Guidelines for Community Treatment Order Applications

These guidelines take into account the legislative criteria in the *Mental Health Act 2007* (including Amendments to the Act commenced in August 2015), the objects of the Act in s 3 and the principles of care and treatment in s 68.

1. Criteria for community treatment orders

Section 53 of the Act permits the making of a CTO if the Tribunal is satisfied that:

- the person would benefit from the CTO as the least restrictive alternative consistent with safe and effective care; and
- the mental health facility has an appropriate treatment plan and is capable of implementing it; and
- if the person has been previously diagnosed as suffering from a mental illness, there must be a history of refusal to accept appropriate treatment,
- but, in the case of a forensic patient or a person who has been the subject of an order over the preceding 12 months there must be evidence that the person would continue in, or relapse into, an active phase of mental illness if the order is not granted.

However a CTO may only be made at a mental health inquiry if the Tribunal is satisfied that the assessable person is a mentally ill person.

The objects of the Act in s 3 reinforce the goal of access to appropriate care while protecting the civil rights of the affected person and facilitating the making of appropriate decisions about their care and treatment with the affected person and their carer. The objects also seek to facilitate voluntary care and, in limited situations, care on an involuntary basis. The principles of care and treatment in s 68 emphasise the importance of holistic care determined in collaboration with the patient and their designated carer(s) or principal carer provider.

2. The scope of treatment plans

S 54 of the Act sets out the content of treatment plans as follows:

- “a treatment plan for an affected person is to consist of the following
  a) in general terms an outline of the proposed treatment, counselling, management, rehabilitation and other services to be provided to implement the order; and
  b) in specific terms, the method by which, the frequency with which, and the place at which, the services would be provided for that purpose”.

As the treatment plan is to ‘consist’ of specified items it may not include terms not falling within s 54 (a) or (b). Accordingly, treatment plans should only include terms which relate to services to be provided and those services should be in respect of a person’s treatment, counselling, management, rehabilitation or other services.

3. Conditions purporting to limit a person's conduct other than in accordance with section 56(1)

It is acceptable for a person's conduct to be controlled by treatment plan conditions which relate to medication, therapy, counselling, management, rehabilitation and acceptance of services as per s 56 (1) (a).

However, treatment plans which include conditions as to a person's conduct, which do not do not relate to the acceptance of services, medication, therapy etc should not be included in treatment plans. This is because s 56 sets out the limits of the affected person's obligations under a CTO and requires that they be present at the reasonable times and places specified in the order to receive services related to medication, therapy, counselling, management, rehabilitation and other services provided in accordance with the treatment plan. S 57 requires the person to comply with the CTO.

Therefore the inclusion of conditions, such as requiring a person not to intimidate or harass the treating team, or to be of good behaviour, or prohibiting the use of alcohol or illicit substances may not be included in the treatment plan.

Nevertheless, it may be helpful in some circumstances for the Tribunal to make clear statements during the hearing about the negative impact on the person's mental health if they engage in behaviour such as illicit drug use or alcohol abuse, but generally a condition prohibiting such conduct should not be included in the treatment plan.

4. Treatment plan conditions

A major purpose of CTOs is to ensure that affected persons receive safe and effective care in the community rather than in the more restrictive setting of a hospital. Another important goal is the delivery of care and treatment of a kind that is recovery focussed and this may be reflected in the kind of services outlined in treatment plans.

Therefore, there may be services stipulated in a treatment plan which if refused would not result in a breach of the order.

For example, CTOs may include a requirement for attendance at counselling services but a person could NOT be breached for non compliance with the clause because a breach requires a deterioration or risk of deterioration in mental state which may be unlikely to flow from non attendance at counselling.

5. Urine drug screen clause

Where a person has an illicit drug use history which impacts on their mental health it can be appropriate to include urine screen clauses and counselling clauses in a treatment plan.

A request to supply a urine sample for illicit drug screening is capable of constituting a "service" if the subject person has a history of illicit drug use, so that the drugs might impact negatively on their mental health. Accordingly, any such clause to be consistent with the requirements of section 54(b) of the Act needs to specify the frequency of the service to be provided over a particular period. For example, a request might be made by the case manager for screening to occur not more than three times during a suitable interval (e.g. monthly) with the frequency in each case

being determined on its own facts. It is recommended that a maximum frequency of drug screening over a particular period be included.

