

Community Treatment Order Guidelines

November 2001

Chief Psychiatrist
Mental Health Branch

The authorised psychiatrist responsible for the monitoring of the person under the CTO, shall be authorised with the authority of the grant of a licence for any other professional regulated by the appropriate medical board. There shall be no overlap of the duties and powers of the authorised psychiatrist.

In these guidelines, authorised psychiatrist should be taken to mean both the authorised psychiatrist and any delegated authorised psychiatrist.

2.1.1.1 The Monitoring Psychiatrist

Pursuant to s. 14(2)(a), the Act requires that an authorised psychiatrist be appointed to monitor the treatment of a person on a CTO. This monitoring authorised psychiatrist need not necessarily be the one who made the CTO (for example, a CTO may be made by an authorised psychiatrist at a inpatient service, to be monitored by another authorised psychiatrist in a community clinic).

The monitoring psychiatrist may also take on the role of the supervising medical practitioner (refer 2.2) for the purposes of the administration of a CTO, or they may appoint another medical practitioner to perform this function.

The monitoring psychiatrist may also be the supervising medical practitioner.

2.2.2 Powers in Relation to CTOs

The supervising medical practitioners does not have the power to make, extend, vary or discharge a CTO, although they are expected to be closely involved in discussions with the monitoring psychiatrist about these matters.

If the monitoring psychiatrist also has the role of supervising medical practitioner, then they may act in accordance with the powers of the monitoring psychiatrist in relation to CTOs.

2.3 Approved Mental Health Services

An approved mental health service is one that has been formally proclaimed as such by the Governor in Council under s. 94 of the Act. The proclamation is subsequently published in the Government Gazette (hence the term 'Gazetted services').

Any premises (including part of any building or place) at which treatment is to be provided, or in which treatment is to be

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Foreword

Since the publication of “Community Treatment Orders and Restricted Community Treatment Orders” by the Department of Human Services in 1994, there have been several changes to the Mental Health Act (1986) that affect this area of practice. Also, an important ruling affecting Community Treatment Orders (CTOs) was made by the Supreme Court in November 2000. Hence, a revised guide, which also establishes best clinical practice standards, is very much needed. It is hoped that this publication will fulfil this requirement.

CTOs give many patients the opportunity to receive psychiatric treatment and care in a much less restrictive environment than that provided by inpatient services. The law surrounding these orders needs to be considered together with the individual treatment needs of each patient. If legal or other expert assistance is in fact required, then professional advice should be sought.

I should like to take this opportunity to show my appreciation to all those individuals, agencies and relevant bodies consulted in the process, who contributed significantly to the production of the guidelines.



Assoc Prof Norman James

Chief Psychiatrist

November 2001

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1 Introduction

1.1 What is a Community Treatment Order?

Community Treatment Orders (CTOs) are provided for by the *Mental Health Act 1986* ('the Act'). They permit involuntary treatment in the community of some people with a mental illness. As such, they offer a less restrictive, community-based, environment for involuntary treatment than the inpatient setting.

The 'Principles of Treatment and Care' (s. 6A) of 'the Act' specify that 'wherever possible people with a mental disorder should be treated in the community', and that the 'provision of treatment and care should be designed to assist people with a mental disorder to, wherever possible, live, work and participate in the community'. Community-based treatment is consistent with the emphasis of 'the Act' on providing treatment and care in the least restrictive environment, in the least intrusive manner possible and with modern models of care for people with a mental illness.

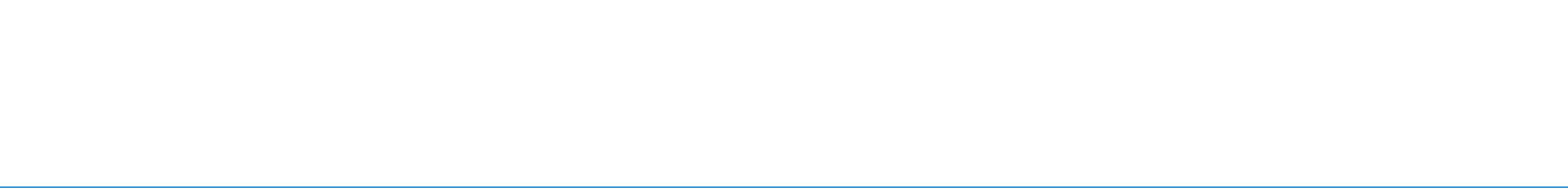
The effectiveness of a Community Treatment Order depends on a mutually respectful relationship between the person on the Community Treatment Order and the treating practitioners. This requires time, consistency of staff, information sharing and negotiation.

1.2 Status of the Community Treatment Order Guidelines

The Community Treatment Order Guidelines are intended to provide information and guidance to assist in the proper understanding and administration of Community Treatment Orders and to promote best practice. They replace the Department of Human Services' publication *Community Treatment Orders and Restricted Community Treatment Orders: Guidelines and Information* published in May 1994.

The Community Treatment Order Guidelines do not give an official interpretation of the law and are not a replacement for professional advice or a substitute for reading the legislation.

Legislation changes from time to time. This document was published in July 2001 and does not reflect any changes that may have been made to the law after that date.



2 Explanation of Terms

2.1 Authorised Psychiatrist

2.1.1 Definition

Each approved mental health service has a psychiatrist specifically appointed under s. 96 of 'the Act' as the authorised psychiatrist for that service.

The authorised psychiatrist has specific powers, duties and functions under 'the Act', and is conferred with the authority to delegate all of these (with the exception of the power of delegation) to any other psychiatrist employed by the approved mental health service. These delegates then act with all the duties and powers of the authorised psychiatrist.

In these guidelines 'authorised psychiatrist' should be taken to mean both the authorised psychiatrist and any delegated authorised psychiatrist.

2.1.1.1 The Monitoring Psychiatrist

Pursuant to s. 14(2)(a), 'the Act' requires that an authorised psychiatrist be appointed to monitor the treatment of a person on a Community Treatment Order. This monitoring authorised psychiatrist need not necessarily be the one who made the Community Treatment Order (for example, a Community Treatment Order may be made by an authorised psychiatrist at an inpatient service, to be monitored by another authorised psychiatrist in a community clinic).

The monitoring psychiatrist may also take on the role of the supervising medical practitioner (refer 2.2) for the purposes of the administration of a Community Treatment Order, or they may appoint another medical practitioner to perform this function.

In these guidelines, the term 'monitoring psychiatrist' will be used to refer to the authorised psychiatrist monitoring the Community Treatment Order.

2.1.2 Powers in Relation to Community Treatment Orders

Only an authorised psychiatrist may make or extend a Community Treatment Order. Only an authorised psychiatrist or the Mental Health Review Board (at a review or appeal hearing), may vary, revoke or discharge a Community Treatment Order.

2.2 Supervising Medical Practitioner

2.2.1 Definition

The supervising medical practitioner in relation to Community Treatment Orders is a registered medical practitioner who, after discussion with an authorised psychiatrist (either the person who made the Community Treatment Order or the person monitoring the Community Treatment Order), agrees to supervise the Community Treatment Order. The supervising medical practitioner may be any registered practitioner in public or private practice, and does not need to be either a psychiatrist or a psychiatric registrar.

The monitoring psychiatrist may also be the supervising medical practitioner.

2.2.2 Powers in Relation to Community Treatment Orders

The supervising medical practitioner does not have the power to make, extend, vary, revoke or discharge a Community Treatment Order, although they are expected to be closely involved in discussions with the monitoring psychiatrist about these matters.

If the monitoring psychiatrist also has the role of supervising medical practitioner, then they may act in accordance with the powers of the monitoring psychiatrist in relation to Community Treatment Orders.

2.3 Approved Mental Health Services

An approved mental health service is one that has been formally proclaimed as such by the Governor in Council under s. 94 of 'the Act'. The proclamation is subsequently published in the Government Gazette (hence the term 'Gazetted' services).

Any premises (including part of any building or place) at which treatment is to be provided, or any service through which treatment is to be provided, may be proclaimed. In practice both situations occur. In some instances a campus of an area mental health service is proclaimed (usually the inpatient unit and the co-located general hospital), and any inpatient services developed at other sites (although being part of the same area mental health service) are proclaimed in their own right. In other instances, an entire area mental health service is proclaimed, and any new premises or programs developed by that service are automatically deemed to be approved.

A person on a Community Treatment Order must be a patient of an approved mental health service. In practice this means that, where only the inpatient campus of a service has been proclaimed, the necessary paperwork must be completed such that the person is a patient of the approved (inpatient) service, although they reside in the community.

The names of the approved mental health service and the specific site where the person is to receive their primary treatment (for example, the community clinic) are specified on the Community Treatment Order (PSY4) form. The inpatient unit of the approved mental health service is the one to which the person should be returned if the Community Treatment Order is revoked.

3 Criteria for a Community Treatment Order

3.1 Circumstances in which a Community Treatment Order Might be Considered

CTOs are provided for under s. 14 of 'the Act', and are intended to offer a less restrictive setting for the treatment of people who would otherwise be involuntary inpatients. The person must therefore fulfil all of the s. 8 criteria for being an involuntary patient in order to be considered for a Community Treatment Order.

A person on a Community Treatment Order is still subject to involuntary treatment, and as such due consideration must be given to both the potential benefits as well as the restrictions consequent on placing a person on a Community Treatment Order.

There are two occasions when a Community Treatment Order should be considered:

- **As an alternative to continued involuntary inpatient detention.**

A Community Treatment Order can be made instead of continuing to detain a person as an involuntary inpatient. In this way, treatment is provided in a less restrictive community setting.

- **As an alternative to confirming the admission of the person as an involuntary inpatient.**

If an authorised psychiatrist considers that a person requires involuntary psychiatric treatment, but that inpatient treatment is not necessary, then a Community Treatment Order can be made as an alternative to inpatient admission.

3.2 Criteria

A person placed on a Community Treatment Order must meet all of the legislative criteria contained in ss. 14(1) and 14(1A) of 'the Act'.

The s. 14(1A) criteria are reproduced below, with brief supplementary remarks. These remarks have been extracted from decisions of the Mental Health Review Board¹ and may assist in their interpretation. They should not be taken as an official or complete interpretation of the law, and the published decisions of the Board² should be referred to for further clarification of the criteria. It should be noted that the decisions of the Board are not binding, and that the interpretation of the criteria will vary according to Board membership and clinical circumstances.

(a) The person appears to be mentally ill.

- The person must be currently exhibiting, or have recently exhibited, symptoms of mental illness.
- The disturbance of mental functioning must either constitute an identifiable syndrome, or if not, the symptoms must be present to such a degree as to be considered pathological³.

and

(b) The person's mental illness requires immediate treatment and that treatment can be obtained by making the person subject to a community treatment order.

- 'Requires immediate treatment' in this context means the introduction or extension of an ongoing treatment regime⁴.
- In determining whether or not immediate treatment is required, consideration needs to be given to the:
 - Likelihood of relapse in the short to medium term should the person not commence, or immediately cease, treatment;
 - Possible severity of the relapse;
 - Degree of disruption a relapse would be likely to cause⁵.
- All available information should be taken into account in making the assessment, including the person's current state, information from family and carers, and the person's longitudinal history.

¹ Mental Health Review Board of Victoria 1998, Decisions of the Mental Health Review Board of Victoria Volume 1, 1987-1991 and Volume 2, 1991-1997, MHRB of Victoria, 1998.

