CHAPTER 4 - INVOLUNTARY TREATMENT ORDERS

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1. Introduction

Under the Mental Health Act 2000 (the Act), administration of involuntary treatment without consent may be authorised by an involuntary treatment order.

The Act also establishes additional requirements for treatments and/or interventions such as electroconvulsive therapy, seclusion and restraint. These are explained in chapters 12 and 13 of the Resource Guide.

The provisions of the Act summarised below can be read in full in the Mental Health Act 2000, Chapter 4 (Involuntary treatment) and Chapter 6 Part 1 (Reviews by Tribunal for patients under involuntary treatment order).

1.1 Director of Mental Health resources

Director of Mental Health resources of particular relevance to this chapter include:

- Fact sheet 3 – Involuntary treatment
- Guideline - Information sharing between mental health workers, consumers, carers, family and significant others

2. Commencing involuntary treatment orders

2.1 Making an involuntary treatment order (s108-111)

An involuntary treatment order can only be made by an authorised doctor who has examined the patient during the involuntary assessment period (see chapter 3 of the Resource Guide).

A second examination by an authorised psychiatrist is required in certain circumstances (see section 2.2 in this chapter).

When an authorised psychiatrist can/cannot make an involuntary treatment order

The Act aims to ensure that the involuntary assessment, treatment or care processes are not based on the opinion of one clinician. Hence, a psychiatrist who makes a recommendation for assessment for the patient cannot make the involuntary treatment order. The psychiatrist can however undertake the second examination (to confirm or revoke the involuntary treatment order) if the involuntary treatment order is made by another authorised doctor.
Note that an authorised doctor who is not a psychiatrist can make a recommendation for assessment and an involuntary treatment order. In this instance, a second examination by an authorised psychiatrist will be required.

Key requirements for making an involuntary treatment order

In making an involuntary treatment order, the authorised doctor must:

- be satisfied that all treatment criteria are met (see section 2.4 of this chapter);
- complete the involuntary treatment order form and state:
  - the time the order is made;
  - the basis on which the doctor is satisfied the treatment criteria apply to the patient, including the facts indicating mental illness observed by the authorised doctor;
  - the category of the order (see section 2.5 of this chapter); and
  - the authorised mental health service responsible for ensuring the person receives treatment.
- tell the patient:
  - that the order has been made;
  - the category of the order; and
  - the basis on which the doctor is satisfied that the treatment criteria apply;
- prepare a treatment plan for the patient (see section 2.6 of this chapter) and talk to the patient about the treatment plan; and
- prepare an absent without permission response plan or if already in place, review existing plan. An absent without permission response plan is mandatory for all inpatients and preferable for community patients (see section 2.7 of this chapter).

In addition, the authorised doctor should document relevant details in the patient’s clinical record including:
- mental state examination/s undertaken in the assessment period;
- confirmation that the patient has been informed of the making of the order; and
- confirmation that the treatment plan has been discussed with the patient.
The administrator must ensure the information system is updated to reflect the making of an *involuntary treatment order*, including the category of the order and whether a second examination is required.

### 2.2 Second examination (s112)

#### When second examination is required

The Act contains safeguards that ensure an *involuntary treatment order*:
- is made or ratified by an authorised psychiatrist; and
- does not rely solely on assessment conducted by audio-visual link.

To achieve this, the Act requires a second examination by an authorised psychiatrist when:
- the authorised doctor who made the *involuntary treatment order* was not a psychiatrist; or
- the *involuntary treatment order* was made by a psychiatrist who assessed the patient using an audio-visual link.

The second examination must be in person if the *involuntary treatment order* was made on an assessment (by either an authorised doctor or authorised psychiatrist) using an audio-visual link. The Act allows the second examination to be undertaken by the same psychiatrist who made the order (i.e. the order is made on an examination conducted by audio-visual link and the second examination is face to face).

The second examination must occur within 72 hours of the making of the *involuntary treatment order*. The following declaration and flowchart appears on the back of the *involuntary treatment order* to assist the authorised doctor determine if a second examination is required.

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**Declarations**

- I am satisfied that the treatment criteria apply to the patient.

