The Mental Health (Care and Treatment) (Scotland) Act 2003

Extend a Compulsion Order

Following first mandatory review

CO1 | **Part A Application**

This box is for the use of the Mental Health Tribunal for Scotland only

Instructions v7.0

The following form is to be used:

where the RMO has undertaken the ***FIRST*** review of a compulsion order and considers that it should be extended without variation. For subsequent reviews, form CTO3a should be used to extend the order without variation.

Where the RMO wishes to extend ***AND*** vary the order, form CTO4 should be used.

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the application.

Where not completing this form electronically, to ensure accuracy of information, please observe the following conventions:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example

2	5		M	A	R	K	E	T		S	T

Shade circles like this -> ●

Not like this -> ⊘ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number

Surname

First Name (s)

Other / Known As

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title

DoB
dd / mm / yyyy

Gender ○ Male ○ Female

Patient's home address

Postcode

Correspondence address for the patient is:

○ Home address noted above

○ Detention hospital/ward (enter in text box)

○ Other address (enter in text box)

Part 1: Record of First Review **To be completed by RMO**

RMO Details:

Surname

First Name

Title

GMC Number

Hospital

Hospital address

Postcode

Telephone No.

e-mail address

Approved under section 22 of the Act by:

Health Board **NHS**

Part 1: Record of First Review(cont) **To be completed by RMO**

Compulsion Order Details

The compulsion order was first made on: ☐☐ / ☐☐ / ☐☐☐☐

The order will cease to authorise the measures specified at midnight at the end of: ☐☐ / ☐☐ / ☐☐☐☐

The patient is detained in / under the care of:

Hospital

Ward

Examination Details

The patient was examined on - Date ☐☐ / ☐☐ / ☐☐☐☐

Complete A or B as appropriate

A ○ I, the RMO named above, examined the patient as part of the first mandatory review.

OR

B ○ I, the RMO named above, made arrangements for the patient to be examined by an approved medical practitioner as part of the first mandatory review. The patient was examined by -

Surname

First Name

GMC Number

Hospital

Ward / Clinic

Health Board

Part 1: Record of First Review (cont)

To be completed by RMO

Criteria for compulsion

I am satisfied, for the reasons stated below, that the patient has the following type(s) of mental disorder -

			Primary ICD 10 Code
Mental illness	○ Yes	○ No	F ☐☐.☐☐
Personality disorder	○ Yes	○ No	F ☐☐.☐☐
Learning disability	○ Yes	○ No	F ☐☐.☐☐

Please enter primary ICD 10 diagnosis code for each disorder present.

1	

I am satisfied, for the reasons stated below, that medical treatment which would be likely to prevent the mental disorder worsening, or alleviate any of the symptoms or effects of the disorder, is available for the patient.

2	

I am satisfied, for the reasons stated below, that if the patient were not provided with such medical treatment there would be a significant risk -

○ to the patient's health, safety or welfare

○ to the safety of any other person

3	

I believe, for the reasons stated below, that compulsory powers continue to be required, and that the patient cannot be treated on a voluntary basis

4	

Part 1: Record of First Review (cont) **To be completed by RMO**

Measures currently authorised

Please indicate which compulsory measures were authorised within the original compulsion order

○ (a) The patient's detention in a specified hospital.

○ (b) Giving the patient medical treatment in accordance with Part 16 of Act.

○ (c) Requiring the patient to attend on: specified or directed dates; or at specified or directed intervals, specified or directed places with a view to receiving medical treatment (including associated travel where appropriate).

○ (d) Requiring the patient to attend on: specified or directed dates; or at specified or directed intervals, specified or directed places with a view to receiving community care services, relevant services or any treatment care or service (including associated travel where appropriate).

○ (e) Requiring the patient to reside at a specified place.

○ (f) Requiring the patient to allow any of the following parties to visit the patient in the place where the patient resides. Those parties are; the patient's MHO, the patient's RMO, or any person responsible for providing medical treatment, community care services, relevant services or any treatment, care or services to the patient who is authorised for this purpose by the patient's RMO.

○ (g) Requiring the patient to obtain the approval of the MHO to any proposed change of address.

