Protective Division – Mental Health Stream

Mental Health Act 2013

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| Application for Treatment Order (Child) | S 37 |

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| --- | --- |
| 1 | **The patient** *(complete or alternatively, if patient label available, please affix)* |
| Name |  |
| Address |  |
| Suburb |  | State |  | P/code |  |
| DoB |  |  |  |
| Gender  | [ ]  Male [ ]  Female [ ]  Other  |
| Email |  |
| Phone |  | Mobile |  |
| Facility |  | Patient ID |  |

Please indicate the status of the patient at the time of this application[ ] Inpatient[ ]  Outpatient

Aboriginal or Torres Strait Islander ? [ ]  Yes [ ]  No

Is a guardianship order in place? [ ] Yes [ ] No

Is the patient supporting dependent children? [ ] Yes [ ] No

Is the patient supporting frail/ elderly family members? [ ]  Yes [ ]  No

Does the patient require an interpreter or other assistance with communication? [ ]  Yes [ ]  No

Type of assistance required:

[ ]  Interpreter - language/dialect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other – please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have a representative/support person(s)? [ ]  Yes [ ]  No

Representative/support person 1 (as nominated by the patient):

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Email |  |
| Suburb |  | State |  | P/code |  |
| Phone |  | Mobile |  |

Relationship to patient:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Partner/Spouse | [ ]  Parent | [ ]  Sibling | [ ]  Case Manager |
| [ ]  Lawyer/Advocate | [ ]  Other: |  |

Representative/support person 2 (as nominated by the patient):

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Email |  |
| Suburb |  | State |  | P/code |  |
| Phone |  | Mobile |  |

Relationship to patient:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Partner/Spouse | [ ]  Parent | [ ]  Sibling | [ ]  Case Manager |
| [ ]  Lawyer/Advocate | [ ]  Other: |  |

Person responsible / Family/ Other:

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Email |  |
| Suburb |  | State |  | P/code |  |
| Phone |  | Mobile |  |

Relationship to patient:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Partner/Spouse | [ ]  Parent | [ ]  Sibling` | [ ]  Case Manager |
| [ ]  Lawyer/Advocate | [ ]  Other: |  |

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| 2 | **Approved medical practitioner making the application** |
| Name |  |
| Address |  |
| Telephone |  |
| AMP status expiry date |  |

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| 3 | **Assessment** |
| **Is the patient subject to an assessment order**? | [ ]  Yes [ ]  No |
| **If YES the patient is subject to an assessment order, please attach a copy of the order and advise**:* whether the applicant assessed the patient under the authority of the assessment order; and
* whether the applicant is satisfied from the assessment that the patient meets the treatment criteria
 | [ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| **If NO the patient is not subject to an assessment order, please advise**:* whether the patient has been assessed by the applicant within the seven (7) days preceding the date of the application
	+ The date of the assessment
* whether the patient has been separately assessed by another approved medical practitioner (AMP) within the seven (7) days preceding the date of the application
* the name of the other AMP
	+ the date of the assessment
* whether the applicant and the other AMP are both satisfied from their respective assessments that the person meets the treatment criteria
 | [ ]  Yes [ ]  No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Yes [ ]  No |

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| 4 | **History** |
| **Provide details of relevant psychiatric history, prior diagnoses, admissions, symptoms and any prior involuntary orders:** |
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| **Describe the events/circumstances leading to the application for the treatment order:** |
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| 5 Statement addressing treatment criteria | S 37(5) |

Under s 37(5)(a) of the *Mental Health Act 2013*, the applicant for a treatment order **must** provide a statement **affirming that (and explaining how)** the person meets the treatment criteria.

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| A | **s40 (a)The patient has a mental illness – please outline the nature of the patient’s mental illness and current symptoms** |
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| B | **s40 (b) Without treatment, the mental illness will, or is likely to, seriously harm the patient’s health or safety or the safety of other persons** |
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| C | **s40 (c) The treatment will be appropriate and effective** |
| **Proposed treatment setting or settings:** |
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|  |
| **Treatment currently being administered (including psychological and details of any side effects associated):** |
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|  |
|  |
| **Proposed future treatment (including any other proposed interventions eg. blood tests, urine tests, diagnostic radiology or medical imaging):** |
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| **Why proposed future treatment is appropriate and effective (including details of anticipated treatment outcomes and how the treatment proposed will impact on the patient’s current presentation):** |
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| D | **s40 (d)The treatment cannot be adequately given except under a treatment order** |
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| E | **s40 (e) The patient does not have decision making capacity** |
| **(a) is the patient unable to make decision about their own assessment or treatment because of an impairment of, or disturbance in, the functioning of the mind or brain** [ ]  Yes. Explain how: [ ]  No |
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| **AND****(b) is the patient unable to****(i) understand information relevant to the decision;** [ ]  Yes. Explain how: [ ]  No |
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| **(ii) retain information relevant to the decision;** [ ]  Yes. Explain how: [ ]  No |
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| **(iii) use or weigh information relevant to the decision;** [ ]  Yes. Explain how: [ ]  No |
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| **(iv) communicate the decision (whether by speech, gesture or other means).** [ ]  Yes. Explain how: [ ]  No |
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| 6 | **Capacity** |
| Is the patient sufficiently mature to make decisions regarding his or her treatment? | [ ] Yes [ ]  No |
| If yes, please provide details: |
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| Is a patient able to provide informed consent to treatment? | [ ]  Yes [ ] No |
| If no, * advise if the patient’s parents have been consulted regarding treatment:
 | [ ]  Yes [ ]  No |
| Please provide details of all consultation that has occurred, including the date of any family meetings, the parties attending and the outcome: |
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| If a parent is not able to prove consent, please advise relationship status between the parent and the child – e.g. history of abuse, whether the patient lives with the parents, whether Child Protection is involved: |
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| Have the patient’s parents consented to the treatment? | [ ]  Yes [ ]  No |
| Please provide details, including attaching a copy of a signed consent form: |
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| If the patient’s parents have consented to treatment, please advise why a treatment order is still required: |
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| 7 | **Interim Treatment Order** |
| Is an interim treatment order required? | [ ]  Yes [ ]  No |
| If yes, would the delay in making a treatment order be likely to seriously harm the patient’s health or safety or the safety of other persons? | [ ]  Yes [ ]  No |
| Please provide details: |  |
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| 8 **Treatment Orders Sought (this section must be completed in full)** |
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| Please provide details of the treatment order sought: |
| * Where will the patient be detained for treatment: (name of approved facility)