<table>
<thead>
<tr>
<th>Authorised doctor</th>
<th>Authorised psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date:  / / / 24 hour</td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Mark applicable boxes</th>
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</thead>
<tbody>
<tr>
<td>Authorised psychiatrist</td>
</tr>
<tr>
<td>Assessment carried out</td>
</tr>
<tr>
<td>Second examination</td>
</tr>
</tbody>
</table>

**Information to decide if a second examination is required within 72 hours**

- Assessment by Authorised psychiatrist
  - Assessment in person
  - Second examination not required
  - Assessment conducted via audio-visual link
  - Second examination by authorised psychiatrist required must be in person and may be by same psychiatrist

- Assessment by other authorised doctor
  - Assessment in person
  - Second examination by authorised psychiatrist required may be in person or by audio-visual link
  - Assessment conducted via audio-visual link
  - Second examination by authorised psychiatrist must be in person
Treatment of the patient before second examination

Treatment may be administered without the patient’s consent once the *involuntary treatment order* is made by an authorised doctor. This includes an order made by way of audio-visual link and/or an order made by an authorised doctor who is not a psychiatrist.

The second examination must be undertaken as soon as possible and, in any case, within 72 hours of the *involuntary treatment order* being made.

Role of authorised psychiatrist undertaking second examination

In undertaking the second examination, the authorised psychiatrist must determine whether the treatment criteria apply (see section 2.4 of this chapter).

If the psychiatrist is satisfied the treatment criteria apply, the psychiatrist must confirm the *involuntary treatment order*. If the psychiatrist is not satisfied the treatment criteria apply, the psychiatrist must revoke the *involuntary treatment order*.

The authorised psychiatrist must complete the ‘second examination’ section on the *involuntary treatment order*.

Documentation of the authorised psychiatrist’s examination should be made in the patient’s clinical file.

Cessation of *involuntary treatment order* in second examination period

The *involuntary treatment order* (and the authority to administer treatment without consent) ends if:

- the authorised psychiatrist determines that the treatment criteria do not apply; or
- the order is not confirmed or revoked within the 72 hour period.

The authorised doctor must tell the patient that she or he is no longer an involuntary patient. Confirmation that the patient has been advised should be documented in the patient’s clinical file.

The administrator or the administrator delegate must complete the ‘cessation of an *involuntary treatment order*’ section on the bottom of the *involuntary treatment order*.

The administrator must ensure the information system is updated to reflect the details of the second examination and any change in the patient’s involuntary status.
2.3 Notice of making involuntary treatment order (s113)

Within seven (7) days of making an *involuntary treatment order*, the administrator must give written notice of the order to:

- the patient;
- the Mental Health Tribunal (the Tribunal); and
- the patient’s allied person.

**Notification of an involuntary treatment order when patient is a child**

Under section 144 of the *Hospital and Health Boards Act 2011*, the health professional needs to make a case by case decision on whether the child is of a sufficient age and mental and emotional maturity to understand the making of an *involuntary treatment order*. If a health professional considers the child to have insufficient capacity, then a decision to disclose information to a parent or guardian, needs to be determined if it is in the child’s best interest.

The clinician should document in the patient’s file, how they have reached the decision.

2.4 Treatment criteria (s14)

The treatment criteria apply in making an *involuntary treatment order* and, where relevant, in determining whether the order should be confirmed or revoked on a second examination.

The authorised doctor must be satisfied that all treatment criteria are met. The authorised doctor who makes the *involuntary treatment order* must address each criterion when completing the form.

Note that the treatment criteria are also relevant to the regular review of the patient under an *involuntary treatment order* (see section 3 in this chapter).

The treatment criteria are as follows:

(a) **the person has a mental illness**

The authorised doctor must be satisfied that the patient has a mental illness. The definition of mental illness is discussed in chapter 1 of the Resource Guide.

The patient’s clinical history and information received from others (for example, family, case manager, etc) are critical considerations in determining whether the patient has a mental illness. However, it is...
also important to note that the authorised doctor making an **involuntary treatment order** is required to document facts indicating mental illness observed by the doctor. The doctor cannot rely solely on the patient’s history and information received from others.

In addressing the criterion on the **involuntary treatment order**, the authorised doctor should record the patient’s diagnosis and the facts upon which their opinion relies including facts indicating mental illness observed during the involuntary assessment period.

(b) **the person’s illness requires immediate treatment**

‘Treatment’ is defined to mean ‘anything done, or to be done, with the intention of having a therapeutic effect on the person’s illness’ (Schedule). The authorised doctor must be satisfied the proposed treatment intervention/s are necessary and should not be delayed.

