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
Registrar:	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 middle-aged man, who self-reports a history of Post-Traumatic Stress Disorder (PTSD). He has one documented previous inpatient admission for a "psychotic episode" for which he was treated with anti-psychotic medication. He first came to the attention of Queensland Mental Health Services after being referred to the Acute Care Team (ACT) from the Mental Health Intervention Coordinator (MHIC). The referral occurred in the context of the patient allegedly sending aggressive, delusional and paranoid texts. He was subsequently closed to ACT shortly after with the impression that his presentation was exacerbated by his intermittent pattern of bingeing on crystal methamphetamine. The patient was re-referred to ACT some months later by MHIC, after the Queensland Police Service reported a deterioration in his mental state. As with his previous encounter with ACT, the patient is reported as presenting with a preoccupation of "themes of pedophilia" and "expressing persecutory delusional content", agitation, paranoia, tangentiality and declining self-care over the preceding six months. He was made subject to a Treatment Authority and was admitted to the mental health service as an involuntary inpatient and later discharged under a community Treatment Authority.

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 confirmed that he received the clinical report and had had sufficient time to consider its contents.

Summary of evidence and findings

Do the treatment criteria apply?

Does the person have a mental illness?

The written evidence states that the patient had a short inpatient admission interstate five years prior at which time he was diagnosed with a psychotic episode. The clinical report states that "he presented with paranoid delusions that people had been calling him a pedophile", and that a family member "had been disseminating defamatory messages in the post and reading his private mail". The patient was treated with Risperidone for 12 months under a psychiatrist's supervision.

The patient's next reported contact with mental health services occurred earlier in this year. The circumstances of that contact are set out in the previous section. It appears based on the written material, that this presentation was similar to his earlier interstate presentation. However, this presentation was complicated by co-morbid crystal methamphetamine use in the context of historical trauma. It was noted that he "recognise(d) that ICE use exacerbates his baseline distress and (he was) motivated to engage with a drug and alcohol service", "(was) well linked in with his GP and his psychologist who reported to staff that he (had) no acute health concerns". It is not clear, but it appears that beyond referring him to drug and alcohol service, the patient was not prescribed any ongoing treatment.

Three months later he was made subject to the current Treatment Authority. At the time he is reported as: "alleging that his family had been spreading rumours about him being a pedophile"; accusing "his family members of being pedophiles themselves"; and there were concerns around potential aggression towards his family and his ex-partner's new partner due to his delusional belief system.

Additionally, the clinical report states that the patient had been carrying a knife. He was subsequently diagnosed with Schizophrenia, commenced on a depot anti-psychotic and had a 12-day inpatient stay.

On the day of hospital discharge, the treating psychiatrist observed that the patient appeared "disheveled" with "average cares" and "poor foot care"; was not exhibiting formal thought disorder, denied "paranoia" "although remained somewhat guarded regarding prior trauma or his thoughts regarding pedophiles, though (reported) not thinking about this". The psychiatrist recorded that patient "denied any anger or frustration towards his family", however his insight was impaired.

The clinical report states that while an inpatient, the patient was reviewed by a second psychiatrist.

At the hearing, the patient was asked his views regarding the contents of the clinical report and the diagnosis. He told the tribunal that he "struggles with chronic anxiety" and the loss of liberty was upsetting and had motivated him to ensure that he would not require involuntary treatment again. As regards his diagnosis, he stated that he accepts that he has "mental health issues" but does not accept the diagnosis of schizophrenia nor the documented circumstances that led to the Treatment Authority. He told the tribunal that he believed he had experienced a nervous breakdown.

Given that the patient's prior presentation was in the context of a methamphetamine binge, he was asked about his substance use. He denied using methamphetamine at the time of the hearing stating that he was a "recreational" drug user and had last used methamphetamine "months ago". He did however concede that he is a regular cannabis user. He described using three times per day and in the context of "calming (treating) his anxiety". He continued saying that he planned to consult a specialist about using medicinal cannabis for anxiety and Post Traumatic Stress Disorder.

Given his comments regarding the diagnosis, the registrar was asked whether in the treating team's opinion, the patient met the criteria for a mental illness under section 10 of the Act. The registrar stated unequivocally that the patient satisfied the definition of a mental illness within the terms of the Act, as he suffers an underlying psychotic illness. The registrar said the diagnostic formulation was based upon the following: his clinical presentation in hospital; the second psychiatrist opinion; the collateral and history; the patient's reported recent functional decline; and his response to treatment with anti-psychotic medications.

In terms of the patient's mental state at the date of the hearing, the registrar noted that initially and prior to commencing treatment he was presenting as dysregulated and focused on certain themes whereas at the hearing he presented as "better" and less focused on those themes.

Having regard to the written and oral evidence, the tribunal prefers the evidence of the registrar especially regarding the diagnostic formulation and finds that the patient has a mental illness in accordance with section 10 of the *Mental Health Act 2016.*

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 written evidence stated simply that the patient "does not have insight into his mental illness" and therefore "does not have capacity to consent to treatment".

