

Treatment plans under the Mental Health Act

Chief Psychiatrist's Guideline

Key message

Every patient under the *Mental Health Act 1986* must have a treatment plan.

Purpose

To provide information about section 19A of the *Mental Health Act 1986*, that provides for treatment plans.

To provide area mental health services (AMHS) with a policy framework in which to prepare and implement treatment plans.

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Background and scope

The *Mental Health Act 1986* (the Act) provides a legislative framework for the care, treatment and protection of people with mental illness. Section 19A of the Act requires that every patient under the Act must have a treatment plan. The term 'patient' is used throughout this guideline for this reason and means involuntary, security and forensic patients under the Act.

Treatment plans apply across all program areas, including child and adolescent, adult, aged and specialist public mental health services.

While section 19A does not apply to people receiving mental health treatment on a voluntary basis, section 6A(j) of the Act envisages that all consumers will have a treatment plan that is regularly reviewed and revised as necessary.¹

Introduction and purpose

Feedback from patients and carers has consistently indicated that they would benefit from having more information and greater involvement in treatment planning decisions.²

Treatment planning should be a continuous process that involves the parties – treating team, patient and carers – in a collaborative exchange of ideas about the best ways to provide treatment for the individual patient. Treatment planning provides a framework within which to:

- engage the patient and carers
- conduct a constructive dialogue between the treating team, the patient, carers and other relevant service providers
- enable the patient to reflect upon their own health
- identify priority needs and potential risk factors
- discuss preferred treatment strategies and objectives, and to consider alternatives
- discuss the benefits and risks of preferred treatments, alternative treatments and no treatment.

¹ Standard 11.4.9 of the National standards for mental health services, 1996 also requires that every consumer have a current individual care plan.

² See *Consumer participation – an action plan for consumer involvement in Victoria's public mental health services*, February 2007 and *Caring together – an action plan for carer involvement in Victorian public mental health services*, August 2004.

At key points during treatment, a treatment plan will be prepared to document the settled treatment goals and strategies and to communicate this information to all those involved. The plan should incorporate realistic, measurable goals, accompanied by defined actions, responsibilities and timelines. The plan will be revised from time to time as the person's needs or circumstances change.

This guideline has been prepared to promote improved practice in the preparation, implementation, review and revision of treatment plans. Area mental health services (AMHS) are expected to develop local procedures and clinical guidelines for preparing treatment plans that address issues raised in these guidelines and reflect the broader policy and legislative requirements.

Planning for a treatment plan

The authorised psychiatrist is responsible under the Act for the treatment and care each patient receives. If a patient refuses to consent to necessary treatment or is unable to consent to treatment for mental illness, the authorised psychiatrist gives consent on their behalf.³

Under section 19A, the authorised psychiatrist is responsible for preparing, reviewing on a regular basis and revising as required the treatment plan for each patient.⁴ The plan should be authorised and signed by the authorised psychiatrist.

An initial treatment plan should be prepared as soon as practicable following an admission or the confirmation of an involuntary treatment order.

In practice, all members of the treating team will have a role in contributing to and implementing a treatment plan. The extent to which each clinician is involved will depend on the clinical setting and local practice. The clinician who has the greatest involvement with the patient, such as the case manager or psychiatric registrar and as delegated by the authorised psychiatrist, should take a lead role in coordinating the contributions of team members. AMHS should prepare guidelines to clarify clinical roles and responsibilities in this regard. Where other service providers will be partners in the plan, for example, general practitioners, private psychiatrists or psychiatric disability rehabilitation and support services (PDRSS), their role should be negotiated before formulating the plan.

There are six legislated matters to be taken into account to prepare, review and revise a treatment plan for a patient:⁵

1. The wishes of the patient, as far as they can be ascertained

The authorised psychiatrist must take into account the wishes of the patient. This requires ongoing dialogue between members of the treating team and the patient in which the person is given information about their illness, proposed methods of treatment and beneficial alternative treatments and the patient's views are elicited. Regular clinical review points should be used as prompts to discuss treatment with the patient. Summaries of these discussions and the outcomes must be documented in the patient's clinical record.

