

# Community treatment orders

Chief Psychiatrist's Guideline  
November 2005

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Chief Psychiatrist  
Mental Health Branch  
Victorian Government  
Department of Human Services

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## Foreword

The past decade has seen a shift from institutional treatment and care of involuntary patients to a primary focus on community-based treatment. The amendments to the *Mental Health Act 1986* (Vic) which commenced on 6 December 2004 reflect this shift. The underlying structure of the Act, which was based on a model of detention, has been replaced by a focus on whether a person should be an involuntary patient for the purpose of providing treatment. The new 'involuntary treatment order' provides clear pathways by which a person requiring involuntary treatment is either made subject to a community treatment order and allowed to receive treatment in the community or is taken to an approved mental health service and detained for treatment.

These changes and other new legislative provisions, such as the requirement to prepare treatment plans, affect clinical practice in relation to persons on community treatment orders. The Department of Human Services has updated the *Community treatment order guidelines* to incorporate these changes. I hope that this updated guide assists clinicians to understand the legislative requirements and establish best clinical practice standards.

A handwritten signature in black ink, reading 'Amgad Tanaghow'. The signature is fluid and cursive, with a long horizontal flourish extending to the right.

**Associate Professor Amgad Tanaghow**  
**Chief Psychiatrist**

14 November 2005

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## 1 Introduction

### 1.1 Community treatment orders

Community treatment orders 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 who are subject to an involuntary treatment order. 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 possible restrictive environment, in the least possible intrusive manner 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

These 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.

These 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 does not reflect any changes made to the law after 3 August 2005.

## 2 Explanation of terms

The following terms used in these guidelines are discussed below:

- approved mental health service
- authorised psychiatrist
- involuntary treatment order
- mental health practitioner
- patient
- supervising medical practitioner
- treatment plan.

### 2.1 Approved mental health service

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 or is subject to an emergency declaration by the Secretary to the Department of Human Services pursuant to s. 94A. The proclamation or declaration is subsequently published in the *Victorian Government Gazette* (hence the term ‘gazetted’ services).

Any premises (including part of any building or place) at which treatment is to be provided to patients under the Act, or any service through which treatment is to be provided, may be proclaimed. In practice both situations occur. In some instances the entire campus of a public hospital that has an acute psychiatric inpatient unit is proclaimed. Any inpatient services subsequently developed at other sites (although being part of the same area mental health service) must be proclaimed in their own right. In other instances, an entire hospital group or network 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 a designated approved mental health service. The name of the relevant approved mental health service is specified on the *Community treatment order* (MHA 6) form. The specific site where the person is to receive their primary treatment (for example, the community clinic) must be included in the person’s treatment plan. 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.

## 2.2 Authorised psychiatrist

### 2.2.1 Definition

Each approved mental health service has a psychiatrist specifically appointed under s. 96 of the Act as the authorised psychiatrist for that service.<sup>1</sup> The authorised psychiatrist has specific powers, duties and functions under the Act, and is able to delegate all of these functions (with the exception of the power of delegation and the duty to provide the Forensic Leave Panel with the documents listed in s. 96(4) of the Act) to any other psychiatrist employed by the approved mental health service. These delegates then act with all the powers of the authorised psychiatrist.

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

### 2.2.2 Monitoring psychiatrist

Section 19A(4)(b) of the Act requires that an authorised psychiatrist be appointed to monitor the treatment of a person on a community treatment order. This monitoring 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 person’s treatment plan must include the name of the monitoring psychiatrist.

The monitoring psychiatrist may also be appointed to take on the role of the supervising medical practitioner (refer chapter 2.6) for the purposes of the administration of a community treatment order, or another medical practitioner may perform this function.

In these guidelines, the term ‘monitoring psychiatrist’ will be used to refer to the authorised psychiatrist monitoring the community treatment order.

### 2.2.3 Powers in relation to community treatment orders

Only an authorised psychiatrist may make or extend a community treatment order, although the Mental Health Review Board may order the authorised psychiatrist to make a community treatment order under s. 36(4). 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.

## 2.3 Involuntary treatment order

An involuntary treatment order is a legal document and is the basis for involuntary treatment while a person remains an involuntary patient. When an involuntary treatment order is made, the person becomes an involuntary patient of the relevant approved mental health service.

The order also establishes the point in time when the 24-hour clock commences for the examination by the authorised psychiatrist under s. 12AC.

If a person subject to a request and recommendation has been taken to an approved mental health service (or the person has been recommended while in the approved mental health service), the involuntary treatment order must be completed by a medical practitioner employed by the approved mental health service or a mental health practitioner (refer chapter 2.4) (s. 12AA).

A person subject to a request and recommendation can be assessed in the community by a medical practitioner employed by an approved mental health service or a mental health practitioner.

The practitioner can make an involuntary treatment order without the person being taken to an approved mental health service (refer chapter 5.1.2) (s. 12).

<sup>1</sup> Further information is provided in the Chief Psychiatrist’s guideline, *Appointment of authorised psychiatrist* (Department of Human Services, September 2005). The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

## 2.4 Mental health practitioner

A ‘mental health practitioner’ is a member of the following categories of health professionals employed by a public sector mental health service within the meaning of s. 120A of the Act that is an approved mental health service or a community mental health service, who are engaged in the provision of acute psychiatric assessment and treatment functions in the community:

- registered nurses
- registered psychologists
- social workers
- occupational therapists.

The definition of a mental health practitioner is contained in regulation 5(5) of the Mental Health Regulations 1998.

## 2.5 Patient

The Act establishes a regime for the treatment, care and protection of patients (involuntary, security and forensic) under the Act. The term ‘patient’ is used at times in this guideline for this reason.

These guidelines relate to involuntary patients who are subject to an involuntary treatment order.

## 2.6 Supervising medical practitioner

### 2.6.1 Definition

The supervising medical practitioner in relation to community treatment orders is the 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 treatment of the person subject to the community treatment order. The supervising medical practitioner may be any registered medical practitioner in public or private practice, and does not need to be either a psychiatrist or a psychiatric registrar.

The monitoring psychiatrist may also take on the role of the supervising medical practitioner.

In these guidelines, the term ‘supervising medical practitioner’ will be used to refer to the registered medical practitioner who will supervise the patient’s treatment on the community treatment order.

### 2.6.2 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.

The supervising medical practitioner is responsible for ensuring treatment is provided to the person in accordance with the treatment plan, and for advising the monitoring psychiatrist if the treatment plan requires revision.

Section 14A requires the supervising medical practitioner to assess the person subject to the community treatment order at regular intervals. If the supervising medical practitioner does not consider that the criteria for involuntary treatment apply to the person, or the treatment required can still be obtained under a community treatment order, they must notify the monitoring psychiatrist as soon as practicable.

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.

## 2.7 Treatment plans

Every patient under the Act must have a treatment plan (s. 19A). The purpose of treatment plans is to provide a brief clear statement about the treatment and services to be provided to a patient, to establish mutual expectations and in doing so, improve communication between treating teams and patients. Chapter 6 of these guidelines contains information about the content of treatment plans and how they should be prepared and reviewed.<sup>2</sup>

<sup>2</sup> Further information is provided in the draft Chief Psychiatrist’s guideline, *Treatment plans under the Mental Health Act 1986* (Department of Human Services, October 2004). The guideline is available at <[www.health.vic.gov.au/mentalhealth/mh-act/treatment-plan.htm](http://www.health.vic.gov.au/mentalhealth/mh-act/treatment-plan.htm)>.

## 3 Criteria for a community treatment order

### 3.1 Circumstances in which a community treatment order should be considered

Community treatment orders are provided for in ss. 14–14E of the Act, and are intended to offer a less restrictive setting for the treatment of people subject to involuntary treatment orders who would otherwise be inpatients.

All of the s. 8(1) criteria must apply to a person and the person must be suitable for treatment in the community to be considered for a community treatment order.

There are two occasions when a community treatment order should be considered:

- **when the authorised psychiatrist is performing the ‘within 24-hour’ examination of a person to decide whether to confirm the involuntary treatment order or discharge the person from the order.** The effect of s. 12AC(5) of the Act is that if the authorised psychiatrist decides to confirm an involuntary treatment order, the authorised psychiatrist must make a community treatment order unless he or she is satisfied that the treatment the person requires cannot be obtained through the making of a community treatment order. The person may be an inpatient or in the community when the examination takes place.
- **as an alternative to continued involuntary inpatient treatment.** A community treatment order can be made instead of continuing to treat a person as an involuntary inpatient. In this way, treatment is provided in a less restrictive community setting.

