Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to the section 756 of the *Mental Health Act 2016*. The patient and person 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.

Patient details	
Matter:	Treatment Authority Review
Attendees	
Patient:	Attended
Psychiatrist:	Attended, but was excused
Case Manager:	Attended
Other attendees:	The Patient's lawyer The Patient's daughter The Patient's mother
Decision	
Decision:	The treatment authority is revoked.
Treatment Authority	
Category prior to this review:	Community
Documents before the Tribunal at hearing:	• Two Clinical Reports • A report from a psychiatrist external to the health service • A report from a psychologist external to the health service • A copy of the Treatment Authority

This hearing represented the second periodic review of the treatment authority. The hearing had been adjourned on one occasion as the patient's lawyer was unavailable and then on another occasion after a previous panel required the presence of the treating psychiatrist to give evidence. A different psychiatrist was treating the patient at the time the previous panel made that request.

During the adjournment period, the treating psychiatrist took over care of the patient. He attended the hearing as required. He explained that he had only seen the patient on one occasion for the purpose of updating the clinical report. He had signed the most recent clinical report before the Tribunal, however stressed that he did not know the patient and would not be able to give his own medical opinion as to the treatment criteria. The treating psychiatrist was then excused to return to clinical duties. The Tribunal was told that the previous psychiatrist had left the service and would not be attending. The hearing proceeded with the case manager representing the treating team.

The patient's lawyer provided the Tribunal with two further medical reports. The first was a detailed medical assessment and opinion prepared for the Tribunal by a consultant psychiatrist external to the health service. The second was a one-and-half page letter written by a clinical psychologist external to the health service. It is not clear why the letter was written or who the intended audience was. In general terms, the letter expressed agreement with the psychiatrist external to the health service without particularising a basis for that concurrence.

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 and her solicitor had received both clinical reports within the required timeframe and confirmed that they had been allowed sufficient time to consider them. The patient and her solicitor told the panel that they wanted the hearing to proceed.

Summary of evidence and findings

Does the person have a mental illness?

Both clinical reports listed two diagnoses:

1. Mental and behavioural disorders due to use of other stimulants, including caffeine, psychotic disorder; and
2. first episode psychosis.

The patient's first admission was in October 2020. The clinical reports state that she presented with persecutory delusions and auditory hallucinations. She had made multiple calls to the police of a delusional nature.

At the previously adjourned hearing the case manager confirmed that the treating team's diagnosis was as listed in the clinical reports. It was at this previous hearing that the panel required the presence of the treating psychiatrist.

At that hearing the treating team did not provide any evidence as to the patient's diagnosis.
The report from the psychiatrist external to the health service provided a diagnosis of trauma related anxiety. That doctor also gave a working diagnosis of post-traumatic stress disorder.

It appears that the patient told the psychiatrist and psychologist (both external to the health service) that her diagnosis with the treating team was delusional disorder. The Tribunal was provided with some evidence that the patient experienced delusions as part of her symptoms, but not that she had a diagnosis of 'delusional disorder'.

There was no evidence given of any history of mental illness prior to the current episode. The patient told the Tribunal that she does use cannabis, and occasionally amphetamines. The Tribunal could not make a finding of diagnosis. On balance, the Tribunal accepted that the patient did have a mental illness, though the precise diagnosis was not clear.

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?

Both clinical reports stated, *"At this stage, it is our opinion that [the patient] lacks the capacity to consent to treatment due to her impaired insight and judgement. In view of these, [the patient] currently does not have full, comprehensive understanding of the nature of the illness, the purpose of treatment, benefits, and risks of treatment and its consequences."* The basis for this conclusion is not clear on the face of the clinical reports, beyond the patient's statement that she would not remain engaged with the health service as a voluntary patient.

The case manager told the Tribunal that she 'did not have good communication' with the patient. Her relationship with the patient was distant and had not been very productive. She was not able to speak to the patient's understanding in terms of section 14.

The patient's lawyer submitted her client had capacity to consent to treatment because she had sought support independently and understood the benefits and risks of not engaging in treatment.

The patient disputed the diagnosis of delusional disorder, though it is noted that no such diagnosis had been provided. The patient accepted the diagnosis from the psychiatrist external to the health service and wished to pursue treatment with that doctor.

