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.

Matter:	Treatment Authority Review
Attendees	
Registrar:	Attended
Decision	
Date of decision:	2021
Decision:	Confirm Treatment Authority, community category

The patient was commenced on a Treatment Authority after he was taken to hospital on an emergency examination authority (EEA) following a relapse of psychosis. At the time the Treatment Authority was commenced, the patient had attracted charges for public nuisance. He was identified as exhibiting symptoms including religious grandiosity, spiritual delusions and he was significantly thought disordered. He was at risk of serious mental state deterioration without intervention and care and was thought to be at physical risk through misadventure. As a result of his deteriorated mental state, the patient was not deemed to have the capacity to understand that his experiences were symptoms of a mental illness that would continue to deteriorate without appropriate treatment and care.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the *Mental Health Act 2016* (**Act**) that are relevant when the Tribunal reviews a treatment authority.

Clinical Report

The patient received the clinical report within the statutory timeframe.

Summary of evidence and findings

Do the treatment criteria apply?

Does the person have a mental illness?

The patient's first presentation occurred approximately three years ago. At that time, the patient was recuperating at home following an injury. He was smoking cannabis excessively and collateral indicated he had been overdosing on pain medications. After ceasing the cannabis abruptly, he was noted to be significantly thought disordered, exhibiting religious grandiosity, pressured speech and poor sleep. He was admitted to a high-dependency area of a mental health service. During that admission he continued with disinhibited behaviours. While he was initially compliant with medication and abstinent from illicit substances, the patient then re-commenced using illicit substances and discontinued his medication.

The patient's second admission was for a number of months. He was admitted on an EEA when a member of the public notified police of his bizarre behaviour. He was subsequently charged with public nuisance. He was exhibiting grandiose religious and spiritual delusions, pressured speech and thought disorder. A family member of the patient passed away during this admission and this contributed to increased stress for the patient, resulting in destabilisation, poor sleep and prolonged psychosis. While he was eventually stabilised and managed to maintain abstinence during his stay at the mental health service, he declined further engagement on discharge. Post discharge, the patient moved to reside closer to other family members.

During this period post-discharge, the patient resumed using illicit substances, namely cannabis. It was identified that during times of increased usage, the patient's religious pre-occupation also increased. He also became opposed to the authorised mental health service and the administration of the depot anti-psychotic medication, resulting in a strained therapeutic relationship with the treating team. He was admitted again secondary to a relapse of psychosis last year. At this time the patient was disinhibited, intrusive and agitated. The patient has required seclusion in psychiatric intensive care and as a result of an inadequate response to medications, he also required electro-convulsive therapy (ECT).

Since discharge the patient has been in the care of the Mobile Intensive Rehabilitation Team (MIRT). He remains pre-contemplative regarding changing his cannabis use habits, though states that he has ceased using other illicit drugs. The results of his urine drug screens (UDS) demonstrate that this

is correct.

The treating doctor advised the Tribunal that the patient's diagnosis has been revised to schizoaffective disorder. The patient does not sufficiently acknowledge the events surrounding his admissions and he continues to require significant encouragement to attend appointments, including for his depot and to take his medications. The treating doctor also informed the Tribunal that she has not yet met the patient when he has not been intoxicated with cannabis. At baseline, he continues to have unusual religious ideas and conspiracy theories.

The patient did not attend the hearing nor did he provide a self-report.

The Tribunal was persuaded by the evidence demonstrating the severity of the patient's decline in mental state, including the return of florid psychosis, religious grandiosity and agitation when he uses cannabis and becomes unwell. While there is evidence that many of these thought processes exist at baseline, the Tribunal accepted that there has not been a consistent amount of time that the patient has been abstinent of illicit substances since he has been working with this treating team.

As a result of these considerations, the Tribunal accepted that the patient has a mental illness, namely, schizoaffective disorder which is complicated by his ongoing cannabis dependence. Further, the Tribunal also accepted that he would likely relapse without the ongoing treatment and care provided under the Treatment Authority. Given these considerations, the Tribunal was therefore satisfied to the criteria that the patient has a mental illness.

