25.19 – 25.25 of the Code and the Trust's 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 community treatment order and thereafter if the following criteria (and the certificate criteria) is met under S64D:

- The treatment is given under the direction of the approved clinician in charge of the treatment
- It is not inconsistent with a valid and applicable advance decision to refuse treatment
- It is not inconsistent with a decision by an attorney, deputy or a Court of Protection decision

After the first month, a second opinion appointed doctor must certify that such treatment is appropriate on a Part 4A certificate (form CTO11) if the person continues to lack capacity.

The Second Opinion Appointed Doctor will consult with two other people who have been involved with the patient’s care. These people are known as ‘statutory consultees’.

The Second Opinion Appointed Doctor 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 13.3 above.

Form CTO11 should be kept with the original supervised community treatment and detention papers but a copy must be kept in the clinical records and a copy attached to any community prescription chart.

The arrangements surrounding the Second Opinion Appointed Doctor’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 Second Opinion Appointed Doctor and coordinate the process. This will usually be the care coordinator.

Other than in exceptional circumstances, Second Opinion Appointed Doctor examinations will be arranged in a hospital or clinical setting. If the Responsible Clinician agrees that it is necessary to visit a community treatment patient in a hostel or home, the Second Opinion Appointed Doctor will always be accompanied by an appropriate member of the care team, who will act as one of the statutory consultees. At least one statutory consultee shall not be a Doctor and neither of the statutory consultee’s can be either the Responsible Clinician or the “Approved Clinician in charge of the treatment in question”

In the event that the patient has not been seen by a Second Opinion Appointed Doctor within the required time-frame (one month from Community Treatment Order taking effect or three months from beginning of detention whichever is the

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27 The Code, para 24.26
later), and the Approved Clinician in charge of the treatment is of the opinion that the treatment is immediately necessary for a patient who lacks capacity to consent to it section 64 may be used to authorise treatment whilst waiting for the Second Opinion Appointed Doctor to complete form CTO11. The Approved Clinician must complete the Trust's section 64 form which can be found at appendix 2. The original should be kept with the original Community Treatment Order and detention papers but a copy should be kept in the patient's clinical records and a copy attached to the community prescription chart.

14.17 If a person has capacity and is consenting to treatment in the community, the approved clinician in charge of that treatment should complete form CTO12 (see appendix 3) certifying the patient has capacity and is consenting. If a person is judged to have capacity but is refusing treatment in the community, the Second Opinion Appointed Doctor will visit to consider certifying on form CTO11 that certain treatment proposed for the patient whilst in the community is appropriate even though such certification provides no authority to give it if the patient is refusing; and/or certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital. Form CTO12 should be kept with the original community treatment order and detention papers but a copy must be kept in the clinical records and a copy attached to any community prescription chart.

14.18 Section 61 - It is a requirement for the Approved Clinician in charge of the treatment (usually the RC) to complete a review of treatment and document it on the form and send to the CQC for a Community Treatment Order patient if the Community Treatment Order extension is furnished and during the preceding period the patient had been recalled to hospital AND was treated under the authority of the CTO11 because the Second Opinion Appointed Doctor has authorised treatment on recall AND the patient lacked capacity or refused that treatment at the time; or at any other time as required by the Care Quality Commission.

15.0 Community Treatment Order Patients who are Absent Without Leave

15.1 Community Treatment Order patients are considered absent without leave if they fail to return to hospital following recall, or who have absconded from hospital following being recalled.

15.2 Community Treatment Order patients who are deemed absent without leave may be taken into custody under section 18 and returned to the hospital to which they have been recalled by an Approved Mental Health Professional, a Police Officer, a member of staff (of the hospital to which they have been recalled) or anyone authorised in writing by the Hospital Managers or the Responsible Clinician within the relevant period (see 15.5). If the power of entry is required, an application using S135 (2) may be made for a warrant, authorising Police entry.

15.3 If a community treatment patient order is absent without leave, the Missing and Absent without Leave Policy MUST be implemented

15.4 A community treatment order patient cannot be taken back into custody after their Community Treatment Order has ceased to be in force or six months have
elapsed since the patient was first absent without leave, which ever is the later date.

15.5 If a Community Treatment Order patient is absent without leave for more than 28 days, they must be re-examined by the Responsible Clinician on their return to establish whether they still meet the criteria for community treatment (Section 21B). If this does not happen, the Community Treatment Order will expire automatically at the end of the week starting with the day of their arrival back to hospital. The Responsible Clinician must submit their report using CT08, following consultation with both an Approved Mental Health Professional and another professional who has been professionally concerned with the patient. If the Responsible Clinician is not a registered medical practitioner, the second consultee must always be a registered medical practitioner. A report is not required if the community treatment order is revoked instead. If a CTO8 is completed after the Community Treatment Order would have expired, it automatically extends the patients Community Treatment Order from when it would otherwise have expired in the normal way. It may also act as an extension report if the Community Treatment Order will expire in the next two months.

15.6 If a Community Treatment Order patient returns to hospital within 28 days BUT the deadline for their extension report has approached and has not yet been made, i.e. at any point during the week which end on the day their community treatment order is due to expire, their Community Treatment Order is treated as not expiring until the end of the week starting with when the day on which they returned. The Responsible Clinician therefore has a week to submit an extension report using CTO7. An Approved Mental Health Professional is required to also agree that the criteria are met and it is appropriate. The Responsible Clinician must also consult with another professional who has been professionally concerned with the care of the patient. If the Responsible Clinician is not a registered medical practitioner, the second consultee must always be a registered medical practitioner.