The extent to which this dialogue will occur will depend on the nature and severity of the person's illness, the level of disturbance and the person's willingness to participate in planning treatment. AMHS must ensure any special needs of the patient are considered at all stages of preparing a plan, for example it may be necessary to engage an interpreter to ensure adequate communication with a person who cannot speak English, or who has limited English speaking skills.⁶

Some patients make psychiatric advance directives (PADs), which outline the person's preferences concerning treatment (and other matters) that they would like to be taken into account in the event the person becomes unable to make their own decisions. These should be considered and honoured wherever possible in developing the treatment plan.

Regardless of a person's capacity or willingness to participate, they should still be given information about their treatment in a timely and sensitive way and to the greatest extent possible.

2. The wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient, unless the patient objects

Families and carers can play an important role in supporting people with mental illness. The role can often be difficult and the effect of the patient's

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

4 In situations where a program specific authorised psychiatrist, for example rural CAMHS, is not readily available to oversee the preparation, review or revision of treatment plan for a patient, an authorised psychiatrist within the AMHS must be nominated to undertake these functions.

5 See section 19A(2)(a)-(f).

6 See Use of language services in area mental health services, October 2006 and Cultural diversity plan for Victoria's specialist mental health services 2006-2010, October 2006.

illness on the family can be significant. Families and carers will often have views and preferences that they would like the treating team to take into account when developing a treatment plan. The role of families and carers in the treating relationship should therefore be raised with the patient as early as possible.⁷

The extent to which families and carers have their wishes taken into account will depend on the patient. Where family members or carers are to be involved in the treatment planning process, including dependent children, the treating team should consult with them on a regular basis. In addition, the treating team should ensure an assessment is made of the carer's needs, both to support the recovery of the patient and to maintain their own health and welfare, that these needs are taken into account, and that the assessment is updated at critical points.

The patient's clinical record should identify nominated carers and family members for the purposes of consultation and document their involvement in any decisions and discussions as appropriate.

If the patient refuses any involvement for family or carers, or only permits limited involvement, this subject should be periodically re-visited to see if the patient has changed their mind or to encourage greater involvement.

Regardless of whether their wishes are taken into account, families and carers who are involved in providing ongoing care or support to a patient will require information about mental illness, how to respond to disturbing behaviours, how to access practical assistance and general assistance in dealing with the illness.

Giving identified patient information to families and carers is governed by the confidentiality provisions of the Act in section 120A and is discussed below under the heading 'Confidentiality'.

3. **Whether the treatment to be carried out is only to promote and maintain the patient's health or well-being**
4. **Any beneficial alternative treatments available**
5. **The nature and degree of any significant risks associated with the treatment or any alternative treatment**

The requirements covered in points (3), (4) and (5) are matters of good clinical practice. It is expected that authorised psychiatrists will routinely take these matters into account when developing or reviewing a treatment plan. However, consideration should be given to how this decision-making should be documented for the purposes

of review by the Mental Health Review Board (see 'The Mental Health Review Board and treatment plans' later in this guideline).

6. Any prescribed matters

There are currently no prescribed matters.

Content of treatment plans

A treatment plan must outline the treatment the patient is to receive. It should include a brief, clear statement of the treatment objectives and strategies and be easily understandable by all involved, in particular the patient and any nominated carers.

It must be based on a current assessment of the patient's needs and any identified risk factors. Assessments should consider psychiatric symptoms and medical and physical needs. Risk factors, drug and alcohol, social, accommodation, family (including parenting) and personal issues should also be considered, although not all need to be commented on—the treatment plan should only reflect current priorities for the patient and the treating team.

There should be capacity to record the patient's own treatment goals, their views about the plan and any actions to deal with conflicts.

A treatment plan should specify what the AMHS will do to address each identified need, state who is responsible for each identified action and expected outcomes. The treatment objectives for each identified need must be realistic, focused on recovery and achievable within the expected timeframe of the plan.

Details that change regularly do not need to be listed, except in the broadest sense. For example, a patient might be required to attend a clinic on a fortnightly basis. However, the plan would not need to specify a regular day or time because these should be kept sufficiently flexible to accommodate the changing needs of both the patient and the clinicians. Similarly precise doses of medication for a patient in the acute phase of illness would not need to be specified given the necessity for frequent change during an acute admission episode. Rather the plan may specify that medication would be given as an essential part of the treatment in order to treat and stabilise the patient's condition.

