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
Support Person:	Attended
Registrar:	Attended
Case Manager:	Attended
Legal Representative:	Attended
Decision	Confirm Treatment Authority (community category)

The patient was placed on an involuntary treatment order (**ITO**) under the *Mental Health Act 2000* by an authorised doctor. The authorised doctor assessed the patient as guarded, exhibiting odd behaviours, delusional and lacking capacity. He was admitted to an authorised mental health service and an authorised consultant psychiatrist confirmed the ITO without amendment.

The *Mental Health Act 2000* is no longer in force. However, under section 815 of the *Mental Health Act 2016* (**Act**), an ITO in force immediately before the commencement of the Act, is taken to be a treatment authority (**TA**) under the Act. That means, on commencement of the Act, the patient was taken to be on a TA.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the Act that are relevant when the Tribunal reviews a treatment authority.

Clinical Report

The patient confirmed he received the clinical report before his previous hearing which was adjourned. The Tribunal was satisfied the patient received his clinical report within the prescribed timeframe.

Summary of evidence and findings

Does the person have a mental illness?

The patient told the Tribunal he believes he has schizophrenia to a certain extent. He has attention deficient hyperactivity disorder (**ADHD**) and post-traumatic stress disorder (**PTSD**).

The clinical report states the patient has a primary diagnosis of paranoid schizophrenia and mental and behavioural disorders due to harmful use of cannabinoids. During the hearing, the registrar confirmed that diagnosis.

The Tribunal accepted the medical evidence and was satisfied the patient has the mental illness paranoid schizophrenia.

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?

A consultant psychiatrist assessed the patient as having no formal thought disorder and no thoughts of harming himself or others. There were no paranoid delusions, and he was able to cope with hearing voices which were less frequent. His cognition was good, but his insight was limited.

The registrar and case manager told the Tribunal, the patient didn't have insight into his mental illness and didn't have capacity to consent to treatment. The registrar said the patient's illness was well-managed when he was compliant with a particular medication. However, that medication became unavailable approximately four years ago and the treating team have been working on finding the right medication for him since then.

The patient said mental health has failed to look at the root cause of his schizophrenia. When he first became unwell, he was going through the family law system and had no support. He had a meltdown from the extreme stress. When the Tribunal asked the patient how finding the root cause of his

schizophrenia would change his situation, he responded it would change mental health services' attitude towards him. He said the medication gives him side effects. He would like to seek advice from other doctors and seek medication for the root problem. He would like the TA revoked.

The patient submitted to QCAT, that once a person is diagnosed with schizophrenia "it is assumed that you have it for life". His self-report stated a person had to experience abuse to recognise it and defend yourself against "them". He stated he had the right to manifest "ones' own beliefs". The patient's self-report stated the patient would like his medication reviewed and his diagnosis looked at. It stated the patient believed he has had complex PTSD.

The patient's legal representative submitted the patient is open to the diagnosis of schizophrenia, but he has PTSD and ADHD. He would like a second opinion. She submitted the patient is aware he has a mental condition and sees the benefits of the medication despite experiencing side effects. However, the patient told the Tribunal there were no positive effects from being on his current medication and his self-report wanted his diagnosis looked at.

The patient told the Tribunal he had 10% schizophrenia and there were no positive effects from being on his current medication. The Tribunal was not satisfied the patient understood the nature of his mental illness of paranoid schizophrenia, the benefits of ongoing treatment - particularly medication compliance - and the consequences of not remaining compliant with his treatment.

The Tribunal was not satisfied the patient had the capacity to 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 patient was first diagnosed as having paranoid schizophrenia and has had numerous admissions to mental health services since then. Over a number of years:

- he was admitted into hospital after threatening to shoot the police.
- he intentionally overdosed due to the distress of his delusional beliefs.
- he was admitted into hospital after making violent threats to his probation and parole officer.
- he was floridly psychotic, thought disordered and fixated on telepathy and telekinesis.