Does the person not have capacity to consent to be treated for the illness, or if the person has capacity to consent, is that capacity not stable?

The Tribunal heard that the patient shows little acknowledgment of the circumstances surrounding his admissions. In addition, he requires assertive follow-up to attend appointments and to accept his depot and oral medications while continuing to use illicit substances. The Tribunal was informed that the patient accepts his treatment only because of the Treatment Authority. He does not want to return to hospital and sees that adherence to the wishes of the team will achieve that goal. He does not recognise the risks of non-adherence being a relapse of psychosis or deterioration of his mental state. He demonstrates therefore that he does not understand the nature and purpose of treatment, the benefits and risks of the treatment or the consequences of not receiving treatment.

The treating team determined that, as a result of these factors, they considered that the patient did not have capacity to make decisions about his treatment and care. The Tribunal was not able to consider the patient's views in this regard because he did not attend the hearing or provide a self-report for their consideration.

Based on the evidence of the treating team, the Tribunal considered that, at the time of the hearing, the patient did not demonstrate an understanding of the nature and purpose of treatment, the benefits and risks of alternative treatment options or the consequences of not receiving treatment. The Tribunal therefore accepted that the patient lacked the necessary capacity to consent to treatment at the time of the hearing.

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?

Evidence presented by the treating doctor during the hearing indicated that the risks at the time of the hearing were consistent with those identified in the clinical report. Namely, the greatest risk is for deterioration in mental state secondary to non-adherence with treatment and continued use of illicit substances. When the patient's mental state declines, he becomes increasingly

grandiose with religious and spiritual delusions, thought disorder, disinhibition and agitation. At these times, his risk of misadventure increases and could potentially compromise his physical safety and well-being, especially from retaliation from others when he becomes disinhibited. The Tribunal noted that the patient has required seclusion in psychiatric intensive care during previous admissions given the extent of his agitation and problematic behaviours. Further, when he has been very unwell in the past, the patient has required very lengthy admissions and the use of ECT to stabilise his mental state.

The Tribunal therefore accepted the evidence that without involuntary treatment, the patient would be at risk of a deterioration in his mental state. This deterioration in his mental state could also contribute to serious harm to himself or others though misadventure.

Is there a less restrictive way for the person to receive treatment and care for the person's mental illness?

The Tribunal considered and accepted that at the time of the hearing, the patient was engaging with the treating team as a means of remaining out of hospital. Further, that the level of oversight he currently requires is intensive and that assertive management is necessary for ensuring his adherence. In addition to this level of oversight and management by the treating team, his family is also encouraging him to accept and engage with ongoing follow-up and support.

In terms of his current presentation in the community, the Tribunal considered very carefully whether or not there was a less restrictive way for the patient to receive treatment and care for his mental illness by way of support from his family members. In this regard, the Tribunal accepted evidence that the patient's family had recently had to move out of their home because the patient had allowed their associates to join them at the home. This incident demonstrates that family's influence alone is not likely to be sufficient to ensure the patient will accept and receive necessary ongoing treatment and care. Further, putting the patient's family in the position of having to enforce treatment the patient does not want to accept could jeopardise the stability of their relationship and be counter-productive to his rehabilitation.

Taking into consideration the recurrent and relatively severe nature of the relapses the patient has suffered, as well as his lack of commitment to the treatment regime, his ongoing use of illicit substances and the absence of a family member or other support who could enforce his adherence, the Tribunal decided that the Treatment Authority continued to be the least restrictive way to manage the patient's treatment and care.

Category and conditions of the treatment authority

At the time of the review, the category of the Treatment Authority was community. The Tribunal decided to confirm the category of the Treatment Authority as community because it considered that the patient's treatment and care needs, and safety and welfare could be adequately met in the community with the oversight and input of MIRT and the consultant psychiatrist.

