

**Guidelines for the Provision of Community Treatment Orders under Section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (revised June 2006)**

## **12. Section 29: Community Treatment Orders**

### **12.1 Scope of a community treatment order**

The Act operates on the presumption that compulsory treatment orders will be delivered in the least restrictive environment, and that unless the patient cannot be treated adequately as an outpatient, all such orders will be community treatment orders (see section 28(2)). Before making a community treatment order, the Court must be satisfied that the patient can be provided with 'care and treatment on an outpatient basis that is appropriate to the needs of the patient' (section 28(4)(a)).

A community treatment order requires the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified institution or service, and to accept that treatment (section 29(1)).<sup>1</sup> The concept of 'treatment' is not defined in the Act but must be 'treatment for mental disorder'.

The powers to enforce compliance with a community treatment order are outlined in the following sections of the Act.

- **Section 29(1):** The patient is required to attend and is 'required to accept' treatment for mental disorder at the direction of the responsible clinician during the first month of the community treatment order and thereafter if a psychiatrist (not the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the interests of the patient (section 59(1) and 2(b)). In all other cases, the patient's informed and written consent to treatment must be obtained (section 59(2)(a)).
- **Section 29(2):** Employees of the service specified in the order are empowered to enter the specified place for the purpose of treating the patient.
- **Section 40(2):** A duly authorised officer (DAO) may take 'all reasonable steps' to take the patient to the place where he or she is required to attend for treatment.
- **Section 41(3):** The police may be called to assist a DAO and may use *necessary force* to take the patient to the place where he or she is required to attend for treatment.
- **Section 112(2):** A warrant may be issued authorising the police to apprehend a patient who refuses to attend and to take the patient to the place specified for treatment. The police are not empowered to enforce treatment.

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<sup>1</sup> See also P Trapski (ed). *Trapski's Family Law Vol III (1993)*. Mental Health, Brookers, Wellington.

## 12.2 Community treatment versus inpatient treatment

There are several important distinctions between a compulsory community treatment order and a compulsory inpatient treatment order. The key features of a community treatment order are as follows.

- Section 29 does not provide for the detention of a patient in the community for the purposes of treatment, *irrespective* of the level of care provided to the patient.
- Patients subject to a community treatment order cannot be required to live at a particular place.<sup>2</sup> However, it may not be possible to adequately treat a patient as an outpatient without a certain level of support, thereby limiting the patient's community treatment option.
- The scope of treatment must be clearly specified in the order. A treatment plan may include a specific residential requirement, but this does not amount to the power to detain at the residence.
- A patient subject to a community treatment order can be treated as an inpatient in the following circumstances:
  - with his or her written consent (which can be withdrawn at any time)
  - without consent, subject to section 29(3)(a), whereby the patient may be readmitted to hospital for no more than two 14-day periods within any six months.

There is a wide range of community treatment facilities, some with a level of care similar to that offered in hospital. However, treatment in the community (even in a facility that provides a high level of care) cannot be regarded as the same as inpatient care for the purposes of the Act. The Act and subsequent legal considerations clearly differentiate between an inpatient order (which authorises detention in hospital) and a community treatment order (which does not authorise detention in any way).

In some cases, the 'treatment' of a patient may include placement in a particular community setting. There has, however, been some uncertainty over whether a responsible clinician can direct a patient subject to a community treatment order to live in a specified place. This issue is discussed in *Department of Health v D* (1999) 18 FRNZ 233; NZFLR 514, in which Judge Robinson found that there is no statutory power for a responsible clinician to direct where a patient resides while on a community treatment order for the purposes of treatment.

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<sup>2</sup> In *Department of Health v D* (1999) 18 FRNZ 233; NZFLR 514.

### **12.3 Terms of a community treatment order**

The Act requires that the place of attendance for treatment and the service or institution whose employees are providing the treatment be specified in the community treatment order.

It is recommended that the application for the treatment order specify the proposed treatment plan in detail, to assist the Court in making an order based on a clear plan of treatment.

Where an application is made, the responsible clinician should state in writing exactly what is sought in the proposed order, setting out:

- the proposed treatment (medication and other treatment) that is considered necessary (If it is likely that there will be a variation of treatment during the course of the order, this should be specified as far as possible. It is best not to name particular drugs or dosages, because medication may need to be altered. There needs to be enough flexibility to allow a reasonable degree of change, bearing in mind the requirements of section 59 (consent to treatment.)
- the type/method of treatment as the patient's condition changes
- the location where treatment will take place
- the service(s) or institution(s) responsible for providing the treatment
- monitoring arrangements that will be put in place
- an indication of the services and support that will be available to meet the needs of the patient, additional to those specified as compulsory.

