Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to section 756 of the *Mental Health Act 2016*. The patient and persons attending the hearing have been de-identified and, in some cases, may be allocated pseudonyms for privacy reasons. Other details that may lead to the identification of the patient may have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Decision made prior to 1 January 2020 so *Human Rights Act 2019* not applicable

Matter:	Treatment Authority Review
Attendees	
Patient:	Attended
Psychiatrist:	Attended
Registrar:	Attended
Case Manager:	Attended
Other attendees:	Consumer Consultant Attended
Decision	
Decision:	The Treatment Authority is confirmed. The Category of the Treatment Authority is inpatient.

At the hearing, the treating psychiatrist provided a current diagnosis for the patient of schizoaffective disorder. The patient first presented to an authorised mental health service (**AMHS**) with 'challenging behaviour', anxiety, seizures, eating disorder, cluster B personality and substance use disorder. There is no evidence of mental illness prior to approximately five years ago before this Tribunal.

The patient is recorded in the clinical report to have presented multiple times this year with *'concerns regarding mental state'*. She was remanded in custody earlier this year for common assault. She was then referred to the Prison Mental Health Service after being reviewed by a consultant psychiatrist. She was transferred and admitted to hospital from the correctional centre, and the current Treatment Authority was made.

During the hearing, the patient stated that she shares the care of her child with that child's father. She reported being distressed by this arrangement. She expressed that one of her motivations to be discharged was to resume the care of her child and take her travelling. Regarding this, the Clinical Report notes *'living with daughter – child removed by DOCS [sic].'*

Statutory Framework and Issues to be determined by the Tribunal

Set out in Appendix A to these Reasons is a summary of the principal provisions of the *Mental Health Act 2016* (**Act**) that are relevant to the Tribunal's conducting a review of a person's Treatment Authority. Further reference will be made to these under "Application of evidence before the Tribunal to relevant provisions".

The issues for determination at the review were:

1. whether the treatment criteria in section 12 of the Act continue to apply to the person.
2. whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness.
3. if a Treatment Authority is confirmed, whether the category should be community or inpatient.
4. if the category is community, whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.
5. if the category is inpatient, whether any limited community treatment is approved or extended for the person. If the Tribunal approves or extends limited community treatment, whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.
6. what, if any, conditions should be imposed on the Treatment Authority?

Clinical Report

The patient received the clinical report within the statutory timeframe.

<u>Application of evidence before Tribunal to relevant provisions</u>

Treatment Criteria

In order to be satisfied that the patient should continue to be subject to a Treatment Authority, all of the treatment criteria in section 12(1) of the Act must apply. The Tribunal considered each of the criteria in turn.

1. Does the person have a mental illness?

There was no evidence before the Tribunal as to whether a diagnosis was made during the patient's admission approximately five years earlier. Regarding the 'multiple presentations' earlier this year the clinical report notes that it is *'unclear what diagnosis was made at this time.'*

The listed diagnosis of mental illness in the clinical report before the Tribunal is 'unspecified nonorganic psychosis'. At the hearing, the treating psychiatrist stated that the patient had required seclusion at times. She required constant daytime observations and 15-minute night observations. The previous four weeks had seen the patient improve in her mental state. Based on her own observations as well as the history of the patient's mental illness detailed in the clinical report, the treating psychiatrist formed the opinion that the patient had a diagnosis of schizoaffective disorder with both mood and psychosis elements.

In respect of this criterion, the patient's self-report states that she does not believe that she has a mental illness and believes that she has been traumatized by a drug gang. This position was confirmed by the patient at the hearing.

The Tribunal considered that there was strong support for the treating psychiatrist's opinion regarding diagnosis within the clinical report before the Tribunal. The treating psychiatrist's evidence as to the patient's mental illness was accepted.

2. Does the person have capacity to consent to be treated for the illness?

In her self-report, the patient describes that her difficulties have arisen in connection with people chasing her regarding child pornography, rather than any mental illness. As for her intentions regarding treatment she states, that she strongly objects to taking the medication and is only doing so because she is scared that otherwise she would be kept there long. She stated that she believes she would not cause harm to herself or others if she were not taking the medication.

At the hearing, the patient told the Tribunal that she wanted to be a voluntary patient and that she would take the medication for a while to see if it works.