² Recent decisions are available on the Mental Health Review Board's website: <http://www.mhrb.vic.gov.au>

³ In the appeal of GW (aka GD) (1990) 1 MHRBD (Vic) 160-207; In the review of RJS (1994) 2 MHRBD (Vic) 199-207; In the appeal and review of ASB (1994) 2 MHRBD (Vic) 188-193

⁴ In the review of PT (1987) 1 MHRBD (Vic) 34-39, the Board determined that treatment must be immediate in the sense that it must be given immediately; it is not a requirement that it take effect immediately.

⁵ In the review of RD (1997) 2 MHRBD (Vic) 425-432.

- Potential benefits of the treatment need to be weighed against the person's views concerning involuntary treatment (particularly in relation to medication)⁶.

and

(c) Because of the person's mental illness, the person should be made subject to a Community Treatment Order for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public.

- Being subject to a Community Treatment Order must be considered necessary to secure treatment for the person's existing mental illness, or to prevent significant deterioration - due to mental illness - in the person's mental or physical health in the short or medium term⁷.
- There must be a substantial risk of non-compliance (which must be shown to be likely from the person's immediate past record of treatment, or from an established pattern of non-compliance), which must not be too remote in time⁸.
- There must be a significant risk of deterioration as a result of non-compliance with treatment. 'Significant' means more than minimal or trivial, but does not need to reach the level of 'substantial', 'serious' or 'severe'⁹.
- 'Protection' of members of the public does not permit placing someone on a Community Treatment Order merely to lessen the impact of their illness (for example, in the form of nuisance) on other people¹⁰.

and

(d) The person has refused or is unable to consent to the necessary treatment for the mental illness.

- An understanding of the broad nature and purpose of treatment is necessary to establish informed consent¹¹.
- A person does not have to have total insight into the nature of their illness in order to be able to provide consent¹².

and

(e) The person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

- The compulsion and obligation that a Community Treatment Order entails must be considered crucial to ensuring the person's compliance with the prescribed treatment regime.
- The psychiatric services required for the person's treatment must be both available and appropriate¹³.
- In assessing whether or not a person requires involuntary treatment in the community, due regard must also be given to the influence of the person's support and social circumstances in assisting them to comply with treatment¹⁴.

⁶ In the review of RD (1997) 2 MHRBD (Vic) 425-432; In the appeal of MW (1993) 2 MHRBD (Vic) 91-97.

⁷ In the appeal of HL (1997) 2 MHRBD (Vic) 485-500.

⁸ In the review of MF (1993) 2 MHRBD (Vic) 81-86.

⁹ In the appeal of HL (1997) 2 MHRBD (Vic) 485-500.

¹⁰ In the review of MW (1987) 1 MHRBD (Vic) 14-21.

¹¹ In the review of RD (1997) 2 MHRBD (Vic) 425-432; In the appeal of JC (1991) 2 MHRBD (Vic) 1-5; In the appeal of SF (1989) 1 MHRBD (Vic) 137-146

¹² In the review of MF (1993) 2 MHRBD (Vic) 81-86.

¹³ In the appeal of RH (1991) 1 MHRBD (Vic) 363-368.

¹⁴ In the review of LR (1995) 2 MHRBD (Vic) 214-218.

4 Before Making a Community Treatment Order

4.1 Ensuring the Least Restrictive Option

'The Act' requires (in s. (2)(a)) that treatment must be provided in the least possible restrictive environment, and least possible intrusive manner consistent with the effective giving of the treatment and care. While being on a Community Treatment Order is less restrictive than being an involuntary inpatient, it is still a significant intrusion upon a person's rights. The decision to place someone on a Community Treatment Order must therefore be based on a careful evaluation of the person's need for treatment, and of other strategies for engaging the person (such as greater involvement in discussions and decisions concerning treatment, and the enlistment of family or other social support).

4.2 Discussion with the Person

An authorised psychiatrist considering making a Community Treatment Order must discuss it with the person, and give consideration to their preferences in relation to medication, where the treatment will be provided, and who will provide the treatment (including who the supervising medical practitioner might be).

Particular effort should be made to ensure the person has an understanding of:

- Why the Community Treatment Order is being proposed.
- What the person might expect if they are put on a Community Treatment Order, including the:
 - Proposed course of treatment (including clinic appointments, case management, medication and potential side-effects).
 - Proposed duration of the Community Treatment Order.
 - Expectations with respect to adherence to treatment, including being available for review by the case manager, the supervising medical practitioner and the monitoring psychiatrist.
 - Degree of flexibility that may be afforded in adhering to the treatment, and the potential consequences of not doing so.

The authorised psychiatrist also has a duty

(pursuant to s. 18 of 'the Act') to ensure that the person is provided with a copy of the patient's rights brochures *Community Treatment Orders and Restricted Community Treatment Orders and The Mental Health Review Board*, that they are given an explanation of these in a form and language most likely to be understood, and that any questions the person may have are addressed.

Extra time will be required for people with poor literacy skills, communication difficulties (due to illness or medication), and those from non-English speaking backgrounds. Professional interpreters must be utilised where there is any doubt that the person may not have understood due to language difficulty.

4.3 Discussion with Family and Carers

In most instances, family, carers and other community supports are integral to supporting a person on a Community Treatment Order in the community. Collaboration with them is often crucial to assessing the need for a Community Treatment Order in the first instance, in developing a treatment plan, and in supporting them in their role. Better outcomes are usually achieved when an ongoing dialogue occurs between family, carers and treating staff.

4.3.1 Confidentiality

Discussions with family and carers must be handled sensitively, and with respect for the wishes of the person on the Community Treatment Order. Before speaking with family and carers, staff must first seek the consent of the person on the Community Treatment Order (as required by s. 120A(3)(a) of 'the Act'), and should endeavour to ascertain their preferences with respect to what information may and may not be disclosed. In most instances, the person will agree to treating staff discussing their treatment and care with relatives and carers if appropriate consent is sought, and time is taken to discuss any issues that arise.

If the person does not consent to the disclosure of information to relatives and carers, then information may not be conveyed unless it is

exempted under s. 120A(3)(ca) of 'the Act'. This provides for the release of information, at the discretion of clinical staff (doctors, nurses, psychologists, social workers and occupational therapists) to the primary carer, family member or legal guardian of a person on a Community Treatment Order. This only applies, however, if:

- The information is reasonably required for the ongoing care of the person on the Community Treatment Order;

and

- The person to whom the information is being disclosed will be involved in providing that care.

Note that information not specifically required to assist with the person's care cannot be disclosed without consent, and that relatives and carers do not need to be living with the person on the Community Treatment Order in order to be involved in providing care. Care provision is broader than cohabitation, and information should not be withheld on the basis that the person is no longer living with the relative or carer.

The release of information without the person's consent should only occur in exceptional circumstances, and wherever possible be accompanied by a discussion with the person on the Community Treatment Order about the nature of, and reasons for, the disclosure.

For people not involved in providing ongoing care to the person on the Community Treatment Order, information may only be communicated in general terms (as provided for under s. 120A(3)(c)(i)).

4.4 Negotiation with Clinical Staff

The authorised psychiatrist considering making a Community Treatment Order should ensure that the provision of necessary treatment is discussed with, and agreed to by, the monitoring psychiatrist (if relevant), the supervising medical practitioner, the case manager, and any other service that will be providing treatment as part of the Community Treatment Order.

4.4.1 The Monitoring Psychiatrist

If an authorised psychiatrist making the Community Treatment Order does not intend to be the monitoring psychiatrist, then they should negotiate with the proposed monitoring psychiatrist prior to making the Community Treatment Order. The monitoring psychiatrist should ensure they are well informed of the details of the Community Treatment Order prior to accepting this role.

4.4.2 The Supervising Medical Practitioner

The supervising medical practitioner should be contacted prior to a Community Treatment Order being made to confirm their willingness to take on this role, and to ensure a smooth transition of care and a co-ordinated response.

The supervising medical practitioner will assume day-to-day responsibility for the treatment of the person on the Community Treatment Order, and as such will need to be informed of the:

- Reasons for the Community Treatment Order.
- Person's relevant clinical history, current and proposed treatment, and the degree of flexibility that may be appropriately afforded in relation to the person's adherence to treatment.
- Extent to which the authorised psychiatrist is agreeable to treatment being altered by the supervising medical practitioner.
- Factors that may warrant a review of the need for a Community Treatment Order, and the requirement that the person be discharged as soon as they no longer fulfil the s. 14 criteria.
- Clinical features which may warrant the Community Treatment Order being revoked.
- Duration of the Community Treatment Order.
- Method and frequency of reporting required of the supervising medical practitioner by the monitoring psychiatrist.
- Means whereby they can contact the monitoring psychiatrist.

4.4.3 The Case Manager

People on a Community Treatment Order will generally require the support of a multidisciplinary area mental health service and a case manager. As the mental health professional likely to have the most contact with the person on the Community Treatment Order, the case manager must also be fully consulted about the Community Treatment Order.

4.4.4 Confidentiality

In relation to discussions with other services and practitioners (including the staff of residential facilities), it is desirable that consent be obtained prior to the sharing of information. Section 120A(3)(e) provides for the communication of information without consent where that information is in connection with the further treatment of the person, though care must be taken to disclose only that information that is clinically relevant, and only to those people involved in providing treatment.

5 Making a Community Treatment Order

5.1 The Procedure

5.1.1 Following an Inpatient Admission

A person who was an involuntary inpatient under s. 12 ceases to be an involuntary patient on discharge unless they are placed on a Community Treatment Order.

If the person meets the s. 14 criteria and a Community Treatment Order is considered appropriate, then a *Community Treatment Order* (PSY4) form should be completed. A *Discharge of a Patient* (PSY11) form should **not** be completed, as the person is not being discharged from involuntary status. They are deemed an involuntary patient of the approved mental health service, though they are living in the community.

In order to facilitate the person's community treatment, a verbal handover should be given by the inpatient service to relevant staff that will be providing treatment in the community. This should be done prior to or soon after discharge, in order that the community practitioner has the relevant clinical information at hand when assuming (or resuming) care of the person on the Community Treatment Order. Copies of the discharge summary and the Community Treatment Order must be forwarded to the monitoring psychiatrist (if not the authorised psychiatrist making the Community Treatment Order), the supervising medical practitioner and the treating mental health service as soon as possible. The original Schedule 1 and Schedule 2 to the Mental Health Regulations 1998 the Regulations), *Examination of Involuntary Patient by Authorised Psychiatrist* (PSY1), and *Community Treatment Order* (PSY4) forms should be retained at the approved mental health service.

5.1.2 Without an Inpatient Admission

A person cannot be placed on a Community Treatment Order without first being made an involuntary patient. Section 12(4A) of 'the Act' provides that a person may be admitted as an involuntary patient to an approved mental health service without being required to be taken to the service for the purposes of admission. This

means that a Community Treatment Order may be made in the community without the person needing to attend an inpatient service for the purposes of initiating the Community Treatment Order. The term 'admission' is being used in s. 12(4A) in the legal sense, and is considered to occur when the person first comes into contact with the approved mental health service following the recommendation. It is not being used in the clinical/administrative sense of physically becoming an inpatient.

Therefore, if an authorised psychiatrist considers that a person in the community requires involuntary treatment, but that inpatient treatment is not necessary, then, following a request and recommendation, a Community Treatment Order can be made as an alternative to inpatient admission. The person may have been seen at home, in a community mental health service or in an emergency department.

In practice, a person being placed on the Community Treatment Order from the community would usually be known either by the community team or by the authorised psychiatrist. It is this prior contact with the person that helps to inform the authorised psychiatrist's judgement as to the requirement of a Community Treatment Order, the appropriateness of its initiation in the community, and the formulation of a treatment plan.