16.0 Care Quality Commission roles and responsibilities

16.1 The Care Quality Commission will undertake some visiting activity to meet with Community Treatment Order patients and monitor its use.

16.2 Commissioners will monitor the initial decision making process and planning that leads to Community Treatment Orders through visits to inpatient units and scrutiny of documentation. It is important therefore that all documentation meets the requirements of paragraph 4.0 above.

16.3 The Commission will also require access to Community Treatment Order patients once they have been discharged from hospital onto their community treatment order. These meetings will take place at locations which are deemed convenient for the Community Treatment Order patients; documentation will have to be available to the Commissioners in whatever location they are meeting the Community Treatment Order patients. It is the responsibility of the care coordinator(s) to arrange the suitable location, inform the patient of the visit, and ensure patient records are available for the Commission to inspect. Commissioners’ will NOT visit patients in their own homes. It is very unlikely that visits to see Community Treatment Order patients will be unannounced and the Commission will therefore make their initial contact with the Mental Health Law

28 This is a Trust Policy requirement as opposed to the requirements of the MHA 1983

29 This is a Trust Policy requirement as opposed to the requirements of the MHA 1983
Administration Office who will in turn alert the relevant care coordinator(s) of the visit.

17 Responding to concerns raised by carers

17.1 Care co-ordinators are responsible for ensuring that carers are given information on how and to whom any concerns are raised. This may include carers concerns relating to a deterioration of the persons mental health or a failure to comply with conditions.

17.2 Local protocols will determine who is responsible for coordinating a response to any concern raised by a carer but as a minimum requirement, any concerns raised by a carer must be considered by the multi-disciplinary team at the earliest opportunity and the responsible clinician must consider whether the criteria for recall is met.

18 Monitoring

18.1 Internal procedures are in place to record the use of Community Treatment Orders, their extensions, recall and revocations and treatment. This data is maintained by the Mental Health Law Administration and generates reports as required for assurance purposes.

18.2 A quarterly audit will be carried out of a random sample of Community Treatment Order patients to ensure compliance with the Act, the Code and this policy. Results will be presented to the local directorate management team and the trusts quality committee.

18.3 Training on Community Treatment Orders will be delivered to appropriate staff via face to face or eLearning as required.
1. There are signs that the patient’s mental health is deteriorating. The carer may be worried or the patient may have broken one of the conditions, such as not turning up for treatment on some occasions.

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

3. After review & discussion, the patient remains at home and the CTO remains unchanged, or the CTO is subject to variations (RC completes form CTO3).

4. The RC decides that treatment is needed urgently and completes a recall notice (Form CTO3).

5. The patient is informed about their recall to hospital in writing through the recall notice (form CTO3 – see notes, then either stage 6 or 7 occurs).

6. The patient agrees to return to hospital with a member of the community team and form CTO4 is completed by the Hospital Managers on the patient’s return.

7. The patient refuses to return and the team decide that they need assistance to convey him or her.

8. With the help of the ambulance service and/or police (if necessary), the patient is taken to hospital.

9. A copy of the notice of recall (Form CTO3) is given to the hospital managers, and Form CTO4 is completed.

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

11. Within the 72 hours, if the patient’s condition stabilises and the patient is discharged, the SCT continues. If variations are made to the conditions, the RC completes Form CTO2. The patient may agree to remain in hospital on a voluntary basis for further treatment.

12. The patient is still too ill to return home within the 72 hours. The RC and the AMHP decide that the CTO should be revoked. The patient is re-admitted to hospital under s3 of the Act or the equivalent and a new renewal period of six months begins. The hospital managers are supplied with a copy of form CTO5 completed by the RC and the AMHP.
Appendix 2

Urgent treatment under section 64 Of the Mental Health Act 1983

Name of Patient: __________________________________________

Section: 17A - Community Treatment Order

I am __________________________________________

I confirm that I am the Approved Clinician responsible for the above named patient and that the following treatment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Delete option that does not apply)

1. is emergency treatment which is authorised under Section 64G as the patient lacks the capacity to consent to it;

(PLEASE TICK) AND

a) is immediately necessary to save the patient's life { }; or
b) which (not being irreversible) is immediately necessary to prevent a serious deterioration in their condition { }; or
c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient { }; or
d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others { }.

(Note: If treatment plan involves ECT only a) and b) of the above options apply)

I confirm that full details of this course of treatment under S64 is recorded in the case notes.

Signed ________________________________________________

Date ____________________________

Appendix 3

Form CTO12 Regulation 28(1A) Mental Health Act 1983
Section 64C(4A) – Certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so

(Part 4A consent certificate)
(To be completed on behalf of the responsible hospital)

I (PRINT full name and address)

am the Approved Clinician in charge of the treatment of
(PRINT full name and address of patient)

who is subject to a Community Treatment Order.

I certify that this patient has the capacity/is competent to consent [delete the one that is not appropriate] and has consented to the following treatment.
The treatment is [Give description of treatment or plan of treatment]

Signed……………………………………………………………………………………

Date…………………………………….