

<b>Reference Number:</b> UHB 407 <b>Version Number:</b> 2	<b>Date of Next Review:</b> 28/04/2025 <b>Previous Trust/LHB Reference Number:</b> N/A
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**Community Treatment Order Policy  
Mental Health Act, 1983**

**Policy Statement**

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for a community treatment order (CTO).

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering a CTO and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

**Policy Commitment**

We will set out the requirements for provision of community treatment orders under section 17A of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patient's subject to a CTO.

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

**Supporting Procedures and Written Control Documents**

This Policy and the Community Treatment Order Procedure describe the following with regard to a CTO:

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patient's subject to a CTO

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**Other supporting documents are:**

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment) (Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

**Scope**

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

**Equality and Health Impact Assessment**

There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

<b>Policy Approved by</b>	Mental Health and Capacity Legislation Committee
<b>Group with authority to approve procedures written to explain how this policy will be implemented</b>	Mental Health and Capacity Legislations Committee
<b>Accountable Executive or Clinical Board Director</b>	Chief Operating Officer

**Disclaimer**

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

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<b>Summary of reviews/amendments</b>			
<b>Version Number</b>	<b>Date Review Approved</b>	<b>Date Published</b>	<b>Summary of Amendments</b>
1	26/06/2018	02/07/2018	New document
2	28/04/2022	05/08/2022	N/A

## Equality & Health Impact Assessment for

### COMMUNITY TREATMENT ORDER POLICY

<b>1.</b>	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	COMMUNITY TREATMENT ORDER POLICY
<b>2.</b>	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Mental Health Act Manager 029 21824746 <a href="mailto:David.Seward@wales.nhs.uk">David.Seward@wales.nhs.uk</a>
<b>3.</b>	Objectives of strategy/ policy/ plan/ procedure/ service	<p>The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs.</p> <p>Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>Ensure that statutory requirements under the Mental Health Act 1983 are met.</p> <p>Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p>
<b>4.</b>	Evidence and background information considered. For example	<b>Related policies/information</b> - Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental

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<ul style="list-style-type: none"> <li>• population data</li> <li>• staff and service user’s data, as applicable</li> <li>• needs assessment</li> <li>• engagement and involvement findings</li> <li>• research</li> <li>• good practice guidelines</li> <li>• participant knowledge</li> <li>• list of stakeholders and how stakeholders have engaged in the development stages</li> <li>• comments from those involved in the designing and development stages</li> </ul> <p>Population pyramids are available from Public Health Wales Observatory<sup>1</sup> and the UHB’s ‘Shaping Our Future Wellbeing’ Strategy provides an overview of health need<sup>2</sup>.</p>	<p>Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010</p> <p><b>Stakeholders</b> - Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services.</p> <p><b>Age</b> - 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind “Our Communities, Our Mental Health)</p> <p>Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016).</p> <p>Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and</p>
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<sup>1</sup> <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

<sup>2</sup> <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

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		<p>impact on their education, social participation and ability to find and sustain employment.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016: -</p> <p>Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey.</p> <p>The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient’s treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p> <p><b>Disability</b> - Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind “Our Communities, Our Mental Health)</p> <p>Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people</p>
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		<p>living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people</p> <p>The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure.</p> <p><b>Gender</b> - There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016: -</p> <p>A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.</p> <p>Health (and social care) services have a duty to treat people fairly and</p>
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		<p>equally. However, the Stonewall <b>Unhealthy Attitudes 2015</b> report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey  With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p> <p>This policy will apply regardless of gender.</p> <p><b>Gender Reassignment</b> - Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.( Mind, “Our Communities, Our Mental Health”)  This policy will apply regardless of whether patients have transitioned or not.</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall <b>Unhealthy Attitudes 2015</b> report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p>
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		<p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a <a href="#">Top Tips for Making your Service Inclusive and Welcoming for Trans People</a></p> <p><b>Human Rights</b> - The proposed policy promotes human rights in ensuring that all patients are detained lawfully.</p> <p><b>Pregnancy and Maternity</b> - Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. ( Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016</p> <p>Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no</p>
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		<p>access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%.</p> <p>According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times.</p> <p>This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff.</p> <p><b>Race/ Ethnicity or nationality –</b> A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation ‘Mind’, the admission rate for ‘other black’ groups is six times higher than average, suggesting discrimination within the mental health system.</p> <p>Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK,</p>
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		<p>people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts. Young women from ethnic minorities are much more likely to take their own life than White British women. ( Mind, “Our Communities, Our Mental Health”)</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p> <p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity.</p> <p>The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p>
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		<p>A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh.</p> <p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p><b>Religion or Belief</b> - Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”).</p> <p>There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are</p>
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		<p>keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health.</p> <p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p><b>Sexual Orientation</b> - Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. ( Mind “Our Communities, Our Mental Health”).</p> <p>Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall <b>Unhealthy Attitudes 2015</b> report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>Gay and Bisexual Men’s Health Survey  With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.</p>
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		<p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p><b>Welsh Language</b> - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p><b>Welsh Language and its use in Cardiff &amp; Vale of Glamorgan</b>  The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups.  When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%.  In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers.</p> <p>As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.</p> <p><b>The impact of mental ill health on employment rates</b></p>
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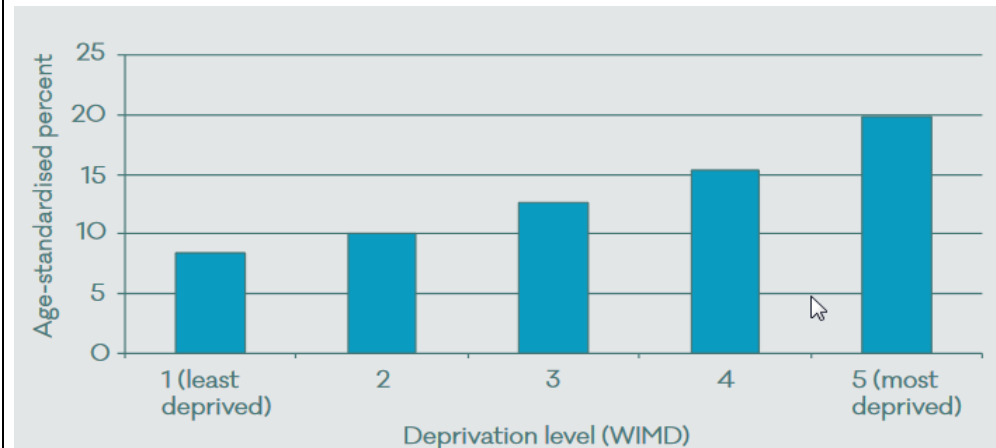
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		<p>A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)<sup>8</sup>. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).</p> <p>Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence</p>
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of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