5.1.2.1 The Procedure

- A request for admission of the person as an involuntary patient (schedule 1 of the of the Mental Health Regulations 1998) must be made pursuant to s. 9(1)(a) of 'the Act'. This may be signed before or after a recommendation is made, and may be completed by any person over the age of 18 years (including relatives of the person being recommended).
- A registered medical practitioner must examine the person. This may occur at any location, including the person's home, a general practitioner's surgery or at a community mental health service.
- Having decided that the person meets all of

the s. 8 criteria for involuntary admission, a recommendation form (schedule 2 of the Mental Health Regulations 1998) must be completed pursuant to s. 9(1)(b) of 'the Act';. Following this, 'the Act' does not require the recommended person to be physically transported to an approved mental health service, though the recommending medical practitioner must ensure that an examination by an authorised psychiatrist occurs within 24 hours of admission to the approved mental health service.

Admission should be considered to occur when the person first has contact with the approved mental health service following the recommendation¹⁵. If a medical practitioner employed by the approved service completed the recommendation, then admission is considered to have occurred at the point of recommendation. If the recommending medical practitioner was not employed by the approved service (for example, was a GP), then the point of 'admission' is when the person first has contact with the approved mental health service after the recommendation (for example, when the person is contacted by a community nurse). This should be as soon as practicable, and in any case no longer than 72 hours after the registered medical practitioner's examination for the recommendation.

- An authorised psychiatrist must examine the person within 24 hours of the admission. This examination may occur in any location, including a person's home, in a general practitioner's surgery or at a community mental health service. An *Examination of Involuntary Patient by Authorised Psychiatrist* (PSY1) form must be completed.
- The authorised psychiatrist must be satisfied that the person meets the s. 14 (1A) criteria for involuntary treatment, and that a Community Treatment Order is appropriate. At this point the authorised psychiatrist can make a *Community Treatment Order*. A (PSY4) form must be completed, and a copy given to the person on the Community Treatment Order, the monitoring psychiatrist, the

supervising medical practitioner, and placed in the person's clinical file. The original should be filed in accordance with local protocols.

In summary, the required paperwork is:

- Schedule 1 (a 'request') and Schedule 2 (a 'recommendation') to the Regulations;
- An *Examination of Involuntary Patient by Authorised Psychiatrist* (PSY1) form;
- A *Community Treatment Order* (PSY4) form.

5.2 Minimum Duration

Section 14(2)(d) of 'the Act' allows for a Community Treatment Order to be made for a maximum period of 12 months. This should **not** be taken as the default duration, and Community Treatment Orders should be made for the minimum period considered necessary to achieve the objectives of treatment as an involuntary patient. A Community Treatment Order may be extended if the original duration proves too short to secure the objectives of treatment.

5.3 Conditions of the Community Treatment Order

5.3.1 Treatment

A person on a Community Treatment Order is deemed to be an involuntary patient in the community, on a Community Treatment Order for the purposes of treatment. Section 3 of 'the Act' defines treatment as 'things done in the exercise of professional skills to remedy the mental disorder, or lessen its ill effects or the pain and suffering which it causes'.

Treatment includes not only medication, but also social and psychological interventions. It may consist entirely of the latter (such as case management) provided the criteria for being on a Community Treatment Order continue to be fulfilled. For example, if a person is being monitored without medication, then the treatment being provided must continue to be considered necessary in order to prevent

¹⁵ Note that a court has not made a definitive interpretation of when admission actually takes place outside an approved mental health service.

significant deterioration in the person's health in the short to medium term.

The aim of treatment is to promote sustained recovery and successful functioning in the community. Treatment is dynamic, and therefore the potential benefits and negative aspects of interventions need to be regularly evaluated, and the treatments adjusted or ceased if they cannot be shown to be of benefit.

In relation to Community Treatment Orders, the treatment provided must be for the primary benefit of the person on the Community Treatment Order, and not merely to lessen the impact of that person's illness on other people (unless there is risk to others).

5.3.1.1 The Use of Force

Consistent with the principle of providing treatment in the least restrictive and intrusive manner possible, it is not acceptable to use physical force to impose treatment in any community setting, whether this is a person's home, a GP's surgery, or in a community mental health service. Similarly, it is not acceptable to use the presence of others (especially police) to coerce a person to take treatment in the community.

If such a degree of force or coercion is considered necessary to ensure adherence to the Community Treatment Order, then the Community Treatment Order should be revoked, whereafter the person must be admitted to an inpatient unit. This allows the opportunity for the reconsideration of their clinical state, treatment needs, and treatment regime.

Exceptions to this are where services have clinical staff employed 24 hours, such as Community Care Units (CCUs), Psychogeriatric Nursing Homes (PGNHs) or Secure Extended Care Units (SECUs) (but excluding Psychiatric Disability Support Services (PDSSs)). In these clinical settings, after alternative strategies have been exhausted, and after discussion with a senior clinician, staff may use minimal force to ensure adherence to the Community

Treatment Order. Appropriate consideration must be given to the intrusion the use of force would represent, the ability of the service to safely manage the event, and whether or not revocation and inpatient review would be more appropriate. In the event that force is used, it is expected that staff will discuss the proposed course of action with the person on the Community Treatment Order both before and after the event. It is not appropriate to use police to enforce treatment in these settings.

5.3.2 Residence Condition (s. 14(2A))

Section 14(2A) of 'the Act' provides for the authorised psychiatrist to direct where a person on a Community Treatment Order must reside if this is necessary for the treatment of their mental illness. This condition may only be considered when, to enable a person to live in the community, a person requires treatment that is both **essential** to maintaining them in the community and **only** available at a particular place of residence. An example is where a person requires special personal care to ensure that they may safely remain in the community, and this support is only available in a supported residential service.

The inclusion of a residence condition must not be taken lightly, and full account must be taken of the support that families and carers are willing to provide in order to assist the person to live in the place of their choice.

A residence condition should not be included:

- As a matter of course.
- As a matter of convenience.
- When the extra care available in the proposed residence is not an essential or integral part of treatment.
- Merely to lessen the impact of someone's mental illness on others (for example, by physically removing them from an environment).

Note that a residence condition may only require that a person live in a particular place if their needs can be met there by existing services. Accommodation services should not be expected to provide anything more than would normally be available to their residents.

If the authorised psychiatrist includes a residence condition as part of the Community Treatment Order, then they must:

- Be satisfied that the person would not be successfully treated in the community without the support of the services available at the proposed place of residence.
- Discuss the factors they have taken into consideration when applying the residence condition with the person on the Community Treatment Order, their family and carers (subject to confidentiality considerations).
- Discuss the proposed residence condition with the person in charge of the accommodation. This is to confirm that the required services are available and will be provided, and to give the service any information they will require to optimally care for the person (subject to confidentiality considerations).
- Attempt to give the person on the Community Treatment Order an indication of the likely period for which the residence condition will be required, and the factors that will be taken into consideration when making the decision regarding its removal. This is to assist the person to appropriately plan for their future accommodation needs.
- Document in the medical record the:
 - Reasons for the residence condition;
 - Services provided by the residence that constitute a necessary part of the person's treatment;
 - Intervals at which the condition will be reviewed, and indications for earlier review.
- Discuss the above in detail with the supervising medical practitioner.
- Complete the relevant section on the *Community Treatment Order (PSY4)* form, specifying the exact address where the person is to live.

If a residence condition is applied to a Community Treatment Order, the monitoring psychiatrist may remove it without affecting the other requirements of the Community Treatment Order. This allows for the residence condition to apply only for the period considered necessary, and for it to be withdrawn should it no longer be required. A residence condition should not routinely apply for 12 months. It should frequently be reassessed with regard to its continuing necessity. The Mental Health Review Board also has the power to remove a residence condition at a review or appeal hearing.

6 Responsibilities to a Person on a Community Treatment Order

Placing someone on a Community Treatment Order imposes a duty on services to provide the best treatment possible to meet the person's health care needs. Consistent with the 'Principles of Treatment and Care' of 'the Act' (s. 6A), treatment should be based upon a plan that is developed, as far as reasonably practicable, with the involvement of the person on the Community Treatment Order, and that is reviewed regularly and revised as necessary.

6.1 The Monitoring Psychiatrist

After the initial making of a Community Treatment Order, an authorised psychiatrist must monitor the Community Treatment Order and perform such duties as are required under 'the Act'.

The monitoring psychiatrist's role is important, and is not merely administrative. It is expected that the monitoring psychiatrist will stay informed of, and involved in, the management of the person on the Community Treatment Order via written reports, liaison with the supervising medical practitioner and case manager, and personal examination.

The monitoring psychiatrist should:

- Be available to the supervising medical practitioner to discuss relevant issues.
- Ensure that they have a clear system for tracking Community Treatment Order progress reports, and for prompting in relation to key dates relevant to the Community Treatment Order (in particular the expiry date).
- Examine the reports submitted by the supervising medical practitioner, follow up any that are late, and address any clinical issues that arise.
- Stay informed of, and ensure that they are satisfied with, the treatment and clinical condition of the person on the Community Treatment Order.
- Aim to personally examine the person on the Community Treatment Order every three months, or as otherwise indicated.
- Regularly consider whether or not the person continues to satisfy the criteria of s. 14(1A) for being on a Community Treatment Order, and immediately discharge the person if these

criteria are no longer fulfilled.

- Regularly consider whether or not the Community Treatment Order might be varied to a less restrictive option (such as shortening its duration, or withdrawing a residence condition).
- Revoke a Community Treatment Order when clinically appropriate.
- Ensure the person on the Community Treatment Order has an annual examination of their mental and physical health, and submit a written report to the Chief Psychiatrist as required by s. 87(2) of 'the Act'. These examinations may be delegated to other medical practitioners, but must be signed by the monitoring psychiatrist.
- Extend the Community Treatment Order as appropriate. This may only be done following a personal examination by the monitoring psychiatrist.
- Organise for a new supervising medical practitioner should the existing practitioner be unable to fulfil their role.
- Organise for the transfer of the person on the Community Treatment Order to a different approved mental health service should this be required.
- Ensure the necessary preparatory steps have been taken prior to Mental Health Review Board hearings, and be available to appear before, or speak by telephone to, the Board at the hearing.

6.2 The Supervising Medical Practitioner

Although the monitoring psychiatrist retains the responsibility for the discharge, variation, extension and revocation of Community Treatment Orders, the supervising medical practitioner is responsible for the day-to-day clinical management of the person on the Community Treatment Order.

The supervising practitioner operates under delegation from the monitoring psychiatrist, and therefore major changes in the person's clinical state or proposed alterations to treatment should be discussed with the monitoring psychiatrist. The practitioner should also remain alert to the possibility that it might be appropriate to alter or discharge the Community Treatment Order, and

should discuss any changes they believe to be appropriate with the monitoring psychiatrist.

The supervising medical practitioner should:

- Be involved, with the monitoring psychiatrist and the case manager, in the development of a realistic Individual Service Plan (ISP).
- Be available to the person on the Community Treatment Order to discuss their treatment and other relevant issues, and provide information.
- Ensure the person understands the specific requirements of the Community Treatment Order, the flexibility that may be afforded with respect to adherence to treatment, and the indications for the possible discharge or revocation of the Community Treatment Order.
- Liaise with the case manager as required.
- Regularly personally examine the person on the Community Treatment Order as clinically indicated to:
 - Monitor the person's mental health (including an assessment of risk and vulnerability);
 - Prescribe and monitor the treatment against clinical indications, and discuss significant alterations to the treatment with the monitoring psychiatrist;
 - Discuss significant changes in the person's behaviour with the monitoring psychiatrist.
- Regularly review the ongoing need for the Community Treatment Order, and give consideration to its possible discharge or variation to a less restrictive option (for example, by withdrawal of a residence condition).
- Monitor the person's physical health, and treat or refer as appropriate.
- Report regularly to the monitoring psychiatrist in the required manner (refer 6.2.1).
- Prepare a report for the Mental Health Review Board at the time of a review of, or appeal by, the person on the Community Treatment Order, and be available to appear before, or speak by telephone to, the Board at the hearing.
- Promptly notify the monitoring psychiatrist of any difficulties they may be having in fulfilling their responsibilities as a supervising medical practitioner.