### 3.2 Criteria for making a community treatment order

A person subject to an involuntary treatment order may be placed on a community treatment order if:

- all of the legislative criteria in s. 8(1) of the Act apply to the person
- and
- the treatment required for the person can be obtained through the making of a community treatment order (s. 14(1)).

#### 3.2.1 Section 8(1) criteria

The s. 8(1) criteria are as follows:

- (a) the person appears to be mentally ill
- and
- (b) the person’s mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order
- and
- (c) because of the person’s mental illness, involuntary treatment of the person is necessary 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
- and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness
- and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

These criteria are discussed below with brief supplementary remarks. These remarks have been extracted from decisions of the Mental Health Review Board and may assist in interpreting the criteria. They should not be taken as an official or complete interpretation of the law, and the published decisions of the board should be referred to for further

clarification of the criteria.<sup>3</sup> 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.<sup>4</sup>

(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 pathological.<sup>5</sup>
- The person is not to be considered to be mentally ill only because they satisfy one or more of the exclusionary criteria listed in s. 8(2), which include that the person expresses or refuses to express particular political or religious beliefs or sexual preferences or that the person has an antisocial personality.<sup>6</sup>

(b) **The person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order.**

- 'Requires immediate treatment' in this context means the introduction or extension of an ongoing treatment regime.<sup>7</sup> 'Treatment' is defined in the Act to mean, 'things done in the course of the exercise of professional skills to: (a) remedy the mental disorder; or (b) lessen its ill effects or the pain and suffering which it causes' (s. 3).

- 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 cause.<sup>8</sup>
- 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.
- Potential benefits of the treatment need to be weighed against the person's views concerning involuntary treatment (particularly in relation to medication).<sup>9</sup>
- (c) **Because of the person's mental illness, involuntary treatment of the person is necessary 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 involuntary treatment 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 term.<sup>10</sup>

3 Mental Health Review Board of Victoria, *Decisions of the Mental Health Review Board of Victoria*, Volume 1, 1987–1991 (Melbourne 1992) and Volume 2, 1991–1997 (Melbourne 1998). Although these decisions pre-date the amendments to the Act which commenced on 6 December 2004, it is not expected that the amendments will significantly change the factors the Board considers in interpreting the criteria.

4 Recent decisions are available on the Mental Health Review Board's web site at <[www.mhrb.vic.gov.au](http://www.mhrb.vic.gov.au)>.

5 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.

6 See s. 8(2) of the Act for the complete list of exclusionary criteria.

7 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.

8 In the review of RD (1997) 2 MHRBD (Vic) 425–432.

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

10 In the appeal of HL (1997) 2 MHRBD (Vic) 485–500.

- 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 time.<sup>11</sup>
- 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'.<sup>12</sup>
- '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 people.<sup>13</sup>

(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 consent.<sup>14</sup>
- A person does not have to have total insight into the nature of their illness in order to be able to provide consent.<sup>15</sup>

(e) **The person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.**

- The compulsion and obligation that involuntary treatment 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 appropriate.<sup>16</sup>
- 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 treatment.<sup>17</sup>

All of the criteria listed in s. 8(1) need to be met before a person can be placed on an involuntary treatment order and a community treatment order.

### 3.2.2 Treatment can be obtained by making a community treatment order

In addition to being satisfied that the s. 8(1) criteria apply to the person, the authorised psychiatrist needs to be satisfied that the treatment required for the person can be obtained through the making of a community treatment order (s. 14(1)). Section 14(1) should be read in conjunction with s. 12AC(5), which reflects the principle underlying the Act that the least restrictive option for treatment of a person is to be preferred. Section 12AC(5) provides that the authorised psychiatrist may confirm an involuntary treatment order without making a community treatment order only if the authorised psychiatrist is satisfied that the treatment required for the person cannot be obtained through the making of a community treatment order.<sup>18</sup>

11 In the review of MF (1993) 2 MHRBD (Vic) 81–86.

12 In the appeal of HL (1997) 2 MHRBD (Vic) 485–500.

13 In the review of MW (1987) 1 MHRBD (Vic) 14–21.

14 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.

15 In the review of MF (1993) 2 MHRBD (Vic) 81–86.

16 In the appeal of RH (1991) 1 MHRBD (Vic) 363–368.

17 In the review of LR (1995) 2 MHRBD (Vic) 214–218.

18 See also the explanatory memorandum to the *Mental Health (Amendment) Act 2003* (which inserted the new s. 14(1) into the Act), clause 12.

## 4 Before making a community treatment order

### 4.1 Ensuring the least possible restrictive option

The Act requires 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 (s. 4(2)(a)). The Act also requires that a community treatment order be made for a person when their involuntary treatment order is confirmed, unless the treatment required for the person cannot be obtained by making a community treatment order (s. 12AC(5)).

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 the order with the person. The authorised psychiatrist must also discuss the proposed treatment plan with the person or ensure that the plan is discussed with the person by a registered medical practitioner (such as the proposed supervising medical practitioner) or the person's case manager.

As required by s. 19A of the Act, the authorised psychiatrist must take into account the wishes of the patient as far as they can be ascertained in relation to the treatment plan. This would include consideration of the person's 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 patients' rights booklet, *Involuntary patients*, containing information about community treatment orders, that they are given an explanation of this information in a form and language most likely to be understood, and that any questions the person may have are answered.<sup>19</sup>

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

<sup>19</sup> Copies of the booklet can be viewed, downloaded or ordered at <[www.health.vic.gov.au/mentalhealth/patientrights/index.htm](http://www.health.vic.gov.au/mentalhealth/patientrights/index.htm)>.

### 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. The Act requires that the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to a patient are taken into account in developing a treatment plan, unless the patient objects (s. 19A(2)(b)). Better outcomes are usually achieved when an ongoing dialogue occurs between family, carers and treating staff.

#### 4.3.1 Confidentiality and families and carers

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 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. 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.<sup>20</sup>

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)).

<sup>20</sup> Further information is provided in the Chief Psychiatrist's guideline, *Working together with families and carers* (Department of Human Services, April 2005). The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

## 4.4 Negotiation with clinical staff

The authorised psychiatrist considering making a community treatment order should ensure that the proposed treatment plan 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 and treatment plan.

### 4.4.1 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 and the treatment plan. The monitoring psychiatrist should ensure they are well informed of the details of the community treatment order and treatment plan prior to accepting this role.

### 4.4.2 Supervising medical practitioner

The supervising medical practitioner should be contacted prior to a community treatment order and a treatment plan being made, to confirm their willingness to take on this role and to ensure a smooth transition of care and a coordinated 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 supervising medical practitioner will be able to adjust treatment without a formal review of the treatment plan

- factors that may warrant a review of the need for a community treatment order or a review of the treatment plan, and the requirement that the person be discharged as soon as they no longer fulfil the s. 8 criteria
- clinical features that 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 as set out in the treatment plan
- means by which they can contact the monitoring psychiatrist
- other matters which the authorised psychiatrist may have included in the treatment plan.

### 4.4.3 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 and the proposed treatment plan.

### 4.4.4 Confidentiality and other service providers

In relation to discussions with other services and practitioners (including the staff of residential facilities), it is desirable that consent be obtained prior to making referrals and sharing 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 who will be involved in providing that treatment.

## 5 Making a community treatment order

### 5.1 Procedure

#### 5.1.1 Following an inpatient admission

A person who is subject to an involuntary treatment order and detained in an approved mental health service may be placed on a community treatment order if the s. 8 criteria apply to the person and the treatment required for the person can be obtained through the making of a community treatment order. This might occur:

- when the authorised psychiatrist is performing the 24-hour examination for a person made subject to an involuntary treatment order. If the authorised psychiatrist confirms the person's involuntary treatment order, he or she might decide to make a community treatment order instead of detaining the person

or

- as an alternative to continuing to detain a person as an involuntary inpatient.

A *Community treatment order* (MHA 6) form should be completed. Note that a *Discharge of a patient* (MHA 16) form should not be completed, because the person is not being discharged from involuntary status; the person is still subject to an involuntary treatment order.

A revised treatment plan will need to be prepared for the person when the community treatment order is made. As a minimum, the revised treatment plan should contain the matters specified in s. 19A of the Act (refer chapter 6.2), and sufficient information to enable the person to engage with the relevant community mental health service and to comply with the community treatment order. The treatment plan will need to be further developed by the community treating team after the handover has taken place.

As outlined above, preparing the revised treatment plan will require discussion with the person, family and carers and clinical staff. In addition, a verbal handover should be given by the inpatient service to relevant staff who will be providing treatment in the community. This should be done before or soon after the person leaves the inpatient setting so that

the community clinicians have the relevant clinical information at hand when assuming (or resuming) care of the person on the community treatment order.