Pursuant to section 14 of the Act, a person has capacity to consent to treatment if the person understands in general terms that they have an illness or symptoms of an illness that affects their mental health and wellbeing; the nature and purpose of the treatment for the illness; the benefits and risks of treatment; alternatives to treatment; the consequences of non-treatment; and is capable of making a decision and communicating said decision.

The tribunal notes that whilst the patient acknowledges that he has "mental health issues" he was unable to elaborate on the signs and symptoms of same. He disagreed that at the time the Treatment Authority was made, he was aggressive, paranoid and had suffered a significant decline in his overall occupational functioning. He told the tribunal that he has chronic anxiety issues, complex family matters and was worried about an upcoming court case. He does not accept that he is suffering with a psychotic disorder.

When asked about his current treatment with depot anti-psychotic medication, he told the tribunal that he "agreed to have it" so that he could be discharged from the inpatient unit. However, he was "not sure what it was doing" to assist him, preferring to consult with his general practitioner and psychologist about the need to continue with it.

In oral evidence, the registrar confirmed the written evidence that as the patient disagrees with the diagnosis, he does not have insight into his illness.

Having regard to the totality of evidence and specifically the patient's oral evidence, the tribunal is satisfied on balance, that the patient: does not appreciate his signs and symptoms are those of a psychotic illness and represent more than anxiety and PTSD; does not understand the nature and purpose of the anti-psychotic treatment; believes that he would be better treated with medicinal cannabis; and does not appreciate the risks of non-treatment. Accordingly, the tribunal finds that as at the date of the hearing the patient does not have capacity to consent or withhold consent to treatment.

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 written evidence is that without involuntary treatment, the patient is at risk of acting out on his psychotic beliefs which increases the risk of self-harm (verbal threats of self-harm) and aggression towards others.

Historically he is reported to have carried a knife for protection in the context of psychotic symptoms (a matter he denies) and he is currently the subject of multiple Domestic Violence Orders (DVOs) for threats of aggression.

He is due to appear in court in relation to breaches of the DVOs and is at risk of further charges and DVOs if he was to act out on his psychotic beliefs.

The clinical report states that the patient previously worked in a professional capacity interstate and overseas. He moved to Queensland approximately two years ago and worked as a laborer for six months. He has not worked for the last 18 months, has accused family members and other social contacts of paedophilia, withdrawn from family and friends and has suffered significant decline in his occupational functioning and personal cares.

Finally, the clinical report identifies the patient's intermittent amphetamine and regular cannabis use elevating all risks in the context of his chronic psychotic illness.

The only risk mitigation factors identified in the clinical report are that the patient has a service dog and is reported as seeing a private psychologist regularly.

At the hearing, the registrar confirmed the risks to the patient as set out in the clinical report continued at the time of the hearing. The registrar noted that since his discharge to the community there had been further functional decline and expressed the view that due to the patient's lack of insight around both the diagnosis and the requisite treatment, he was at high risk of disengaging with the treating team and stopping medication if he was to be a voluntary patient.

At the hearing the patient told the tribunal that he intended to consult with his general practitioner and psychologist around continuing with his current treatment. He also stated that he intended to attend a drug rehabilitation program a few weeks after the hearing. The tribunal's concerns were not allayed by the patient's evidence as his comments were made in the context of him not understanding his illness nor the nature of the requisite treatment.

In view of the foregoing, the tribunal accepts the evidence of the treating team and finds that in the absence of involuntary treatment the patient would not be minded to continue with his current community follow-up which includes both mandated medication and regular monitoring of his mental state. The patient is unable to identify the early warning signs of a fulminating psychotic illness. He has an impoverished familial and social network, lives an isolated life and although abstinent from amphetamine use, continues to be a heavy cannabis user. These factors are likely to increase the chance of an undetected relapse and consequent serious mental and physical deterioration.

Historically, when unwell the patient has engaged in threatening and aggressive behaviours towards others and is the subject of DVOs.

The tribunal therefore finds that in the absence of the Treatment Authority, the patient is likely to suffer serious mental and physical deterioration with an increased risk of serious harm to others.

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

The clinical report states that the patient has not appointed a substituted decision maker such as an attorney under an Enduring Power of Attorney or made an Advanced Health Directive. Further, no guardian has been appointed by QCAT.

In the absence of a formally appointed substituted decision maker, sections 62 and 63 of the *Powers of Attorney Act 1998* provide a legislative default. Those provisions authorise a close relative or friend of an adult with impaired capacity, as a statutory attorney, to give consent for health treatment in those circumstances.

The registrar was asked whether or not the treating team could identify somebody who could act as the patient's statutory health attorney and if so, whether such a person giving consent on behalf of

the patient would result in the patient receiving the prescribed treatment. The registrar told the tribunal that the treating team could not identify such a person. Further, the team could not envisage a less restrictive way for the patient to receive his treatment other than as involuntary patient.