6.2.1 Reporting to the Monitoring Psychiatrist

Section 14(2)(c) of 'the Act' requires that the supervising medical practitioner submit written reports concerning the person's treatment to the monitoring psychiatrist. The frequency of reporting should be negotiated between the monitoring psychiatrist and the supervising medical practitioner, and depends on clinical circumstances. In any case, the monitoring psychiatrist must ensure that they are sufficiently informed as to the person's condition to allow them to fulfil their functions under the 'Act'.

The reports should be sufficiently detailed and comprehensive to enable the monitoring psychiatrist to adequately establish the progress of the person on the Community Treatment Order, the appropriateness of the person's treatment, and the ongoing need for a Community Treatment Order. Reports may be on the *Progress Report on Community Treatment Order* form (PSY10), or on a local purpose-designed form. Where the monitoring psychiatrist is, or is at the same location as, the supervising medical practitioner, the report may take the form of a readily identifiable summary in the clinical file.

The supervising practitioner should be clear about where to forward the progress report. This may be directly to the monitoring psychiatrist, or to the authorised psychiatrist via a centralised tracking system in the approved mental health inpatient service, depending on local protocols.

6.2.1.1 When the Monitoring Psychiatrist is the Supervising Practitioner

Progress reports should still be written even if the monitoring psychiatrist is the supervising medical practitioner. This is to provide a readily identifiable record of clinical review in the file, and would normally occur at the times of the psychiatrist's personal examinations of the person.

6.3 The Case Manager

Most people on a Community Treatment Order will require the specialist input of a community mental health service case manager to address

their treatment needs, and to ensure that flexible and mobile services are provided. The case manager should:

- Develop, maintain and facilitate the execution of a realistic ISP in consultation with the person on the Community Treatment Order, their relevant family and carers (where consent has been given by the person on the Community Treatment Order), and the supervising medical practitioner. A copy of the ISP should be provided to the person on the Community Treatment Order, and to relevant clinical staff.
- Be available to the person on the Community Treatment Order to discuss their treatment and other relevant issues.
- Provide assertive case management.
- Regularly monitor the needs and health of the person on the Community Treatment Order, and facilitate any necessary adjustments to their treatment (medical, psychological and social) in consultation with the supervising medical practitioner.
- Provide liaison with, and education to, the person's primary carers.
- Coordinate regular reviews by the supervising medical practitioner and monitoring psychiatrist.
- Contribute any relevant information to reports prepared for the Mental Health Review Board.

6.4 The Area Mental Health Service

It is the responsibility of the area mental health service to develop and maintain a system to facilitate the proper administration of Community Treatment Orders. Such a system should specify procedures for handling of statutory paperwork (such as Schedules), and the tracking of progress reports and key dates in relation to an individual's Community Treatment Order.

7 Revoking a Community Treatment Order

7.1 What it Means

Revocation of a Community Treatment Order means that the person on the Community Treatment Order is no longer suitable for treatment in the community, and must return as an inpatient to the approved mental health service (as specified on the *Community Treatment Order* (PSY4) form). Once the Community Treatment Order is revoked, the person is deemed to be absent from the approved mental health service without leave (s. 14(4A)(a)).

7.2 Circumstances Under Which a Community Treatment Order May be Revoked

Under s. 14(4)(b) of 'the Act', a Community Treatment Order may only be revoked if the authorised psychiatrist is satisfied on reasonable grounds that a person on a Community Treatment Order:

- Has failed to comply with the Community Treatment Order;
- or
- Satisfies the criteria for involuntary detention specified in s. 8(1) but no longer satisfies the criteria for treatment in the community specified in s. 14(1A).

7.2.1 Failure to comply with the Community Treatment Order

Sometimes the existence of a Community Treatment Order will be enough to ensure adherence to treatment. In other cases the person will passively or actively resist treatment. In these circumstances, the case manager or supervising medical practitioner may be able to encourage the person to adhere to treatment if the reasons for their resistance are explored, and some flexibility is afforded.

If a person on a Community Treatment Order fails to adhere to treatment (for example, they consistently refuse or fail to meet with the supervising medical practitioner or case manager, or repeatedly refuse medication) and

all reasonable efforts to secure collaboration have been explored, then the Community Treatment Order may, if necessary, be revoked pursuant to s. 14(4)(b)(i). The decision to revoke a Community Treatment Order is a clinical judgement that should take into consideration a number of factors, including the person's mental state, their longitudinal history, and the potential risk they might pose to themselves or to others.

The authority of the authorised psychiatrist to revoke a Community Treatment Order for failing to comply with the Community Treatment Order places the responsibility on treating practitioners to have:

- Previously informed the person on the Community Treatment Order of the requirements of their Community Treatment Order - this should be based on the Individual Service Plan;
- Attempted to ascertain the reasons for the person's failure to adhere to treatment, and made all reasonable efforts to assist the person to do so (such as allowing some flexibility in how and when treatment might be delivered)
- Made all reasonable assertive attempts to contact and meet with the person.

7.2.2 No Longer Suitable for Treatment in the Community

Should a person on a Community Treatment Order fulfil all of the criteria for involuntary treatment in s. 8(1), but no longer be suitable for treatment in the community (usually due to a deterioration in their mental state), then the Community Treatment Order may be revoked pursuant to s. 14(4)(b)(ii).

7.3 Who May Revoke a Community Treatment Order

A Community Treatment Order may only be revoked by an authorised psychiatrist of the approved mental health service of which the person is a patient, or by the Mental Health Review Board (at the time of a review or appeal hearing). Where possible, the monitoring

psychiatrist rather than the duty psychiatrist should make decisions concerning revocation, as the monitoring psychiatrist will have a greater knowledge of the person and their treatment.

If a clinician of one area mental health service forms the opinion that the Community Treatment Order of a patient of another approved service should be revoked (for example, if a person who normally lived in Melbourne became unwell while visiting friends in a rural area), then the clinician should contact the service of origin and discuss the clinical circumstances. If appropriate, the authorised psychiatrist at the service of origin should revoke the Community Treatment Order and fax the revocation in order to facilitate the person's transport back to their service of origin. If it was in the person's best interests to be admitted temporarily to the service in contact with the person, then the revocation should also be accompanied by the necessary paperwork to transfer care.

If a course of action is unable to be mutually agreed (for example, the Community Treatment Order was not revoked by the authorised psychiatrist from the service of origin), then the service in contact with the person should continue to provide full and appropriate clinical care until such time as a formal transfer occurs (either of care to the service in contact with the person, or of the person back to the service of origin).

In cases where treatment is urgently required, the service in contact with the person should institute immediate treatment and care.

7.4 The Procedure

In deciding whether or not to revoke a Community Treatment Order, the authorised psychiatrist must ensure that the person fulfils the legislative criteria for revocation (refer 7.2), and that all reasonable efforts to assist the person to remain in the community have been made.

7.4.1 Making the Assessment

A decision to revoke a person's Community Treatment Order should be based primarily on an assessment of the person's current mental state. Wherever possible, this should be made in person by the authorised psychiatrist. Where a personal examination by the authorised psychiatrist is not practicable, the authorised psychiatrist may rely on an assessment conducted by another qualified professional, such as the supervising medical practitioner, case manager or Crisis Assessment and Treatment (CAT) team member.

7.4.2 Revoking the Community Treatment Order

If the authorised psychiatrist considers revocation of the Community Treatment Order to be appropriate, then they should complete a *Revocation of Community Treatment Order* form (PSY9).

Where the authorised psychiatrist is not available in person, they may revoke the Community Treatment Order verbally (by telephone), or by faxing the completed *Revocation of Community Treatment Order* (PSY9) form to the assessing clinician. Where the revocation has occurred by telephone, the clinician receiving the authorisation should carefully record the details on the PSY9 form. The authorised psychiatrist must then complete the required sections of the PSY9 as soon as is practicable, but in any case by the next working day.

Copies of the completed PSY9 should be given to the:

- Person on the Community Treatment Order (refer 7.4.3);
- Monitoring psychiatrist (if not the authorised psychiatrist who revoked the Community Treatment Order);
- Supervising medical practitioner;
- Clinical file.

The original should be filed according to local protocols.

7.4.3 Informing the Person on the Community Treatment Order

Once a Community Treatment Order has been revoked, s. 14(5) of 'the Act' requires the authorised psychiatrist to make reasonable efforts to inform the person of the revocation and that they must return to the designated approved mental health service as an inpatient.

It is preferable for this information to be communicated in person, but where this is not possible it may be given by telephone or letter. In all instances it should be followed at the earliest opportunity in writing by giving the person on the Community Treatment Order a copy of the *Revocation of a Community Treatment Order (PSY9)* form. These tasks may be delegated to other mental health practitioners, but the authorised psychiatrist retains responsibility for ensuring that they occur.

7.4.4 Returning to the Approved Mental Health Service

7.4.4.1 Of the Person's Own Accord

Following revocation of their Community Treatment Order, a person may choose or be persuaded to return to the approved mental health service with the assistance of family, carers or mental health service staff. Every effort should be made to assist the person to return in this manner.

7.4.4.2 Apprehension and Safe Transport

Should the person not return of their own accord, s. 43(1) and subsections 5, 6 and 7 of s. 9 of 'the Act' permit the apprehension of the person for the purposes of returning them to an approved mental health service (similar to the procedures surrounding a 'request and recommendation').

The experience of being apprehended and transported following revocation of a Community Treatment Order can be quite traumatic for the individual, and every effort should be made to involve the person in a

negotiation about their return, and to transport them in the least restrictive manner. In many instances, the person can eventually be persuaded to accompany the apprehending person in an agency vehicle. Should this not occur, ambulance transport should be sought in the next instance. The use of restraint, assistance of police, and transport in police vehicles should be avoided where alternatives are available and appropriate¹⁶.

Clinical staff should attend to any need the person may have to discuss the reasons for the revocation, and the circumstances surrounding their apprehension and transport, and where possible and appropriate, accompany the person to the approved mental health service.

Who may Apprehend

Section 43(1) enables a 'prescribed person,' the authorised psychiatrist, or any person authorised by the authorised psychiatrist, to apprehend a person following the revocation of a Community Treatment Order.

Section 9 of the Mental Health Act and regulation 5(7) of the Mental Health Regulations define a 'prescribed person' as a person employed by a psychiatric service (which includes mental health inpatient and community services, but excludes agencies providing community support services such as PDSSs), and who is a:

- Registered medical practitioner;
- Registered nurse;
- Registered psychologist;
- Social worker;
- Occupational therapist;
- Member of the police force;
- Ambulance officer.

Evidence of revocation of the Community Treatment Order is sufficient authorisation for the person's apprehension by a prescribed person for the purposes of returning them to the approved mental health service.

¹⁶ The Departmental Department of Human Services' guideline *Ambulance Transport of People with a Mental Illness* should be consulted for further information regarding the appropriate use of ambulance assistance.

Specific authorisation in the form of an *Authority to Apprehend an Involuntary Patient Without Leave or Permission* form (PSY15) by the authorised psychiatrist is only required if the person apprehending is not either a prescribed person or the authorised psychiatrist. In practice this would rarely occur.