In addressing the criterion on the **involuntary treatment order**, the authorised doctor should record the reasons for the immediacy including, for example, the likely consequences of not providing treatment at this time.

(c) **the proposed treatment is available at an authorised mental health service**

The authorised doctor must be satisfied that the proposed treatment intervention/s can be provided at an authorised mental health service. The criterion would not be satisfied, for example, if the patient has a condition for which treatment is not effective or if the condition requires treatment that is not available at an authorised mental health service.

In addressing the criterion on the **involuntary treatment order**, the authorised doctor should record, in broad terms, the proposed treatment interventions to be provided by the authorised mental health service (for example, anti-psychotic medication, psycho-social support through case management etc). Further detail about proposed treatment interventions should be documented in the **treatment plan** (see section 2.6).

(d) **because of the person’s illness** –

- there is an imminent risk that the person may cause harm to himself or herself or someone else; or
- the person is likely to suffer serious mental or physical deterioration
Imminent risk of harm to self or others

The authorised doctor must be satisfied that the risk is imminent and results from the patient's mental illness.

Risk of harm is not necessarily limited to risk of physical injury. The authorised doctor may, for example, take account of adverse financial or social impacts, particularly where these are of a significant nature.

In addressing the criterion on the involuntary treatment order, the authorised doctor should document the nature of the risk of harm, how this is attributable to the patient’s illness, and the basis for the doctor's view that the risk of harm is imminent.

Likely serious mental or physical deterioration

The criterion requires the authorised doctor to be satisfied that serious mental or physical deterioration is 'likely' in the absence of treatment.

In addressing the criterion on the involuntary treatment order, the authorised doctor should document the basis for their opinion including, for example, the nature and course of the illness and the patient’s clinical history.

(e) **there is no less restrictive way of ensuring the person receives appropriate treatment or care for the illness**

The authorised doctor must be satisfied that there is no less restrictive way of ensuring that the person is treated.

In addressing the criterion on the involuntary treatment order, the authorised doctor should document the reasons involuntary treatment is necessary including, for example, recent efforts to engage the patient in voluntary treatment, the patient’s level of insight and their history of compliance with treatment.

(f) **the person –**

- lacks the capacity to consent to be treated for the illness or
- has unreasonably refused proposed treatment for the illness

**Capacity to consent**

The issue of consent relates to the person’s own capacity to consent. If a guardian has been appointed under the Guardianship and Administration Act 2000 for a person, the guardian’s consent to the person’s treatment is not effective.
For the purposes of treatment, ‘capacity’ (defined in the Act’s dictionary) means the person is capable of -

- understanding the nature and effect of decisions about the person’s assessment, treatment, care or choosing of an allied person;
- freely and voluntarily making decisions about the person’s assessment, treatment, care or choosing of an allied person; and
- communicating the decision in some way.

In addressing the criterion on the involuntary treatment order, the authorised doctor should document the elements of capacity that are not met and the basis for this opinion.

It must be noted that capacity can fluctuate. Capacity can be regained and it may deteriorate. Regular assessment of capacity is imperative. Capacity to make a decision can fluctuate with the person’s emotional state, mental state, time of day and medication side-effects. It is therefore imperative that there is regular assessment of capacity, with documentation of the questions asked and overall clinical impression of the patient’s capacity.

**Unreasonable refusal**

‘Unreasonably refused’ is not specifically defined in the Act. Examples of when a person’s refusal could be considered unreasonable include:

- when the refusal would put the patient’s safety or the safety of others at risk; or
- when the basis of the person’s decision to refuse assessment is not rational.

In addressing the criterion on the involuntary treatment order, the authorised doctor should document the basis for the opinion that the patient’s refusal is unreasonable.

**2.5 Involuntary treatment order category (s109)**

In making an involuntary treatment order, the authorised doctor must determine whether the patient requires treatment as an inpatient (involuntary treatment order (inpatient)) or in the community (involuntary treatment order (community)).

In making the determination, the authorised doctor must have regard to the general principles that underpin the Act. In particular, the doctor should ensure that the decision provides the least restriction necessary to protect the patient's health and safety, and to protect others.
An involuntary treatment order (inpatient) authorises the administration of treatment without consent and detention in the authorised mental health service. Limited community treatment may be authorised for the patient (see chapter 9 of the Resource Guide).