The plan may contain anything else the authorised psychiatrist thinks appropriate. This would include relevant programmes offered by other service providers, such as drug and alcohol counselling or psychiatric disability rehabilitation and support services (PDRSS).

⁷ See *Caring together – An action plan for carer involvement in Victorian public mental health services*, August 2004, and the Chief Psychiatrist's guideline *Working together with families and carers*, April 2005 at www.health.vic.gov.au/mentalhealth.

Each patient must be given a copy of their treatment plan and the information discussed.

Acute inpatient treatment

The treatment plan for an acute inpatient will address the person's immediate needs and any identified risk factors. Given the dynamic nature of treatment and care in an inpatient setting, a plan will not specify many details (which may change rapidly), but should instead focus on treatment objectives and in broad terms how these will be achieved. The emphasis should be on the information the patient needs to know about their treatment to assist them in understanding the focus of treatment and what they might expect. Where appropriate, the plan will specify the discharge plan and follow-up care.

Community treatment orders and restricted community treatment orders

An initial treatment plan should be prepared at the same time that a community treatment order (CTO) or restricted community treatment order (RCTO) is first made. At this point the plan will be fairly simple and may only include sufficient information to enable the patient to engage in treatment with a community-based service. Later, the community treating team will develop a more comprehensive plan in collaboration with the patient and family or carers. It is envisaged that this might occur in tandem with development or revision of the individual service plan (ISP) or other recovery plan.

The treatment plan for a person subject to a CTO or RCTO should give clear guidance about the person's obligations under the order. This is necessary because the authorised psychiatrist can revoke a patient's CTO or RCTO if they do not comply with the order or their treatment plan. The plan should identify those parts of the plan that are compulsory or actions that could result in the order being revoked, for example, refusal to take prescribed medication.⁸

Where possible, the treating team may establish a role for family or carers in the treatment plan in collaboration with the patient and the nominated family members or carers. Where nominated family members or carers have an agreed role, this should be specified in the plan and they should be provided with a copy of the plan.

Similarly, other service providers who may be partners in the plan and the CTO or RCTO, for example, general practitioners, private psychiatrists or PDRSS, should be provided with a copy of the plan.

Relapse prevention and crisis plan

The plan should include the actions the client and any nominated carer should take in the event of a relapse or crisis. It should identify early warning signs, relapse indicators and any known triggers and list the actions the patient and family members or carers can take in response. It should also outline the likely service response to a crisis and include a 24-hour contact number to seek advice and help.

Legal requirements

Under section 19A(4), the treatment plan for a patient on a CTO or RCTO must also specify:

- the authorised psychiatrist who is to monitor the patient's treatment—the 'monitoring psychiatrist'
- the registered medical practitioner who is to supervise the patient's treatment—the 'supervising medical practitioner'
- the patient's case manager
- the place at which the patient is to receive treatment
- the times at which the patient is required to attend to receive treatment
- the intervals at which a progress report must be sent to the monitoring psychiatrist.

Implementing the plan

Under section 19A(6) of the Act, the authorised psychiatrist must ensure the patient is given a copy of the treatment plan (or the revised plan if changes have been made) and the information discussed. This should occur as soon as possible after the plan is completed. Where it is reasonably practicable, the authorised psychiatrist should personally discuss the plan with the patient, but this can be delegated to the person's case manager, their treating doctor or any other member of the treating team under section 19A(6) (b). An interpreter should be used as necessary to assist communication with patients from different cultural and linguistic backgrounds. These discussions should be recorded in the patient's clinical record.

This requirement of section 19A should not detract from the ongoing requirement for all members of the treating team, and in particular the case manager, to regularly discuss treatment issues and available services with the patient. The treatment plan is meant to augment not substitute for other discussions with patients regarding their treatment and needs.

⁸ Under section 14D(2) of the Act, the authorised psychiatrist may revoke a CTO if satisfied on reasonable grounds that the patient has not complied with the CTO or their treatment plan. Reasonable steps must have been taken, without success, to obtain compliance with the order and the plan. The authorised psychiatrist must also be satisfied that there is a significant risk of deterioration in the patient's mental or physical condition because of the non-compliance.