### People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment;



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		<p>greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits.</p> <p>Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the <i>distribution</i> of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty.</p>
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		<p>Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression.</p> <p>It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).<sup>3</sup> However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' <i>a/so</i> influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004).</p> <p>This policy will apply regardless of where a person lives.</p> <p>(From:  <a href="http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf">http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf</a></p>
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		<p><b>Homeless</b></p> <p>Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity.</p> <p>Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights.</p> <p>Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health.</p> <p>Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.</p>
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		<p>It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common</p> <p>This policy will apply regardless of where a person lives.</p> <p><b>Asylum Seekers</b> Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. <a href="http://www.fph.org.uk/uploads/bs_asylum_seeker_health.pdf">http://www.fph.org.uk/uploads/bs_asylum_seeker_health.pdf</a></p> <p><b>Prisoners</b> 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.</p>
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		<p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.</p> <p>49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression.</p> <p>46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide.</p> <p><a href="http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth">http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</a></p> <p><b>Information in relation to multiple protected characteristics</b> - Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups.</p> <p>Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.</p>
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		<p>These risk factors may be present in any protected group.</p> <p>Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital stay, improved medication adherence or patients' quality of life, and have queried whether community treatment orders are an effective alternative to standard care. Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale'.</p> <p><b>Ethical Considerations</b> Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions, community treatment orders will commonly be imposed on people who have capacity.</p> <p>Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns)</p> <p><b>Examples of patient experience</b> Participants perceived both positive and negative impacts of CTOs. The positives included affirmation of experiences with the mental health system; improved rapport with the case management and clinical team,</p>
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		<p>increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it.</p> <p>(Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system – Magnus Mfoafo-McCarthy International Journal of Equity in Health Sept 2014 )</p> <p>Findings of <b>NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) ( DoH 2011)</b> - The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO.</p> <p>A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.</p>
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		<p>( A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales” Simon Lawton Smith for the Kings Fund Sept 2005)</p> <p>Community treatment orders are designed to ensure patients live in their home or supported accommodation. The power of recall under section 17E is used when a patient is not compliant with their conditions or becomes mentally unwell. They are used for patients who have frequent repeated admissions to hospital.</p>
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients.</p> <p>The Community Treatment Order Policy covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis. The functions are carried out on a day to day basis.</p>



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## 6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
<p><b>6.1 Age</b> For most purposes, the main categories are:</p> <ul style="list-style-type: none"> <li>• under 18;</li> <li>• between 18 and 65; and</li> <li>• over 65</li> </ul>	<p>There is potential for a positive impact in that there is an awareness of this protected characteristic.</p>	<p>N/A</p>	<p>Under Policy Statement</p>
<p><b>6.2 Persons with a disability as defined in the Equality Act 2010</b> Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes</p>	<p>Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected</p>	<p>A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully</p>	<p>Under Policy Statement</p>

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	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
<p><b>6.3 People of different genders:</b> Consider men, women, people undergoing gender reassignment</p> <p><b>NB</b> Gender-reassignment is anyone who proposes to, starts, is going through or</p>	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans**" is made available to staff</i>	Under Policy Statement

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
<b>6.4 People who are married or who have a civil partner.</b>	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	Under Policy Statement
<b>6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.</b> They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
<p><b>6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers</b></p>	<p>There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.</p>	<p>A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an</p>	<p>Under Policy Statement</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.</p>