An involuntary treatment order (community) authorises the administration of treatment without consent. Note that force can only be used to administer treatment in an authorised mental health service, not in the person’s home or another place that is not an authorised mental health service.

### 2.6 Preparing a treatment plan (s124)

In making an involuntary treatment order, the authorised doctor must prepare a treatment plan for the patient and clearly document the plan in the patient’s clinical file. The doctor may use the consumer care review and summary plan contained within the statewide standardised clinical suite of documentation at: http://qheps.health.qld.gov.au/mentalhealth/docs/a_cc_review_sum.pdf

The treatment plan sets out the patient’s treatment under the involuntary treatment order and ensures accountability in the involuntary treatment process. In line with the principles underpinning the Act, the patient should, as far as possible, be involved in the development of the treatment plan.

The treatment plan must include:

- an outline of proposed treatment to be provided;
- details of the services to be provided including who will provide service, where and how often it will be provided and the duration for which it will be provided; and
- intervals for the patient’s regular review by an authorised psychiatrist (see section 3.1 in this chapter).

If the patient is on an involuntary treatment order (community) and being treated at a health service other than an authorised mental health service, the treatment plan must state the name of the health service and the health practitioner providing the treatment.

The treatment plan must also take into account any existing plan of treatment or care for the patient and recognise the patient’s wishes as expressed in an advance health directive under the Powers of Attorney Act 1998. However, these matters are not binding on the health practitioner, recognising that the treatment plan needs to be responsive to the patient’s particular needs at the time.
The administrator must ensure the patient is treated according to the treatment plan and that regular assessments by an authorised psychiatrist are carried out.

Where possible, family, carers and others should be consulted in the preparation and delivery of treatment plans. The guideline Information sharing between mental health workers, consumers, carers, family and significant others provides information on the legislative framework within which consumer information can and should be shared, and how it can be applied in a clinical setting.

Taking pathology specimens

The Act provides authority for clinicians to provide treatment under an involuntary treatment order. If the treating doctor is of the view that taking a blood sample is necessary to promote and maintain the mental health and wellbeing of a patient under an involuntary treatment order, the blood sample may be taken in the absence of consent. If taking blood samples is considered necessary to promote and maintain the patient’s mental health and wellbeing, it should be documented in the patient’s treatment plan.

2.7 Preparing an absent without permission prevention and response plan

An absent without permission prevention and response plan is mandatory for involuntary inpatients and is recommended for community patients. It must be based on assessment of the patient’s risk of becoming absent without permission or failure to comply with conditions of leave.

An absent without permission prevention and response plan outlines clinical strategies to mitigate and manage absence without permission risk and actions to be undertaken by the service if the patient becomes absent without permission. It is intended to supplement clinical judgment at the time of an absence without permission event and must be consistent with the requirements of the Absence Without Permission Checklists.

The absent without permission prevention and response plan must be incorporated into care planning and documented in CIMHA and/or the patient’s local service clinical record.

The absent without permission prevention and response plan must be reviewed regularly and amended in line with any changes in the patient’s situation or clinical needs and following any unauthorised absence event.
2.8 Administrator responsibilities

Review of involuntary treatment order

The administrator must review the involuntary treatment order as soon as possible to ensure compliance with legislative requirements. Any errors or omissions identified should be rectified without delay.

Notifications (s113)

Within seven (7) days of the involuntary treatment order being made or confirmed, the administrator must give written notice of the order to:

- the patient;
- the Tribunal; and
- the patient’s allied person.

A notice of making of involuntary treatment order letter is used to notify these parties.

The patient should be informed of their right to choose an allied person or to change an existing nomination and supported in exercising this right. The patient should be provided with written and verbal information about their rights as an involuntary patient, including their right to choose an allied person.

Under section 541A of the Act, the administrator must tell or explain something to a patient:

- in a way that the patient is most likely to understand; and
- in a way that has appropriate regard to the patient’s age, culture, mental illness, communication ability and any disability.

If the administrator believes that the patient has not understood what they were told or explained, they must record details of the fact in the patient’s file (see Chapter 11 of the Resource Guide).

3. Ongoing treatment and review

3.1 Regular clinical review by authorised psychiatrist

An authorised psychiatrist must, at a minimum, assess the patient at the intervals specified in the treatment plan.
In making the assessment, the authorised psychiatrist must determine whether the criteria for involuntary treatment continue to apply to the person (see section 2.4).