Where the inclusion of a clause is considered to be necessary, the following wording is suggested:

Because Mr/Ms X has a history of illicit drug use which adversely impacts on his/her mental health he/she ***should refrain*** *from using such substances and he/she is required to accept the urine screening and/or counselling services referred to in the following conditions".*

> *(insert client's name) is required to have blood tests as requested by the case manager/treating doctor/psychiatrist no more than* ***(insert maximum number)*** *times in (****insert number of months)*** *months* ***(OR as clinically indicated).***

Where it is considered that counselling is an appropriate adjunct to urine drug screening the preferred clause is as follows:

> *(insert client's name) is required to attend drug and alcohol counselling* ***(insert maximum number)*** *times* ***(insert frequency)*** *as requested by the case manager/ treating doctor/ psychiatrist*.

The need for such clauses will depend on there being evidence that there is a history of illicit drug use which might affect the subject person's mental health adversely.

In cases where the patient has a clear history of relapse in the context of drug use but there is not contained in the treatment plan a clause in the above terms it may be appropriate for the Tribunal discuss the merits of doing so with the treating team and applicant of the CTO at the hearing. However, the clause should only be included if the case manager/ treating doctor agree to its inclusion.

6. Blood tests and other testing

Blood tests clauses are often inserted in treatment plans to monitor medication levels or test for side effects to medication or the emergence of syndromes as a result of taking medication are often a necessary component of an affected person's treatment. In such cases it is appropriate to have a clause as follows:

> *(Insert affected person's name) is required to comply with blood tests as requested by the case manager/treating doctor/psychiatrist or delegate.*

If the frequency of blood tests is known by the treating team then it should be specified in the treatment plan (for example the full blood count for clozapine patients is done each month).

In cases where the tests are not required to occur at specified intervals it is appropriate to state that they are to occur as *"clinically indicated and at the direction of the case manager/and or treating doctor".*

Treatment Plans should not include a general clause allowing for tests unless the medication in the treatment plan requires such testing.

From time to time blood tests are included in treatment plans for the purpose of testing for co morbid conditions, such as HIV, thyroid, infection or general health. Consistent

with paragraph 10, such blood tests are not to be included in Treatment Plans. If there is a need for such testing it should be resolved under the Guardianship Act.

In cases where blood tests may be required because of a change of medication the treating team should seek a variation to the treatment plan (see variation to treatment plans at paragraph 12).

7. Travel restrictions

Persons subject to CTOs may wish to travel intrastate, interstate or overseas. The Act is silent on the issue of travel while subject to a CTO. However, unless arrangements are agreed with the treating team in advance, travel may result in the breach the terms of their order to be present at the times specified in the treatment plan for treatment and other services.

In appropriate cases the affected person's treating team may be able to make reciprocal arrangements at the place of destination such that they receive care and treatment in a manner which is consistent with safe and effective care. Whether the treating team can approve of a travel plan is a judgement call and this can be explained by the panel to the affected person at the hearing.

In cases where the treating team consider that a reciprocal arrangement cannot be made or that it would not be consistent with safe and effective care this should be explained to the affected person, and it may be sufficient to advise them that if they travel they are likely to breach the conditions of the order. The Tribunal panel may also wish to advise the person at the hearing that travel which results in a failure to comply with the terms of a treatment plan may lead to a breach of the order.

Nevertheless, a condition prohibiting travel should not be in a treatment plan as it is not a 'service', and does not accord with the principles of care and treatment in s 68.

8. Residence restrictions

The Act does not allow the Tribunal to compel a person subject to a CTO to live at a particular place or area, although community facilities operating under the local network system may decline to provide support unless the person lives in their area. Consequently it may not be possible to ensure a person is adequately treated in the community with an appropriate level of support, unless a community facility is persuaded to accept responsibility for them.

It has sometimes been argued that patients who frequently move residences to avoid a CTO should be required to reside at a particular place so that safe and effective care treatment can be given to them in the least restrictive environment. This is a matter which is relevant to whether a person is likely to benefit from the order and the capacity of the treating team to implement the order.

Similarly a CTO cannot compel a person to reside in a rehabilitation facility or other residential facility. However, a person subject to an order may admit themselves to a residential facility or be placed in a facility by a guardian and still be treated under a CTO.