Copies of the discharge summary, community treatment order and treatment plan 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 *Request* (Schedule 1), *Recommendation* (Schedule 2), *Examination of involuntary patient by authorised psychiatrist* (MHA 1) and *Community treatment order* (MHA 6) forms should be retained at the approved mental health service (unless treatment and case management of the person is to be transferred to another approved mental health service (refer chapter 9.2)).

#### 5.1.2 Without an inpatient admission

A person can be placed on a community treatment order without being detained in an approved mental health service.

Following a request and recommendation, a registered medical practitioner employed by an approved mental health service or a mental health practitioner can assess the person in the community (s. 12). Having regard to the criteria in s. 8(1), the practitioner can make an involuntary treatment order without the person being taken to an approved mental health service (s. 12(2)(b)). A practitioner should make an involuntary treatment order in the community if they believe a community treatment order would be appropriate for the person.

The authorised psychiatrist must then examine the person in accordance with s. 12AC in the community and may confirm the involuntary treatment order and make a community treatment order for the person. These steps can occur in any community setting, including the person's home or in a community mental health service.

A treatment plan will need to be prepared for the person when the community treatment order is made.

In practice, a person being placed on a 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 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.

If the medical practitioner or mental health practitioner believes that the person requires inpatient treatment, or if they have insufficient knowledge of the person and their circumstances to form a view about whether the person could be treated on a community treatment order, the practitioner should take the person, or arrange for the person to be taken, to an approved mental health service.

### 5.1.3 Documents and procedures

The procedures and documentation required to commence involuntary treatment and to place a person on a community treatment order are:

- A *Request* (Schedule 1) for a person to receive involuntary treatment from an approved mental health service 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), but not the doctor making the recommendation.
- A *Recommendation* (Schedule 2) for a person to receive involuntary treatment from an approved mental health service must be made pursuant to s. 9(1)(b) of the Act. A registered medical practitioner makes a recommendation. The registered medical practitioner must examine the person and must be satisfied that all the criteria in s. 8(1) apply to 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.

- A request and recommendation are sufficient authority to:
  - take the person to an approved mental health service (s. 9(5)(b))
  - or
  - arrange for a registered medical practitioner employed by an approved mental health service or a mental health practitioner to assess the person (s. 9(5)(a)). The practitioner can either:
    - make an involuntary treatment order<sup>21</sup> for the person (s. 12(2)(b))
    - or
    - take the person or arrange for the person to be taken to an approved mental health service (s.12(2)(a)).
- The authorised psychiatrist must examine the person within 24 hours of the involuntary treatment order being made.
- The examination by the authorised psychiatrist may occur in any location, including a person's home, a general practitioner's surgery or a community mental health service. An *Examination of involuntary patient by authorised psychiatrist* (MHA 1) form must be completed.
- If the authorised psychiatrist is satisfied that the s. 8(1) criteria apply to the person and a community treatment order is appropriate, the authorised psychiatrist may confirm the involuntary treatment order and complete a *Community treatment order* (MHA 6). The authorised psychiatrist can confirm the involuntary treatment order without making a community treatment order only if the authorised psychiatrist is satisfied that the treatment required for the person cannot be obtained through a community treatment order (s. 12AC(5)).

<sup>21</sup> If the practitioner considers that the s. 8(1) criteria apply to the person and the person could be treated on a community treatment order, the practitioner should make an *Involuntary treatment order* (Schedule 6) for the person. The practitioner should then arrange for an authorised psychiatrist to examine the person in accordance with s. 12AC.

- The authorised psychiatrist must inform the person that the community treatment order has been made, give the person a copy of the order, and inform the person of the grounds on which the order is made (s. 14(4)).
- A copy of the community treatment order must be placed in the person's clinical record. Copies should be made and sent to the monitoring psychiatrist and the supervising medical practitioner as required. The original order should be filed in accordance with local protocols.

In summary, the required paperwork is:

- a *Request* (Schedule 1) and a *Recommendation* (Schedule 2)
- an *Involuntary treatment order* (Schedule 6)
- an *Examination of involuntary patient by authorised psychiatrist* (MHA 1)
- a *Community treatment order* (MHA 6).

An initial treatment plan should be prepared at the same time that a community treatment order is first made. In most cases, the community treating team will develop a more comprehensive plan in collaboration with the patient and family or carers (refer chapter 6).

## 5.2 Minimum duration

Section 14(3)(a) 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 (s. 14B).

## 5.3 Residence condition

Section 14(3)(b) 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 the person's mental illness. A residence 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).

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 a community treatment order, then he or she 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 clinical record the:
  - reasons for the residence condition
  - services provided at the place of residence that constitute a necessary part of the person's treatment
  - intervals at which the residence 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* (MHA 6) 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 vary the community treatment order to remove the condition without affecting the other requirements of the community treatment order. This allows 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 vary a community treatment order to remove a residence condition at a review or appeal hearing (s. 36C(3)(a)).

## 5.4 Making a community treatment order following an 'out of area' admission

From time to time, people will be admitted as an involuntary inpatient to an approved mental health service that is not their usual service. This is sometimes known as an 'out of area' admission.

Following the admission, the authorised psychiatrist might decide to make a community treatment order for the person and transfer the person's treatment and case management back to their service of origin. In these circumstances, the authorised psychiatrist will make the community treatment order (refer chapter 5.1) and prepare a treatment plan (refer chapter 6.2). The authorised psychiatrist should then arrange the transfer of the patient in accordance with s. 39 of the Act (refer chapter 9.2).

Following the transfer, the receiving authorised psychiatrist should vary the community treatment order to amend the name of the approved mental health service (refer chapter 9.2) and revise the treatment plan to change the details of the treating clinicians and the place and times the person is required to attend to receive treatment (refer chapter 6.2).

In summary, the required documents to make a community treatment order and transfer a patient are:

### Sending authorised psychiatrist

- a *Community treatment order* (MHA 6)
- a *Treatment plan* (MHA 4)
- a *Transfer of an involuntary patient to another approved mental health service* (MHA 19)

### Receiving authorised psychiatrist

- a *Variation of a community treatment order* (MHA 8)
- a *Treatment plan* (MHA 4).

## 6 Treatment

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. Treatment should be based on a treatment plan which is developed for the person and which is reviewed regularly and revised as necessary.

### 6.1 Treatment

#### 6.1.1 Definition 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 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).

#### 6.1.2 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 general practitioner's surgery, or 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, the community treatment order should be revoked and the person must be admitted to an inpatient unit. This allows the opportunity for reconsideration of the person's clinical state, treatment needs and treatment regime.

Exceptions to this are where services have clinical staff employed 24 hours, such as community care units, psychogeriatric nursing homes and secure extended care units (but excluding psychiatric disability rehabilitation and support services). 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 on the person and other residents, 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.

#### 6.1.3 Treatment in an inpatient setting

The definition of a community treatment order in s. 14(2) of the Act is: 'a community treatment order is an order requiring the person to obtain treatment for their mental illness while not detained in an approved mental health service'. This means that if a person is required to obtain treatment that can only be provided in an inpatient setting, such as electroconvulsive therapy as a day procedure, their community treatment order does not need to be revoked. This will only apply if the person attends for the treatment and does not need to be forcibly taken to the approved mental health service or detained for

the treatment to be given. If the person does need to be forcibly taken to the approved mental health service or is detained at the service for the treatment to be given, then the community treatment order should be revoked (refer chapter 8).

This provision should only be used to permit admissions for periods up to 24 hours, although this could include an overnight admission (for example, to observe the fasting requirements necessary for the general anaesthetic given with electroconvulsive therapy). If a longer period of admission is necessary, even where the patient agrees to the admission, it is expected that the community treatment should be revoked. This is necessary because, in these circumstances, the treatment the person requires cannot be obtained subject to a community treatment order in the community.

Note that the issues concerning admission of a person on a community treatment order to a private psychiatric hospital are different. These are discussed in more detail in chapter 13.2.

### **Electroconvulsive therapy**

Electroconvulsive therapy is a psychiatric treatment that may be administered as a same-day procedure. As described above, a person on a community treatment order can receive electroconvulsive therapy as a day procedure without their order being revoked. Although commonly referred to as outpatient electroconvulsive therapy, a person receiving electroconvulsive therapy while residing in the community on a community treatment order must be admitted as a same-day inpatient for this procedure.<sup>22</sup>

### **Medical treatment in hospital**

As most major public hospitals are currently gazetted as approved mental health services (refer chapter 2.1), a person on a community treatment order admitted for medical treatment to a gazetted public hospital is therefore technically admitted to an approved mental health service. As described above, the person's community treatment order does not need to be revoked, provided the person is not detained in the hospital in order to receive the medical treatment. The person may continue to receive their psychiatric treatment during this period as though they were in the community.