The Tribunal considered that the patient's evidence provided some support for the treating psychiatrist's position regarding a current lack of capacity. The treating psychiatrist reviewed the patient's capacity 10 days prior to the hearing and noted that her insight was absent and her judgement impaired. The doctor stated that the patient does not possess capacity to consent to treatment and that she is acutely unwell with psychotic illness and insight is absent. The doctor further that stated that the patient attributes her psychological distress to trauma and grief.

At the hearing, the treating psychiatrist's view was that the patient remained totally insightless, and she confirmed her position regarding capacity as outlined in the clinical report.

The Tribunal held concerns that the patient's decisions about her treatment would be based on her delusional beliefs and motivated by her enthusiasm to stop treatment. There was no evidence to suggest that she possessed an ability to consider the benefits and risks of treatment, or the consequences of choosing to decline it. For those reasons, the Tribunal found on balance that the patient did not have capacity to consent to treatment for her mental illness.

3. Are the person's illness and an absence of involuntary treatment or continued involuntary treatment likely to result in either:
   a. imminent serious harm to the person or others; or
   b. the person suffering serious mental or physical deterioration?

As far as this Tribunal is aware, this is the first time that the patient has been subject to any involuntary treatment. It is convenient to summarise the circumstances surrounding the Treatment Authority being made.

As mentioned above, notes in the clinical report reveal some contact with an AMHS earlier in the year. Some alleged criminal offending lead to the patient's imprisonment. There is no evidence to suggest that the offending itself resulted from the patient's mental illness.

A consultant psychiatrist's review at the correctional centre identified that the patient was extremely unwell. She refused to accept the possibility of a mental illness and consequently any treatment for it.

A short time after the review, the patient attempted suicide. Following that attempt, she was transferred to hospital upon a second review by the consultant psychiatrist. It is important to note the patient's own evidence is that she in fact feigned this suicide attempt in order to get out of the correctional centre. Further attempts of self-harm or suicide within an inpatient setting are described in the clinical report. The Tribunal declined to make any findings about the patient's intentions behind any of these behaviours. Rather, it was considered that a risk of imminent serious harm to the patient herself existed.

The treating psychiatrist explained that the patient has required seclusion and the clinical report notes the risk of self-harm and referred to the patient's violence generally during the current admission. The criminal offending mentioned earlier is also listed under the risk section of the clinical report, however it is not clear on the evidence that any criminal conduct in the community has occurred as a result of mental illness.

That said, the patient had displayed violent behaviours sporadically through her two months of admission. This included aggression towards staff and property damage, at times requiring seclusion. The Tribunal found on balance that in the absence of involuntary treatment the patient was likely to cause serious harm to other persons as a result of mental illness.

Additionally, the Tribunal found that the patient's mental state was highly likely to deteriorate further, and in a serious way, if she was to cease treatment.

It was made clear to the Tribunal by the patient at the hearing that she did not appreciate that there could be any risk attached to her voluntary treatment or to her decision to cease treatment. She remained motivated to return to the community to take on the care of her mother and child. The patient did not appear to make any connection between her recent risky behaviours and her mental illness.

Relevant Circumstances

In reaching a decision, the Tribunal had regard to the relevant circumstances of the person subject to the Treatment Authority.

<u>Mental state and psychiatric history</u>

The evidence suggests that the patient has not experienced any mental illness requiring treatment for the majority of her life. In that context, her recent decline in mental state has been sudden and severe. The aggregate of her psychiatric history has been summarised above.

It appeared that her mental state had dramatically improved at the time of the hearing. She did not display any aggression or violence towards the members or other witnesses at the hearing. Despite her fixed delusional beliefs, the patient articulated her views and wishes clearly at the hearing. She took care in preparing the self-report provided. It is clear that neither her appearance nor self-report would have been possible without the efforts of her treating team in stabilising her mental state.

<u>Social circumstances, including, for example, family and social support</u>

The Tribunal considered that the patient has a child who she is very keen to care for. Additionally, the patient stated that she intends to care for her mother in the community. The presence of any family or social support for the patient herself is not clear on the evidence. The patient stated she is

distressed by the fact that her child is being cared for by the father.

Response to treatment and care and the person's willingness to receive appropriate treatment and care

It appears that some non-compliance with treatment during the current admission had affected the patient's response to her treatment and care. The patient is now accepting the treatment with a strong reluctance and the improvement in her mental state is marked when her presentation at the hearing is compared with her presentation at the time this Treatment Authority was made.

