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 have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Attendees	
Patient:	Attended
Psychiatrist:	Attended
Registrar:	Attended
Other attendees:	Support worker, attended
Decision:	Treatment authority: confirmed Category: inpatient
Documents before the Tribunal at hearing:	Clinical report Treatment authority Minutes of Assessment and Risk Management Committee

[1] The patient was a 24-year-old single woman who, at the time of the hearing, was an inpatient at a secure mental health unit (**SMHU**), after transfer from hospital three years ago. She had been placed on the treatment authority six years ago by an authorised doctor when she was admitted to hospital exhibiting marked behavioural change and psychotic symptoms including delusional thought content and auditory hallucinations. Her mental health care thereafter had been provided mostly by the same mental health service, inpatient and community, until her transfer to SMHU.

[2] The patient attended the hearing of the statutory review of her treatment authority and was accompanied by her support worker. The Tribunal was appreciative of the attendance of the patient at the hearing and for the opportunity to hear directly from her regarding her views, wishes and preferences. The patient advised the Tribunal that the decision she wanted was to be discharged to live in the community and was less concerned about being on the treatment authority.

[3] After considering all available evidence, the Tribunal decided to confirm the treatment authority. The Tribunal's decision was made in the context of the objects and principles set out in the *Mental Health Act 2016* (**MH Act**) and the *Human Rights Act 2019* (**HR Act**). The Tribunal's reasons are as follows.

Statutory Framework

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

Clinical Report

[5] The patient received the clinical report on nine days before the hearing from her treating team. The Tribunal was satisfied that the patient had sufficient time to consider the clinical report.

Summary of evidence and findings

Do the treatment criteria apply?

Does the person have a mental illness?

[6] According to the clinical report, the patient had a mental illness namely schizoaffective disorder, manic type and other conditions including chronic thyroiditis; mild cognitive disorder; mental and behavioural disorders due to multiple drug use and use of psychoactive substance, harmful use; and emotionally unstable personality disorder, impulsive type. The presentation when the treatment authority commenced six years ago was thought to be a drug induced psychosis given the history of ICE use the preceding day. Thereafter, the patient had multiple admissions to inpatient mental health units, and given her poor progress and unstable community accommodation, was eventually transferred three years ago to a SMHU. Repeated assessments over time had occurred during the SMHU stay including a second opinion, which confirmed the diagnosis as schizoaffective disorder complicated by substance use and thyroiditis. The report also noted the involvement of Community Forensic Outreach Service (**CFOS**) prior to the patient's SMHU admission and the periodic reviews by the Assessment and Risk Management Committee (**ARMC**) in the oversight of her clinical treatment and care while at the SMHU. The ARMC were involved during the patient's SMHU admission including

in review of her suitability to access limited community treatment (**LCT**) i.e. leave on and off the hospital grounds.

[7] The consultant psychiatrist confirmed the diagnosis at the hearing. She noted there had been another exacerbation of psychotic symptoms for the patient in the week prior to the hearing which had increased her risk profile – the patient had been prescribed an additional psychotropic medication, haloperidol, to assist at that time.

[8] At the hearing, the patient told the Tribunal that the clinical report was correct, that the medication helped her mood and paranoia but that she did not like how often the medication treatment was changed, and that she wanted to be in the community rather than be an inpatient. The patient advised that she did not want to use drugs anymore as she did not like the impact these had on her, though she did not want to be transferred back to the unit at the hospital as she preferred to seek community accommodation with her aunt.

[9] The Tribunal considered the patient's view that she had received treatment that was helpful for her mood and paranoia. The Tribunal noted the evidence of the treating team that included the history of treatment and care for mental illness that was initially thought to be drug induced but with repeated assessments over time had been clarified during the SMHU stay as schizoaffective disorder-complicated by substance use and thyroiditis in particular. The Tribunal concluded that the patient did have a mental illness. The Tribunal came to this conclusion because it gave weight to the contemporaneous evidence from the current treating psychiatrist and the clinical history provided in the written evidence that referred to confirmation of mental illness by previous treating psychiatrists, a second opinion assessment, and reviews conducted by CFOS and ARMC.