The 24-hour time limit described above does not apply to a person receiving medical treatment in a gazetted public hospital. The period of a medical admission will be determined by the person's medical needs. However, if the person becomes unsuitable for treatment on a community treatment order, the community treatment order may be revoked (s. 14D). For example, if the person is refusing concurrent psychiatric treatment and the other requirements in s. 14D are met, the community treatment order will need to be revoked. This will not necessarily require the person to be physically transferred to the psychiatric inpatient unit; 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 (non-psychiatric treatment) for which they are incapable of giving informed consent, then the processes for obtaining substitute consent in s. 85 of the Act should be followed.<sup>23</sup>

<sup>22</sup> Services and practitioners should also refer to *ECT manual – licensing, legal requirements and clinical practice guidelines* (Department of Human Services, January 2000). The manual is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

<sup>23</sup> Refer to the Chief Psychiatrist's guideline, *Non-psychiatric treatment and special procedures* (Department of Human Services, September 2005) for further information. The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

## 6.2 Treatment plans

### 6.2.1 Content of treatment plans

Section 19A of the Act requires that every patient under the Act must have a treatment plan.<sup>24</sup> For a person on a community treatment order, the treatment plan must contain or specify the following information:

- (a) an outline of the treatment the patient is to receive
- (b) the name of the monitoring psychiatrist
- (c) the name of the supervising medical practitioner
- (d) the name of the patient's case manager
- (e) the place at which the patient is to receive treatment
- (f) the times at which the patient is required to attend to receive treatment
- (g) the intervals at which the supervising medical practitioner must submit a written report concerning the patient's treatment to the monitoring psychiatrist.

The treatment plan can also contain any other information the authorised psychiatrist believes is appropriate.

### 6.2.2 Preparation and review

An initial treatment plan should be prepared when a community treatment order is made. If the person is an inpatient when the community treatment order is made, their treatment plan will need to be revised. A copy of the treatment plan should be attached to the copy of the community treatment order given to the patient.

In practice, the initial treatment plan which is attached to the community treatment order will be fairly simple and may only include sufficient information to enable the patient to engage

in treatment with a community-based service. Nevertheless, the treatment plan must contain sufficient information to meet the requirements of s. 19A. The community-based treating team should subsequently develop a more comprehensive treatment plan in collaboration with the patient and family or carers.

The treatment plan should give clear guidance about the person's obligations under the community treatment order. This is particularly important because failure to comply with a treatment plan may constitute grounds for revocation of a community treatment order (refer chapter 8). The Mental Health Review Board reviews treatment plans pursuant to s. 35A as part of appeal or review hearings (refer chapter 10).

The Act requires that a person's treatment plan is reviewed on a regular basis by the authorised psychiatrist and revised as required (s. 19A(1)). The authorised psychiatrist must ensure the person is given a copy of the revised treatment plan (s. 19A(6)(a)).

### 6.2.3 Matters to be taken into account

The Act stipulates that the following matters must be taken into account by the authorised psychiatrist when a treatment plan is prepared, reviewed or revised:

- (a) the wishes of the patient, as far as they can be ascertained
- (b) unless the patient objects, the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient
- (c) whether the treatment to be carried out is only to promote and maintain the patient's health or wellbeing
- (d) any beneficial alternative treatments available

<sup>24</sup> Further guidance about treatment plans is provided in the draft Chief Psychiatrist's guideline, *Treatment plans under the Mental Health Act 1986* (Department of Human Services, October 2004). The guideline is available at <[www.health.vic.gov.au/mentalhealth/mh-act/treatment-plan.htm](http://www.health.vic.gov.au/mentalhealth/mh-act/treatment-plan.htm)>.

- (e) the nature and degree of any significant risks associated with the treatment or any alternative treatments
- (f) any prescribed matters (s. 19A(2)). Note that no matters are currently prescribed.

The authorised psychiatrist should discuss the proposed treatment plan with the person or ensure the plan is discussed with the person by a registered medical practitioner (such as the person's supervising medical practitioner) or the person's case manager. The authorised psychiatrist should take into account the person's 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). The role of families and carers should be discussed with the patient as early as possible to determine the extent to which their wishes should be taken into account.

Discussions will also need to take place with the proposed treating team, including the monitoring psychiatrist and supervising medical practitioner, before the treatment plan can be completed.

### 6.2.4 Relationship with the individual service plan

Treatment plans are not meant to be a substitute for individual service plans or other management plans. They 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. It is envisaged that they will be a more general statement or outline of the priority treatment and needs at a given point of time and for the period of the plan. By contrast, an individual service plan or recovery and rehabilitation plan would be expected to be more comprehensive in its coverage of all psychosocial domains and the full range of strategies to address them over time.

### 6.2.5 Powers of the Mental Health Review Board

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 s. 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 (s. 35A). This means that the board must inquire into whether the authorised psychiatrist has followed the process outlined in s. 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 template for the *Report on involuntary status for the Mental Health Review Board* incorporates these matters<sup>25</sup>; however, the authorised psychiatrist (or medical practitioner representing the authorised psychiatrist at a hearing) should be prepared to answer any questions about the development of the treatment plan.

The board does not have the power to determine the particular merits of a treatment plan (for example, whether one treatment should be preferred over another). The board's role is to be satisfied that the correct process in s. 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 s. 19A in making, reviewing or revising the plan, or that the plan is not capable of being implemented by the approved mental health service (s. 35A(2)).

## 7 Responsibilities to a person on a community treatment order

### 7.1 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 name of the monitoring psychiatrist must be included in the person's treatment plan (s. 19A(4)(b)). 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 through 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 the receipt of progress reports (*Progress report on community treatment order* (MHA 7)), 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. The intervals at which the supervising medical practitioner is required to submit a written report to the monitoring psychiatrist is specified in the person's treatment plan
  - stay informed of, and ensure they are satisfied with, the treatment and clinical condition of the person on the community treatment order
  - review the person's treatment plan on a regular basis and ensure the plan is revised as required
  - aim to personally examine the person on the community treatment order at least every three months, or as otherwise indicated
- regularly consider whether or not the criteria in s. 8 still apply to the person, 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<sup>26</sup>
  - 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.

### 7.2 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. The supervising medical practitioner is clinically accountable to the monitoring psychiatrist, and

<sup>26</sup> For further information, refer to the Chief Psychiatrist's guideline, *Physical examination, the annual examination and attention to clients' general medical health needs* (Department of Human Services, August 2002). The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

therefore major changes in the person's clinical state or proposed alterations to treatment should be discussed with the monitoring psychiatrist. Alterations to the person's treatment may require the treatment plan to be amended.

The supervising medical practitioner is also required to regularly assess whether the criteria in s. 8(1) of the Act still apply to the person and whether appropriate treatment can be obtained under the community treatment order (s. 14A). If the practitioner considers that the community treatment order should be varied, discharged or revoked, the practitioner must notify the monitoring psychiatrist as soon as practicable.

The supervising medical practitioner should:

- be involved, with the monitoring psychiatrist and the case manager, in reviewing the person's treatment plan on a regular basis, and developing a realistic individual service plan
- 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 and the treatment plan, 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 the person's treatment plan, 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 and at the intervals set out in the person's treatment plan (refer chapter 7.2.1)
- 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.

### 7.2.1 Reporting to the monitoring psychiatrist

Section 19A(4)(g)(i) 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, depending on clinical circumstances, and should be specified in the person's treatment plan. In any case, the monitoring psychiatrist must ensure 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 should be made on the *Progress report on community treatment order* (MHA 7) form. 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 through a centralised tracking system at the inpatient service, depending on local protocols.

### **Progress reports when the monitoring psychiatrist is the supervising medical 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 person's clinical record, and would normally occur at the times of the psychiatrist's personal examinations of the person.

## **7.3 Case manager**

The treatment plan for a person on a community treatment order must specify the patient's case manager (s. 19A(4)(d)). Case managers provide specialist input to address the person's treatment needs and to ensure flexible and mobile services are provided. The case manager should:

- be involved in the development and regular review of a treatment plan for the person, in consultation with the person, their relevant family and carers, unless the patient objects (s. 19A(2)(b)), and the supervising medical practitioner and monitoring psychiatrist. A copy of the treatment plan must be given to the person on the community treatment order and other clinicians and carers who are partners to the plan (subject to confidentiality requirements)
- develop, maintain and facilitate the execution of a realistic individual service plan 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 individual service plan 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, their treatment plan 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
- attend Mental Health Review Board hearings to provide information to the board and to provide support and advice to the person on the order.

## **7.4 Area mental health service management**

It is the responsibility of the area mental health service providers to develop and maintain a system to facilitate the proper administration of community treatment orders. Such a system should specify procedures for handling statutory paperwork (such as schedules) and treatment plans and tracking progress reports and key dates in relation to an individual's community treatment order.