The psychiatrist must document the details of the assessment in the patient’s clinical file.

### 3.2 Changing the involuntary treatment order category (s119)

An authorised doctor at the patient’s treating health service may change the category of the involuntary treatment order:

- if the authorised doctor is satisfied the change of category is necessary to meet the patient’s treatment needs (includes situations whereby a patient is admitted to hospital for medical treatment); or
- if a change of category is ordered by the Tribunal.

If the category of the order is community and the patient subsequently becomes a classified patient, an authorised doctor must change the category of the order to inpatient (see chapter 5 relating to classified patients).

In changing the category of an involuntary treatment order, the authorised doctor must:

- complete a change of category form, specifying the reasons for the change; and
- talk to the patient about the change if this is reasonable and practicable and in the interests of the health or safety of the patient or others.

The authorised doctor should also document the change of category and the reasons for the change of category in the patient’s clinical file. The entry should confirm communication with the patient or provide the reasons for not discussing the matter with the patient.

Under section 541A of the Act, the authorised doctor must tell or explain something to a patient:

- in a way that the patient is most likely to understand; and
- in a way that has appropriate regard to the patient’s age, culture, mental illness, communication ability and any disability.

If the authorised doctor believes that the patient has not understood what they were told or explained, they must record details of the fact in the patient’s file.
The administrator must ensure the information system is updated to reflect the change in category of the *involuntary treatment order*.

**Notice of change of category**

Within seven (7) days of the category of the order being changed, the administrator must give written notice of the change to:

- the patient;
- the Tribunal; and
- the patient’s allied person.

A *notice of change of category of involuntary treatment order* letter is used to notify the patient and the patient’s allied person. A copy of the *change of category* form is provided to the Tribunal.

**Return of patient to inpatient facility on change of category to involuntary treatment order (inpatient)**

If the category of order is changed to *involuntary treatment order (inpatient)*, a health practitioner is authorised to take the person to the authorised mental health service.

The health practitioner may take the patient to the health service with the help, and using the minimum force, that is necessary and reasonable in the circumstances. If required, the health practitioner may contact the police to request assistance. A *request for police assistance* form should be provided to police in this instance. Note that a health practitioner should be involved in the return process, even where police assistance is provided.

The *request for police assistance* form should be completed and a copy forwarded to the administrator for placement on the patients file. Police may be requested to assist in moving the patient. A *request for police assistance* is provided to police in this instance.

The *request for police assistance* form should be completed and a copy forwarded to the administrator for placement on the patient’s clinical record.

The *request for police assistance* should be followed up with telephone call to the relevant police to confirm the form has been received and to establish arrangements for the police assistance.

The health practitioner should, as far as possible, explain the change of category and the reasons for the change of category. This is of particular
relevance where it has not been possible for the authorised doctor to provide this explanation. Where practicable, the *notice of change of category of involuntary treatment order* may be provided to the patient in the course of the patient’s return.

In circumstances where the patient’s location is unknown, processes relating to the return of patients absent without permission may be applied (see chapter 10 of the Resource Guide).

### 3.3 Changing the treatment plan (s124-126)

An authorised doctor for the patient’s treating health service may change the person’s *treatment plan* or authorise a health practitioner to make changes. Changes to the *treatment plan* initiated by the treatment team should, as far as practicable, occur in consultation with the patient.

Note that the *treatment plan* must also be changed to be consistent with an order of the Tribunal or Mental Health Court, or a decision of the Director of Mental Health (the Director) to transfer the patient to another authorised mental health service.

The authorised doctor or the health practitioner authorised to change the *treatment plan* must document changes on the *treatment plan* and in the patient’s clinical file. The clinical file entry should confirm communication with the patient or provide the reasons for not discussing the matter with the patient.

The authorised doctor should also document the change of category and the reasons for the change of category in the patient’s clinical file. The entry should confirm communication with the patient or provide the reasons for not discussing the matter with the patient.

Under section 541A of the Act, the authorised doctor must tell or explain something to a patient:

- in a way that the patient is most likely to understand; and
- in a way that has appropriate regard to the patient’s age, culture, mental illness, communication ability and any disability.

If the authorised doctor believes that the patient has not understood what they were told or explained, they must record details of the fact in the patient’s file.