The Use of Force and Restraint

Section 14(4B), incorporating s.9(5), of 'the Act' permits the prescribed person, in apprehending and transporting the person safely to the approved mental health service, to:

- Use such assistance as is required and such force as may be reasonably necessary to enter any premises on which they have reasonable grounds to suspect the person may be found; *and*
- If necessary to enable the person to be safely transported, use such restraint as may be reasonably necessary.

Force and restraint should only be used in exceptional circumstances, and not without assistance. If significant force is expected to be required in order to enter a premise, then police assistance should be sought. If a need for restraint is anticipated in order to enable the person to be safely transported to the approved mental health service, then the person should be transported by ambulance. Police assistance, such as a police officer travelling in the ambulance with the person, may be necessary in such circumstances, but transport by police vehicle should be an option of last resort and should only occur when all other options are unsuitable.

Particulars of the use of restraint must be documented on Form 1 of Schedule 3 of the Mental Health Regulations 1998, and a copy placed in the clinical file.

Sedation

Section 14(4B), incorporating s. 9(6), provides for the use of sedation where it is required for the safe transport of the person to the approved

mental health service. It may only be ordered by a 'prescribed registered medical practitioner', defined in the Mental Health Regulations 1998 5(6) as a registered medical practitioner who is:

- The practitioner who made the recommendation; or
- In general practice; or
- The head of the emergency department of a hospital; or
- Employed in a mental health service (in hospital or in the community); or
- A psychiatrist; or
- A forensic physician.

Only a registered medical practitioner or a registered nurse may administer sedation. If sedation has been required, its use must be documented on Form 2 of Schedule 3, and the person must be transported to the approved mental health service by ambulance.

7.4.4.3 Return to which Mental Health Service?

Section 14(5)(b) requires that, once a Community Treatment Order has been revoked, the person must return to an approved mental health service as an inpatient. It is therefore not appropriate to transport a person following the revocation of their Community Treatment Order to a community mental health clinic or to a private hospital for examination or review.

The appropriate inpatient service is that of the approved mental health service designated on the *Community Treatment Order* (PSY4) form.

If a Bed is not Available

Occasionally a bed will not be available at the person's designated approved mental health service. In this instance, a bed should be negotiated at another approved mental health service¹⁷, and the name of this service entered on the *Authority to Apprehend an Involuntary Patient Without Leave* form (PSY15), if this is required. A completed *Transfer of an Involuntary Patient to Another Approved Mental Health Service* (PSY12) form should accompany the transfer to the receiving service.

¹⁷ Refer to the Program Management Circulars *Out of Area Patients and Accessing Services Across Regions and Areas*.

If the Person is Apprehended 'Out of Area'

If a person whose Community Treatment Order has been revoked is apprehended at a location closer to an approved mental health service other than that of which they are a patient, then, wherever practicable, they should still be returned to their designated approved mental health service.

However, under some circumstances it might be most appropriate for the person to be treated at another approved mental health service first, however, and clinical discretion should apply. If a patient of an approved metropolitan service was apprehended in a rural area, for example, then the most appropriate course may be to admit to, and initiate treatment at, the rural service in the first instance, and then transfer the person to the designated metropolitan service when their clinical condition permits this to be done safely.

A completed *Transfer of an Involuntary Patient to Another Approved Mental Health Service* (PSY12) form should accompany all transfers.

7.4.4.4 If the Person Cannot be Located

A person on a revoked Community Treatment Order is deemed to be absent from an approved mental health service without leave, and it is therefore incumbent on services to take all reasonable measures to locate the person.

If the person cannot be located, their absent without leave status remains valid for 12 months from the date of revocation. If they remain **absent without leave** continuously for this period, then they are automatically discharged as an involuntary patient (s. 42(1))¹⁸.

In practice, circumstances may arise where a person unable to be located may be appropriately discharged. This may occur, for example, if the monitoring psychiatrist learns that the person has moved interstate and their return is not imminent, or that they are receiving appropriate treatment from an

alternative service. It may also occur if the monitoring psychiatrist forms the opinion (for example, after discussion with the person's carers) that the person may be discharged from the Community Treatment Order on clinical grounds. If this occurs, the reasons informing this opinion must be carefully documented, and the person on the Community Treatment Order and relevant clinical staff should be notified. The decision to discharge a person on a revoked Community Treatment Order under these circumstances is a clinical one, and **must not** be made for administrative reasons.

7.4.5 When the Person Arrives at the Inpatient Service

A person whose Community Treatment Order has been revoked should be taken directly to the mental health inpatient service unless there are clinical reasons for admitting them via the emergency department.

An authorised psychiatrist should examine the person as soon as practicable, or in any case within 24 hours of their return to the inpatient service (or emergency department), and make a decision regarding their admission. The potential outcomes of the authorised psychiatrist's review include:

- Continued detention as an involuntary inpatient;
- Discharge from involuntary status (whether or not the person remains an inpatient);
- A new Community Treatment Order.

There is no need to complete an *Examination of Involuntary Patient by Authorised Psychiatrist* (PSY1) form, although if the person is discharged from involuntary status (either to remain in hospital as a voluntary patient, or to be discharged to the community), then a *Discharge of a Patient* (PSY11) form should be completed and a copy given to the person.

If it is considered appropriate for the person to be placed on a Community Treatment Order (irrespective of the duration of their inpatient

¹⁸ Note that in exceptional circumstances, section s. 42(3) provides for an application to be made to the Mental Health Review Board for an order that the person not be discharged.

admission), then a new Community Treatment Order must be initiated. Preferably the monitoring psychiatrist of the previous Community Treatment Order should do this, although this is not always practicable. If it is not possible, then the new Community Treatment Order should be made in consultation with the authorised psychiatrist who monitored the previous Community Treatment Order. A new Community Treatment Order form should be completed (refer 5.1.1).

7.4.5.1 'Out of Area' Admissions

A person whose Community Treatment Order has been revoked, and who has been admitted to an approved mental health service other than their designated approved service, should be assertively treated upon admission, and until transfer back to their service of origin. The status of the person as an 'out of area' admission should not delay or compromise their treatment.

If the treating psychiatrist forms the opinion before transfer that the person can be discharged from involuntary status, or can be managed in the community on a Community Treatment Order, then these decisions should be put into effect. It is expected, however, that such decisions will be made in consultation with the service of origin, and that appropriate follow-up will be organised collaboratively between the services.

Unless the person is discharged from involuntary status, a completed *Transfer of an Involuntary Patient to Another Approved Mental Health Service* (PSY12) form should accompany the transfer back to the person's designated approved service, whether this be as an inpatient or on a Community Treatment Order.

8 Variation, Transfer and Extension of a Community Treatment Order

8.1 Summary

Proposed alterations to the conditions of a Community Treatment Order should be first discussed and negotiated with all relevant parties.

Details of all alterations, the reasons for their introduction, and the discussions with the parties should be carefully documented in the clinical file. Some changes may be introduced by the supervising medical practitioner, and do not require any further documentation. These include, for example, the frequency of review by the mental health service, or minor adjustments to the person's medication regime.

Other alterations to the Community Treatment Order may only be made by the monitoring psychiatrist, or by the Mental Health Review Board at the time of appeal or review, and must be recorded on the prescribed form as follows:

Variation of a Community Treatment Order form (PSY5) records:

- A change of supervising medical practitioner or monitoring psychiatrist.
- Variations to the intervals at which the supervising medical practitioner must report to the monitoring psychiatrist.
- A transfer of the location at which the person receives treatment to another within the boundaries of the same approved area mental health service (for example, from GP surgery to community mental health clinic).
- The removal or introduction of a residence condition.
- Shortening the duration of a Community Treatment Order.

Transfer of an Involuntary Patient to Another Approved Mental Health Service form (PSY12) Records:

- The transfer of the person's treatment to another approved mental health service (this does not include transfer to another community mental health service within the same approved area mental health service).

Extension of a Community Treatment Order form (PSY6) records:

- Extensions to the duration of the Community Treatment Order.

8.2 Varying a Community Treatment Order

A variation occurs when some details on the Community Treatment Order are changed, but the duration of the Community Treatment Order is not lengthened. Only the monitoring psychiatrist or the Mental Health Review Board (at the time of appeal or review) may vary a Community Treatment Order.

It is appropriate to use a variation for:

- A change of supervising medical practitioner or monitoring psychiatrist.
- Variations to the intervals at which the supervising medical practitioner must report to the monitoring psychiatrist.
- The transfer of the person's treatment to another location within the catchment area of the same approved area mental health service (for example, from GP surgery to area mental health clinic).
- The introduction or removal of a residence condition.
- Shortening the duration of a Community Treatment Order.

Variations should be recorded on a *Variation of a Community Treatment Order* form (PSY5), and copies given to the person on the Community Treatment Order, the supervising medical practitioner, the approved mental health service, the Mental Health Review Board, and placed in the clinical file. The original should be filed in accordance with local protocols.

8.3 Transferring Treatment

From time to time, people on Community Treatment Orders move between area mental health services. In these circumstances, the supervision and monitoring of the Community Treatment Order should be transferred to the approved mental health service where the person is to live.

The transferring service should do as much as possible to ensure the smooth transition of the person's care. A comprehensive handover to relevant staff, the setting up of appointments, and the personal introduction of the person on the Community Treatment Order to the new

treating team (where possible) are crucial elements of good clinical practice.

The timing of the transfer should be decided in negotiation with the person on the Community Treatment Order and the approved service that will assume responsibility for the Community Treatment Order. In all circumstances, the best interests of the patient should be the guiding principle. People on a Community Treatment Order have a right to access local services in a timely fashion, and there should be no time specifications (for example, three months) set around the transfer of care of a person on a Community Treatment Order. The area mental health service where the patient settles should assume primary responsibility from the time of residency unless previously negotiated with the transferring service. Delays in the receipt of the transfer documentation do not relieve the receiving service of the responsibility to provide full and appropriate care to a person who has taken up residence in their area.

It is desirable that services assume full responsibility for a Community Treatment Order. It is rarely appropriate for a Community Treatment Order to 'straddle' area mental health services (such as when the person is a patient of one approved mental health service, being monitored by an authorised psychiatrist of another approved service), and such arrangements, where the lines of responsibility are split, invite difficulties.

8.3.1 The Procedure

The transfer of the Community Treatment Order is the responsibility of the monitoring authorised psychiatrist. Before initiating the transfer, they should:

- Be satisfied that the transfer will be of benefit to the person on the Community Treatment Order, or is necessary for their treatment (pursuant to s. 39(1)(a)).
- Ensure that the proposed transfer is discussed with the person on the Community Treatment Order, and that they understand the reasons for the transfer.
- Negotiate with the receiving service and ensure that the authorised psychiatrist of that

service accepts the transfer (pursuant to s. 39(1)(b) of 'the Act'), and that adequate arrangements are made to link the person to the receiving service.

- Forward a completed *Transfer of an Involuntary Patient to Another Approved Mental Health Service* form (PSY12) to the authorised psychiatrist of the receiving service.
- Forward relevant clinical information and the **original** warrants (that is, schedules 1 and 2, the PSY1 *Examination of Involuntary Patient by Authorised Psychiatrist*, the PSY4 *Community Treatment Order*, and any *Variations, Revocations and Extensions of the Community Treatment Order*) from the medical record. This information should be sent with or shortly after the PSY12. The requirement for timeliness is explicit in 'the Act' (s. 39(3)), and **must** be addressed.

Note that the **originals of all of the statutory documentation** relevant to the Community Treatment Order should be held by the service that has assumed clinical responsibility for the person on the Community Treatment Order.