If nominated carers have an agreed role in the plan, they should be given a copy of the plan as soon as practicable. Similarly, where other service providers are partners in a treatment plan, they should also be provided with a copy of the plan as soon as practicable.

The treatment plan records the agreed treatment goals and strategies for a patient and should be a point of reference for all parties to the plan. In this regard, it should be readily accessible at any point of service contact by the patient.

Reviewing treatment plans

As discussed earlier, treatment planning is a continuous process that should involve the treating team and the patient and carers in an ongoing dialogue about meeting the treatment needs of the patient. As a result, treatment plans should be regularly reviewed and revised as required. The matters in section 19A(2)(a) – (f) (see ‘Planning for a treatment plan’ above) must be taken into account when reviewing and revising a plan, similar to preparing a plan.

The review of a treatment plan by the direct treating team, patient and nominated carers should be responsive to the changing needs of the patient. Within the legislative framework, the process should be as fluid and interactive as possible.

For patients in acute inpatient units, the treating team should review treatment plans as often as is clinically indicated. This may coincide with existing activities such as when the authorised psychiatrist reviews the progress of the patient, or as part of the regular team review.

For CTO or RCTO patients and those living in residential services, such as community care units, secured extended care services and aged persons residential mental health services, treating teams should consider reviewing treatment plans concurrently with other reviews, such as ‘outcome measurement’ for efficiency purposes.

The treatment plan form should be updated to record any revisions and a copy given to all the parties in a timely manner. The authorised psychiatrist should discuss the revisions with the patient, or ensure another delegated member of the treating team discusses the revisions.

Role of private practitioners

There will be occasions when a patient on a CTO or RCTO will have their order and treatment supervised by a general practitioner or private psychiatrist as the ‘supervising medical practitioner’. The authorised psychiatrist is still responsible to prepare, review and revise as required the treatment plan for the patient in accordance with the principles outlined above, but will do this in collaboration with the private practitioner.

The authorised psychiatrist will also negotiate the role of the private practitioner in providing treatment to the patient and reporting requirements.

Confidentiality

Section 120A of the Act governs the circumstances when information about patients may be disclosed. All clinicians should be familiar with the provisions of section 120A. Decisions about disclosure of information should be reviewed on a regular basis.

Families and carers

Where carers and families are involved in providing ongoing care and support to a patient, they will require information to provide that support and care. The amount of information provided in each individual case will depend on the extent the patient wishes their family or carers to be involved. The disclosure and exchange of information is complex. Clinical staff have a responsibility to explore issues about information sharing with each patient at the most appropriate and earliest possible stage.

Clinicians will generally seek the consent of the patient prior to disclosing information about treatment and care.⁹ Most patients will agree to the giving of information to carers and immediate family members if time is taken to discuss the reasons and benefits, although they may wish to place limits on the disclosure of some information, particularly private or sensitive information. These wishes should generally be respected.

Where consent is refused, section 120A(3)(ca) permits information to be disclosed to a guardian, family member or primary carer if the information is reasonably required for providing ongoing care and the person who receives the information will be involved in providing the care. Members of the treating team will need to make individual judgements about whether or not to release information under section 120A(3)(ca), how much information to release and for what purpose and to whom it should be released. Where family members and carers have an agreed role in the treatment plan, they should be given a copy of the plan.

Where family members and carers are affected by non-consent, their needs should be sensitively addressed. In all circumstances it is possible to give carers and family members general information about mental illness, its likely consequences and services and supports available to them and the person for whom they care. They should also be given an explanation of the confidentiality provisions of the Act.

⁹ See section 120A(3)(a) of the Act.

Other service providers

Expectations about sharing information should be discussed with other service providers at the earliest opportunity. The legal basis for sharing information should be established at the outset.

Sharing information with other service providers should be discussed with the patient. Most patients will agree to have information exchanged if they believe that it will help to promote coordinated treatment and services, although they may wish to place limits on the disclosure of some information, particularly sensitive information.

If the patient does not consent to the sharing of information, section 120A(3)(e)(i) permits disclosure of information where it is required for the further treatment of a person with a mental disorder. In these circumstances, only information that is necessary for the continuing treatment of the patient's mental illness should be disclosed under this exception. Where other service providers have an agreed role in the treatment plan, they should be given a copy of the plan.