The *treatment plan* should be reviewed and amended when a significant change in the treatment needs occurs (for example change of patient’s status).
3.4 Non-compliance with *involuntary treatment order (community)* (s117)

The Act provides processes to facilitate a patient’s compliance with a *treatment plan* under an *involuntary treatment order (community)*. These processes may, for example, be applicable where the patient has not attended for depot medication or medical appointments as specified in their *treatment plan*.

For these processes to apply, the authorised doctor must be of the opinion that:

- the person has not complied with their *treatment plan*;
- reasonable steps have been taken to obtain compliance without success; and
- there is a significant risk of deterioration in the patient’s mental or physical condition because of non-compliance.

The Act sets out a number of steps aimed at giving the patient appropriate opportunity to respond before being returned to the service to receive treatment.

- The authorised doctor must:
  - make a written record of their opinion and the reasons for their opinion (i.e. how the patient has failed to comply with the *treatment plan*, the steps taken to obtain compliance and the risk of deterioration resulting from non-compliance); and
  - if practicable, talk to the patient about their non-compliance and the consequences of further non-compliance.

- If the patient again fails to comply with their *treatment plan*, the authorised doctor should request the administrator to issue a written notice ordering the patient to attend the service for treatment on a particular day and time. An order to attend *authorised mental health service - involuntary treatment order - community category* form must be completed by the administrator (or delegate) and given to the patient; and

- If the patient does not comply with the administrator’s order, a health practitioner is authorised to take the patient to the health service for treatment.

Note that these processes are not intended to apply where there is clear clinical indication that the patient requires inpatient care. In that instance, the authorised doctor should change the category of the order and make arrangements for the patient to be taken to the inpatient facility (see section 3.2).
Taking patient to authorised mental health service for treatment

A health practitioner authorised to take the patient to the health service may do so with the help, and using the minimum force that is necessary and reasonable in the circumstances.

Where necessary, the health practitioner may request police assistance in taking the patient to the service. A request for police assistance form should be provided to police in this instance. Note that a health practitioner should be involved in the return process, even where police assistance is provided.

The request for police assistance form should be completed and a copy forwarded to the administrator for placement on the patient’s clinical record.

The request for police assistance should be followed up with telephone call to the relevant police to confirm the form has been received and to establish arrangements for the police assistance.

The health practitioner should, as far as possible, explain the process to the patient.

The patient may be detained in a community or inpatient facility of the authorised mental health service for the treatment to be given. An assessment should be made about whether the patient should continue treatment under the community category, or whether the patient requires inpatient treatment.

After the treatment has been administered, the patient must be returned to the place from which they were taken or to another place the patient reasonably asks to be taken.

Non-compliance in a custodial setting

The large majority of patients in custody who are subject to an involuntary treatment order (community) will have been residing in the community prior to incarceration. A small minority will have been returned to custody from an inpatient mental health setting.

For the most part, patients who are subject to an involuntary treatment order (community) while in custody are able to have their treatment needs met through the relevant Prison Mental Health Service for the duration of their custodial stay. However, if during the patient’s detention in custody, concerns about treatment non-compliance arise, the Prison Mental Health Service treating doctor must, if practicable, talk to the patient about their
non-compliance with the treatment plan and the consequences of further non-compliance.

The Prison Mental Health Service treating doctor must make a written record of the doctor’s opinion that:

♦ the patient has been non-compliant with their treatment plan;
♦ the steps taken to obtain compliance with the treatment plan have been unsuccessful; and
♦ there is a significant risk of deterioration in the patient’s mental or physical condition because of the non-compliance.

If the patient again fails to comply with the treatment plan the Prison Mental Health Service treating doctor must:

♦ contact the authorised doctor at the authorised mental health service responsible for the patient’s involuntary treatment order to discuss the patient’s failure to comply with the treatment plan; and
♦ notify the Team Leader of the relevant adult or child and youth Prison Mental Health Service of the patient’s non-compliance.

If it is determined that the patient requires assessment or treatment at an authorised mental health service, the classified provisions should be applied (see chapter 5 of the Resource Guide).