Over the last 12-18 months,

- the patient was admitted into hospital for his mental illness three times.
- he was found walking with plans to reach a destination about 400 kilometres away. The registrar said the patient was very dehydrated and a risk to himself on that occasion.
- the Queensland Police Service brought the patient into hospital after an authority to transport an absent person was completed. The patient was not engaging with mental health services and his mental health was assessed as deteriorating. He was talking about having sexual experiences with minors with his caregivers and friends and, despite having an easier route to get home, was walking home through a primary school while intoxicated.

The patient's legal representative submitted the clinical report highlighted the patient's risk of suicide, but he did not have current thoughts of self-harm.

The Tribunal was not satisfied the patient had the capacity to consent to treatment and, if the TA was revoked, the Tribunal was not satisfied the patient would continue to take his medications and engage

with mental health services. This is consistent with the patient's belief that he has 10% schizophrenia, and his current medication has not positive benefits. This would place the patient and others at risk.

The Tribunal was satisfied that, in the absence of involuntary treatment, it was likely the patient would suffer a serious mental deterioration and others would be at risk of imminent serious harm.

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

In reaching a decision, the Tribunal had regard to the patient's relevant circumstances.

Mental state and psychiatric history

The clinical report indicates the patient has a diagnosis of paranoid schizophrenia and has been involved with various mental health services since then. It stated that, even when the patient is at his baseline, he continues to experience chronic residual symptoms.

Any intellectual disability

The patient does not have an intellectual impairment.

Social circumstances, including, for example, family and social support

The patient lives in a semi-detached townhouse and correspondence before the Tribunal indicated he has 21 support worker hours per week. The case manager told the Tribunal that the patient's support worker is initiative-taking in bringing the patient to all his appointments with mental health services. When the support worker was away, the patient did not attend for his depot medication and the case manager had to go to his home to administer it.

The evidence before the Tribunal was the patient had stable accommodation, a good relationship with his neighbours and 21 NDIA support worker hours per week.

Response to treatment and care and the person's willingness to receive appropriate treatment and care

The clinical report indicates the patient's mental state deteriorates when he ceases or reduces his medication. His current treatment includes a depot injection every fortnight, face to face reviews every fortnight and consultant psychiatrist reviews every three months.

The patient's legal representative submitted the patient is willing to engage in treatment and take his medication. He has friends and support workers who he can reach out to if he becomes unwell. He has stable accommodation and manages his own finances.

The Tribunal was satisfied the patient responds to treatment and considered there was a real risk of him disengaging from mental health services and self-ceasing his medication if the TA was revoked. The Tribunal accepts the patient has stable accommodation, friends and support workers who assist him to live independently in the community. However, the Tribunal was not satisfied the patient would willingly receive appropriate treatment and care for his mental illness if he wasn't on a TA.

Less Restrictive Way

The patient is living in the community and having 21 hours per week of NDIA support worker assistance. He has a good working relationship with his key support worker who is instrumental in facilitating the patient's compliance with treatment.

The Tribunal was satisfied there was no less restrictive way for the patient to receive adequate care and treatment for his mental illness other than under a TA in the community.

Human Rights

The Tribunal acknowledges the *Human Rights Act 2019*. The patient received his clinical report within the statutory requirements, he attended the hearing with his key support worker and had legal representation. The Tribunal allocated adequate time to hear the patient's review and considered his evidence and his representative's submissions. The Tribunal was satisfied the patient was afforded a fair hearing.

The human rights related to disclosure of personal information and administering medical treatment in the absence of a person's free and full consent, amongst others, are potentially engaged and limited by the process and/or decision of the Tribunal. However, the Tribunal was satisfied that any limitations placed on the patient's human rights are lawful, proportionate to his circumstances and compatible with the *Human Rights Act 2019*. The Tribunal reached this decision because the human rights engaged are balanced against the significant likelihood of the patient's mental health deteriorating if he did not receive treatment and care under the TA.

Conclusions of the Tribunal

The Tribunal concluded that the treatment criteria were met. The Tribunal accepted the treating consultant psychiatrist's opinion that the patient has paranoid schizophrenia that requires ongoing treatment. The Tribunal considered the evidence in relation to the patient's current lack of insight, his capacity and diagnosis and was satisfied that without involuntary treatment in the community it was likely he would suffer a serious deterioration in his mental health and represent an imminent risk of serious harm to others.

The Tribunal decided to confirm the TA as a 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.