<u>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?</u>

[10] According to the clinical report, the patient had a lack of insight into her mental illness and its impacts, and also the need for treatment on a consistent basis over time. The treating team also advised that the patient underestimated the risks of not receiving treatment on her mental and physical well-being and the adverse consequences of previous substance use. The treating team were hopeful that there were signs of improvement in her capacity during the admission to the SMHU, and, combined with further abstinence from substances and sustained remission of her psychotic symptoms, that this may allow for further improvements over time in her capacity.

[11] The patient advised the tribunal that she planned to stay on the treatment as she experienced the paranoia as bad and did not want to experience this again. She also advised that she did not want to use drugs again as she did not like the cycle she had previously experienced of drug use and subsequent hospital admissions.

[12] At the hearing, the treating psychiatrist confirmed that the information regarding capacity in the clinical report had not changed and was of the opinion that the patient still lacked the capacity to consent to be treated for her mental illness. The treating psychiatrist added that while the patient had advised the Tribunal of her commitment to continue her medications, the treating psychiatrist considered that the patient's progress was still to be tested over time with periods of leave into the community given the history of non-adherence with prescribed medications and use of substances previously. The treating psychiatrist also advised that the patient could not always appreciate or recall the psychotic symptoms she experienced. The treating

psychiatrist had observed this pattern as recently as the preceding week to the hearing when the patient experienced a relapse of psychosis.

[13] The Tribunal considered the patient's capacity to consent to be treated and noted the patient's submissions regarding her commitment to treatment and care. The Tribunal preferred the evidence of the treating team, both written and oral through the treating psychiatrist, noting the recent and serial assessments of the patient's mental state during her stay at the SMHU, finding this evidence to be relevant and credible. The Tribunal concluded that the patient did not have the capacity to consent to be treated for her illness. While the patient is aware of her diagnosis of a mental illness in general terms, she varies in her appreciation of how the symptoms affect her and is not capable of understanding the nature and purpose of the prescribed treatment, the benefits and risks of treatment, the alternatives to treatment, and the consequences of not receiving the 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?

[14] According to the clinical report, the treating team were concerned that without the treatment authority in place, the patient would seek to discharge to the community, likely without a confirmed discharge address. In this situation, the treating team were concerned that she would not continue with her prescribed medication regime, and potentially resume the use of illicit substances, which was likely to lead to a serious mental deterioration.

[15] The report outlined the risks based on the history of when her mental state has previously deteriorated. The risks identified included to herself via misadventure, absconding from her care environment, vulnerability to herself with lapses in judgement worsened by co morbid substance use, neglecting or avoiding care of her known physical condition of thyroid disease which had previously posed a risk to her life, and experiencing episodes of self-harm, suicidal thoughts and actions. The clinical report also identified risk to others, which were considered low in her current care setting but previously included multiple episodes as outlined of aggressive and irritable behaviour and involvement with the criminal justice system.

[16] At the hearing, the treating psychiatrist confirmed the risk assessment provided in the clinical report though in the secure inpatient environment of a SMHU, noted that this risk profile was low. While the patient was an inpatient at the SMHU, the treating team regularly assessed her mental state, including before and after leave periods and responded quickly to any variations. The patient continued to be supported in receiving her prescribed treatment and to reduce her access to illicit substances. The team were carefully assessing her progress to allow for periods of leave on the hospital grounds and into the community.

[17] At the hearing, the patient told the Tribunal that she could recall sometimes previously not taking her medications because of sedation, but that she did not want to be paranoid again. Also she recalled, that when she has been off her medication in the past, she had been violent, so did not want that to happen either.

[18] The Tribunal had regard to the clinical report, and the oral evidence of both the patient and the treating psychiatrist. The Tribunal gave weight to the clinical history and the evidence from the treating psychiatrist and concluded that in the absence of the treatment authority, there is the

risk of serious mental deterioration with associated risks to the patient including her physical wellbeing and risks to others.

[19] The Tribunal therefore concluded that each of the treatment criteria applied.

