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 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:	Confirm Treatment Authority – Community Category

The patient is an indigenous lady who was placed on a treatment authority 6 weeks prior to the hearing. She attended the Mental Health Review Tribunal (Tribunal) hearing.

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 Tribunal was satisfied that the patient had sufficient time to consider the clinical report. She advised she initially declined to accept the clinical report but was subsequently provided with a copy a day before she was discharged from hospital. The patient advised she had read the report, was prepared, and wanted to proceed with 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 schizoaffective disorder, manic type.

The clinical report noted the patient was diagnosed with schizoaffective disorder more than 10 years prior, when she first presented for treatment. She has had two subsequent inpatient admissions due to psychotic episodes and was commenced on paliperidone depot which was later swapped to aripiprazole depot. She maintained a stable mental state and was changed to oral medication and had no further contact with mental health services over the last 2 years, prior to the recent inpatient admission.

At the time the patient was placed on the treatment authority she displayed thought derailment, paranoia, and increased aggression requiring sedation. She had ceased her antipsychotic medication and her thyroxine for the underactive thyroid. The clinical report stated that this represented a relapse of her schizoaffective disorder with manic symptoms.

The patient gave evidence that she believed her symptoms at the time of her admission were due to thyroid disease. She reported that she had a lot of thoughts going through her head and she could not concentrate. She did however state that she had previously been treated with paliperidone for schizoaffective disorder and that she was now being treated with olanzapine for schizophrenia.

The Tribunal accepted the evidence of the consultant psychiatrist, as contained in the clinical report, that the patient suffered symptoms of a relapse of schizoaffective disorder with manic symptoms.

Accordingly, the Tribunal finds the patient suffers from schizoaffective disorder and therefore has a mental illness as defined by s10 of the Act.

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 stated that the patient believed her mental state decline was due to not taking thyroxine in the community and attributes improvement in her mental state to recommencing thyroxine rather than the antipsychotic medication. It reported that the patient does not believe she has schizoaffective disorder and the ability to make decisions regarding her treatment is lacking.

At the hearing the psychiatrist stated that the patient's insight is still poor. Whilst she has improved in her mental state, she had only recently been discharged from hospital and was noted to have residual symptoms including irritability. The patient had refused to accept an increase in her dose of antipsychotic medication even though this was strongly recommended by the treating team. The psychiatrist said that the patient still lacked capacity.

The patient stated that she was happy to comply with her depot medication but that she did not agree to a higher dose which was recommended by the treating team. She believed the antipsychotic medication had given her hives and she would be discussing this with her general practitioner.

The Tribunal finds on the evidence that the patient did not understand or accept that she was suffering from symptoms of a mental illness or that she needed treatment. The Tribunal finds that the patient lacks insight into her illness and did not understand the role of medication.

Accordingly, the Tribunal finds the patient does not have capacity to consent to treatment for her 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?

The patient is a single parent of four children, two of whom live with her, in a shared custody arrangement with their father. She lives in a private residence and is employed as an administration assistant on a part-time basis.

The clinical report stated that the patient was a moderate to high risk for medication non-compliance. She has a history of medication non-compliance and her current insight into the need for medication is low.

At the hearing the psychiatrist stated that given the patient's lack of capacity and impaired insight into the need for treatment he did not believe she would take her prescribed medication if she was made a voluntary patient. He stated that she was still ambivalent that she had suffered a deterioration in her mental state, and she continued to refuse to increase her dose of antipsychotic medication despite education about the need for this from the treating team. He also stated that when she is unwell, she becomes manic with psychotic symptoms and without treatment there was a risk of further decompensation of her mental state. Additional risks included damage to her reputation and relationships and her ability to care for her young children.

The psychiatrist noted that shortly before her inpatient admission the patient attended the emergency department with her children for assessment due to her paranoid suspicions that she and her children had been poisoned but she did not wait to be seen.

The patient stated that she believed her children had eaten copper that was dispensed from a water filter, but she could tell she wasn't taken seriously, so she left. She stated that she thought the problem was coming from the beads in the filter and she had now spoken to the company about that.

The patient stated that she would continue to take her medication but only at the current dose. She would not agree to a higher dose because she did not want the medication to affect her concentration.

The Tribunal accepted the evidence of the psychiatrist that if untreated, the patient's mental health would deteriorate. The Tribunal accepted that when unwell the patient can become manic and suffer psychotic symptoms and as such there is a risk to her reputation and relationships and her ability to care for her young children. The Tribunal considers such deterioration and impacts were serious.

The Tribunal finds if not on a treatment authority, the patient would likely cease her medication. The Tribunal finds that with the cessation of her medication it is likely to result in a serious deterioration in her mental health.

Accordingly, the Tribunal finds that in the absence of continued involuntary treatment for her mental illness, the patient was likely to suffer a serious mental deterioration.

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

The psychiatrist stated that the treatment authority, community category was the less restrictive way for the patient to receive care and treatment for her mental illness. Initially the patient did not allow the treating team to discuss her care with her family, but she had now agreed to this.

The patient stated that she has trust issues with her family because since she disclosed her thoughts to a family member she was brought in for assessment and admitted for treatment.

Given the patient's lack of insight and risk of mental health deterioration, the Tribunal considered a treatment authority, community category was the least restrictive way for her to receive treatment and care. There was no other person identified as a suitable substituted decision maker for the patient who could ensure she received the necessary treatment for her mental illness.

Category and conditions of the treatment authority

The Tribunal was satisfied from the evidence that the patient's treatment needs could be adequately provided in the community and decided to confirm community category. The Tribunal also decided that an authorised doctor may, at a future time reduce the extent of treatment in the community received by the patient.

Human Rights

The Tribunal acknowledges the Human Rights Act 2019. In particular, the Tribunal considers that the following human rights under that Human Rights Act 2019 are potentially engaged and limited by the Tribunal decision: sections 15, 17(c), 19, 25, 28, 31 & 37.

Nevertheless, the Tribunal is satisfied that these limitations are lawful, proportionate to the circumstances and compatible with the Human Rights Act 2019. The Tribunal reached this decision because of the following:

- the criteria of the relevant test for a treatment authority under the Mental Health Act 2016 were met.
- the treatment authority, community category, has been determined to be the least restrictive way for the patient to receive care and treatment for her mental illness.
- the human rights engaged have been balanced against the need for the patient to receive care and treatment for her mental illness.

The Tribunal was satisfied that the patient's rights under section 15 & 31 were not limited given she was treated with equality, received the clinical report, and attended and participated at the hearing.

The Tribunal finds the decision is compatible with human rights as defined in s8 of the Human Rights Act 2019.

Conclusions of the Tribunal

The Tribunal was satisfied that the treatment criteria were met as the patient has a mental illness, does 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 her suffering a serious mental deterioration.

For these reasons, the Tribunal has decided to confirm the treatment authority, community category and an authorised doctor may at a future time, reduce the extent of 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.