In this instance, the following process applies:

♦ the relevant documentation for a classified patient admission must be completed:
  o a doctor or authorised mental health practitioner must complete a recommendation for assessment;
  o the administrator must complete an agreement for assessment; and
  o the custodian at the correctional facility must complete a custodian’s assessment authority.
♦ an authorised doctor must change the category of the involuntary treatment order from community to inpatient;
♦ the patient becomes a classified patient on production of the recommendation for assessment and custodian’s assessment authority to a health service employee; and
♦ on becoming a classified patient, the patient is detained in the authorised mental health service and the administrator assumes legal custody of the classified patient.
3.5 Moving and transfer of patients

The administrator may move the patient from one facility to another within the authorised mental health service for the purpose of providing assessment, treatment or care.

The Director or an authorised doctor may order the transfer of a patient on an involuntary treatment order to another authorised mental health service.

Chapter 8 of the Resource Guide provides further information about move and transfer of patients subject to an involuntary treatment order.

3.6 Limited community treatment

Limited community treatment for a patient subject to an involuntary treatment order (inpatient) may be authorised by an authorised doctor.

Chapter 9 of the Resource Guide provides further information about limited community treatment for patients subject to an involuntary treatment order.

Child safety issues

For all patients on periods of authorised leave, the authorised mental health service is required to identify any children that the patient has care, custody or access to in their place of residence and who may be affected by the patient’s mental illness, or intellectual or cognitive disability. An assessment must be undertaken, including the patient’s parenting abilities, the presence of other adults who may be involved in providing care to the children and the risk of abuse and neglect. All staff should be aware of the mandatory reporting requirements under section 186 and section 197A of the Child Protection Act 1999.

Follow-up of patients discharged

Mental health service staff must document the patient’s residential address in the clinical file, including any temporary addresses.

Mental health staff must review the patient face-to-face during the first week after the patient’s discharge. This review may occur by way of a home visit or at the mental health service. In certain circumstances, there may be a need to deviate from this practice (for example, where face-to-face review is not possible due to the person’s residence in a remote location).
Where a deviation is necessary, alternative arrangements should be made as far as possible (for example, follow-up through a remote area nurse or telephone contact with the patient). Any deviation from the practice must be approved by the Clinical Director of the service, or in the absence of the Clinical Director, another senior doctor nominated by the administrator.

### 3.7 Absence without permission

Requirements relating to absence without permission are covered in chapter 10 of the Resource Guide.

### 3.8 Mental Health Review Tribunal reviews

The Tribunal provides an important statutory safeguard by undertaking independent review of the *involuntary treatment order* (see chapter 2 of the Resource Guide for further information about the Tribunal).

**When review of an *involuntary treatment order* is conducted**

The Tribunal is required to review an *involuntary treatment order*:

- within six (6) weeks of the order being made (the ‘initial review’); and
- at six (6) monthly intervals after the initial review.

In addition to routine statutory reviews, the patient is entitled to apply to the Tribunal for review. If the patient makes an application for review prior to the initial review, the Tribunal must undertake the review within seven (7) days of the application. In any other case, the Tribunal reviews the matter as soon as practicable. The Tribunal may dismiss an application if satisfied the application is frivolous or vexatious.

The Director is also entitled to apply for a review.

**Matters reviewed by the Tribunal**

On a review of an *involuntary treatment order*, the Tribunal considers whether the treatment criteria apply to the patient. The Tribunal must confirm or revoke the *involuntary treatment order*.

The Tribunal may also:

- order a change to the category of the order;
- order or revoke limited community treatment (i.e. if the category of the order is inpatient); and
- order that the patient be transferred to another authorised mental health service.
Responsibilities of the authorised doctor

When a Tribunal hearing is scheduled (either as a routine statutory review or as a result of an application for review) the authorised doctor is required to provide a report to the Tribunal and attend the hearing to provide evidence. The patient’s case manager and/or other clinical staff involved in the patient’s treatment may also attend the hearing.

The Tribunal has established a pro-forma report as well as timeframes for providing the report to the Tribunal. Further information about Tribunal procedures and requirements can be obtained from the Authorised Mental Health Service Guide available from the Tribunal hearings coordinator (refer to [http://www.mhrt.qld.gov.au/](http://www.mhrt.qld.gov.au/) for Tribunal contact details).

Tribunal reviews provide a critical safeguard in the involuntary treatment process. The timely provision of reports and attendance of senior clinicians at Tribunal hearings therefore warrants high priority. Administrators are responsible for ensuring service compliance with Tribunal requirements.