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
<p><b>6.7 People with a religion or belief or with no religion or belief.</b> The term 'religion' includes a religious or philosophical belief</p>	<p>There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient.</p>		<p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.</p>
<p><b>6.8 People who are attracted to other people of:</b></p> <ul style="list-style-type: none"> <li>• the opposite sex (heterosexual);</li> <li>• the same sex (lesbian or gay);</li> <li>• both sexes (bisexual)</li> </ul>	<p>We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual</p>	N/A	N/A

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
	patient.		
<p><b>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</b></p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	<p>There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.</p>	<p>A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be</p>	<p>Under Policy Statement</p> <p>Staff are made aware of the translation and interpretation policy.</p>

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
<p><b>6.10 People according to their income related group:</b> Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health</p>	<p>There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient.</p> <p>Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.</p>	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
<p><b>6.11 People according to where they live:</b> Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities</p>	<p>No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.</p>	<p>N/A</p>	<p>Under Policy Statement</p>
<p><b>6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service</b></p>	<p>Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.</p>	<p>A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a</p>	<p>Under Policy Statement</p>



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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate.</b> Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

**7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?**

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts and any particular groups affected</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate</b> Make reference to where the mitigation is included in the document, as appropriate
<p><b>7.1 People being able to access the service offered:</b> Consider access for those living in areas of deprivation and/or those experiencing health inequalities</p> <p>Well-being Goal - A more equal Wales</p>	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
<p><b>7.2 People being able to improve /maintain healthy lifestyles:</b> Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or</p>	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts and any particular groups affected</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate</b> Make reference to where the mitigation is included in the document, as appropriate
<p>non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc</p> <p>Well-being Goal – A healthier Wales</p>			
<p><b>7.3 People in terms of their income and employment status:</b> Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions</p>	<p>No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.</p>	<p>N/A</p>	<p>Under Policy Statement</p>

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts and any particular groups affected</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate</b> Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
<p><b>7.4 People in terms of their use of the physical environment:</b> Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces</p> <p>Well-being Goal – A resilient Wales</p>	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts and any particular groups affected</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate</b> Make reference to where the mitigation is included in the document, as appropriate
<p><b>7.5 People in terms of social and community influences on their health:</b> Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos</p> <p>Well-being Goal – A Wales of cohesive communities</p>	<p>No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.</p>	N/A	Under Policy Statement
<p><b>7.6 People in terms of macro-economic, environmental and sustainability factors:</b> Consider the impact of</p>	<p>No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social</p>	N/A	Under Policy Statement

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<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts and any particular groups affected</b>	<b>Recommendations for improvement/ mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate</b> Make reference to where the mitigation is included in the document, as appropriate
<p>government policies; gross domestic product; economic development; biological diversity; climate</p> <p>Well-being Goal – A globally responsible Wales</p>	<p>and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.</p>		

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**Please answer question 8.1 following the completion of the EHIA and complete the action plan**

<p><b>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</b></p>	<p>There is some concern and debate around effectiveness of Community Treatment Orders. Whilst some protected groups may be disproportionately represented in the numbers accessing mental health services and who may be subject to the CTO Policy, there is no evidence at this stage that any individuals or group/s will be discriminated against or adversely impacted by the policy if implemented fairly and equitably.</p> <p>There is some concern that Community Treatment Orders may impact adversely on the human rights of people with mental health issues who have capacity as the decision making process is risk based rather than capacity based (Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns). However, this is rebutted within the debate citing no difference between CTO and a hospital based imposed treatment regime.</p> <p><a href="https://www.google.co.uk/search?q=Impact+of+community+treatment+orders+on+protected+groups&amp;oq=Impact+of+community+treatment+orders+on+protected+groups&amp;gs_l=psy-ab.12...1837221.1854919.0.1857397.59.38.1.0.0.0.531.5383.0j2j4j6j3j1.16.0....0...1.1.64.psy-ab..50.0.0.gB1dGnixrkY">https://www.google.co.uk/search?q=Impact+of+community+treatment+orders+on+protected+groups&amp;oq=Impact+of+community+treatment+orders+on+protected+groups&amp;gs_l=psy-ab.12...1837221.1854919.0.1857397.59.38.1.0.0.0.531.5383.0j2j4j6j3j1.16.0....0...1.1.64.psy-ab..50.0.0.gB1dGnixrkY</a></p> <p>CTOs are intended 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 harm to the patient or to others.</p>
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## Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<b>8.2 What are the key actions identified as a result of completing the EHIA?</b>	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
<b>8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?</b>  This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action



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Approved By: MHCLC		

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<p><b>8.4 What are the next steps?</b></p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> <li>• Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> <li>○ continues unchanged as there are no significant negative impacts</li> <li>○ adjusts to account for the negative impacts</li> <li>○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops.</li> </ul> </li> <li>• Have your strategy, policy, plan, procedure and/or service proposal approved</li> <li>• Publish your report of this impact assessment</li> <li>• Monitor and review</li> </ul>	<p>No significant negative Impact.</p> <p>The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval.</p> <p>Once the policy has been approved the documentation will be placed on the intranet and internet.</p> <p>The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.</p>	N/A	N/A	<p>N/A</p> <p>Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.</p> <p>The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.</p>

