

MHRT No: \_\_\_\_\_

Date Reg'd: \_\_\_\_\_

## ***Application for a Community Treatment Order for a forensic or correctional patient or an inmate in a correctional centre***

### ***Under Section 67 of the Mental Health (Forensic Provision) Act 1990***

A Community Treatment Order for a forensic or correctional patient or an inmate in a correctional centre (known as a Forensic Community Treatment Order or FCTO) is a legal order made by the Mental Health Review Tribunal. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services. The treatment plan is usually developed and implemented by Justice Health, but the FCTO continues if the person is released from a correctional centre.

FCTOs can be made for any period of time up to twelve months. It is possible for a person to have more than one consecutive FCTOs and for a subsequent Community Treatment Order to be made after a person is released from custody.

A FCTO authorises compulsory care. If a person breaches a FCTO 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.

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#### **DETAILS OF THE PERSON THE APPLICATION IS ABOUT**

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

ADDRESS: \_\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Daytime* *After hours* *Fax*

DATE OF BIRTH: \_\_\_\_\_ COUNTRY OF BIRTH \_\_\_\_\_

☐ MALE ☐ FEMALE MIN NO: \_\_\_\_\_

#### **CURRENT STATUS:**

☐ Forensic Patient ☐ Correctional Patient ☐ Inmate in a correctional centre inc. subject to transfer order

☐ Current FCTO 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. Notice should generally be served at least 7 days before the hearing to ensure reasonable notice.

DATE OF SERVICE: \_\_\_\_\_ HOW SERVED: \_\_\_\_\_

#### **DETAILS OF THE PERSON MAKING THE APPLICATION**

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

ADDRESS: \_\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Daytime* *After hours* *Fax*

RELATIONSHIP (eg medical officer, 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:**

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HOW LONG DO YOU WANT THE FCTO TO BE FOR? (max 12 months) : \_\_\_\_\_

DOES THE CLIENT SUPPORT THE APPLICATION: ☐ YES ☐ NO

Please indicate reasons why and any problems with the FCTO identified by the patient:

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**BACKGROUND INFORMATION:**

**SHORT HISTORY OF THE PERSON'S ILLNESS:**

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

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

**EFFICACY OF CURRENT FORENSIC COMMUNITY TREATMENT ORDER (if applicable)**

**ANY DIFFICULTIES IN ASSISTING THE CLIENT DURING THE CURRENT ORDER (if applicable):**

**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 the designated carer(s), 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: \_\_\_\_\_

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: \_\_\_\_\_

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) 9879 6811 or Email: [mhrtforensic@doh.health.nsw.gov.au](mailto:mhrtforensic@doh.health.nsw.gov.au)**

**For further information or assistance please contact the Tribunal on the following numbers:**

**Phone: (02) 9816 5955 Toll Free: 1800 815 511**