On receipt of the PSY12, the new authorised psychiatrist who will be monitoring the Community Treatment Order should:

- Familiarise themselves with the details of the person's circumstances and treatment.
- Satisfy themselves that the person continues to meet the s. 14 criteria for a Community Treatment Order.
- Vary the name of the monitoring psychiatrist, the supervising medical practitioner named on the Community Treatment Order and other details as necessary, by completing a *Variation of Community Treatment Order* PSY5 form.
- Sign the PSY5 form as the new monitoring psychiatrist.
- Provide copies of the completed form to the:
 - Person on the Community Treatment Order.
 - New supervising medical practitioner.
 - Clinical file.

The original should be retained at the new approved mental health service and filed according to local protocols.

Under s. 39(5) of 'the Act', a person on a Community Treatment Order has the right to appeal to the Mental Health Review Board

against a transfer to another service. The Board must consider whether or not the transfer will be of benefit to the person, or is necessary for their treatment (pursuant to s. 39(6)).

8.4 Extending a Community Treatment Order

Section 14(6) of 'the Act' provides for the extension of a Community Treatment Order for a further period not exceeding 12 months. This may only be made after a personal (that is, face-to-face, not telephone or telepsychiatry) examination by the monitoring psychiatrist, and may not be delegated to other staff.

If the monitoring psychiatrist considers that an extension may be appropriate, then plans should be made to review the person prior to the expiry date of the Community Treatment Order. **Unless a Community Treatment Order is extended or revoked prior to its expiry date, a person ceases to be an involuntary patient upon expiry of the Community Treatment Order¹⁹. The examination for, and the making of, a valid extension must occur before or on the expiry date of the Community Treatment Order.** It is therefore essential that services have effective administrative systems that track the Community Treatment Orders of patients and **flag** expiry dates in time for reviews to be scheduled and decisions made before the Community Treatment Order expires.

The monitoring psychiatrist must be satisfied that the s. 14(1A) criteria are still met before making an extension. If these criteria are not satisfied, then the Community Treatment Order **must** be discharged pursuant to s. 14(4)(c); an extension must not be regarded merely as a **rolling over** of a Community Treatment Order.

A Community Treatment Order should not be allowed simply to run out in lieu of discharge; if an extension is not appropriate, the person should be formally discharged.

If, after examining the person on the Community Treatment Order, the monitoring psychiatrist forms the view that an extension is appropriate,

then they should make an extension on an *Extension of a Community Treatment Order* form (PSY6). This should be completed on the day of the examination, **and dated to commence on the day of the examination**. The existing Community Treatment Order will effectively expire at the time of commencement of the extension.

The extension may be made for a maximum of 12 months (that is, one year less one day) from the date of its commencement.

Copies of the completed PSY6 should be given to the person on the Community Treatment Order, the supervising medical practitioner, the approved mental health service and placed in the clinical file. Originals should be filed in accordance with local protocols.

For the purposes of review by the Mental Health Review Board, an extension of a Community Treatment Order is deemed to operate as an admission as an involuntary patient. It is therefore subject to review by the Board within eight weeks of the date of the extension. This review may coincide with the Board's annual review of the person (refer 9.1).

There are no limits on how many times a Community Treatment Order may be extended, provided the s. 14(1A) criteria continue to be met, and that the Community Treatment Order is extended for the minimum period considered necessary.

8.4.1 If the Expiry Date Passes Prior to Review by the Monitoring Psychiatrist

It is the responsibility of the monitoring authorised psychiatrist to ensure that a decision is made concerning a Community Treatment Order prior to its expiry.

If the expiry date passes without the Community Treatment Order being either revoked or extended, then the person ceases to be an involuntary patient. It is then the responsibility of the monitoring psychiatrist to liaise with the person and the clinicians involved in their treatment to determine an appropriate course of action. Options include continuing treatment of

¹⁹ Wilson v Mental Health Review Board [2000] VSC 404.

the person as a voluntary patient, discharging the person, or if appropriate, making a new Community Treatment Order (refer 5.1).

As the person is no longer subject to a Community Treatment Order, extension or revocation may not be considered, nor may such actions be backdated. Placing the person on leave is not a valid action as the person is no longer an involuntary patient.

9 Mental Health Review Board Reviews and Appeals

9.1 Schedule of Reviews, and Right to Appeal

The Mental Health Review Board was established by s. 21 of the Mental Health Act. It is an administrative review tribunal with jurisdiction to determine a range of decisions made pursuant to 'the Act'.

Under s. 30 of 'the Act', the Board is required to review all involuntary patients within eight weeks of admission to involuntary status (whether as an inpatient or as a patient on a Community Treatment Order), and thereafter at intervals not exceeding 12 months. If the Board's review within eight weeks of the person's admission occurred before the Community Treatment Order was made (for example, if the Community Treatment Order followed an inpatient admission) then, unless the Community Treatment Order was appealed or extended, the Board would not generally conduct another review of the person until the person's annual review.

The person, a community visitor, and anyone who satisfies the Board they have a genuine concern for the person may make appeals to the Board regarding a person's involuntary status at any time. Pursuant to s. 29(4) of 'the Act', the Board must commence the hearing of an appeal without delay.

If a Community Treatment Order is extended, then the Board will review the person within eight weeks of the date of the extension (for the purposes of review by the Board an extension is deemed to be an admission, pursuant to s. 14(8)).

Pursuant to s. 31 of 'the Act', the Board is permitted to conduct an appeal and a review of a person at the same time, and will do so if possible.

9.2 Powers and Requirements of the Board

On hearing an appeal or review, the Board has the power to discharge, vary and revoke a Community Treatment Order. In so doing, it must consider whether or not the person

continues to meet the legislative criteria set out in ss. 8(1) and 14(1A) of 'the Act', and 'have regard primarily to the patient's current mental condition and consider the patient's medical and psychiatric history and social circumstances' (s. 22(2)).

On the day of the hearing the Board will require:

- Access to the person's clinical file;
- Copies of the document *Report on Continued Detention for the Mental Health Review Board* (refer 9.4.2);
- The originals of the statutory documentation (Schedules 1 and 2, the PSY1 *Examination of Involuntary Patient by Authorised Psychiatrist*, the PSY4 *Community Treatment Order*, and any *Variations, Revocations and Extensions* of the Community Treatment Order).

Further, the Board requires that all relevant information be available in order to make a determination. This means that where relevant and possible, the person, their legal representative (if relevant), friends, relatives and carers (subject to the person's consent), the person's case manager, treating doctor and other involved clinical staff should be present at the hearing.

If the person requires an interpreter to fully understand the proceedings at the Board hearing, then the case manager should notify the Executive Officer of the Board well prior to the hearing. The Board will arrange (at its expense) for an interpreter to be present if required.

9.3 Rights of the Person in Relation to Board Hearings

9.3.1 Explanation of Rights

Section 18 of 'the Act' requires that on admission as an involuntary patient, all people should be given the appropriate prescribed printed statements of patient rights, and an explanation of those rights in a form and language most appropriate to the person. It is the responsibility of the authorised psychiatrist to ensure that this occurs.

On being advised of a Board hearing, the authorised psychiatrist should ensure the person on the Community Treatment Order has received a

copy of the patient rights brochure Mental Health Review Board (schedule 12 to the Regulations), has had an oral explanation of the information contained therein, and has had the opportunity to address any questions they may have.

9.3.2 Access to Documents²⁰

Section 26(7) entitles the person on the Community Treatment Order and their legal representative or advocate to inspect or otherwise have access to any of the documents that will be presented to the Board **at least 24 hours prior to the hearing**. This includes the *Report on Continued Detention for the Mental Health Review Board* and the clinical file.

Section 26(8) provides for the authorised psychiatrist to apply to the Board to restrict access to a document or part of any document if it would:

- Cause serious harm to the patient's health or the health or safety of another person; or
- Involve the unreasonable disclosure of information relating to the personal affairs of any person; or
- Breach a confidentiality provision imposed by a person who supplied the information contained in the document.

The authorised psychiatrist should satisfy themselves as to the contents of the clinical file and the *Report on Continued Detention for the Mental Health Review Board* before making them available to the patient. If they wish to restrict access, the authorised psychiatrist should notify their intention to make an application to the Board by contacting (preferably by telephone) the Executive Officer of the Board at least 24 hours prior to the hearing. The Executive Officer will advise as to the appropriate manner in which to deal with the document(s) prior to the application being heard.

The Board will hear the authorised psychiatrist's application to restrict the document(s) as a preliminary issue before the full review or appeal hearing, and make a decision as to whether or not the person should see the document(s). This occurs in the absence of the person on the

Community Treatment Order, although their legal representative or advocate may be present.

If the Board decides that the person may see the document(s), or parts of the document(s), it will adjourn to allow the person sufficient time to read them. If the Board decides the person should not see a document, it may still allow the person's legal representative or advocate to have access. The Board may also decide not to allow anyone to read the document(s) and not to view the material itself. This is in accordance with the rules of natural justice, which require that a determination of the Board should be based on information that is available to all parties.

9.3.3 Advocacy and Second Opinion

A person who is an involuntary patient has the right to obtain a second opinion by the psychiatrist of their choice. They may wish to seek a second opinion in preparation for the Board hearing, and case managers should make every effort to facilitate this. The person should be informed that if they choose a private psychiatrist then they might be required to pay a fee.

The person also has a right to legal advice, and to representation by a legal representative at Board hearings. They should be informed of this right, and that there are three potential sources of legal assistance free of charge for people with limited financial means:

- The Mental Health Legal Centre;
- Victoria Legal Aid;
- Victoria Legal Aid-funded private solicitors.

Contact details for these organisations appear in Appendix 3.

9.3.4 Attendance

Although they are not **required** to attend, the person has the right to attend the Board hearing (accompanied by friends and relatives if they wish), or to authorise someone to attend on their behalf. Clinicians should encourage the person to attend, and support this in whatever way possible (such as organising transport, and attending the hearing to support the person).

²⁰ Further information is provided in the Program Management Circular Patient Access to Documents (Appendix 1).

If the person indicates an intention not to attend the hearing, a written notification document (available from the Board) should be signed by the patient, and placed with the original warrant documents for the Board to consider.

9.4 The Procedure²¹

9.4.1 Notification of the Hearing

The Board is required to notify a person of the date and place of their review or appeal hearing as early as possible.

If the Board is aware that a person is on a Community Treatment Order, they will send a Notice of Hearing directly to them. If an approved mental health service inadvertently receives a Notice of Hearing for a person who has been discharged from a Community Treatment Order, then the authorised psychiatrist of the service should ensure that the Executive Officer of the Board is notified immediately. Otherwise, all efforts should be made to notify the person of the details of the hearing as soon as practicable.

9.4.2 Preparatory Steps, and Responsibilities of the Service

Overall responsibility for ensuring that the necessary preparatory steps have been taken prior to Board hearings, rests with the monitoring psychiatrist. These steps may be performed by the case manager or the supervising medical practitioner, and include:

- Notifying the Executive Officer of the Board immediately if the person scheduled for a hearing has been discharged from a Community Treatment Order, or if their care has been transferred to another service (the hearing will need to be adjourned to another location).
- Notifying the Executive Officer of the Board immediately if an interpreter will be required at the hearing, or if the person has other special needs.
- Informing the person of their rights in relation to Board hearings, and providing them with a copy of the patient rights brochure *Mental*

Health Review Board (schedule 12 to the Regulations).