In making the order, the Court should specify (in writing) the conditions of the order in a similar manner. The patient must be given a copy of the order (section 28(5)), clearly specifying the requirements and conditions of the order.

Non-compliance with the specified terms of a community treatment order may be sufficient grounds to require reassessment under section 29(3) of the Act.

### **12.4 Admissions during the term of a community treatment order**

From time to time, a patient subject to a community treatment order may require and consent to admission to hospital as an inpatient, for treatment of his or her mental disorder. Because prolonged inpatient admissions (even on a voluntary basis) are at odds with the concept of community treatment orders, the Act has been amended to permit no more than two periods of 14 days within a six-month period under a community treatment order. The following processes should be used in administering such admissions.

### **12.4.1 Voluntary admissions**

Patients who are subject to a community treatment order may be admitted to hospital as voluntary inpatients, with their fully informed consent, preferably in writing.

Whenever a patient is admitted as a voluntary inpatient during the terms of a community treatment order, the District Inspector must be notified as soon as possible.

It is suggested that such an admission should be for a short period (of no more than 14 days). After this time, the situation should be reviewed and consideration should be given to either discharging the patient from the community treatment order, or reassessing the patient under section 29(3) of the Act.

If, during the course of the admission, the patient withdraws consent or becomes incapable of giving consent, consideration should be given to their reassessment under section 13.

### **12.4.2 Compulsory admissions**

Section 29(3) of the Act enables a responsible clinician to direct that a patient subject to a community treatment order be treated as an inpatient for up to 14 days, without the need to begin the assessment process and without nullifying the community treatment order. This section enables two such 14-day treatment periods within any six-month period.

Before considering such an option, the patient's consent to admission should be sought.

If the circumstances are urgent and the patient's responsible clinician cannot be contacted, the consultant psychiatrist on call can instruct a DAO (by phone if necessary) to direct the patient to be admitted as an inpatient. The form directing this should be signed by the responsible clinician or the consultant psychiatrist as soon as practicable.

If a direction is made under section 29(3)(a) after the first month of the patient's compulsory treatment order and the patient does not consent to the proposed treatment, the responsible clinician should obtain the opinion of a psychiatrist appointed by the Review Tribunal (section 59) that the treatment is considered to be in the interests of the patient.

Note that consent includes consent to any changes in medication (eg, changes from oral to intramuscular injection (IMI) or complete changes to a medication regime).

It is not necessary to first obtain the opinion of a psychiatrist appointed by the Review Tribunal that any change in treatment is in the interests of the patient in situations of urgency, where the particular treatment is necessary to save the life of the patient, or to prevent serious damage to his or her health, or to prevent the patient from causing serious injury to himself or others.

A direction for inpatient treatment for any patient on a community treatment order cannot be made more than twice in any six-month period. If a patient requires more than 14 days' continuous inpatient treatment, or more than two 14-day periods in a six-month period, the responsible clinician must reassess the patient in accordance with sections 13 and 14 of the Act. It must also be noted that case law has clarified that the two 14-day periods cannot be consecutive (see *Director of Mental Health Services v Brown* 24/10/00, Judge Adams, FC Middlemore MA048/156/00).

When a patient is reassessed under section 29(3)(b) of the Act, the community treatment order ceases to have effect and the patient is reassessed under the provisions of sections 13 and 14 of the Act.

Both the written notice directing a change to inpatient status under section 29(3)(b) and a section 13 form are required to be completed by a responsible clinician, who must examine the patient. Pursuant to sections 58 and 59, the patient must then accept such treatment as the responsible clinician directs. The section 13 form not only provides a clear indication of the start and end of the assessment period, but the copy sent to the District Inspector also helps to safeguard the rights of the patient.

When a direction is made under either section 29(3)(a) or 29(3)(b), the patient can apply for a review under section 16 of the Act.

The patient continues to have the right to review under section 79 of the Act by the Review Tribunal in respect of the existing order, and any finding by the tribunal relates only to the existing order.

## **12.5 Overseas travel during the term of a community treatment order**

From time to time, patients subject to a community treatment order wish to travel overseas and in some cases will seek the permission of their responsible clinician.

The Act is silent on the issue of travel outside New Zealand while subject to a compulsory treatment order. However, in doing so, most patients will be breaching the terms of their order to 'attend a certain place for treatment'. In addition, if a patient becomes unwell while overseas they cannot be treated under the terms of their community treatment order. This can cause considerable distress to the patient and their family, and in some cases results in their repatriation to New Zealand, at considerable cost.

For some patients (and their families) it will be sufficient to advise them that they are not allowed to travel, and that to do so would breach the terms of their compulsory treatment order. For other patients, it may be worth considering whether they have recovered sufficiently so that they are no longer mentally disordered and can be discharged from the order.