Form CTO7 *Regulation 13(6)(a) and (b), and 13(7)* Mental Health Act 1983

Section 20A – community treatment order: report extending the community treatment period

Parts 1 and 3 of this form are to be completed by the responsible clinician and Part 2 by an approved mental health professional. Part 4 is to be completed by or on behalf of the managers of the responsible hospital.

PART 1

To the managers of
(*name and address of the responsible hospital*)

I am (*PRINT full name, address and, if sending by means of electronic communication, email address of the responsible clinician*)

the responsible clinician for

(*PRINT full name and address of patient*)

The patient is currently subject to a community treatment order made on (*enter date*)

/ /

I examined the patient on

/ / (*date*)

In my opinion,

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;

(b) it is necessary for

(i) the patient's health

(ii) the patient's safety

(iii) the protection of other persons

(delete any indent which is not applicable)

that the patient should receive such treatment;

Form amended by SI 2020/1072 for use from 1 December 2020

(c) 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;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) to recall the patient to hospital;

(e) taking into account 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.

My opinion is founded on the following grounds –

(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)

I confirm that in determining whether the criterion at (d) above is met, I have considered what risk there would be of deterioration of the patient's condition if the patient were to continue not to be detained in hospital, with regard to the patient's history of mental disorder and any other relevant factors.

Signed	Date
	/ /

Responsible clinician

PART 2

I (*PRINT full name, address and, if sending by means of electronic communication, email address*)

am acting on behalf of (*name of local social services authority*)

and am approved to act as an approved mental health professional for the purposes of the Act by, *(delete as appropriate)*

that authority.

(name of local social services authority that approved you, if different).

I agree that:

(i) the patient meets the criteria for the extension of the community treatment period and

(ii) it is appropriate to extend the community treatment period.

Signed | Date

/ /

Approved mental health professional

PART 3

Before furnishing this report, I consulted
(*PRINT full name and profession of person consulted*)

who has been professionally concerned with the patient's treatment.

I am furnishing this report by: *(Delete the phrase which does not apply)*

today consigning it to the hospital managers' internal mail system.
today sending it to the hospital managers, or a person authorised by them to receive it, by means of electronic communication.
sending or delivering it without using the hospital managers' internal mail system.

Signed | Date

/ /

Responsible clinician

THIS REPORT IS NOT VALID UNLESS PARTS 1, 2 & 3 ARE COMPLETED AND SIGNED

PART 4

This report was *(Delete the phrase which does not apply)*

furnished to the hospital managers through their internal mail system.
furnished to the hospital managers, or a person authorised by them to receive it, by means of electronic communication.
received by me on behalf of the hospital managers on

/ / (*date*)

Signed

on behalf of the managers of the responsible hospital

PRINT NAME

Date

/ /