○ (h) Requiring the patient to inform the mental health officer of any change of address before the change of address takes effect.

Other Relevant Information

Any other information relevant to this section 149 application

5	

To be completed by RMO

MHO Details

Surname

First Name

Title

Address

Postcode

Telephone No.

e-mail address

Local Authority

eg Glasgow City, City of Edinburgh, Highland, Scottish Borders, etc (the word "council" can be omitted)

Before making this application to extend the order, I gave notice to the patient's MHO of my intention to make this application on:

Date / /

To be completed by RMO

MHO views on application - Complete only A (MHO) or B (RMO), but not both

The MHO should complete A before the RMO signs page 13 wherever practicable. Where not practicable, A should be left blank and the RMO should complete B

A ***MHO views*** ***To be completed by MHO if practicable***

I, the aforementioned MHO,

○ agree with this application to extend the order

○ disagree with this application to extend for the following reasons:

6	

Signed
by MHO

Date
dd / mm / yyyy

B ***Record by RMO of MHO views*** ***To be completed by RMO where A is not practicable***

The aforementioned MHO,

○ agrees with this application to extend the order

○ disagrees with this application to extend for the following reasons:

6a	

OR

○ The MHO has failed to comply with his/her duty to inform me whether s/he agrees or disagrees with this application.

To be completed by RMO

Consultation With Other Persons

In advance of making the section 149 application, I have consulted with, and considered the views of, certain persons with respect to the application. These persons are:

- ○ the patient's MHO and, (if applicable), others I consider appropriate to consult:
- ○ persons who provide medical treatment of the kind set out in the patient's care plan
- ○ persons who provide community care or relevant services of the kind set out in the patient's care plan
- ○ persons who provide other treatment, care or service of the kind set out in the patient's care plan
- ○ other persons I considered appropriate, as detailed below:

7	

Named Person Details

- ○ The patient does not have a named person
- ○ The patient does have a named person - detailed below

Surname

First Name

Title

Address

Postcode

Telephone

Advance Statement

- ○ As far as I am aware, the patient has made and not withdrawn an advance statement made under the terms of section 275 of the Act.
- ○ As far as I am aware the patient has not made an advance statement under the terms of section 275 of the Act.

If the patient has an advance statement, please ensure it is enclosed with this application.

To be completed by RMO

Primary Carer, Advocacy Worker, Welfare Attorney, Welfare Guardian

Full name and address of the patient's primary carer (if any)

Full name and address the patient's advocacy worker where applicable (including contact telephone number and email address where known)

Full name and address of the patient's welfare attorney where applicable (See note)

Full name and address of the patient's welfare guardian where applicable (See note)

Notes

"Welfare attorney" means an individual authorised, by a welfare power of attorney granted under section 16 of the Adults with Incapacity (Scotland) Act 2000 (asp 4) and registered under section 19 of that Act, to act as such.

"Guardian" means a person appointed as a guardian under the Adults with Incapacity (Scotland) Act 2000 (asp 4) who has power by virtue of section 64(1)(a) or (b) of that Act in relation to the personal welfare of a person.

Record of Contact Details of Others Relevant to the Application

Please provide the names and addresses of others who may be relevant to this application, where not available elsewhere on this form or the Mental Health Reports, and whom the Mental Health Tribunal for Scotland may wish to hear evidence from, for example: the patient's GP. Also record any others who should be invited to the hearing.

To be completed by RMO

Primary Carer, Advocacy Worker, Welfare Attorney, Welfare Guardian

Curator Ad Litem

If, in your view, the patient requires a Curator Ad Litem, please indicate this here and give your reasons.

Signature / Date

As a result of this review and having complied with all the relevant duties linked to such a review, I am satisfied the patient continues to meet the conditions set out in section 139 (4) of the Act, and that it continues to be necessary for the patient to be subject to a compulsion order. I do not consider it necessary to modify any of compulsory measures specified in the order.

I hereby confirm that I am making an application to extend this compulsion order by 6 months.

By signing this certificate I confirm that I have no conflict of interest as defined in the regulations.

Signed
by patient's RMO

Date
dd / mm / yyyy

/ /

Name, address, telephone number and email address of contact at Medical Records