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	
Patient:	Attended
Psychiatrist:	Attended
Case Manager:	Attended
Decision	
Date of decision:	2021
Decision:	The Treatment Authority is confirmed. The category of the Treatment Authority is community. An authorised doctor may, at a future time, reduce the extent of treatment in the community received by the patient.

The patient is a woman with a history of schizoaffective disorder which has required her hospitalisation on two occasions since she relocated to Australia.

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 legislative timeframe.

Summary of evidence and findings

Do the treatment criteria apply?

Does the person have a mental illness?

The clinical report reflected a diagnosis of schizoaffective disorder, mixed type. At the time the report was settled, the patient was experiencing some hypomanic symptoms without delusions and poor insight. The treating psychiatrist gave oral evidence to the effect that the diagnosis was inherited from a previous treating team and there had not yet been a cross sectional assessment in relation to that diagnosis due to difficulties engaging with the patient. The treating psychiatrist opined that the current depot is managing some level of her current symptoms but that the patient was continuing to experience some mood affective symptoms which required stabilisation.

The patient did not agree that she had a mental illness and when asked about her inpatient admissions to hospital she attributed them to difficulties adjusting to a new country and some use of cannabis which has not occurred since.

The Tribunal took extensive evidence from the patient during the hearing. She was quite elevated in her presentation, was speaking rapidly, was at times very emotional, and at times her responses were tangential and completely unrelated to the questions asked of her. The treating psychiatrist noted in respect of her current presentation that the patient was presenting with symptoms of a mental illness and that her medication levels were suboptimal.

In view of the patient's presentation at the hearing, the evidence contained within the clinical report and the oral evidence of the treating psychiatrist, the Tribunal concluded that the patient has a mental illness in that she has a clinically significant disturbance of mood.

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 clinical report incorporated an assessment of capacity to consent to treatment. It was assessed that the patient lacked capacity to consent to treatment because she did not agree with the diagnosis or that there was a need for treatment. She was said to display fluctuating insight into her condition. For example, at the review which took place prior to the report being settled, the patient was observed to have pressured speech, an elevated mood and increased energy levels, which she attributed to her intake of coffee.

In oral evidence at the hearing, the treating psychiatrist confirmed his opinion that the patient's capacity to consent to treatment was lacking and tended to fluctuate. There was a need to improve her understanding of her mental illness and the need for care and treatment. The

treating psychiatrist opined the patient had limited understanding of the purpose of antipsychotic treatment and how it manages her symptoms, or the role of the mood stabiliser. The treating psychiatrist observed that the patient has a firm belief that she should not be on any treatment.

The patient was frustrated by being on the Treatment Authority and referred to her desire to have children and her worries that the medication may impact a baby. She expressed that she wanted to be off the medication but would take it if it was reduced from three monthly to six-monthly. She experiences regular headaches as a result of the medication though she currently felt well. The medication had not been healing for her. The patient expressed the view that she would not have any symptoms if she did not take the medication. When asked what impact it would have on her if the Treatment Authority was revoked, the patient said she will never be in the hospital again. As to what she would do if she was to become unwell again, the patient indicated that she is a very positive person. The patient then proceeded to describe her upbringing, the weather, and her weight loss before reiterating her desire to be off the Treatment Authority and not have medication.

The Tribunal accepted the evidence of the treating psychiatrist that the patient did not have capacity to consent to treatment. It was clear from the patient's own evidence during the hearing that she did not understand that she had an illness or symptoms of an illness that affected her mental health and wellbeing. Because of her fixed view in relation to that and her attribution of her difficulties to various other factors such as language difficulties, lack of sleep, use of cannabis and coffee, the Tribunal concluded the patient was not capable of understanding the nature and purpose of treatment, the benefits and risks of treatment or the consequences of not receiving it. In fact, the patient considered there would be no consequences of not receiving treatment for her illness.

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?