The [Mental Health Review Tribunal Rule (2009)](http://www.mhrt.qld.gov.au/) issued by the Governor-in-Council under section 479 of the Act prescribes the mandatory timeframe for the provision of reports to the Tribunal as being at least seven (7) days prior to the Tribunal hearing. While the Rule itself does not provide for measures to address non-compliance with this timeframe, the Tribunal has the discretionary power under the Act to address non-compliance through issuing attendance notices.

Appeals against Tribunal decisions

An appeal against a decision of the Tribunal on a review of an involuntary treatment order may be made to the Mental Health Court. An appeal can be made by:

- the patient; or
- the Director.

An appeal must be lodged within 60 days of the Tribunal decision (if the appellant is the Director) or receipt of the Tribunal decision (if the appellant is the patient).

The administrator must ensure the information system is updated to reflect the decision of the Tribunal and inform the treating team of the decision.
4. Ceasing an involuntary treatment order

4.1 When involuntary treatment order ends

An involuntary treatment order ends when:

- the order is revoked;
- the patient has not received treatment under the order for six (6) months; or
- a forensic order is made (see chapter 7 of the Resource Guide).

Revocation of an involuntary treatment order

An involuntary treatment order may be revoked by:

- an authorised doctor at the patient’s treating health service;
- the Director;
- the Tribunal; or
- the Mental Health Court on an appeal against a decision of the Tribunal.

An authorised doctor must revoke an involuntary treatment order if the doctor is satisfied that the treatment criteria no longer apply to the patient. A revocation of involuntary treatment order form must be completed outlining how the treatment criteria no longer apply. If the authorised doctor is not a psychiatrist, consultation with a psychiatrist should occur before the order is revoked.

Ceasing order when patient has not received treatment for six months

An involuntary treatment order ceases to have effect if the patient has not received treatment under the order for six (6) months (for example, as a result of a patient’s absence without permission).

The administrator is responsible for maintaining a system to monitor instances where a patient has not received treatment under the involuntary treatment order.

4.2 Administrator notifications

Within seven (7) days of an involuntary treatment order being revoked or ceasing to have effect, the administrator must notify:

- the patient;
- the patient’s allied person;
the Tribunal, and
the Director, if the order was revoked by an authorised doctor and the
patient was a classified patient or subject to Chapter 7 Part 2
processes.

If the order is revoked:

- a copy of the revocation of involuntary treatment order form is provided
to the Tribunal and the Director (where relevant); and
- a copy of the notice of revocation of involuntary treatment order letter is
issued by the administrator and forwarded to the patient and the
patient’s allied person.

If the order ceased as a result of the patient not receiving treatment under
the order for six (6) months:

- a copy of the involuntary treatment order has ceased to have effect
form is provided to the Tribunal and the Director (where relevant); and
- a copy of the notice involuntary treatment order has ceased letter is
issued by the administrator and forwarded to the patient and the
patient’s allied person.

The administrator must ensure the information system is updated to reflect
the cessation of the involuntary treatment order.

5. Flowchart

The following flowchart illustrates the involuntary treatment or care
processes. This flowchart has been reproduced from the Act.
Involuntary treatment/care processes

- Person no longer an involuntary patient (Can only be treated with consent)
  - No
  - Are treatment criteria met? (s 14)
  - Yes
    - Authorised doctor makes an involuntary treatment order (s 108)
    - Community category
      - person may be treated in the community
      - No
      - Category may be changed by authorised doctor (s 119)
      - Yes
    - Is in-patient treatment needed? (s 109)
      - No
      - Category may be changed by authorised doctor (s 119)
      - Yes
      - In-patient category
        - person may be treated in the AMHS
      - Regular assessment by authorised psychiatrist (s 116)
        and review by MHRT (ch 6, pt 1)
  - Involuntary treatment order revoked by:
    - authorised doctor (s 121)
    - MHRT (s 191)
    - Director of Mental Health (s 122)
  - No
    - Are treatment criteria still met? (s 14)
    - Yes
      - Person continues to be an involuntary patient
    - No
      - Are treatment criteria met? (s 14)
    - Yes
      - Person continues to be an involuntary patient

When second examination is required (s 112)
  - A psychiatrist must conduct a second examination of the person within 72 hours if:
    - the authorised doctor who makes the ITO is not a psychiatrist;
    - the ITO is initially made on the basis of an assessment carried out by audio visual link.
  - If the psychiatrist is not satisfied the person meets the treatment criteria, the person ceases to be an involuntary patient.