- Encouraging and assisting the person to attend the hearing, and, with the person's consent, informing any relatives or other concerned parties of the hearing.
- Preparing a report entitled *Report on Continued Detention for the Mental Health Review Board*. The monitoring psychiatrist, supervising medical practitioner, case manager and members of the treating team should have input into this report, or prepare separate reports for the Board. Three copies of the report(s) will need to be provided to the Board on the day of the hearing.
- Reviewing the clinical file prior to the hearing to identify information, if any, that the monitoring psychiatrist considers should be exempted from perusal by the person (and their legal representative or advocate if relevant) under s. 26(8). An application for exemption should then be made to the Board by telephoning the Executive Officer of the Board at least 24 hours prior to the hearing. The information may then be temporarily removed from the file or a photocopy may be given to the person with the exempted material deleted or covered (the Executive Officer will provide advice as to the appropriate action).
- Giving the person on the Community Treatment Order (and their legal representative or advocate, if relevant) the opportunity to inspect and discuss the clinical file and the *Report on Continued Detention to the Mental Health Review Board* **at least 24 hours prior to the Board hearing**. Access should be provided in a quiet and private area, and, if considered necessary, a member of staff may sit with the patient to assist and answer any questions. The presence of a staff member should be a positive experience and not intimidating or restrictive in any way. If the person has a legal representative or advocate, staff presence will generally be unnecessary.

If any documents have been withheld pending an application under s. 26, the person should be informed and the process explained.

²¹ Further information is provided in the Mental Health Review Board Practice Direction 98/2 (Appendix 2).

During their examination of the file and the report(s) to be provided to the Board, the person may wish to take notes or photocopy some pages. This should be facilitated by staff, as should any request to spend an extended period of time examining the file or for further access at a later time. Decisions about these requests should be made in the context of what is fair and reasonable in the circumstances.

9.4.3 The Hearing, and Responsibilities of the Service to Attend

The supervising medical practitioner must attend the Board hearing (subject to the agreement of the Board) or be available by telephone when the Board is conducting the hearing.

The case manager, community support workers and other members of the treating team may also appear before the Board if requested by the person whose Community Treatment Order is being reviewed, or if they consider it to be in the person's interest that the Board hear the information they have to offer. As the staff likely to have most contact with the person on the Community Treatment Order, their input will greatly assist the Board in its determinations.

The monitoring psychiatrist is a party to any appeal or review before the Board. As such, they may attend each appeal or review brought before the Board, although the supervising medical practitioner will often act as their representative in these matters. Wherever possible, however, the monitoring psychiatrist should be available in person or by telephone during the hearing, particularly where there are complex clinical or legal issues.

9.4.4 After the Hearing

Pursuant to s. 36(4), the potential outcomes of the hearing are for the Board to:

- Find that the person should remain as an involuntary patient on a Community Treatment Order.
- Find that the person should be discharged as an involuntary patient.
- Vary the Community Treatment Order.
- Revoke the Community Treatment Order.

Clinical staff should give consideration to how they may continue to support and engage the person following the Board hearing, irrespective of the outcome. This may involve a discussion concerning the processes surrounding the hearing, an explanation and discussion of the outcome (to both the person and, with consent, their carers and friends), and further negotiations regarding treatment.

10 Discharging a Community Treatment Order

Only an authorised psychiatrist or the Mental Health Review Board (on review or appeal) can discharge a person from a Community Treatment Order. A person discharged from a Community Treatment Order is no longer an involuntary patient under 'the Act', although they may wish to continue to receive treatment from the service on a voluntary basis.

'The Act' requires that if the monitoring psychiatrist 'is satisfied' that the criteria for a Community Treatment Order (in s. 14(1A) and s. 8(1)) are no longer met, then the person must be discharged from the Community Treatment Order (s. 14(4)(c)). The monitoring psychiatrist must therefore remain mindful of their responsibility to continue to review the need for the Community Treatment Order. They need not personally examine the person prior to discharging the Community Treatment Order, and in practice would often rely on information conveyed by the case manager and the supervising medical practitioner.

When a person is discharged, a *Discharge of a Patient* form (PSY11) must be completed, and a copy given to the patient, the supervising medical practitioner, and placed in the clinical file. The original should be filed according to local protocols. If relevant to a pending hearing of the Mental Health Review Board, a copy should also be forwarded to the Board.

It is not necessary to complete a *Discharge of a Patient* form (PSY11) if the person is discharged by the Board.

11 Special Issues

11.1 Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is a psychiatric treatment administered as a same-day procedure. Although commonly referred to as outpatient ECT, a person receiving ECT while residing in the community must be admitted as a same-day inpatient for this procedure.²²

A person on a Community Treatment Order, therefore, being treated with ECT, should have the Community Treatment Order revoked for the purposes of the procedure, as the treatment is not available in the community, and a Community Treatment Order 'does not apply to a person who is 'a patient in an approved mental health service' (pursuant to s. 3 of 'the Act'). These circumstances should be explained to the person on the Community Treatment Order.

Following the ECT, the authorised psychiatrist must review the person and make a determination as to their continuing treatment. This may involve making a new Community Treatment Order, continuing the person's admission as an involuntary inpatient, or discharging the person as an involuntary patient (either to the community, or to continue their treatment as a voluntary inpatient).

11.2 Police Custody, Prisons, and Youth Training Centres

Section 3 of 'the Act' states that a Community Treatment Order 'does not apply to a person who is in prison.' If a person on a Community Treatment Order is remanded or detained in custody, whether in police custody, prison, or a youth training centre, then the Community Treatment Order effectively goes into abeyance until the person's release.

It is the monitoring psychiatrist's responsibility to ensure that if a person goes into custody, relevant medical and nursing staff are contacted and provided with the information necessary for the further treatment of the person. If the person

is in police custody awaiting transfer to prison, then the forensic nursing service should be informed. If the person is detained in prison, the prison medical practitioner should be contacted.

The monitoring psychiatrist should make a judgement based on the available information as to whether to continue the Community Treatment Order (and resume responsibility for treatment on the person's release) or to discharge the person (for example if the period of custody is longer than the period of the Community Treatment Order). If the person will still be on a Community Treatment Order upon their release from prison, then prison mental health staff should ensure that they liaise closely with the monitoring psychiatrist as the date of release approaches in order to facilitate the person's continuing treatment.

11.3 When a Person on a Community Treatment Order Dies

The Coroner's Act 1985 requires that all 'reportable deaths' be reported to the coroner, and s. 106A of the Mental Health Act also requires that such deaths be reported to the Chief Psychiatrist.

A 'reportable death' is defined as (among other things) a death:

- That appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury;
- or
- Of a person who immediately before death was a person held in care.

A person on a Community Treatment Order is arguably a 'person held in care', and so all deaths should be reported both to the coroner and the Chief Psychiatrist. The notification to the Chief Psychiatrist should be on a *Notice of Death* (PSY25) form, and should be forwarded by the authorised psychiatrist. A copy of the report should be filed in the deceased person's medical record.²³

²² Services and practitioners should also refer to the Department's ECT Manual regarding practice guidelines for ECT.

²³ Further information is available in the Program Management Circular Reportable Deaths.

11.4 When a Person on a Community Treatment Order Cannot be Contacted for Review

Provisions for leave of absence (under ss. 40 and 41 of 'the Act') do not apply to people on Community Treatment Orders (pursuant to s. 14(3)(c)). Therefore, if a person on a Community Treatment Order is unable to be contacted, they cannot be placed on leave.

In such circumstances, the monitoring psychiatrist must make a clinical decision as to what action needs to be taken based on the available information. In many instances it will be appropriate to simply continue efforts to contact the person on the Community Treatment Order. If the person continues to be unable to be contacted, the monitoring psychiatrist must decide whether to revoke or discharge the Community Treatment Order. This decision is a clinical one, taking into account all factors and available information, and **must not** be made for administrative reasons.

11.5 Medical Treatment in Hospital

Section 3 of 'the Act' states that a Community Treatment Order 'does not apply to a person who is a patient in an approved mental health service'. As most major public hospitals are Gazetted (refer 2.3), a person on a Community Treatment Order admitted for medical treatment to a public hospital is therefore technically admitted to an approved mental health service. As the focus of treatment is medical and not psychiatric, however, the Community Treatment Order remains in effect and they may continue to receive psychiatric treatment as if they were in the community.

If, while admitted to the general hospital, the person becomes unsuitable for treatment on a Community Treatment Order, then the Community Treatment Order may be revoked and they will become 'patients' of the approved mental health service for the purposes of 'the Act'. This will **not require** them to be physically transferred to the psychiatric inpatient service; the person should be treated at the location

within the hospital most suitable to their medical and mental health needs.

If a person on a Community Treatment Order requires medical treatment for which they are incapable of giving informed consent, then the processes in s. 85 of 'the Act' should be followed.

11.6 Guardians (under the Guardianship & Administration Act 1986)

If a person is being considered for a Community Treatment Order and has a guardian appointed under the *Guardianship and Administration Act 1986*, or an agent under the *Medical Treatment Act 1988*, the ability to consent **of the person being considered for the Community Treatment Order** is relevant (required to be assessed for s. 14(1A)(d)), and not that of the guardian or agent. This is pursuant to s. 14(1B) of the Mental Health Act. Notwithstanding this, the authorised psychiatrist and treating clinicians should liaise closely with the guardian or agent regarding any proposed course of action and treatment, subject to the confidentiality provisions discussed in 4.3.1.

The authorised psychiatrist must ensure that the guardian is informed when a person is placed on a Community Treatment Order (pursuant to s. 12(6) of the Mental Health Act).

11.7 When a Person on a Community Treatment Order Leaves Victoria

The Mental Health Act is Victorian legislation, and does not apply in other States or Territories. If a person moves interstate they therefore move outside of the jurisdiction of 'the Act'. The interstate provisions of 'the Act' (Part 5A) await agreement between the States, and are not presently enacted.

If a person on a Community Treatment Order leaves the State, a clinical decision concerning the Community Treatment Order should be made along the same lines as when a person cannot be contacted for review (refer 11.4). It is not

appropriate to place the person on leave, but the Community Treatment Order may be continued, revoked or discharged depending on the circumstances.

A Community Treatment Order may not be used to attempt to prevent a person leaving the State.

11.8 Gazetted Psychogeriatric Nursing Homes

Psychogeriatric Nursing Homes (PGNHs) are governed by both the Victorian Mental Health Act, and the federal *Aged Care Act 1997*. Section 3 of the Mental Health Act states that a Community Treatment Order 'does not apply to a person who is ...a patient in an approved mental health service', therefore, if a person requires involuntary treatment in a Gazetted PGNH for the purposes of the treatment of their mental illness, then they should be admitted as a s. 12 patient.

11.9 Gazetted Community Care Units

As a Community Treatment Order 'does not apply to a person who is.'a patient in an approved mental health service', (pursuant to s. 3 of 'the Act'), a person may not be on a Community Treatment Order in those Community Care Units (CCUs) that are Gazetted as part of an approved mental health service. If a person requires admission as an involuntary patient to a gazetted CCU for the purposes of the treatment of their mental illness, therefore, then they should be admitted as a s. 12 patient.

Appendix 1: Chief Psychiatrist Guidelines

Patient Access to Files for Mental Health Review Board Hearings

Purpose

To provide information about section 26 of the Mental Health Act 1986, which allows patients to have access to documents for Mental Health Review Board (MHRB) hearings.

Background

For many years, it was required by the Mental Health Act that patients be given access to their clinical file and other relevant documents before a MHRB hearing.

This practice led to concerns by some clinical staff about the release of sensitive information contained in the file. In ordinary circumstances, access to clinical files is regulated by the Freedom of Information Act 1982.

The Mental Health Act was amended in 1996 to provide a statutory right of access to information prior to a MHRB hearing. This guideline explains the relevant provisions and addresses some practical issues.