Human Rights

Section 17: *Protection from torture and cruel, inhumane or degrading treatment*: The Tribunal accepts that the patient is receiving medical treatment that is, essentially, being given without his full and free consent. The Tribunal is satisfied however, that the giving of the medication is lawful, proportionate to the circumstances and compatible with the *Human Rights Act*. The Tribunal reached this decision because of the risk associated with deterioration in mental state secondary to having an untreated mental illness. The Tribunal therefore considered that the patient's lack of capacity with respect to consenting to treatment for his illness and the risks of having an untreated mental illness necessitates the provision of medication without his consent.

Section 19: *Freedom of Movement:* The Tribunal accepts that the patient's freedom of movement is limited by imposition of the Treatment Authority, in that he must seek approval from the treating psychiatrist to travel out of the region for any length of time and he must attend reviews and appointments that necessitate a restriction of his free movement. The Tribunal is satisfied that the limitations on the patient's movements are lawful, proportionate to the circumstances and compatible with the *Human Rights Act*. The Tribunal reached this decision because the patient does not yet demonstrate insight into the nature and severity of his illness. The Tribunal therefore considered that the patient requires ongoing input from the treating team under the Treatment Authority to effectively monitor and manage his recovery.

Section 25. *Privacy and reputation:* The patient may feel his privacy regarding health issues is impacted due to his ongoing treatment under a Treatment Authority which necessitates the writing of clinical reports and external assessment of the criteria by the Tribunal. The Tribunal is satisfied however, that the limit on his privacy and reputation is lawful, proportionate to the circumstances and compatible with the *Human Rights Act* because it is necessary to ensure his safety and access to appropriate treatment. Ongoing assessment by mental health clinicians and the writing of associated reports therefore provides information upon which treatment decisions can be made. This limit on the patient's privacy therefore safeguards against further deterioration in mental state through provision of appropriate treatment.

Section 31. *Fair Hearing:* The judgment made by the Tribunal to proceed in the patient's absence was justified in order to be able to make a decision in a timely manner on the continuation of the Treatment Authority. The patient was afforded the opportunity to attend the hearing and provided a timely copy of the material before the Tribunal. It was his preference not to attend the hearing and not to provide a self-report instead. Proceeding in his absence was therefore reasonable and demonstrably justified in order to ensure that he received a timely and fair hearing based on impartial clinical and complete information provided by the treating team.

Section 37: *Right to health services:* Confirming the Treatment Authority limits the patient's right to choose his own health services. This right is appropriately limited because the patient does not demonstrate the capacity to be able to make choices and weigh the risks and benefits of treatment to be received by health services given his lack of insight into her mental illness and associated risks. The risks associated with non-adherence to treatment are so significant that the limit on this right is justified in the current circumstances.

Conclusions of the Tribunal

The Tribunal accepted the treating psychiatrist's opinion that the patient has a mental illness, namely, schizoaffective disorder with a secondary diagnosis of drug induced psychosis. They also considered that the patient's inability to acknowledge the circumstances around previous admissions, his resistance to accepting and engaging with ongoing treatment and care as well as his ongoing substance use, indicates a diminished capacity to consent to treatment. Further, without involuntary treatment, there was a likelihood the patient would suffer serious deterioration in his mental state because of his lack of understanding and acceptance of treatment, treatment options and his ongoing substance use.

In addition, the Tribunal felt that due to the inability of his family to enforce adherence, as well as the peril this may put their relationship in, the patient's family would not be in a position to undertake the responsibility of managing the patient's ongoing treatment and care.

As a result of these factors, the Tribunal considered that the treatment criteria continued to apply and the patient could not be managed in a less restrictive way.

Relying on the evidence of the treating team, the Tribunal accepted that the patient has a mental illness and that he lacks capacity by virtue of his mental illness and ongoing substance abuse.

Further, removal of the authority would likely lead the patient to disengage and cease his medication, he would then suffer serious harm through mental state deterioration.

For these reasons, the Tribunal decided to confirm the Treatment Authority, community category.

Presiding 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).

Below are extracts of sections from the Act relevant to the Tribunal's review of a treatment authority.

412 Matters to which tribunal must have regard

(1) In making a decision under this part in relation to a review of a treatment authority, the tribunal must have regard to the relevant circumstances of the person subject to the authority.
Examples of decisions in relation to a review of a treatment authority:
- deciding whether to confirm or revoke the authority
- deciding whether to confirm or change the category of the authority
- deciding whether the person is to receive any treatment in the community
- deciding whether to change or remove a condition to which the authority is subject or to impose a condition on the authority.