The clinical report outlined a brief history of the patient's mental illness and treatment. There was collateral information that the patient had been diagnosed with a psychotic disorder overseas and was treated with various antipsychotic medication. It was unclear when or in what circumstances those medications were ceased. The patient previously had a month-long admission to a mental health unit following a two-year functional decline. She was discharged on a Treatment Authority but was non-compliant with oral medication, so she was commenced on a monthly depot injection. The patient had required assertive follow up to ensure her continued engagement with treatment. At times, even whilst subject to the Treatment Authority, the patient had refused to have her depot injection. A further inpatient admission occurred following a deterioration in the patient's mental state. The clinical report highlighted the need for the Treatment Authority to continue in light of previous relapses which have occurred in the context of non-compliance with medication.

The clinical report highlighted that there was a risk of deterioration in the patient's mental state secondary to disengagement with mental health services and the treatment regime. When unwell previously the patient had reflected suicidal ideation and had demonstrated impaired judgement, impulsive and disorganized behavior and sexual disinhibition.

The treating psychiatrist was asked during the hearing to address the Tribunal on what if any were the likely risks if the patient was to become a voluntary patient. The treating psychiatrist said that historically the patient has come off the medication which has led to a deterioration in mental state, increased sexual disinhibition, property damage and erratic behavior. There was also a risk to her reputation.

The patient said she is not an aggressive person but has had previous misunderstandings with her family. She is now very happy, has friends and a normal life. Time had been healing for her. She

expressed there was no risk if she was to come off the medication (which she would do if she was not subject to a Treatment Authority). She was a respectful person and had the support of her friends and her partner.

In light of the patient's limited understanding of her illness and the previous episodes of disengagement with treatment which have resulted in reasonably lengthy stays as an inpatient in order to stabilise her mental state, the Tribunal decided that the absence of continued involuntary treatment in the patient's case was likely to result in her suffering serious mental deterioration. The patient quite candidly admitted she would not comply with treatment if she was a voluntary patient. Even with the Treatment Authority in place, she was presenting with suboptimal medication levels and mood symptoms which would necessitate further stabilisation.

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

The Tribunal found there was no less restrictive way for the patient to receive treatment and care for her mental illness. While the patient has stable rental accommodation, a supportive partner and friends, it was not considered that either the patient's family or partner could presently take on a personal guardian type of role to assist in the less restrictive management of the patient's illness. The patient's family has previously been consulted in that respect and the treating psychiatrist confirmed it was not an appropriate option for the reasons detailed in the clinical report.

Category and conditions of the treatment authority

The Tribunal decided to confirm the Treatment Authority. The category of the Treatment Authority was confirmed as community. In that respect it was noted that the Tribunal may only change the category to inpatient if the Tribunal considered it reasonably necessary for an authorised doctor to examine the person in order to review the person's treatment and care needs, and such a review was not called for in the patient's case. The Tribunal decided that an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.

Human Rights

The Tribunal considered that the following human rights were potential engaged and limited by the Tribunal's decision in confirming the Treatment Authority:

- s17 – Protection from torture and cruel, inhuman or degrading treatment
- s19 – Freedom of movement.

The Treatment Authority will require the patient to be subjected to medical treatment without her full, free and informed consent. That limitation on her human rights is reasonable and justifiable in circumstances where she has a serious mental illness which, in the absence of continued treatment, causes her to become unwell and require treatment as an inpatient for reasonably prolonged periods of time which is itself more restrictive than receiving treatment in the community. There are risks to the patient when she becomes unwell which are reduced when she receives treatment under the Treatment Authority. To the extent the Treatment Authority requires her to present for appointments it does restrict her freedom of movement, but only to the extent necessary to ensure she receives adequate treatment for her mental health condition.

Conclusions of the Tribunal

The Tribunal was satisfied the treatment criteria were met and there was no less restrictive way for the patient to receive treatment and care.

The patient has a mental illness which has resulted in her requiring inpatient treatment on two

occasions. There is a previous history of her disengaging with treatment and the patient would cease medication if not required to accept it under the Treatment Authority. The evidence reflected the patient does not accept she has a mental illness and does not have capacity to consent to treatment. In the absence of continued involuntary treatment, the patient would refuse medication and would likely then suffer serious mental deterioration. In previous periods where the patient has become unwell she has endured reasonably long stays in hospital, expressed suicidal ideation, sexual disinhibition and erratic behavior.

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

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.