Legislation

Under section 26(7) of the Mental Health Act, a patient or the patient's representative is entitled to inspect any documents to be given to the MHRB in connection with a hearing, at least 24 hours before the hearing.

Section 26(8) provides for the authorised psychiatrist to apply to the MHRB to prevent access by a patient to a document or part of any document if such access is likely to:

- Cause serious harm to the patient's health or the health or safety of another person; or
- Involve the unreasonable disclosure of information relating to the personal affairs of any person; or
- Breach a confidentiality provision imposed by a person who supplied the information contained in the documents.

The MHRB makes the final decision about whether the patient should see the documents. If the MHRB decides the patient should not see any document, it may allow the patient's representative to have access to the document.

Principles

The MHRB is required in all procedural matters to act according to the rules of natural justice or procedural fairness.

Mental health services should ensure that:

- Patients are informed about their right to have access to their file for MHRB hearings.
- Administrative procedures are simple and accessible and do not discourage patients from seeking access.
- Administrative decisions are open and accountable.
- Procedures are in place for resolving disputes.
- The response to all requests is timely.
- Staff are supportive and facilitate all requests.

Local Policy

Each approved mental health service should develop local policy and procedures governing access to documents for MHRB hearings which:

- Conform with the provisions of the Mental Health Act.
- Comply with the rules of natural justice.
- Incorporate the practice standards described in this guideline.

Procedures for Access

The patient is to be given the opportunity to inspect any documents, which are to be given to the MHRB in relation to a hearing.

Prior to authorising and facilitating patient access, the treating consultant psychiatrist (or another doctor under the supervision of the psychiatrist) should review the clinical file and other relevant documents to identify any information, which should not be released to the patient. This information could be temporarily removed from the file or a photocopy could be given to the patient with the exempted material deleted or covered. The rest of the file should be made available to the patient as soon as practicable. Access to the whole file should not be denied on the basis of one or two sensitive entries.

The patient must be allowed to inspect the relevant documents at least 24 hours before the hearing. Access should be provided in a quiet

and private area. If it is considered necessary, a member of staff may sit with the patient to assist and answer any questions. The presence of a staff member should be a positive experience and not intimidating or restrictive in any way.

If any documents have been withheld, pending an application to the MHRB to prevent access to the documents, the patient should be informed and the process explained.

The patient may wish to take notes or photocopy some pages. This should be facilitated.

The patient may also want to spend an extended period of time examining the file or may wish further access at a later time. Decisions about these requests should be made in the context of what is fair and reasonable in the circumstances. For example, where there is extensive documentation, it would be reasonable to allow the patient a longer period of time or a follow-up session. Local policy should establish clear guidelines for dealing with these matters and for resolving disputes if they arise.

Patient's Representative

The Mental Health Act also allows a person authorised by the patient to represent them to inspect all relevant documentation. This may be a friend or family member or it could be an advocate or legal representative. The principles regarding access and procedural fairness apply equally to a personal representative.

Application for Non-Disclosure

The authorised psychiatrist or the medical practitioner representing the authorised psychiatrist may make an application to the MHRB to prevent the patient having access to a document or part of a document.

The MHRB should be informed before the hearing that an application will be made. This can be done on the day of the hearing or earlier by contacting the MHRB's Executive Officer or Legal Officer. The MHRB can be contacted on (03) 8601 5270.

The MHRB will hear the non-disclosure application, which can be verbal or written, as a preliminary issue before the commencement of the hearing. The application should be presented in general terms and address the criteria in section 26(8) of the Mental Health Act. Specific details of the relevant documents are usually not required.

The non disclosure application will be heard and determined by the Board in the absence of the patient. If the patient has a representative, the MHRB may allow the representative to be present and to see the document. The MHRB will ask the representative to undertake to keep the information confidential and not pass it on to the patient if the MHRB makes an order for non-disclosure.

If the MHRB decides the patient should not see a document, it may decide that it too will not see the document. This follows from the rules of natural justice, which require that a determination of the MHRB should be based on information which is available to all parties. The MHRB will decide on a case by case basis whether it should see the document, having regard to the relevant circumstances.

Penalties

If a patient or their representative has not been given the opportunity to inspect all relevant documents before the hearing, the MHRB may need to adjourn the hearing to enable this to occur. If there is no good reason for the patient having been denied access, the MHRB may make an order for costs against the party responsible for the delay (section 131 of the Mental Health Act).

Self Assessment Tool

The following indicators are provided to assist services in the internal quality monitoring of practices, and form the basis for the Chief Psychiatrist's Clinical Review of mental health services.

Each service has local policy and procedures to facilitate timely and appropriate access to documents for MHRB hearings.

The clinical record contains documentation that the patient has been given the relevant Patient Rights Booklet 'Mental Health Review Board: How It Can Help You' , and informed of their right to access their file for MHRB hearings.

All clinicians are fully informed about a patient's right to access their documents for MHRB hearings, and to assist patients in exercising their right.

²⁶ This Practice Direction has been reproduced with the permission of the Mental Health Review Board of Victoria

Appendix 2: Mental Health Review Board

Practice Direction—98/2 Administrative Procedures of the Board²⁶

This Practice Direction replaces No.87/1

In accordance with the provisions of clause 4(1)(b) of Schedule 2 to the *Mental Health Act 1986* as amended ('the Act') the following Practice Direction is made for the assistance of authorised psychiatrists, staff at mental health services, patients appearing before the Board, their representatives and Board members.

1. Service of notices on patients

The Board's Executive Officer will send to each authorised psychiatrist Notices of Hearing for personal service upon each inpatient appearing before the Board. This will be sent by fax to the medical records administrator. The Notice should be served on the patient as soon as possible after it is received. These Notices will be accompanied by Statements of Service and Instructions for Service. The Statement of Service should be completed by the person who gave the Notice to the patient and should be presented to the Board on the day of the hearing.

If the patient cannot be served with the Notice because the patient has been discharged on a community treatment order, the mental health service must notify the Board immediately.

If the Board is aware that a patient is subject to a *Community Treatment Order* it will send the Notice of Hearing directly to the patient.

2. Interpreters and legal representatives

If an interpreter is required, the Board's Executive Officer should be notified as soon as possible.

If the authorised psychiatrist, or his/her representative, is advised that the patient will be legally represented at the hearing the Board's Executive Officer should be notified as soon as possible.

3. Written material placed before the board

3.1 The Board will require access to relevant materials from each patient's file that contains the following administrative documents. These will include the originals of:

- the Request for Admission (Schedule 1);
- the Recommendation for Admission (Schedule 2);
- the PSY1 form, if one was completed following an examination by the authorised psychiatrist, pursuant to section 12(2);
- any community treatment order and extension or revocation of such order.

3.2 The Board will require access to the patient's clinical file(s). This includes (where applicable) the most recent or current out-patient file.

3.3 The Board requires three copies of a "Report on Continued Detention", in the form of the annexure to this Practice Direction, prepared by the medical practitioner responsible for the treatment of each patient appearing before the Board.

4. Patient access to written materials placed before the board

The rules of procedural fairness require that each party must be given an opportunity to inspect the written materials that are placed before the Board. These procedural fairness requirements are also set out in section 26(7) of 'the Act' which provides that "the patient or a person representing the patient is entitled to inspect or otherwise have access to any documents to be given to the Board in connection with the hearing at least 24 hours before the commencement of the hearing".

The only exception is where the Board, following an application by the authorised psychiatrist or his/her representative, orders that the patient be denied access to any specified document, or part of a document, included in those documents. The grounds for such an order are set out in section 26(8) of 'the Act'.

If such an application is proposed, notice should be faxed to the Board's Executive Officer prior to the day of the hearing. The Board will determine this application on the day of the hearing in the absence of the patient. In the meantime the patient should be given access to the remaining parts of the file and should be told that the application for non-disclosure will be made.

5. Patient access to report on continued detention

The Report on Continued Detention should be given to the patient preferably one or more days prior to the hearing. Where there is any doubt about the patient's capacity to read and/or understand the Report, an attempt should be made to read and explain it to them. When such doubt exists, as a consequence of the patient's lack of understanding of the English language, an interpreter of the patient's language should be used.

If the patient is subject to a community treatment order and it is inadvisable for medical reasons that the Report should be read by the patient alone, arrangements should be made to read it to the patient in advance of the hearing.

6. Oral evidence to the board

The Board will require the attendance of a medical practitioner responsible for, or involved in, the treatment of each patient appearing before the Board. As the authorised psychiatrist is a party to each appeal or review coming before the Board, the medical practitioner attending will be viewed as the representative of the authorised psychiatrist. Whilst it is not necessary that the medical practitioner appearing before the Board be a qualified psychiatrist, the Board may, in some cases, feel it necessary to call for the attendance of the authorised psychiatrist or his/her delegate, or to adjourn so that the attendance of the authorised psychiatrist or his/her delegate may be arranged. If it is not possible for a medical practitioner responsible for, or involved in, the treatment of a patient to appear before the Board on the scheduled hearing date, the Board's Executive Officer should be notified as soon as possible.

The attendance of other persons such as case managers and nurses who have a knowledge of the patient can also assist the Board, and should be arranged where relevant.

7. Cancelled hearings

The authorised psychiatrist or his/her representative is requested to notify the Executive Officer of the Board by telephone when a hearing is to be adjourned or cancelled. If the reason is that the patient has not been notified of the hearing because they have been discharged from hospital on a *Community Treatment Order*, a copy of the *Community Treatment Order* should be faxed to the Board. If the reason is that the patient has ceased to be an involuntary patient, a note of the cessation of involuntary status should be made on the Notice of Hearing that was sent to the authorised psychiatrist or the patient. This note should be signed by, or on behalf of, the authorised psychiatrist, dated and returned to the Board. If an appeal is to be withdrawn, written confirmation should be obtained from the patient, and faxed to the Board.

8. Times of hearings

Although most hearings are originally listed for 10.00 a.m., any person attending the hearing should contact the medical records administrator to find out an approximate time for the hearing.

Julian Gardner (President)

10 March 1998

Appendix 3: Contact Details

The Mental Health Review Board of Victoria

Level 30, Marland House
570 Bourke Street
Melbourne 3000
Telephone: (03) 8601 5270
Facsimile: (03) 8601 5299
Toll free: 1800 242 703
Email: mhrb@mhrb.vic.gov.au
Internet address: <http://www.mhrb.vic.gov.au>

The Mental Health Legal Centre Inc

Level 4, 520 Collins Street
Melbourne 3000
Telephone: (03) 9629 4422
Facsimile: (03) 9614 0488
Email: mhlc@vicnet.net.au
Internet address: <http://www.vicnet.net.au/~mhlc>

Victoria Legal Aid

350 Queen Street
Melbourne 3000
Telephone: (03) 9269 0234
Facsimile: (03) 9269 0250
Toll free: 1800 677 402
Internet address: <http://www.legalaid.vic.gov.au>

Office of the Chief Psychiatrist

Level 11, 555 Collins Street
Melbourne 3000
Telephone: (03) 9616 7571
Facsimile: (03) 9616 7697
Internet address: <http://www.dhs.vic.gov.au/acmh/mh/index.htm>

Office of the Health Services Commissioner

Level 30, 570 Bourke St
Melbourne 3000
Telephone: (03) 8601 5200
Facsimile: (03) 8601 5219
Toll free: 1800 136 066
Email: hsc@dhs.vic.gov.au
Internet address: <http://www.dhs.vic.gov.au/hsc>

Office of the Public Advocate

5th Floor, 436 Lonsdale Street
Melbourne 3000
Telephone: (03) 9828 2957
Facsimile: (03) 9603 9500
Toll free: 1800 136 826
Internet address: <http://www.communityvisitors.vic.gov.au>