9. CTOs for persons of no fixed abode

The Act does not require a person to have a permanent residence in order to be eligible for a CTO. In cases where the community team is able to monitor a patient's treatment despite the patient not having a fixed place of abode there is no reason why an order cannot be made, although from a practical point of view it may be more difficult to treat a patient and enforce the conditions in the treatment plan. Indeed, such people may require an order more than others.

Some inner city mental health facilities are able to effectively case manage homeless or itinerant people on a CTO. If there is evidence that an order can be implemented, and all the other criteria for making an order are met, an order may be made.

10. Medications and /or treatments for non psychiatric conditions or illnesses

Sometimes treatment plans include conditions compelling a person to accept treatment or medication for co-morbid conditions or illnesses in addition to their psychiatric medications. These have ranged from contraceptive or anti libidinal medication, to medication to treat diabetes, heart disease, and HIV.

This is a complex area as in some cases the refusal to have medication and/or treatment may be related to the person's mental illness and may cause serious harm or even be life threatening. Further, all mental health facilities are required by Departmental guidelines to have a comprehensive care plan for each patient and are expected to be pro-active in ensuring the person is treated holistically and this includes advocating for their physical health needs. This often leads case managers to argue that non–psychiatric medication should be included in the treatment plan and that the failure to do so means that the person cannot be given safe and effective care. Further, that the inclusion of non-psychiatric medication is likely to result in the person being compliant and this will contribute to their overall well being.

Although each case will turn on its own facts, as a general rule, medications of a non-psychiatric kind should not be included in a person's treatment plan. If a person is refusing to have medication for other conditions or illnesses, and they lack capacity to make informed decisions about their treatment, the appropriate course is for the case manager and treating psychiatrist to seek consent under part 5 of the Guardianship Act. That Act sets out a hierarchy of substitute consent givers depending on the nature of the illness, conditions, treatment or investigations that are required.

In cases where the medications and treatment for the co-morbid condition is not related to the person's mental illness they should not be included.

11. Variation and revocation of a CTO

Section 65 provides that the Tribunal may consider an application to vary or revoke a CTO if there has been a substantial or material change in the circumstances surrounding the making of the order, or if relevant information that was not available when the order was made has becomes available. Typically a variation is needed when the client has moved into a different area, or there has been a substantial change in the treatment plan. For example, a new medication has been introduced which requires regular blood tests and this is not covered in the original treatment plan. Before a variation or revocation hearing can take place the Tribunal must be first satisfied that the threshold has been reached.

Except for inconsequential variations, such as a change in the treating team because the affected person has changed address, variations should be dealt with at a hearing and not “on the papers”.

Examples of when a hearing is required follow, but are not exhaustive.

- Changes in medication can usually be done at the discretion of the treating team but where the change is more intrusive such as changing from an oral to depot medication, or changing to a medication which involves blood or other testing, such as Clozapine, a hearing is required.

- Adding a drug urine clause or breath tests for alcohol use.

- Adding other services or conditions not on the original plan.

12. CTOs for persons presenting for the first time with symptoms of a mental illness

A person who is being treated for a mental illness for the first time can be the subject of a CTO. Some mental health clinicians are mistakenly of the view that it is necessary for a person to have a history of non compliance before a CTO application can be made. This is incorrect. Section 53 states that it is necessary to establish a failure to comply with appropriate treatment **if** there has been a previous diagnosis of mental illness. Most people presenting with a first episode qualify for an order. However, the Tribunal must be satisfied that all criteria for making an order have been met, including that it is the least restrictive option, consistent with safe and effective care.

13. Treatment Plans that nominate health professionals not employed by the mental health facility

The 2007 Act seeks to provide flexibility in the way CTOs are administered. Notably, the Act now allows for applications to be made by medical practitioners and their designated carer(s) or principal carer provider and unlike the 1990 Act there is no requirement that an affected person’s case manager must be an officer or employee of the mental health facility.

As long as a mental health facility has agreed to submit a treatment plan and the Tribunal is satisfied that a CTO will be supervised and monitored by a medical practitioner or treating psychiatrist (or other mental health professional) who agrees to liaise with the director of the mental health facility as to the affected person’s progress, including any failure to attend to the conditions in the treatment plan, then an order may be made.