## 8 Revoking a community treatment order

### 8.1 Definition of revocation

Revocation of a community treatment order means the person is no longer on the community treatment order and must return to the appropriate approved mental health service (as specified on the *Community treatment order* (MHA 6) form). Until the person does return, they are taken to be absent from the approved mental health service without leave (s. 14D(3)(b)).

### 8.2 Circumstances under which a community treatment order may be revoked

Under s. 14D of the Act, a community treatment order may be revoked if the authorised psychiatrist is satisfied on reasonable grounds that a person on a community treatment order:

- is no longer suitable for treatment in the community under a community treatment order

or

- has failed to comply with the community treatment order or the person's treatment plan.

#### 8.2.1 No longer suitable for treatment in the community

If a person on a community treatment order continues to fulfil all of the criteria for involuntary treatment in s. 8(1), but the treatment the person requires cannot be obtained in the community under a community treatment order (usually due to a deterioration in their mental state), then the community treatment order may be revoked (s. 14D(1)).

#### 8.2.2 Failure to comply with the community treatment order or treatment plan

A community treatment order may be revoked if:

- the person has failed to comply with the community treatment order or the person's treatment plan

and

- reasonable steps have been taken, without success, to obtain compliance with the order or plan

and

- the authorised psychiatrist is satisfied on reasonable grounds that there is a significant risk of deterioration in the person's mental or physical condition because of the non-compliance (s. 14D(2)).

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 comply with the terms of the community treatment order or fails to adhere to the treatment outlined in their treatment plan (for example, they consistently refuse or fail to meet with the supervising medical practitioner or case manager, or repeatedly refuse medication) reasonable efforts must be made to secure collaboration by the person. It is important that the community treatment order and the treatment plan specify the obligations of the person so that it is clear when they have failed to comply. The community treatment order can only be revoked under s. 14D(2) if those efforts to obtain compliance have been unsuccessful and the authorised psychiatrist is satisfied on reasonable grounds that there is a significant risk of deterioration in the person's mental or physical condition because of the non-compliance.

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 risk of deterioration in the person's mental or physical condition due to the non-compliance must be significant to warrant a revocation of the community treatment order.

The authority of the authorised psychiatrist to revoke a community treatment order for failing to comply with the community treatment order or the treatment plan places the responsibility on treating practitioners to have:

- prepared a treatment plan which clearly sets out the obligations of the person in terms of their treatment (for example, taking medication and attending appointments) and which is up to date
- previously informed the person on the community treatment order of the requirements of their community treatment order and the treatment 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.

### 8.3 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 (s. 14D), or by the Mental Health Review Board (at the time of a review or appeal hearing) (s. 36C(3)(b)). Where possible, the monitoring psychiatrist rather than a duty psychiatrist should make decisions concerning revocation because the monitoring psychiatrist will have a greater knowledge of the person and their treatment.

#### 8.3.1 Revocation where a person is 'out of area'

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, the patient should also be transferred to that service in accordance with s. 39 of the Act, at the same time the community treatment order is revoked. The revocation form should then 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.

### 8.4 Procedure for revocation

In deciding whether or not to revoke a community treatment order, the authorised psychiatrist must be satisfied that the legislative criteria for revocation apply to the person (refer chapter 8.2), and that all reasonable efforts to assist the person to remain in the community have been made.

#### 8.4.1 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 mental health clinician, such as the supervising medical practitioner, case manager or crisis assessment and treatment service member.

### 8.4.2 Revoking the community treatment order

If the requirements of s. 14D are met and the authorised psychiatrist considers revocation of the community treatment order to be appropriate, then he or she should complete a *Revocation of community treatment order* (MHA 10) form.

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* (MHA 10) form to the assessing clinician. Where the revocation has occurred by telephone, the clinician receiving the authorisation should carefully record the details on a MHA 10 form. The authorised psychiatrist must then complete the required sections of the MHA 10 form as soon as practicable, but in any case by the next working day.

Copies of the completed MHA 10 form should be given to the person on the community treatment order (refer chapter 8.4.3) and included in the clinical record. Copies can be made for the monitoring psychiatrist (if not the authorised psychiatrist who revoked the community treatment order) and the supervising medical practitioner as required. The original should be filed according to local protocols.

### 8.4.3 Informing the person about the revocation

Once a community treatment order has been revoked, s. 14D(3)(a) of the Act requires the authorised psychiatrist to make reasonable efforts to inform the person about the revocation and that they must return to the designated approved mental health service.

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 a copy of the *Revocation of a community treatment order* (MHA 10) form.

These tasks may be delegated to other mental health clinicians, but the authorised psychiatrist retains responsibility for ensuring they occur.

## 8.5 Return to the approved mental health service

### 8.5.1 Return 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 members, carers or mental health service staff. Where it is safe and reasonable, every effort should be made to assist the person to return in this manner.

### 8.5.2 Apprehension and safe transport

If the person does not return of their own accord, ss. 43 and 9B of the Act permit the apprehension of the person for the purposes of returning them to an approved mental health service.

The experience of being apprehended and transported following revocation of a community treatment order can be 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 possible restrictive manner. In many instances, the person can be persuaded to accompany mental health clinicians in an agency vehicle. Where this is not possible, preference should be given to ambulance transport.<sup>27</sup> The use of restraint, assistance of police, and transport in police vehicles should be avoided where alternatives are available and appropriate.<sup>28</sup>

<sup>27</sup> The protocol *Ambulance transport of people with a mental illness* (Department of Human Services, February 2002) should be consulted for further information about the appropriate use of ambulance assistance. The protocol is available at <[www.health.vic.gov.au/mentalhealth/atoz.htm](http://www.health.vic.gov.au/mentalhealth/atoz.htm)>.

<sup>28</sup> Consult the *Protocol between Victoria Police and the Department of Human Services Mental Health Branch* (2004) for further information about the appropriate use of police assistance. The protocol is available at <[www.health.vic.gov.au/mentalhealth/atoz2.htm](http://www.health.vic.gov.au/mentalhealth/atoz2.htm)>.

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.

### Persons 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 7 of the Act and r. 5(7) of the Mental Health Regulations define a 'prescribed person' as:

- a member of the police force
- an ambulance officer
- a member of the following categories of health professionals:
  - registered medical practitioners
  - registered nurses
  - registered psychologists
  - social workers
  - occupational therapists
- employed, appointed or engaged to provide care and treatment to persons with a mental disorder in an approved mental health service, a state child and adolescent psychiatry service, any premises licensed under s. 75 of the Act, a hospital admitting or caring for persons with a mental disorder, a mental health service of a community health centre, a psychiatric outpatient clinic or a community mental health service.

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 an approved mental health service.

Specific authorisation in the form of an *Authority to apprehend an involuntary patient without leave or permission* (MHA 23) form 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 be the circumstance.

### Powers to return a person to an approved mental health service

A prescribed person may apprehend an involuntary patient who is absent without leave for the purpose of returning the person to an approved mental health service. A prescribed person may with such assistance as is required and such force as may be reasonably necessary:

- enter any premises in which they have reasonable grounds to believe that the person may be found and
- if necessary to enable the person to be safely transported, use such restraint as may be reasonably necessary (ss. 43 and 9B).

Force and restraint should only be used in exceptional circumstances, and not without assistance. If significant force might 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 the form, *Restraint for the purpose of safely transporting a person to an approved mental health service* (Form 1 of Schedule 3 of the Mental Health Regulations 1998), and a copy placed in the clinical record.

### Sedation

Sections 43 and 9B provide for the use of sedation where it is required for the safe transport of the person to the approved mental health service.

Sedation may only be ordered by a ‘prescribed registered medical practitioner’, defined in regulation 5(6) of the Mental Health Regulations as a registered medical practitioner who falls within one of the following categories:

- the practitioner who completed the *Recommendation* (Schedule 2)
- in general practice
- the head of the emergency department of a hospital
- employed by a psychiatric service (in hospital or in the community) within the meaning of s. 106 of the Act
- a psychiatrist
- 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 the form, *Sedation for the purpose of safely transporting a person to an approved mental health service* (Form 2 of Schedule 3 of the Mental Health Regulations 1998), and a copy placed in the clinical record. A person sedated for safe transport must be transported to the approved mental health service by ambulance.

### 8.5.3 Mental health service to which the person should return

Section 14D(3)(a) requires that, once a community treatment order has been revoked, the person must go to an approved mental health service. The person should return to the approved mental health service designated on the *Community treatment order* (MHA 6) 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 service and a transfer arranged in accordance with s. 39 of the Act, including completing a *Transfer of an involuntary patient to another approved mental health service* (MHA 19) form. The name of the receiving service

should be entered on the *Authority to apprehend an involuntary patient without leave* (MHA 23) form, if this form is required.

