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Community Treatment Orders (CTOs)(Part 3, Division 3)

Making a CTO (ss.65,66,67,69)

CTOs in their current state can never be used as an alternative to admission. This is because The length of time before a CTO can be acted upon is excessive. The process of writing, confirming, serving, writing the breach notice, to order to attend and to transport order (ss 80, 81, 82, 83, 84) is too cumbersome to enable rapid involuntary treatment of acute psychosis in the community.

Authorised Mental Health Practitioners can not initiate a CTO but they can initiate involuntary admission to an authorised hospital. If community care is seen as a less restrictive alternative, then Authorised Mental Health Practitioners should be able to initiate a CTO more easily than they can refer for admission. This is not presently the case.

I once saw a psychotic patient in RPH emergency whom I would have liked to commence under a CTO. However, it was late on a Saturday night and the person lived in another catchment area. With the current requirements for making a CTO, there was no way that I could obtain the necessary information or permission from a psychiatrist in that area to write a CTO, so I reluctantly referred him to Graylands for in-patient care.

There needs to be a provisional CTO arrangement that would allow acute treatment in the community to commence, with review by the appropriate service within 72 hours.

Terms of a CTO- (ss68,73,74,75,77)

There should be provision within the Act for another person to be given authority to act in the place of the supervising psychiatrist, should the latter not be available at appropriate times (eg. for writing of extension, variation or breach forms). The current provisions do not accommodate the situation of the supervising psychiatrist being on leave for short periods. For longer periods, a patient's care can be transferred. However, it is not worthwhile doing this for a period of only one or two weeks.

Extension of a CTO- (ss76)

A bit of leeway to fill in the extension form a few days before or after the expiry date would be helpful (grace days).

For some patients, it becomes apparent that they require an extended period of time under a community treatment order, sometimes going in to years. In such cases, there should be provision either for a prolonged extension (for example, one year instead of three months), or for multiple extensions.

Breach of a CTO(ss80,81,82,83,84)

If a patient misses a depot injection, we go through the process of breach notice, order to attend and transport order. Then, if they miss the next depot, we have to start the procedure all over again from scratch. There should be a short-cut process for second and subsequent breaches.

Interstate movements (Part 4)

This part of the Act fails to deal with the not uncommon situation of patients who are under community treatment orders in other states migrating to Western Australia, usually with the intention of avoiding compliance with the order. Examples in my experience include people with histories of violence or other crimes committed while mentally ill. However, we are not empowered to continue the treatment of these persons without examination. They inevitably avoid examination and it is not possible to carry out an examination without the patient's consent until their illness begins to relapse, which may be weeks or months later. This exposes the community to risk during the early relapse period.

In my opinion, the Act needs a section that would allow psychiatrists in this State to write a provisional community treatment order on any such patient who has recently arrived, pending a more thorough assessment.

Police powers (Part 10, Division 2)

Taking mentally ill person into protective custody (s.195)

The situation sometimes arises that we are asked by neighbours, relatives, caretakers, local authority employees or non-governmental organisations to evaluate somebody with a possible mental illness. Not infrequently, the individual is unwilling to be examined. Sometimes that person is known to us and may have been treated by us previously. We may be of the opinion that the person is highly likely to have a mental illness and that this may result in harm to the person's finances, relationships or reputation (ie, self-inflicted harm as described in s. 26 (1)(b)(ii)).

Under Section 195, the police are empowered to apprehend a person for examination by a medical practitioner for the reasons mentioned under sections 26 (1)(b) (i) & (iii) but not (ii). Therefore, we are sometimes left with the situation that we are not able to arrange the examination of a person whose condition would warrant involuntary hospitalisation. Section 195 should be altered to include the conditions of risk described in subsection (ii) of section 26.