Mental Health Review Tribunal

MHRT No: _____

Date Reg'd:

Application for a Community Treatment Order

Under Section 51 of the Mental Health Act 2007

A CTO is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. It is implemented by a mental health facility that has developed an appropriate treatment plan for the individual person. CTOs can be made for any period of time up to twelve months. It is possible for a person to have more than one consecutive CTO.

A CTO authorises compulsory care for a person living in the community. If a person breaches a Community Treatment Order, by not complying with the conditions of the Order, the person may be taken to a mental health facility and given appropriate treatment, including medication.

To book a hearing for an application please complete and fax a Hearing Application Form to the Tribunal. These forms are available from the Tribunal's website www.mhrt.nsw.gov.au or by phoning 9816 5955.

DETAILS OF THE PERSON THE APPLICATION IS ABOUT

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

DATE OF BIRTH: _____ COUNTRY OF BIRTH_____

☐ MALE ☐ FEMALE MRN NO: _____

CURRENT ORDER:

☐ **Involuntary Patient** ☐ **Community Treatment Order** ☐ **None**

☐ **Tribunal** ☐ **Magistrate (please attach a copy of order)** **Expiry date:**_____

NOTICE OF APPLICATION:

The applicant must notify the affected person in writing of the application and include a copy of the proposed treatment plan. If the application is for a person who is not detained in a mental health facility the application cannot be heard by the Tribunal earlier than 14 days after the notice is given unless the Tribunal determines that it is in the person best interests that the application be heard earlier.

The applicant must also notify any designated carer and the principal care provider of an application for a CTO.

DETAILS OF THE PERSON MAKING THE APPLICATION

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

RELATIONSHIP (eg case worker, psychiatrist): _____

CLINICAL DETAILS:
Number of admissions to mental health facilities: _____

Date of first admission: _____ **Date Discharged:** _____

Date of last admission: _____ **Date Discharged:** _____

REASON FOR APPLICATION:

_____

_____

_____

_____

_____

_____

_____

_____

DOES THE CLIENT SUPPORT THE APPLICATION: ☐ **YES** ☐ **NO**

Please indicate reasons why and any problems with the CTO identified by the client:

_____

_____

_____

_____

_____

BACKGROUND INFORMATION:

SHORT HISTORY OF THE PERSON'S ILLNESS:

_____

_____

_____

_____

_____

_____

CURRENT MEDICATION AND ANY CHANGES TO MEDICATION DURING LAST 6 MONTHS:

_____

_____

_____

ANY OTHER CONDITIONS AND THEIR TREATMENT (e.g. substance abuse, developmental disability, psychosocial issues)

_____

_____

_____

EFFICACY OF COMMUNITY TREATMENT ORDER OVER THE PERIOD OF THE ORDER (if applicable)

_____

_____

_____

_____

_____

_____

ANY DIFFICULTIES IN ASSISTING THE CLIENT DURING THE CURRENT ORDER:

_____

_____

_____

_____

_____

_____

FAMILY AND COMMUNITY SUPPORT (include problems of non support if applicable)

_____

_____

_____

_____

_____

_____

PLANS FOR PERSON DURING THE PROPOSED ORDER (include: follow-up, habilitation, substance abuse issues and psycho-education)

_____

_____

_____

_____

_____

_____

OTHER PEOPLE INVOLVED - *(If you would like to add more names please attach an extra sheet)*

Please provide the details of any designated carer or principal care provider and any other people who may be able to give information to the Tribunal about the application eg. close friends, relatives, or other involved professionals.

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

RELATIONSHIP:_____

Likely attitude to this application? ☐ Support ☐ Oppose ☐ Don't know

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___) _____
Daytime *After hours* *Fax*

RELATIONSHIP:_____

Likely attitude to this application? ☐ Support ☐ Oppose ☐ Don't know

HEARING ARRANGEMENTS:

Preferred Date for hearing: _____ ☐ AM ☐ PM

Preferred venue:_____ ☐ In Person ☐ Video ☐ Telephone

Interpreter required: ☐ YES (what language) _____ ☐ NO

DECLARATION:

I have read this completed application and believe that to the best of my knowledge all of the information provided is true, complete and accurate.