#### 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 their service of origin, wherever practicable, the person should still be returned to their designated approved mental health service. However, under some circumstances it might be more appropriate for the person to be treated at another approved mental health service first, in which case clinical discretion should apply. For example, if a patient of an approved metropolitan service was apprehended in a rural area, then the most appropriate course may be to admit and initiate treatment at the rural service. In this circumstance, the authorised psychiatrist revoking the community treatment order will also need to transfer the patient to the admitting service. The person should then be transferred back to the service of origin when their clinical condition permits this to be done safely. The requirements of s. 39 for the transfer of a patient should be met and a completed *Transfer of an involuntary patient to another approved mental health service* (MHA 19) form should accompany all transfers (refer also chapter 8.3.1).

The procedures for making a new community treatment order following an ‘out of area’ admission are described in chapter 5.4.

### 8.5.4 Deciding whether a person on a revoked community treatment order needs to be admitted as an inpatient

When a community treatment order is revoked the person is taken to be ‘absent without leave’ (s. 14D(3)(b)). Section 43 of the Act provides that involuntary patients who are absent without leave may be apprehended at any time for the purpose of being returned to the approved mental health service. The use of the term ‘may’ means that clinical staff, and in particular the authorised psychiatrist, have some discretion in deciding what action to take

concerning a patient who is absent without leave following the revocation of a community treatment order.

In most cases, the person should be apprehended and returned to the approved mental health service. This follows because the grounds for revocation are either that:

- the treatment required for the person can only be obtained in an inpatient setting

or

- the person has not complied with their order or treatment plan, and is at significant risk of deterioration.

Admission as an inpatient will allow the person to receive appropriate assessment, treatment and care for their mental illness. However, there might be circumstances where a person subject to a revoked community treatment order does not require admission. For example, a community treatment order may have been revoked because a person failed to attend appointments and could not be located. Subsequently, the person might present at the community mental health service seeking treatment. If after an examination the authorised psychiatrist decides the person does not require inpatient treatment, the authorised psychiatrist can make a new community treatment order without the person being sent to an approved mental health service.

Regardless of the circumstances, when area mental health service clinicians locate a person on a revoked community treatment order, some action must be taken to clarify the person's legal status, either by admission as an inpatient or the making of a new community treatment order. It is not appropriate for the person to remain 'absent without leave' in the community.

### 8.5.5 Action if the person cannot be located

A person on a revoked community treatment order is taken 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 the person remains absent without leave continuously for this period, then they are automatically discharged as an involuntary patient (s. 42(1)).<sup>29</sup>

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 is 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.

Mental health service providers should have in place policies and procedures for locating people who have had their community treatment order revoked, including where necessary, reporting the person as a 'missing person' to police.

Chapter 12 provides some guidance on the options where a person on a community treatment order has gone interstate.

<sup>29</sup> Note that in exceptional circumstances, 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.

### 8.5.6 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 through 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 treatment 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* (MHA 1) form, although if the person is discharged from involuntary status (either to remain in hospital on a voluntary basis, or to be discharged to the community), then a *Discharge from involuntary patient status* (MHA 16) form should be completed and a copy given to the person.

### 8.5.7 Action following an admission

If it is considered appropriate for the person to be placed on a community treatment order (irrespective of the duration of their inpatient 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* (MHA 6) form should be completed (refer chapter 5.1.1).

### '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.

When the person is transferred back to the designated approved mental health service, the requirements of s. 39 should be met. A completed *Transfer of an involuntary patient to another approved mental health service* (MHA 19) form should accompany the transfer back to the person's designated service, whether this is as an inpatient or on a community treatment order. See chapter 5.4 for more details.

## 9 Variation, transfer and extension of a community treatment order

### 9.1 Varying a community treatment order

Only the monitoring psychiatrist (s. 14C) or the Mental Health Review Board (at the time of an appeal or review) (s. 36C(3)(a)) may vary a community treatment order. The elements of a community treatment order that may be varied are:

- the length of the order. The duration of a community treatment order may be shortened by varying the order. If it is proposed to extend the period of a community treatment order, an extension must be completed instead (see chapter 9.3)
- the removal or introduction of a residence condition
- the name of the designated approved mental health service. This would be necessary when the care of a person on a community treatment order is transferred to another approved mental health service.

A proposed variation to a community treatment order should be discussed and negotiated with all relevant parties. The authorised psychiatrist is required to inform the person of the fact their community treatment order has been varied and the grounds on which it has been varied (s. 14C(2)).

Variations should be recorded on a *Variation of a community treatment order* (MHA 8) form. Copies should be given to the person on the community treatment order and placed in the clinical record. Copies should be made for the supervising medical practitioner, the monitoring psychiatrist and the Mental Health Review Board, as necessary. The original should be filed in accordance with local protocols. Details of the variation and the reasons for the variation should also be documented in the clinical record.

Changes to the membership of the treating team, such as the name of the monitoring psychiatrist and the supervising medical practitioner, should be recorded by revising the person's treatment plan.

### 9.2 Transferring treatment

From time to time, people on community treatment orders move residence into a location covered by a different area mental health service. 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 clinicians at the 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 community treatment orders 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.

### 9.2.1 Procedure for transferring treatment

The transfer of a community treatment order is the responsibility of the monitoring psychiatrist. Before initiating a 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 (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 (s. 39(1)(b)), 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* (MHA 19) form to the authorised psychiatrist of the receiving service
- forward all relevant clinical information, including a copy of the person's treatment plan
- forward the originals of all statutory documentation, including the Schedules 1 and 2, the MHA 1 *Examination of involuntary patient by authorised psychiatrist*, the MHA 6 *Community treatment order*, and any variations, revocations and extensions of the community treatment order. Statutory documentation relevant to involuntary status and community treatment orders should always be held by the service that has clinical responsibility for the person on the community treatment order.

All information should be sent at the time of the transfer or shortly after. The requirement for timeliness is explicit in the Act (s. 39(3)) and must be addressed.

Following the transfer, the new monitoring psychiatrist should:

- familiarise themselves with the details of the person's circumstances and treatment
- satisfy themselves that s. 8(1) criteria still apply to the person and that the treatment required for the person can be obtained through a community treatment order
- complete a *Variation of a community treatment order* (MHA 8) form to amend the name of the approved mental health service of which the person will be a patient
- revise the treatment plan, including varying the name of the monitoring psychiatrist, the supervising medical practitioner, the case manager, the place where the person will receive treatment, the times at which the person is required to attend to receive treatment and other details as necessary. The process for revising a treatment plan as outlined in chapter 6 should be followed
- provide copies of the revised treatment plan and the MHA 8 form (as required) to the:
  - person on the community treatment order
  - new supervising medical practitioner
  - new case manager
  - nominated carers
  - other service providers who are partners in the treatment plan
  - clinical record.

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 (s. 39(6)). If the board does not confirm the transfer order, it can direct the management of the person's treatment be transferred back to the original service.

### 9.3 Extending a community treatment order

Section 14B 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. A community treatment order cannot be extended after it has expired (s. 14B(4)). Unless a community treatment order is extended prior to its expiry date, the person ceases to be an involuntary patient upon expiry of the community treatment order (s. 14(5)). The examination and the making of a valid extension must therefore occur before or on the expiry date of the community treatment order. It is 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. 8(1) criteria still apply to the person and the treatment required for the person can be obtained by extending the order, before making an extension. If these criteria are not satisfied, then the community treatment order must be discharged (s. 37(2)). An extension must not be regarded merely as a rolling over of a community treatment order.

A community treatment order should not be allowed to simply '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 complete an *Extension of a community treatment order* (MHA 9) form. The form should be completed at the same time or as soon as practicable

after the examination is conducted. The extension takes effect from the date the form is completed (s. 14B(2)). The existing community treatment order will effectively expire at the time of commencement of the extension.

The extension may be made for up to a maximum of 12 months; that is, one year less one day from the date the form is signed.

Section 14B(5) of the Act requires the authorised psychiatrist to inform the person of the fact the order has been extended and the grounds on which the authorised psychiatrist decided to extend the order. A copy of the extension document (MHA 9) must be given to the person on the community treatment order and a copy placed in the clinical record. Copies should be made for the supervising medical practitioner and the monitoring psychiatrist as required. The original copy should be filed in accordance with local protocols.

The extension of a community treatment order is subject to review by the Mental Health Review Board within eight weeks after the order is extended (s. 30(4)). If this review coincides with the board's annual review of the person, the board may conduct both reviews together (s. 31).