The Tribunal is aware of one patient who is managed by a psychiatrist attached to a hospital based mental health facility because the patient has incorporated the community treating team into his delusional system. Also, some patients prefer to be managed by their own doctor as they find it less stigmatising.

14. The Tribunal’s role in relation to prescribed medication

The Tribunal does not prescribe care and treatment but it is a review body and has a clear role in discussing the relative merits of depot injection or oral medication and poly pharmacy issues at a CTO hearing. The Sheedy case reinforced the need to be

concerned with whether there are less restrictive medication regimes available which are **consistent with safe and effective care**.

15. A treatment plan is not capable of implementation if the patient is resistive to it

The criterion that the CTO must be capable of implementation have on occasions been mistakenly interpreted to mean that an affected person's opposition to it means that it is not capable of implementation.

This view is incorrect as if it were true there would be little point to having CTO legislation. A large percentage of persons on orders are opposed to having them.

The criterion refers to the capacity of the mental health facility to monitor and supervise care and treatment. Page **8** of **9** MHRT – Guidelines for Community Treatment Orders March 2012.

16. The length of a CTO

The length of any order must be determined by reference to the criteria in s 53(7), namely the estimated time to stabilise the condition of the affected person and to establish, or re-establish, a therapeutic relationship between the person and the person's case manager.

The rationale for the provision is likely to be that CTOs should only be for as long as is necessary to achieve mental health stability or a therapeutic alliance such that an affected person is more likely to continue with appropriate treatment without an order. The provision attempts to strike a balance between interfering minimally with a person's civil right to be free from interference and the right to access care and treatment.

It should be borne in mind that any order for more than six months confers a right of appeal to the Supreme Court on the basis of the order's length. It is likely that the legislature intended that orders of 6 months or less would be the norm and anything longer would be require exceptional reasons and must be based on the above criteria.

17. Risk and best interests

CTOs may reduce the risk of the patient becoming unwell and consequently they may reduce other risks such as a client's risk of offending. CTOs may also be in the person's best interest. However, the test is whether the CTO is the least restrictive option for safe and effective care of the person's mental illness NOT whether the CTO will be effective in stopping the person offending or whether it is, in some clinicians view, in the best interests of the patient.

If the Tribunal considers that the person is too unwell for discharge this point can be made in the hearing. But if the panel decides not to make a CTO it will not prevent the person from being discharged. Discharge without a CTO may involve more risk.

18. Risk assessments

The Community Forensic Mental Health Service (CFMHS) is not available to do risk assessments for civil patients except in the most extreme cases. This would require the President's involvement and would usually involve cases where admission to the Forensic Hospital is being considered.

19. Breach of a CTO and Tribunal review

The status of a person admitted under the breach provisions will be that of a detained person in accordance with s 19 of the Act (s 62 (3)).

An Authorised Medical Officer (AMO) must cause a detained person to be brought before the Tribunal not later than three months after the person was detained.

The Tribunal must decide if the person is a mentally ill or a mentally disordered person for whom no care of a less restrictive kind is appropriate or reasonably available. If such a determination is made the Tribunal must determine whether the person should remain in the mental health facility until the end of the CTO or be made an involuntary patient. If the Tribunal does not determine that the person is mentally ill, or if less restrictive care is appropriate and reasonably available, it must make an order that the person be discharged from the facility and the Tribunal may make a new CTO. The Tribunal may defer the operation of the order for discharge for up to 14 days.

If at the end of the CTO the person is still a mentally ill person and there is no less restrictive form of appropriate care available the authorised medical officer may cause the person to continue to be detained in a mental health facility. Section 62(3) of the Act provides that the person is taken to be detained in the mental health facility under s 19 when the AMO takes action to detain the person.

20. Deferring discharge on the making of a CTO for an involuntary patient

Pursuant to s 53(8) the Tribunal can order that the discharge of an involuntary patient for whom a community treatment order is made be deferred for a period of up to 14 days, if the Tribunal thinks it is in the best interests of the patient to do so.

Such an order may be made when a CTO application has been made for an involuntary patient but there is a need for the patient to remain in the facility for a period of time before they can be discharged.

If the CTO is being made at a mental health inquiry, the Tribunal may, if appropriate, firstly make the patient an involuntary patient, then make a CTO and order that the discharge be deferred.