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	
Case Manager:	Attended
Decision	
Date of decision:	2021
Decision:	Treatment Authority Confirmed – Community Category
	An authorized doctor may, at a future time, reduce the extent of the treatment in the community received by the patient.

The patient is a young man, who was made subject to an involuntary treatment order (now known as treatment authority) approximately 6 years prior. This was an annual review by the Tribunal of the patient's 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 did not attend the hearing. The case manager attended the hearing and informed the Tribunal that he had seen the patient recently and he was ambivalent about attending the Tribunal review. The case manager informed the Tribunal that the clinical report was provided to the patient within the statutory timeframe and the patient had nothing to say about it. The Public Guardian informed by email that she was unable to attend the hearing.

The Tribunal was satisfied that the patient was provided the clinical report within statutory timeframes and he did not want to attend the hearing.

Summary of evidence and findings

Do the treatment criteria apply?

Does the person have a mental illness?

According to the clinical report the patient was diagnosed with schizophrenia eight years prior while interstate and had 3 or 4 admissions there, prior to returning to Queensland, where his family were based. He has had subsequent hospital admissions in Queensland for treatment of his schizophrenia, including when he was made subject to the current involuntary treatment order. The patient's symptoms included presentations with pressured speech, delusional ideas with scientific and grandiose themes and paranoia centered on interference by technology devices by unknown people and distressing auditory hallucinations.

The patient had two hospital admissions last year. According to a recent mental state examination, the patient continued to experience positive psychotic symptoms. The consultant psychiatrist was of the opinion that the patient suffered from treatment refractory schizophrenia.

The Tribunal accepted the diagnosis and clinical history and found that the patient suffered schizophrenia. Accordingly, the Tribunal found that the patient suffered a clinically significant disturbance of thought and perception and therefore had a mental illness as defined by s10 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?

According to the clinical report the patient lacked insight into his illness and was unable to fully participate in discussions regarding risks and benefits of treatment. It noted while the patient accepted he had a mental illness, he did not believe that it required medication.

At the hearing, the case manager confirmed that it was the treating team's view that the patient did not have capacity to consent to treatment and that he did not believe he needed medication. The case manager noted that sometimes the patient accepted he had a mental illness and other times he did not. According to the case manager, the patient did not see the benefit of treatment in reducing the severity his symptoms and in the reduction in the number of hospital admissions required since his medication changes last year. The case manager told the Tribunal that prior to the change in medication, he had regular and frequent admissions, but this had been significantly reduced due to the medication change.

While the clinical report noted the patient accepted his mental illness, the Tribunal found on the evidence that the patient did not understand his symptoms or that he needed medication. Further, it was evident from the oral evidence that the patient's acceptance of the illness fluctuated, as at times he did not accept he had a mental illness. The Tribunal found the patient was unable to weigh up the risks and benefits of treatment and understand the consequences if his illness was left treated.

Accordingly, the Tribunal found that the patient did not have capacity to consent to treatment for his mental 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?

According to the clinical report the patient had historically poor medication adherence and engagement with the treating team. If not on the treatment authority he would disengage from medication and treatment. The report noted if not treated for his illness the risks were in all domains (suicide, self-harm, aggression/violence, damage to reputation). For instance, the patient had previously attempted suicide in response to auditory hallucinations.

According to the oral evidence, when unwell, the patient's main risks were also poor self-care, dietary intake, aggression (especially towards his family), physical aggression to others and loss of accommodation.

The Tribunal accepted the treating team and clinical report evidence. The Tribunal finds if not on a treatment authority the patient would cease his medication and disengage from treatment. The Tribunal finds with the cessation of his medication it is likely to result in serious deterioration in the patient's mental health with increased symptoms, including auditory hallucinations and paranoia. The Tribunal accepted that with such a deterioration in his mental health, there was also risk of imminent serious harm to himself (suicide/ self-harm) and aggression to others. The Tribunal also found when unwell the patient's self-care and dietary intake was poor, which could result in a deterioration in his physical health.