The Mental Health Review Board and treatment plans

At the hearing of each appeal or review concerning a patient, the Mental Health Review Board must review the patient's treatment plan to determine whether the authorised psychiatrist has complied with section 19A in making, reviewing or revising the plan (as the case may be) and whether the plan is capable of being implemented by the approved mental health service.

This means that the Board must inquire into whether the authorised psychiatrist has followed the process outlined in section 19A in developing the plan. For example, did the authorised psychiatrist take into account the wishes of the patient and were beneficial alternative treatments considered? The Board's form Report on Involuntary Status for the Mental Health Review Board includes space to record compliance with these requirements. A copy of the patient's most recent treatment plan must be attached to the form. The authorised psychiatrist (or the medical practitioner representing the authorised psychiatrist at a hearing) should be prepared to answer any questions about the development and content of the treatment plan to attest to the process and capacity for the plan to be implemented.¹⁰

This function of the Board does not give it the power to direct what form a patient's treatment is to take, for example, whether one treatment should be preferred over another. The Board's role is to be satisfied that the correct process

in section 19A has been followed. The Board may order the authorised psychiatrist to revise a treatment plan, if the Board is satisfied that the authorised psychiatrist did not comply with section 19A in making, reviewing or revising the plan or that the plan is not capable of being implemented by the approved mental health service. Most commonly, the Board will order a revision where a patient has not been adequately consulted in the preparation of their treatment plan.

Relationship with other management plans

AMHS employ a range of management plans for patients, such as ISPs, care plans, management plans and treatment and recovery plans. Treatment plans are not meant to be a substitute for these plans. These plans often have a different development process, contain more detailed information and may take a longer period of time to develop than the treatment plans required under the Act. By contrast, treatment plans are expected to enable briefer, more active and regular communication about treatment and are, therefore, intended to complement the broader more long-term objectives of these other plans. Treatment plans will be a more general statement or outline of the priority treatment needs at a given point of time and for the period of the plan. By contrast an ISP or recovery plan would be expected to be more comprehensive in its coverage of all risk factors and psychosocial domains and the full range of strategies to address them over time.

AMHS should review the purpose, content and format of these other plans to ensure that they align with treatment plans and to avoid duplication of effort. This may involve integrating treatment plans with these plans and other review processes, such as outcome measurement.

Documentation and forms

The Chief Psychiatrist has developed a template of a treatment plan—Treatment Plan (MHA 4)—in consultation with service providers and other stakeholders (Appendix 1).

Templates for use with people receiving treatment on a voluntary basis and for young persons have also been developed (Appendices 2 and 3).

These templates are provided as examples only and AMHS are able to use them or may develop appropriate local forms that incorporate the required information. At a minimum, the format and content of a treatment plan must incorporate the legal requirements in section 19A, be clear and not open to misinterpretation, jargon and abbreviations should be avoided and any handwriting should be legible.

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

Acknowledgements

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Electronic templates

Generally, treatment plans created electronically are more legible than handwriting and are therefore easier to read and understand. They can also be more time effective because:

- they can be easily added to as the needs of the patient evolve
- different members of the treating team can easily insert their contribution to the plan
- it is not necessary to re-write the whole plan if only parts need a change
- they can be accessed at any point of service contact by the patient
- there is capacity to automatically prompt scheduled review dates.

AMHS that use electronic templates should ensure they are user-friendly and individualised. They should also ensure policies and procedures are developed to protect information stored in these electronic systems from inappropriate access and to ensure access is always in accordance with confidentiality requirements. Adequate IT infrastructure should be developed including training, resources and support for clinical and administrative staff.

Further information

Further information about treatment plans is available on the Department of Health's website at www.health.vic.gov.au/chiefpsychiatrist/treatment-plan or by contacting the Chief Psychiatrist on 9096 7571 or 1300 767 299 (toll free).

Information about the Mental Health Review Board and its requirements concerning treatment plans is available on the Board's website at www.mhrb.vic.gov.au.

An electronic copy of the Act can be viewed or downloaded from the legislation and parliamentary documents website at www.legislation.vic.gov.au.