Less Restrictive Way

The Tribunal considered whether there was a less restrictive way to meet the patient's treatment and care needs and if the category of the Treatment Authority should be changed to Community.

At the hearing, the Tribunal found that there was not a less restrictive way available under section 13(1) on the evidence.

Regarding the application of section 423, it was clear that the patient had not progressed to the point that her treatment and care needs could be met in the community. Parallel to that concern, the Tribunal also found that neither the patient's safety nor the safety of others could be reasonably met if the category was changed to community. This finding was based on a combination of the patient's presentation during her admission, her motivation to cease treatment and her poor understanding of the likely consequences of refusing treatment.

Conclusions of the Tribunal

On balance, the Tribunal was satisfied that the treatment criteria were met.

The evidence in support of the treating psychiatrist's diagnosis is strong, as is the evidence in support of her opinion as to the patient's capacity. The patient herself provided further evidence to the Tribunal that she neither accepted the existence of any mental illness requiring treatment or considered that any of her behaviours or her admission could have been caused by a mental illness. She did not secrete the fact that she would cease treatment if given the opportunity to do so.

To that end, the assessment of risk must be made with the assumption that the patient will decline voluntary treatment. Without treatment, the risks of suicide, other self-harm and harm to others is very high.

The category of the Treatment Authority remains inpatient. The factors leading to that decision are outlined above.

At the hearing, the Tribunal considered that it was not necessary or appropriate to impose any conditions or other orders under section 426 or 429.

For these reasons, the Tribunal confirmed the Treatment Authority, category inpatient.

Legal Member

Appendix A

Statement of the law regarding Treatment Authorities

The main objects of the *Mental Health Act 2016* (**Act**) are set out in section 3(2) and must be achieved in the way outlined in sections 3(2) and 3(3).

Section 413(1) of the Act provides the Mental Health Review Tribunal (**Tribunal**) must review a Treatment Authority within 28 days after it is made, each 6 months for the first year, and at intervals of not more than 12 months thereafter (a ***periodic review***).

Also, the Tribunal must review a Treatment Authority on application by the patient subject to the authority, an interested person for the patient or the chief psychiatrist (an ***applicant review***). Section 413(3) empowers the Tribunal, on its own initiative, to carry out a review of the Treatment Authority (a ***tribunal review***).

Section 419 provides that on a periodic review, the Tribunal must decide to confirm or revoke the Treatment Authority. On an applicant review, the Tribunal must decide whether to make the orders sought by the applicant, and on a tribunal review, the Tribunal must decide any particular matter stated in the notice given under section 418(3) and make orders under Chapter 12, Part 2, Division 4 as it considers appropriate.

Section 421 provides that on a review of a Treatment Authority, the Tribunal must revoke the authority if the Tribunal considers the treatment criteria no longer apply to the patient subject to the authority or there is a less restrictive way for the person to receive treatment and care for their mental illness. However, the Tribunal does not have to revoke the Treatment Authority on the basis that the patient has capacity if the Tribunal considers the patient's capacity to consent is not stable.

Section 412 provides that in making a decision in relation to a review of a Treatment Authority under Chapter 12, Part 2, the Tribunal must have regard to the relevant circumstances of the person subject to the authority. The Act defines **relevant circumstances** of a person, as each of the following:

(a) the person's mental state and psychiatric history;
(b) any intellectual disability of the person;
(c) the person's social circumstances, including, for example, family and social support;
(d) the person's response to treatment and care and the person's willingness to receive appropriate treatment and care;
(e) if relevant, the person's response to previous treatment in the community.

Sections 423 and 428 provide that the Tribunal may change the category of the Treatment Authority from inpatient to community or from community to inpatient depending on the applicable conditions in those sections.

If the category of the Treatment Authority is community, the Tribunal must decide whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person the subject of the authority.

If the category of the authority is inpatient, the Tribunal may approve limited community treatment, or an extension of limited community treatment for the person. In deciding whether to do this, the Tribunal must have regard to the purpose of limited community treatment.

If the Tribunal approves or extends limited community treatment, it must also decide whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.

Section 426 provides that the Tribunal may change, remove or impose a condition on the Treatment Authority. However, the Tribunal may not impose a condition on the Treatment Authority that requires the person to take a particular medication or dosage of that medication.

The Tribunal may order a Treatment Authority patient's transfer to another authorised mental health service under section 427.