Accordingly, the Tribunal finds that in the absence of continued involuntary treatment for his mental illness, the patient was likely to suffer serious mental and physical health deterioration and there would be a risk of imminent serious harm to himself or others.

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

In reaching its decision the Tribunal had regard to the relevant circumstances of the person subject to the treatment authority. The Tribunal had regard to the patient's diagnosis of schizophrenia, which

was treatment resistant with residual symptoms. Of note was that the recent change in medication had reduced the severity of symptoms and frequency of hospital admissions. The patient, however, did not have insight into this benefit or the need for treatment or consequences.

Previously the patient was living with family, but he moved last year. His family were emotionally supportive, but they no longer felt they could contain him safely when he was unwell. The Tribunal noted that the patient now lives on his own in a department of housing home. However, there were recent concerns about his maintenance of the home. As a result, NDIS supports were increased to assist him. The patient was supported also by the Public Guardian who applied for NDIS. However, the case manager told the Tribunal that the patient had sacked his NDIS workers the day before the hearing. According to the clinical report the patient was studying at also at TAFE.

The Tribunal considered that the patient's diagnosis and limited insight into his illness or need for treatment weighed strongly in favour of confirming the treatment authority. The Tribunal considered the patient's family, NDIS supports and Public Guardian were good supports and protective factors. However, the patient lived alone, and his family did not live close by. Further, the patient had recently sacked his NDIS support workers, which was of concern given the assistance they provided to the patient, and in particular in maintaining his accommodation.

Category

At the time of hearing, the Tribunal found that the patient could be managed in the community with the support and assistance of the treating team and while he was medication adherent.

Human Rights Act

The Tribunal had regard to the *Human Rights Act (Qld) 2019 (HRA).*

The Tribunal considered s17, s19, s25, s26 and s31 of the HRA. However, it did not consider that s25 or s26 were engaged. This was because the patient's privacy was not unlawfully or arbitrarily interfered with and his reputation was not unlawfully attacked. Provision of information was in accordance with the MHA. Further, the patient engaged with his family and was not precluded from doing so.

The Tribunal considered s17(c), s19 and 31(3) of the HRA were engaged and limited. The Tribunal considered those human rights were limited due to the patient receiving medical treatment under the treatment authority and the permissions required for freedom of movement in and out of Queensland. Further, Tribunal decisions were not generally publicly available (s31(3)).

However, the Tribunal considered that the limitations were reasonable and justified because it was lawful and in accordance with the *Mental Health Act*, because the patient could not give full and informed consent as he was deprived of capacity to consent to treatment. Further, the treatment (and his location to ensure he received treatment) was necessary to treat his mental illness and manage the risks of harm to himself and others and there was no less restrictive way. The Tribunal considered the benefit of treatment and risks, if not treated, outweighed the limitations and was in the patient's best interests.

Further, having regard to provisions about confidentiality of patient's mental health information in Chapter 17 of the MHA, and in particular s790, the Tribunal considered it lawful, reasonable and justified not to make the decision publicly available. The Tribunal did not consider it in the public

interest to publish the decision. Further, the Tribunal considered the patient's privacy outweighed the s31(3) limitation.

Therefore, the Tribunal finds the limitation of the patient's human rights in that regard was reasonable and justified (s13 of HRA). The Tribunal finds the decision is compatible with human rights as defined in s8 of the HRA.

Conclusions of the Tribunal

The Tribunal was satisfied that the treatment criteria were met as the patient had a mental illness, did not have the capacity to consent to be treated for the illness, and in the absence of involuntary treatment for that illness was likely to result in him suffering serious mental and physical health deterioration and risks to others.

For these reasons, the Tribunal has decided that the treatment authority is confirmed, and the category of the Treatment Authority is Community. An authorised doctor may, at a future time, reduce the extent of the treatment in the community received by the patient.

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.