Dr Ruth Vine
Chief Psychiatrist

<p>Mental Health Act 1986</p> <p>Section 19A</p>	<p>Local Hospital Patient Number: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: _____</p> <p>Alias: _____</p>								
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MHA 4

<p>copy Nominated carer/s should be given a copy of this <i>Treatment Plan</i>.</p>	<p><input type="checkbox"/> Plan discussed with carer</p> <p><input type="checkbox"/> Carer has received a copy</p>	<p>Signature</p>	<p>Date</p>
<p>Notes to completing this form</p> <p>The purpose of this plan is to give the consumer a plain statement of the treatment</p> <p>(Identify the priority needs and any risk factors to be addressed by this plan, that may include: mental health, education, friends/social relationships, family/carers, work/leisure, daily living skills, income, physical health, housing, ethnicity/language, other priorities)</p>	<p>TREATMENT PLAN (please print)</p>		
	<p>Diagnosis:</p>	<p>Current medication:</p>	
	<p>Agreed goal:</p>		
	<p>PRIORITY NEEDS</p> <p>Consumer:</p> <p>Nominated carer/s:</p> <p>Treating team:</p> <p>Other service providers:</p>	<p>ACTION AND EXPECTED OUTCOME</p> <p>(Specify what will be done to address each identified need, and the expected outcome)</p>	
<p>Priority needs:</p>	<p>Action and expected outcome:</p>	<p>Timeline and responsibility</p> <p>Specify the role of any general practitioner, private psychiatrist & other clinicians, who are partners in the plan. If nominated carer/s have an agreed role, it should be specified.</p>	
<p>Role of other clinicians</p> <p>Your responsibilities:</p> <p>X is expected to:</p> <p>Treating team's responsibilities:</p> <p>The treating team is expected to:</p>			
<p>Failure to Comply (CTO & RCTO patients only) Explain to the patient those parts of the plan that are compulsory, for which failure to comply may result in the CTO / RCTO being revoked.</p>	<p>Consumer responsibilities:</p> <p>To comply with your CTO/RCTO: (identify and explain compulsory requirements, for which failure to comply may result in revocation)</p>		
	<p>Consumer comments: (these can be thoughts or feelings about this plan)</p>		
	<p>Carer comments:</p>		

Mental Health Act 1986		Local Hospital
Section 19A		Patient Number: _____
		Family Name: _____
		Given Names: _____
		Date of Birth: _____ Sex: _____
		Alias: _____
Mental Health Statewide Patient Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MHA 4
Discharge planning Where appropriate, the plan will specify discharge planning and follow-up.	For discharge to occur:	

<p>Mental Health Act 1986</p> <p>Section 19A</p>	<p>Local Hospital Patient Number: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: _____</p> <p>Alias: _____</p>								
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MHA 4

YOUR CRISIS ACTION / RELAPSE PREVENTION PLAN	
Signs / Problem	Contact
For mental health issues Monday – Friday: For mental health issues out of hours:	
Green Light – Signs that I am well & strengths to build on	Things I need to do to stay well
Yellow Light – Signs that I am becoming unwell	Things I need to do to stay well
Red Light – Signs that I am unwell	Crisis Response / Actions to be taken
	Actions the patient and/or nominated carer/s (including children) should take in the event of a relapse or crisis:
EMERGENCY ARRANGEMENTS	
If I need to go to hospital, please notify:	(1) Name: _____ (2) Name: _____
When I am unwell I need help with: (please cross <input checked="" type="checkbox"/>)	<input type="checkbox"/> Dependents <input type="checkbox"/> Accommodation <input type="checkbox"/> Pension/Benefit <input type="checkbox"/> Pets <input type="checkbox"/> Employment – please notify:
I have the following specific needs: Examples are: children, dependents, interpreter, cultural diet, communication, physical disability, gender preference for clinician	

Appendix 2

<p>Mental Health Act 1986</p> <p>Section 19A</p>	<p>Local Hospital Patient Number: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: _____</p> <p>Alias: _____</p>								
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APPENDIX 2