There are no limits on how many times a community treatment order may be extended, provided the criteria for extension continue to be met; however a community treatment order should only be extended for the minimum period considered necessary.

The person's treatment plan should be reviewed at the time the community treatment order is extended.

#### 9.3.1 Failure to extend a community treatment order before the expiry date

It is the responsibility of the monitoring psychiatrist to ensure a decision is made concerning a community treatment order prior to its expiry.

If the expiry date passes without the community treatment order being extended, then the person ceases to be an involuntary patient (s. 14(5)). It is then the responsibility of the monitoring psychiatrist to liaise with the person and the clinicians involved

in the person's treatment to determine an appropriate course of action. Options include continuing treatment of the person on a voluntary basis or, if the person continues to require involuntary treatment and meets the s. 8(1) criteria, recommending the person and making a new community treatment order (refer chapter 5.1).

A community treatment order cannot be extended after it has expired (s. 14B(4)), nor can such an action be backdated. Placing the person on leave is not a valid action as the person is no longer an involuntary patient.

### **9.3.2 Extending a community treatment order if the person cannot be located**

The authorised psychiatrist may only extend a community treatment order after personally examining the person on the order. If the person cannot be located, the community treatment order cannot be extended. If no action is taken, the person will be automatically discharged as an involuntary patient when the community treatment order expires.

In these circumstances, the monitoring psychiatrist must make a clinical decision about necessary action. All reasonable efforts should be made to locate and re-engage the person in treatment. If the person still cannot be contacted, the monitoring psychiatrist must decide whether to revoke the community treatment order or discharge the person from involuntary status. If the community treatment order is revoked, the person is taken to be 'absent without leave' from the approved mental health service. This status remains valid for 12 months unless the person returns to the approved mental health service or is discharged by the authorised psychiatrist (refer chapter 8).

## **10 Mental Health Review Board – reviews and appeals**

### **10.1 Schedule of reviews and right to appeal**

The Mental Health Review Board is established by s. 21 of the 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 the person's involuntary treatment order being made (whether the person is an inpatient or on a community treatment order), and thereafter at intervals not exceeding 12 months. The board does not review the making of a community treatment order. If the board's initial 'within eight weeks' review occurs before the community treatment order is made, then unless the community treatment order is appealed or extended, the board will not generally conduct another automatic review of the person until the person's annual review.

A person on a community treatment order, a community visitor, or anyone who satisfies the board they have a genuine concern for the person may appeal to the board regarding a person's involuntary status at any time. The board must commence the hearing of an appeal without delay (s. 29(4)).

If a community treatment order is extended, the board will review the person within eight weeks of the date of the extension (s. 30(4)).

Under 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.

## 10.2 Powers and requirements of the board

### 10.2.1 Powers of the board

On hearing an appeal or review for patients on community treatment orders, the board has the power to confirm, vary, revoke or discharge the community treatment order (s. 36C). In so doing, it must consider whether or not the criteria set out in s. 8(1) of the Act still apply to the person and whether the treatment required for the patient can be obtained under the order. The board must ‘have regard primarily to the patient’s current mental condition and consider the patient’s medical and psychiatric history and social circumstances’ in making its decision (s. 22(2)).

The board may also revoke a community treatment order if the board is satisfied on reasonable grounds that the person has not complied with the order or the person’s treatment plan, reasonable steps have been taken without success to obtain compliance with the order or plan, and there is a significant risk of deterioration in the person’s mental or physical condition because of the non-compliance (s. 36C(4)).

The board is also required to review the person’s treatment plan on each appeal and review (s. 35A). If the board forms the view that the authorised psychiatrist did not comply with s. 19A in making or revising the plan, or believes the plan is not capable of being implemented, the board can order the authorised psychiatrist to revise the treatment plan (s. 35A(2)).

### 10.2.2 Requirements of the board

On the day of the hearing, the board will require:

- access to the person’s clinical record
- three copies of the *Report on involuntary status for the Mental Health Review Board* (refer chapter 10.4.2)

- the originals of the statutory documentation (Schedules 1 and 2, the MHA 1 *Examination of involuntary patient by authorised psychiatrist*, the MHA 6 *Community treatment order*, any variations, revocations and extensions of the community treatment order)
- a copy of the person’s current treatment plan.

The board requires that all relevant information be available on the day 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, 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.

## 10.3 Rights of the person in relation to board hearings

### 10.3.1 Explanation of rights

Each patient must be given a copy of the patient rights booklet, *Involuntary patients*, when they are placed on an involuntary treatment order. The booklet has a chapter on the Mental Health Review Board.

On being advised of a board hearing, the authorised psychiatrist should ensure the person on the community treatment order has a copy of the booklet, has had an oral explanation of the relevant information contained in the booklet, and has had the opportunity to ask any questions and receive appropriate answers.

### 10.3.2 Access to documents

Section 26(7) of the Act entitles a person on a 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 involuntary status for the Mental Health Review Board* and the person's clinical record.<sup>30</sup> The board has issued a practice direction specifying additional requirements concerning timelines for preparing the report and making copies available to the patient and other parties to a hearing.<sup>31</sup>

The authorised psychiatrist may apply to the board to restrict access to a document or part of any document (s. 26(8)) 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 record and the *Report on involuntary status 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 access to 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.

### 10.3.3 Advocacy and second opinion

An involuntary patient has a right to obtain a second psychiatric opinion from a psychiatrist of their choice. A person on a community treatment order may wish to seek a second opinion in preparation for a board hearing, and their case manager 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 available free of charge for people with limited financial means:

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

Further information for patients about legal representation and the contact details for the above organisations are provided in the patients' rights booklet, *Involuntary patients*.

<sup>30</sup> Further information is provided in the Chief Psychiatrist's guideline, *Patient access to files for Mental Health Review Board hearings* (Department of Human Services, November 2001). The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

<sup>31</sup> Mental Health Review Board, Practice Direction 2004/1, *Report on involuntary status for the Mental Health Review Board*, Version 2.1, December 2004. The practice direction is available at <[www.mhrb.vic.gov.au/publications/publications.htm](http://www.mhrb.vic.gov.au/publications/publications.htm)>.

### 10.3.4 Attendance

The person has a right to attend the board hearing (accompanied by friends and relatives if they wish), or to authorise someone to represent them at the hearing. 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).

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

## 10.4 Procedures

Information about the board's procedures is available on the Mental Health Review Board's web site at [www.mhrb.vic.gov.au](http://www.mhrb.vic.gov.au).

### 10.4.1 Notification of the hearing

The board is required to notify a person of the date and place of their review or appeal hearing at least seven days before the hearing unless it believes it is appropriate to reduce this notice period (s. 32).

If the board is aware that a person is on a community treatment order, they will send the notice of hearing directly to the person's home address. If an approved mental health service inadvertently receives a notice of hearing for a person who is on a community treatment order, all efforts should be made to notify the person of the details of the hearing as soon as practicable. If an approved mental health service receives a notice for a person who has been discharged from their community treatment order and therefore their involuntary status, then the authorised psychiatrist of the service should ensure that the Executive Officer of the board is notified immediately.

The board is also required to send the relevant authorised psychiatrist a notice of the hearing (s. 32(1)(c)). The authorised psychiatrist must give a copy of the notice to the person's case manager as soon as practicable after receiving the notice (s. 32(1A)).

### 10.4.2 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 ensuring the person has a copy of the patients' rights booklet, *Involuntary patients*
- 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 involuntary status for the Mental Health Review Board* and attaching a copy of the person's treatment plan to the report. 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) must 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 inspection or access 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 involuntary status for 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.

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.

### 10.4.3 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 and other members of the treating team are also encouraged to attend the hearing because they are usually able to provide valuable information to the board about the person and their social circumstances.

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.

### 10.4.4 After the hearing

Pursuant to ss. 36C and 35A, the potential outcomes of the hearing for a person on a community treatment order 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
- order the authorised psychiatrist to revise the treatment plan.

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.

### 10.5 Power to direct authorised psychiatrist to make a community treatment order

Where a board hearing relates to an involuntary patient who is detained in an approved mental health service, the board has the power to order the authorised psychiatrist to make a community treatment order for the person. This will happen if the board decides that the person requires involuntary treatment but that the treatment can be obtained in the community by the making of a community treatment order (s. 36(4)).

The board will specify a reasonable period of time in which the authorised psychiatrist is required to make the community treatment order. This period of time should be used by the authorised psychiatrist to make the necessary discharge arrangements.

The authorised psychiatrist may apply to the board during this period for reconsideration of its decision to order that a community treatment order be made (s. 36(5)). In practice, this would only be appropriate if the person's mental condition deteriorated or there was some other material change in the person's circumstances. The patient will remain as an inpatient until the board hears the application.

