

Mental Health, Justice Health, Alcohol & Drug Services (MHJHADS)

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

PTO TREATMENT PLAN AND LOCATION DETERMINATION

Pursuant to Section 51(3)(b), 62 (2) and 62 (3) *Mental Health Act 2015*

This form must be completed by the Chief Psychiatrist or delegate who is responsible for a person who is subject to a Psychiatric Treatment Order (PTO) within 5 working days of the order being made, or whenever the determination needs to be updated.

This form may also be submitted as a treatment plan which accompanies an application for a PTO.

Name of person: _____

Residential Address: _____

Date of birth: ____/____/____

Treating Registrar: _____

Region: _____

Treating Psychiatrist: _____

Case Manager: _____

Date of PTO: ____/____/____

Expiry of PTO: ____/____/____

Does the person have an Advance Agreement? Yes No

Does the person have an Advance Consent Direction? Yes No

Treatment Plan (This section is to be completed for all persons)

Detail the nature of the psychiatric treatment to be given to the person:

This treatment does not, or is not likely to have, the effect of subjecting the person to undue stress or deprivation, having regard to the benefit to result from the treatment.

Comment:

Inpatient Treatment Location (complete for people receiving inpatient treatment, care or support)

Does the person require admission to an approved mental health facility Yes No

If yes, which facility or facilities?

Any approved mental health facility, as clinically appropriate

The Canberra Hospital

Calvary Public Hospital Bruce

Brian Hennessy Rehabilitation Centre

Dhulwa Mental Health Unit (subject to DMHU approval)

University of Canberra Hospital



DO NOT WRITE IN THIS BINDING MARGIN

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Is the person required to be detained at the above facility/facilities? (s. 62(2)(a)) Yes No

If the person is detained, can the person be granted **leave** from the facility?

- Yes, when clinically indicated (A clinical decision about each episode of leave will be made on a case by case basis)
- No, because the person remains in corrections, police or other court-ordered custody, or is subject to another order of the court or ACAT
- No the person has a Restriction Order in Place.

Community Treatment Location *(complete for people receiving treatment, care or support in the community)*

Detail the times when, and the place where, the person is required to attend to receive treatment, care or support.

Consultation with the Person

Before making this determination:

- I have consulted with the person and their views are *(please provide details)*:
- I have not consulted the person for the following reasons *(please provide details)*:

Consultation with Other People

Before making this determination, I have consulted with:

	Yes	No	N/A
Each person with parental responsibilities (if the person is a child)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The person's Guardian (if appointed under the <i>Guardianship and Management of Property Act 1991</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The person's Attorney (if appointed with an enduring power of attorney (EPOA) under the <i>Power of Attorney Act 2006</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The person's Health Attorney (the person's domestic partner, close family member, friend or carer consulted by treating team if no guardian, EPOA or Advance Consent Direction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The person's Nominated Person (if appointed under the <i>Mental Health Act 2015</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The person's carer (as defined in s. 12 of the <i>Mental Health Act 2015</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The General Manager of Custodial Operations or Community Corrections (ACTCS) (as appropriate, if person is a detainee, released on parole/license, serving a community-based sentence, or on supervised bail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Director of the Bimberi Youth Justice Centre (if the person is a young detainee, young offender serving a community-based service or a child subject to supervised bail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Chief Psychiatrist or delegate

Signature _____ Print name _____ Date _____

A copy of this form must be:

- forwarded to the Tribunal Liaison Officer at TribunalLiaison@act.gov.au or fax 6244 4558
- scanned and entered into the person's electronic clinical record

This section to be completed by the Tribunal Liaison Officer:

- The Person who is the subject of the PTO
- Public Advocate of the ACT pa@act.gov.au or 6207 0688 (fax)
- ACT Civil and Administrative Tribunal ACATMentalHealth@act.gov.au or 6205 4855 (fax)

and the following people, as relevant:

- The person's Guardian
- The Attorney
- The Health Attorney
- Each person with parental responsibilities
- The person's carer
- The person's Nominated Person

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