That doctor noted in his report that the patient *"agreed that she had a mental illness that was trauma related anxiety, and most likely PTSD, but did not believe that she had a delusional disorder. She therefore believed "I do not need to be on a TA". She told me that she would be compliant with treatment with a private psychiatrist if she were able to come off the Community Treatment Authority."*

That doctor noted the patient wanted to *"end her relationship with the Community Treating Team in order to pursue alternative treatment for the symptoms that she is distressed with."*

On balance, the Tribunal was not satisfied that the patient did not have capacity in terms of Section 14. Her belief that she had been given a diagnosis of 'delusional disorder' was mistaken, therefore it was sensible that she did not agree with it. The best medical evidence before the Tribunal was that the patient needed treatment to manage the symptoms of anxiety and previous trauma. The patient has said on many occasions that she is seeking precisely that type of treatment, and in the external psychiatrist's opinion her insight into the need for such treatment was reasonable.

The treating team's current evidence as to diagnosis and capacity remained unclear after three Tribunal hearings and two clinical reports. The patient mistakenly thought that she had been diagnosed with delusional disorder. It was not reasonable to rely upon her rejection of the treating team's diagnosis as a basis upon which to find a lack of capacity.

The Tribunal was most assisted by the external psychiatrist's report, which provided that the patient had reasonable insight insofar as the diagnosis of trauma related anxiety was concerned. The patient's own evidence was consistent with this. Therefore, the Tribunal found on balance that the patient had the capacity to consent to treatment for that 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 reports provided limited information as to risk, as follows:

> *"Presented to [hospital] in 2014 after making suicidal gestures. Overdose of [pain medication] in 2014 after an argument with her daughter. Combative towards police – required IMI droperidol in ED. Past history of being sexually assaulted."*

At the hearing, the case manager spoke about the level of distress that the patient experienced regarding other members of the community at the time of her admission. She said that the treating team were concerned that the patient could have a relapse of her symptoms if taken off the treatment authority. She understood the patient had an altercation with another person when she was unwell. The case manager said that the police had been concerned with the number of phone calls made to them by the patient. She believed that the main risks were to the patient's reputation and functioning.

In his report, the external psychiatrist stated that he did not see any risks associated with the patient not receiving treatment under the treatment authority. He pointed to the patient's demonstrated willingness to engage with private treatment and her supportive family and friends who can help her access appropriate services. In terms of risk, the Tribunal further considered a statement in that report about the principle of reciprocity. The external psychiatrist requested that the Tribunal consider whether the restrictions imposed upon the patient were appropriate given the side effects of the medication and its limited effectiveness.

That consideration falls outside of this Tribunal's assessment of the treatment criteria. Whether or not a treatment is effective is not part of the criteria in section 12. However, the Tribunal is permitted to have regard to the principle of reciprocity in two ways. Firstly, in terms of its consideration of whether the patient has a mental illness and what the risks are in the context of discontinuing involuntary treatment. Secondly, in terms of the patient's human rights. That is considered under the *Human Rights* heading below.

As to the first consideration, a lack of effectiveness might suggest an absence of the mental illness for which treatment is intended. Further, evidence from an appropriately qualified expert that a patient's involuntary treatment is not effective, suggests that the absence of continued involuntary treatment is *not likely* to result in a realisation of the risks in section 12 (1) (c), where those risks do not already exist.

On balance the Tribunal was satisfied that the absence of continued involuntary treatment was *not* likely to result in imminent serious harm to the patient or others. Nether was the Tribunal satisfied of a likelihood of the patient suffering serious mental or physical deterioration.

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

The patient asked this Tribunal for the opportunity to be treated voluntarily. The case manager agreed that there was a fractured relationship between the patient and the treating team. The Tribunal accepted that the patient was genuinely committed to receiving voluntary treatment from her private psychiatrist, psychologist, and general practitioner.

The external psychiatrist concluded in his report that the use of a treatment authority was not the least restrictive way to treat the patient.

On balance, the Tribunal was satisfied that there was a less restrictive way for the patient to receive treatment, as she could continue to do so voluntarily.

Human Rights

The Patient enjoys the right to not be subjected to medical treatment without her consent pursuant to section 17 (c) of the *Human Rights Act.* Section 13 permits the reasonable limitation of a person's human rights where *"that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom."*

The Tribunal considered the external psychiatrist's evidence that the treatment being provided was ineffective and caused a side effect burden which did not justify its use for the patient's symptoms.

The treating team did not provide the Tribunal with any compelling contradiction of that opinion. The Tribunal considered that the weight of the evidence did not demonstrably justify further limitation of the patient's right under section 17(c) of the *Human Rights Act.*

The decision to revoke the treatment authority did not limit the patient's human rights.

Conclusions of the Tribunal

For the reasons stated, the Tribunal was not satisfied that the treatment criteria were met. The Tribunal found that there was a less restrictive way for the patient to receive treatment and care. The treatment authority was revoked.

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.