The tribunal accepts the registrar's evidence and is satisfied that there is no identified person who could act in the capacity of statutory health attorney to ensure that the patient receives treatment for his illness and there exists no less restrictive way for the patient to receive treatment other than under the auspices of the Treatment Authority.

Category and conditions of the treatment authority

Currently, the patient is receiving treatment as an involuntary patient in the community.

Having regard to the evidence, the tribunal is satisfied that it is appropriate that the patient's treatment continue in the community, as no evidence was put before the tribunal to show that his current treatment and care needs, safety and welfare cannot reasonably be met in the community.

Further, no evidence was put before the tribunal to show that the safety of the community could not be reasonably met if his treatment continues in the community.

Importantly, the tribunal is required to make decisions that are least restrictive of a person's rights. In that regard the tribunal concluded that community treatment under the Treatment Authority strikes the appropriate balance between ensuring that the patient receives the required treatment in a way is the least restrictive of his rights.

Human Rights

The tribunal acknowledges the *Human Rights Act 2019* and considers that the following rights are potentially limited or engaged in the Tribunal's decision making: Section 31, the right to a fair hearing; Section 15, the right to equal and effective protection against discrimination and to enjoy the person's human rights without discrimination; Section 17, the right to be protected from the provision of treatment without full and informed consent; Section 19 the right to freedom of movement (restricted by the terms of the Treatment Authority); Section 25, the right to privacy and reputation; Section 26- Protection of family relationships and Section 37, the right to access health services without discrimination.

The patient's rights under sections 15 and 31 are enlivened but not infringed. The patient was given adequate notice of the hearing and the materials before the tribunal. He attended the hearing in person and gave evidence before the tribunal. The patient's evidence, views, wishes and preferences were considered in the tribunal's deliberations.

The patient's rights under section 25 are also enlivened but not infringed. The tribunal concedes that the clinical report and evidence of the Registrar contain information ordinarily covered by the treating team's duty of confidentiality to the patient. However, the provision of a clinical report to the tribunal is mandated by section 723 of the Act, it is therefore lawful and justified in the circumstances. The hearing is a closed hearing and is confidential.

The tribunal's power to make decisions arises under Chapter 12 of the Act. The objects of the Act are set out in section 3 and include, protecting vulnerable members of society who suffer with mental illness under a legal disability, to ensure that they receive treatment; to divert persons from the criminal justice system if found to have been of unsound mind at the time of committing unlawful acts; and to protect the community, if persons diverted from the criminal justice system may be at

risk of harming others. The objects are to be achieved in a manner which safeguards the person's rights, is least restrictive of those rights and promotes and supports the person's recovery toward self-determination.

In circumstances, (as is the case here) where the tribunal determines that pursuant to section 421 of the Act, the treatment authority must be confirmed, as the treatment criteria are met and there is no less restrictive way for the patient to receive treatment and care for his illness, any limitation of the rights under sections 17, 19 and 25 of the *Human Rights Act 2019* is lawful, reasonable and justified in accordance with section 13 of the *Human Rights Act 2019.* Additionally, in these circumstances, the tribunal considers that the patient's rights to access health services without discrimination under section 37 and the protection of his family relationships (which may be at risk when he is ill) pursuant to section 26 are upheld by the tribunal's decision to confirm the Treatment Authority.

Conclusions of the Tribunal

The tribunal notes that since being placed under the Treatment Authority and commencing regular treatment with anti-psychotic, the patient's mental state has improved. At the hearing, the patient was candid in his views, thoughts and beliefs and rejected any suggestion that his presentation at the time of the Treatment Authority may be emblematic of an underlying psychotic illness that required treatment, (preferring instead a diagnosis of a nervous breakdown in the context of anxiety/PTSD).

The tribunal accepts the patient's evidence that he had not used crystal methamphetamine for up to a month before his presentation and was not using currently. However, the tribunal is concerned that he is a heavy cannabis user and does not understand the potential impact of his cannabis use on his mental state. Further, by his own evidence the patient: does not appreciate his current treatment needs; uses cannabis to treat his anxiety; and wishes to pursue medicinal cannabis in the future to treat what he considers ails him (anxiety and Post Traumatic Stress Disorder).

In view of the foregoing and the patient's observed lack of insight around his diagnosis, treatment and the impact of illicit substances on his mental state, the tribunal concluded that the patient does not have capacity to make decisions around the treatment of his mental illness. On balance, the tribunal accepts that if he was a voluntary patient he would disengage and refuse treatment which would result in significant consequential risks to his physical and mental health, his occupational functioning, his already strained familial and social relationships and potentially place others at risk due to his psychotically driven beliefs.

Accordingly, the tribunal finds that the treatment criteria are met and there is currently no less restrictive way for the patient to receive treatment other than by way of a Treatment Authority, community category.

For these reasons, the Tribunal has 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.