(2) Subsection (1) does not limit any other provision of this part that requires the tribunal to have regard to a stated matter.

413 When reviews are conducted

(1) The tribunal must review (a periodic review) a treatment authority:
(a) within 28 days after the authority is made; and
(b) within 6 months after the review under paragraph (a) is completed; and
(c) within 6 months after the review under paragraph (b) is completed; and
(d) at intervals of not more than 12 months after the review under paragraph (c) is completed.

(2) Also, the tribunal must review (an applicant review) a treatment authority on application by:
(a) the person subject to the authority; or
(b) an interested person for the person mentioned in paragraph (a); or
(c) the chief psychiatrist.

(3) Further, the tribunal may at any time, on its own initiative, review (a tribunal review) a treatment authority.

(4) If the tribunal receives written notice under section 210(3) of the amendment of a treatment authority, the tribunal must review (also a tribunal review) the authority within 14 days after receiving the notice.

(5) This section is subject to sections 414 to 416 and chapter 16, part 2, division 6, subdivision 2.

419 Decisions

(1) On a periodic review of a treatment authority, the tribunal must decide to:
(a) confirm the authority; or
(b) revoke the authority.

Note:
See subdivision 2 for the orders the tribunal may make if it confirms the authority.

(2) On an applicant review of a treatment authority, the tribunal:
(a) must decide whether to make the orders sought by the applicant; and
(b) may make the orders under this division it considers appropriate.

(3) On a tribunal review of a treatment authority, the tribunal:
(a) must decide any particular matter stated in the notice given under section 418(3); and
(b) may make the orders under this division it considers appropriate.

421 Requirement to revoke treatment authority

(1) On a review of a treatment authority, the tribunal must revoke the authority if the tribunal considers:
(a) the treatment criteria no longer apply to the person subject to the authority; or
(b) there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

(2) However, subsection (1) does not apply if the tribunal considers the person's capacity to consent to be treated for the person's mental illness is not stable.
Example of when a person's capacity to consent is not stable:
the person gains and loses capacity to consent to be treated during a short time period.

423 Change of category to community
If the category of the treatment authority is inpatient, the tribunal must change the category of the authority to community unless the tribunal considers that 1 or more of the following can not reasonably be met if the category of the authority is community:
(a) the person's treatment and care needs;
(b) the safety and welfare of the person;
(c) the safety of others.

426 Conditions
(1) The tribunal may:
(a) change or remove a condition to which the treatment authority is subject; or
(b) impose a condition on the treatment authority.
(2) However, the tribunal may not impose a condition on the treatment authority that requires the person to take a particular medication or a particular dosage of a medication.

427 Transfer to another authorised mental health service
(1) The tribunal may order the person's transfer to another authorised mental health service to provide treatment and care for the person.
(2) In deciding whether to order the person's transfer under subsection (1), the tribunal must have regard to the following:
(a) the person's mental state and psychiatric history;
(b) the person's treatment and care needs;
(c) the capacity of the authorised mental health service to which the person is to be transferred;
(d) whether the transfer would be in the best interests of the person, including, for example, closer proximity to the person's family, carers and other support persons.

428 Change of category to inpatient
(1) This section applies if the category of the treatment authority is community.
(2) The tribunal may change the category of the treatment authority to inpatient, but only if the tribunal considers it is reasonably necessary for an authorised doctor to examine the person in order to review the person's treatment and care needs.
Note:
Under section 209, the authorised doctor who examines the person may change the nature or extent of the person's treatment in the community.
(3) If the tribunal changes the category of the treatment authority under this section to inpatient, the tribunal may authorise an authorised person to transport the person to an inpatient unit of a stated authorised mental health service.
(4) For subsection (3), an authorised person may transport the person to an inpatient unit of the stated authorised mental health service.
Note:
For the powers of an authorised person when detaining and transporting a person, see chapter 11, part 6, division 5.