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| [ ] The hospital has facilities/staff to accommodate the patient [ ]  Yes [ ]  No  |
| [ ] The hospital is the most appropriate place to accommodate the patient [ ]  Yes [ ]  No  |
| * Please name all of the classes of medications being applied for (complete below):
 |
| 1. [ ]  Antipsychotic
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| 1. [ ]  Mood stabilising
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| 1. [ ]  Antidepressant
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| 1. [ ]  Benzodiazepine
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| 1. [ ]  Anticholinergic
 |
| 1. [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| * Will the patient be required to attend community mental health appointments [ ]  Yes [ ]  No
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| * What tests will the patient be required to submit to:

[ ]  blood[ ]  medical[ ]  urine [ ]  diagnostic radiological and/or medical imaging[ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Will the patient be required to accept home visits: [ ]  Yes [ ]  No
* Any other orders sought: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 9 | **ECT** |
| When is it proposed to commence ECT? If ECT is required urgently under an interim treatment order (prior to the hearing of the application before a three member Tribunal panel), please provide details: |
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| Have you ascertained the patient’s views to ECT treatment and is so, what are they?: |
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| Have you ascertained the family’s views to ECT treatment and is so, what is it?: |
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| Has the patient had ECT before? If so, when and to what effect?: |
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| What is the anticipated outcome of ECT?: |
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| 10 | **Duration of Order Sought** |
| Duration of order sought: |  |

I have:

[ ]  provided a copy of the application and accompanying documentation to the patient;

[ ]  placed a copy of the application and accompanying documentation on the patient’s clinical records

[ ]  made a note in the patient’s clinical record to the effect that these actions have been completed

**Please note that failure to provide the patient with a copy of the application and accompanying documentation may result in the application being invalid.**

Attached are copies of:

[ ]  the assessment order (if the patient is subject to such an order);

[ ]  the treatment plan

[ ]  the signed parental consent (if applicable).

**Information about lodging the application**

This application should be sent via email to: applications.mentalhealth@tascat.tas.gov.au

Incomplete or otherwise invalid applications will not be considered – the registry will notify the Legal Orders Coordinator as soon as possible if this is the case.

If the patient is on an assessment order, applications are to be received a **minimum of 2 hours prior to**:

1. The **expiry of any assessment order**, and/or

2. the **closing of the Tribunal registry at 5pm**

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| --- | --- |
| **Signed by the Applicant:** | **Please print name:** |
|  |  |
| Applicant’s title:  |  |
| Name of treating consultant: |  |
| Date:  |  | Time: |   |

This application should be sent via email to: applications.mentalhealth@tascat.tas.gov.au

**STATEMENT OF RIGHTS**

Upon receiving an application for a treatment order, the Tribunal is often requested to make an interim treatment order under s 38 of the Act. If such an order is made, it is usually done ‘on the papers’, that is, the Tribunal is not required to conduct a hearing to make an interim treatment order. An interim treatment order can be made for no longer than 10 days duration.

The Tribunal must conduct a hearing however to decide if it should make a treatment order of up to 6 months duration.

The Tribunal will set a hearing date to determine the application for treatment order and all parties will be notified of the date, time and place of hearing. The hearing will be held as soon as practicable and must be determined by the Tribunal within 10 days of the application being lodged with the Tribunal (as per section 39 of the Act). You do not have to attend the hearing, however, if you choose to attend, you have a number of rights at that hearing, including the following:

* the right to be represented by a lawyer, advocate or another person of your choosing;
* the right to put before the Tribunal material that you want it to take into account in making its decision, including:
	+ giving information to the Tribunal yourself; and/or
	+ asking others to give the Tribunal information;
* the right to ask questions of about written material presented to the Tribunal, including the application for treatment order and the treatment plan;
* the right to make oral or written submissions to the Tribunal;
* the right to an interpreter; and
* the right to apply for an adjournment.

Additional information about the process for determining applications can be obtained from the TASCAT website at [www.tascat.tas.gov.au](http://www.tascat.tas.gov.au) or by contacting the Tribunal on 1800 657 500.