Signature of applicant: _____ Date: _____

Please return the completed application **with the proposed treatment plan and other supporting evidence** to:

Mental Health Review Tribunal
PO Box 2019, BORONIA PARK NSW 2111

By Fax: (02) 9817 4543

For further information or assistance please contact the Tribunal on the following numbers:
Phone: (02) 9816 5955 Toll Free: 1800 815 511

MHRT Use Only - **Details of Hearing:**

Day:_____

Date:_____/_____/_____

Time:_____ a.m./ p.m.

Hearing Room: 1 / 2 / 3

Type: Live / Video / Phone

Hearing Application Form

Civil Jurisdiction – Mental Health Act 2007 (updated 14 Sept 2015)

Fax completed form to: *(02) 9817 4543, or*

Email to: *mhrtcivil@doh.health.nsw.gov.au*

Mental Health Review Tribunal

Client Details: **MHRT File No.: C** ……

Surname: …… Given Names: ……..

Date of Birth: ……/……/…… Sex: ☐ Male ☐ Female

Country of Birth: …… Interpreter: ☐ No ☐ Yes – Language: ……

Aboriginal or Torres Strait Islander: ☐ No ☐ Yes MRN: ……

Address: ……..

Phone: Home: …… Work/Mobile: ……

Current Order: ☐ MHRT ☐ Magistrate ☐ None **Date Detained:** ……/……/…….

☐ Involuntary Patient ☐ Voluntary Patient ☐ CTO **Expiry Date:** ……/……/…….

Date made Involuntary Patient: ……/……/……. Mental Health Facility: ……

Application Type: *Please refer to the relevant section/s of the hearing kit regarding requirements for the hearing.*

☐ Mental Health Inquiry – Sec 34
☐ Appeal Against Authorised Medical Officer's Refusal to Discharge – Sec 44
☐ Review of Involuntary Patient Order - Sec 37(1)(a)
☐ Review of Involuntary Patient Order – Sec 37(1)(b) – *3 monthly within first 12 months of being made an involuntary patient*
☐ Review of Involuntary Patient Order – Sec 37(1)(c) – *after first 12 months of being made an involuntary patient*
☐ Review of Voluntary Patient Order – Sec 9
☐ Appeal Against Magistrates CTO – Sec 67(2) – ***Please attach copy of Magistrates Order***
☐ Review of Detained Person on CTO – Sec 63
☐ ECT Administration Inquiry – Invol Patient – Sec 94(2) ☐ ECT Consent Inquiry – Vol Patient – Sec 93(3)
☐ ECT Person under 16 years– Invol Patient Sec 94(2A) ☐ ECT Person under 16 years– Vol Patient Sec 94(2A)
☐ Consent to Surgery – Sec 101(1) ☐ Consent to Special Medical Treatment – Sec 103
☐ Application for a Financial Management Order – Sec 46 (*NSW Trustee and Guardian Act, 2009*)
☐ Review of Interim Financial Management Order – Sec 48 (*NSW Trustee and Guardian Act, 2009*)

☐ Community Treatment Order – Sec 51 – ***Please complete all fields and attach copy of Magistrates Order if applicable***

Applicant: …… **Position:** …… **Contact Number:** ……

Please Select: ☐ Authorised Medical Officer ☐ Medical Practitioner ☐ Designated Carer/Principal Care Provider
☐ Director of Community Treatment ☐ Deputy Director of Community Treatment (under delegation)

Note: The applicant must be an Authorised Medical Officer of a Mental Health Facility in which the client is detained or is a patient: a Medical Practitioner who is familiar with the client's clinical condition: a Director of Community Treatment (or a Deputy Director under appropriate delegation) who is familiar with the client's clinical condition; or the primary carer of the client.

Declared Community Mental Health Facility: ……

Proposed Venue & Address: ……
…… **Date/Time Preferred:** ……a.m./p.m.

Hearing Type: ☐ Live ☐ Video - ISDN number: …… ☐ Phone – number: ……

Mental Health Facility Contact: …… *Case Manager/Doctor/Tribunal Liaison Clerk*

Ph: …… **Mobile:** …… **Fax:** ……

Additional Information:
……
……
……

M.H.R.T. Use Only
Notice to be served by:
In person/faxed to client: ____/____/___
Posted to Client: ____/____/____
Applicant advised: ☐ No ☐ Yes

M.H.R.T. Use Only
M.H.A.S Required: ☐ No ☐ Yes
Security Required: ☐ No ☐ Yes
Booking: ☐ Confirmed ☐ Via Msg
Date: ____/____/____ Initials: _____