## 11 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 considers that the criteria in s. 8(1) no longer apply, then the person must be discharged from the community treatment order (s. 37(2)). 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 from involuntary patient status* (MHA 16) form must be completed and a copy given to the patient and a copy placed in the clinical file. The original should be filed according to local protocols. Copies may also be made and sent to the supervising medical practitioner and the board if a hearing of the Mental Health Review Board is pending.

It is not necessary to complete a *Discharge from involuntary patient status* (MHA 16) form if the board discharges the person.

## 12 Cross-border issues

The Mental Health Act is Victorian legislation and does not apply in other states or territories unless there is a ministerial agreement to activate the interstate provisions in Part 5A of the Act.

Victoria has an agreement with the New South Wales Government concerning involuntary patients, including patients on community treatment orders (see below). There are currently no agreements concerning involuntary patients with other states or territories, although separate agreements have been made with the New South Wales, Queensland and Australian Capital Territory governments in relation to forensic and security patients who abscond interstate.<sup>32</sup> The Chief Psychiatrist should be contacted in relation to necessary action concerning forensic patients who abscond interstate.

### 12.1 Cross-border mental health services: Victoria and New South Wales

A ministerial agreement between Victoria and New South Wales relating to cross-border mental health services commenced on 21 February 2003. This agreement activated the interstate provisions in Part 5A of the Victorian Mental Health Act and Chapter 10A of the New South Wales *Mental Health Act 1990*. In part, this agreement provides that:

- a Victorian community treatment order can be made for a person who resides in New South Wales, and a New South Wales community treatment order can be made by New South Wales for a person who resides in Victoria; however, local protocols still need to be developed by border mental health services before community treatment orders for persons can be administered interstate

- if a Victorian community treatment order is revoked and the person is absent without leave in New South Wales, the person can be apprehended in New South Wales.

Special considerations and procedures must be followed before these steps can be taken. For example, a civil interstate apprehension order must be completed before a person who is absent without leave due to the revocation of a Victorian community treatment order can be apprehended in New South Wales, unless the delay in obtaining the order would place the person or public at risk.<sup>33</sup>

### 12.2 When a person on a community treatment order leaves Victoria

If a person on a community treatment order leaves Victoria, 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 chapter 13.4). 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. If the person is absent without leave and reasonably known to be in New South Wales, consideration can be given to whether to make arrangements for the person to be apprehended in New South Wales (refer chapter 12.1). In the absence of other agreements, this option does not exist if the person absconds to another state or territory.<sup>34</sup>

<sup>32</sup> A ministerial agreement between Victoria and Queensland concerning involuntary patients is being finalised at the time of publication of these guidelines.

<sup>33</sup> Specific advice about these procedures is contained in the program management circular, *Cross-border mental health services: Victoria and NSW* (Department of Human Services, March 2003). The circular is available at <[www.health.vic.gov.au/mentalhealth/crossborder/index.htm](http://www.health.vic.gov.au/mentalhealth/crossborder/index.htm)>.

<sup>34</sup> Refer to footnote 32.

## 13 Special issues

### 13.1 Police custody, prisons, and youth training centres

Section 14E of the Act states that an involuntary treatment order and a community treatment order have no effect while a person 'is in custody under a sentence of imprisonment or under any order of a court requiring the person to be held in custody'. Therefore, if a person on a community treatment order is remanded or detained in custody, whether in police custody, prison, a youth residential centre or a youth training centre, then the community treatment order goes into abeyance until the person's release. The community treatment order may expire while the person is in custody. If the community treatment order does not expire while the person is in custody then it will revive upon the person's release from custody.

It is the monitoring psychiatrist's responsibility to ensure that if a person on a community treatment order goes into custody, relevant medical and nursing staff are contacted and provided with necessary information 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 they liaise closely with the monitoring psychiatrist as the date of release approaches in order to facilitate the person's continuing treatment.

Section 14E also clarifies that a person on a community treatment order who is placed on a hospital order, a hospital transfer order, hospital security order or restricted hospital transfer order is discharged from their involuntary treatment order and community treatment order.

This means that if a person in prison or other place of custody is transferred to an approved mental health service under one of these orders, their involuntary treatment order and community treatment order are automatically discharged. On subsequent release from prison, if the person still requires involuntary treatment, the procedures in s. 9 for making the person an involuntary patient will need to be followed.

### 13.2 Private psychiatric hospitals and community treatment orders

A person on a community treatment order cannot be admitted to a private psychiatric hospital. One criterion in s. 8(1) of the Act for a person to be an involuntary patient and on a community treatment order is that the person 'has refused or is unable to consent to necessary treatment for the mental illness'. While the criteria in s. 8(1) continue to apply to a person, he or she could not give valid informed consent to voluntary admission and treatment at a private psychiatric hospital.

If a person subject to a community treatment order is able to give informed consent, then the person should be reviewed by the authorised psychiatrist of the relevant approved mental health service with a view to discharging the person from involuntary status.

### 13.3 Death of a person on a community treatment order

The *Coroner's Act 1985* (Vic) requires 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 to include the death of an involuntary patient subject to a community treatment order. Therefore, all deaths of patients subject to a community treatment order should be reported both to the coroner and the Chief Psychiatrist. The notification to the Chief Psychiatrist should be on a *Notice of death* (MHA33) form, and should be forwarded by the authorised psychiatrist. A copy of the report should be filed in the deceased person's medical record.<sup>35</sup>

### 13.4 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. 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.

### 13.5 Consent and guardians (under the *Guardianship and Administration Act 1986*)

One of the criteria for placing a person on an involuntary treatment order and a community treatment order is whether the person has refused or is unable to consent to treatment for the mental illness (s. 8(1)(d)). If a person has a guardian or person responsible within the meaning of the *Guardianship and Administration Act 1986*, or an agent under the *Medical Treatment Act 1988*, it is the person's ability to consent and not the consent or refusal of that person's guardian, person responsible or agent that is relevant (s. 3A). Notwithstanding this, the authorised psychiatrist and treating clinicians should liaise closely with any guardian or agent regarding any proposed course of action and treatment, subject to the confidentiality provisions (refer chapter 4.3.1 and s. 120A).

The authorised psychiatrist must ensure a person's guardian is informed when a person is placed on an involuntary treatment order and informed of the grounds for the person becoming an involuntary patient (s. 12AE). The guardian should also be advised when the person is placed on a community treatment order.

### 13.6 Gazetted residential services

Section 14(2) of the Act provides that a community treatment order is an order requiring a person to obtain treatment for their mental illness while 'not detained in an approved mental health service'. Therefore, if a person requires involuntary treatment in a residential service that is, or is part of, a proclaimed approved mental health service for the purposes of the treatment of their mental illness, then they should be admitted as an involuntary inpatient.

<sup>35</sup> Further information is available in the Chief Psychiatrist's guideline, *Reportable deaths* (Department of Human Services, May 2004). The guideline is available at <[www.health.vic.gov.au/mentalhealth/cpg/index.htm](http://www.health.vic.gov.au/mentalhealth/cpg/index.htm)>.

### **13.6.1 Psychogeriatric nursing homes**

Psychogeriatric nursing homes are governed by both the Victorian Mental Health Act and the Commonwealth *Aged Care Act 1997*. If a person requires involuntary treatment in a gazetted psychogeriatric nursing home for the purposes of the treatment of their mental illness, then they should be admitted as an involuntary inpatient. If a psychogeriatric nursing home is not part of a gazetted approved mental health service, the person can be placed on a community treatment order to receive the required treatment.

### **13.6.2 Community care units**

A person may not be on a community treatment order in a community care unit that is gazetted as part of an approved mental health service. If a person requires admission as an involuntary patient to a gazetted community care unit for the purposes of the treatment of their mental illness, they should be admitted as an involuntary inpatient.

## Appendix 1: Useful contact organisations

### **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](mailto:mhrb@mhrb.vic.gov.au)  
Internet address: [www.mhrb.vic.gov.au](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  
Toll free: 1800 555 887  
Internet address:  
[www.communitylaw.org.au/mentalhealth](http://www.communitylaw.org.au/mentalhealth)

### **Victoria Legal Aid**

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

### **Chief Psychiatrist**

50 Lonsdale Street  
Melbourne 3000  
Telephone: (03) 9616 7571  
Facsimile: (03) 9616 7697  
Internet address:  
[www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth)

### **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](mailto:hsc@dhs.vic.gov.au)  
Internet address: [www.health.vic.gov.au/hsc](http://www.health.vic.gov.au/hsc)

### **Office of the Public Advocate**

5th Floor, 436 Lonsdale Street  
Melbourne 3000  
Telephone: (03) 9603 9500  
Toll free: 1300 309 337  
Internet address: [www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au)