TREATMENT PLAN	
<p>Notes to completing this form</p> <p>This treatment plan may be used for people who are receiving treatment or services from a mental health service on a voluntary basis. The purpose of this plan is to give the consumer a plain statement of the treatment they will receive from the mental health service. It must identify the consumer's immediate needs/presenting problems and the actions that will be taken to meet those needs. The expected outcomes must be realistic, focused on recovery and achievable within the expected life of the plan. Preparation of the plan provides a basis for discussion with the consumer and their nominated carer/s. In developing this plan, you must take into account the wishes of:</p> <ul style="list-style-type: none"> • the consumer, as far as they can be ascertained. • nominated carer/s who are involved in providing ongoing care or support to the consumer, unless the consumer objects. <p>The consumer must be given a copy of this <i>Treatment Plan</i> and the information explained.</p> <p>Authorisation Where a psychiatrist is not immediately available to sign the form, a designated senior clinician within the service may authorise the plan until such time as a psychiatrist is available.</p>	<p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of consumer</p> <p>.....</p> <p style="text-align: center;">address of consumer</p> <hr/> <p>TREATING TEAM</p> <p>(1) Psychiatrist:</p> <p>(2) Treating doctor:</p> <p>(3) Case manager / clinician:</p> <p>(4) Clinic / service where you will receive treatment from:</p> <p style="text-align: right;">..... telephone:</p> <hr/> <p>OTHER PARTIES TO THE PLAN</p> <p>(5) General practitioner: telephone:</p> <p>(6) Private psychiatrist: telephone:</p> <p>(7) Nominated carer/s: telephone:</p> <p>(8) Other: telephone:</p> <hr/> <p>REVIEW DATE</p> <p>(9) This plan is due for review on: / /</p> <hr/> <p>Prepared by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of clinician completing form</p> <p>Signed: Designation: Date: / /</p> <hr/> <p>Authorised by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of * delegated/ authorised psychiatrist / senior clinician</p> <p>Signed: Date: / /</p> <hr/> <p>* delete as necessary</p>

Appendix 3

<p>Mental Health Act 1986</p> <p>Section 19A</p> <p>Mental Health Statewide Patient Number <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/></p>	<p>Local Hospital Patient Number: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: _____</p> <p>Alias: _____</p>
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APPENDIX 3

ASSESSMENT & TREATMENT PLAN

<p>Notes to completing this form</p> <p>This plan may be used by CAMHS services for young people who are receiving services.</p> <p>The purpose of this plan is to give the young person and their responsible parent/guardian a plain statement of the services they will receive from the CAMHS service.</p> <p>It must identify the young person's immediate needs/presenting problems and the actions that will be taken to meet those needs.</p> <p>The expected outcomes must be realistic, focused on recovery and achievable within the expected life of the plan.</p> <p>Preparation of the plan provides a basis for discussion with the young person and their parent/guardian. In developing this plan, you must take into account the wishes of:</p> <ul style="list-style-type: none"> • the young person, as far as they can be ascertained. • the responsible parent/guardian. <p>The young person and the parent/guardian should be given a copy of this <i>Assessment & Treatment Plan</i> and the information explained.</p> <p>Authorisation</p> <p>Where a psychiatrist is not immediately available to sign the form, a designated senior clinician within the service may authorise the plan until such time as a psychiatrist is available.</p>	<p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of consumer</p> <p>.....</p> <p style="text-align: center;">address of consumer</p> <hr/> <p>TREATING TEAM</p> <p>(1) Psychiatrist:</p> <p>(2) Treating doctor:</p> <p>(3) Case manager / clinician:</p> <p>(4) Clinic / service where you will receive services / treatment from:</p> <p style="text-align: center;">.....</p> <p style="text-align: right;">..... telephone:</p> <hr/> <p>OTHER PARTIES TO THE PLAN</p> <p>(5) General practitioner/paediatrician: telephone:</p> <p>(6) Private practitioner: telephone:</p> <p>(7) Parent/guardian: telephone:</p> <p>(8) Other: telephone:</p> <hr/> <p>REVIEW DATE</p> <p>(9) This plan is due for review on: / /</p> <hr/> <p>Prepared by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of clinician completing form</p> <p>Signed: Designation: Date: / /</p> <hr/> <p>Authorised by:</p> <p>.....</p> <p style="text-align: center;">GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of * delegated/ authorised psychiatrist / senior clinician</p> <p>Signed: Designation: Date: / /</p> <p>* delete as necessary</p>
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