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

[20] The Tribunal must revoke the treatment authority if it considers there is a less restrictive way for the person to receive treatment and care for their mental illness. The less restrictive ways to be considered are specified in section 13 of the MHA.

[21] The Tribunal did not consider that there was a less restrictive way for the patient to receive treatment and care, other than under the treatment authority. The patient did not have an advance health directive. On the information available, the Tribunal did not identify that the patient had an appointed personal guardian, an appointed attorney or a person who would be eligible to be their statutory health attorney.

[22] Given the treatment criteria were met and there was no less restrictive way for the patient to receive treatment and care for her mental illness, the Tribunal confirmed the treatment authority.

Category and conditions of the treatment authority

[23] Prior to the hearing, the category of the treatment authority was inpatient. The Tribunal must change the category of a treatment authority to community unless one or more of the following cannot reasonably be met if the category is community: the person's treatment and care needs, the safety and welfare of the person, or the safety of others.

[24] The tribunal noted that the patient sought to be discharged as she wanted her ongoing treatment and care to be provided in the community. The Tribunal decided that the category of the treatment authority must be inpatient. Weight was given to the evidence provided by the treating team that while the patient had improved over time as an inpatient at the SMHU, she continued to display brittleness in her mental state. There had been a relapse in psychotic symptoms only the week prior to the hearing that had increased her risk profile particularly to herself. That relapse had required further alteration of her medication treatment and required the treating psychiatrist and the treating team to monitor her response and tolerance of this treatment before approving further periods of leave from the ward. Additionally, limited community treatment over the last review period had been provided but was complicated at times by periods of being absent without authority, use of illicit substances and mental state deteriorations. At the time of the hearing, the treating psychiatrist outlined a plan to support the patient trialling unsupervised off grounds leave once there had been a period of stability following her recent relapse, as the treating psychiatrist had found there to be overall clinical improvement. The treating psychiatrist advised that success with the next step of off ground leave was required to move toward discharge planning from the SMHU.

[25] The treating psychiatrist advised that the preferred plan of the team was an interhospital transfer to another hospital for further rehabilitation at a ward which was an open environment allowing the patient to be closer to her preferred community living location while she transitioned fully to community living. That environment could also support the patient in her vocational goals such as resuming studies. The treating psychiatrist acknowledged that the

patient would seek to be discharged as it had been a long inpatient admission. The treating team had considered options including community accommodation for when the patient recovered from the recent relapse and achieved stability in her mental state, but none had yet been identified. As regards to support in the community, the patient identified her mother, stepfather and grandfather, though none could provide her stable accommodation at that time. At the hearing, the patient advised her preference for accommodation was with an aunt. The treating psychiatrist advised this option was yet to be explored appropriately, given this was a recent preference of the patient.

[26] The Tribunal carefully considered the views, wishes and preferences of the patient to be a community patient. The Tribunal preferred the evidence of the treating team provided by the treating psychiatrist noting it to be comprehensive, and also, responsive to the clinical situation while being mindful of the patient's views. The Tribunal concluded that at the time of the hearing, the category must be inpatient for the patient's treatment and care needs, her safety and welfare, and the safety of others.

[27] The Tribunal decided not to specify limited community treatment on the treatment authority, instead leaving this to the discretion of an authorised doctor. The Tribunal was satisfied with evidence of the treating team, that they were regularly monitoring the patient's progress and providing her with leave based on careful assessment of her mental state and risk profile.

[28] The Tribunal similarly did not impose any conditions on the treatment authority because the Tribunal was satisfied with the evidence provided by the treating team that the patient's treatment and care needs are being appropriately managed by the treating team including when the patient was on periods of limited community treatment, without the need for conditions to be provided by the Tribunal.

Human Rights

[29] The Tribunal considered the following human rights under the HR Act to be relevant:

a. section 15: recognition and equality before the law – the Tribunal recognised that the patient had the right to recognition as a person before the law and was entitled to protection against discrimination. The Tribunal considered that the requirements of the MH Act had been met in relation to the Tribunal's decision and the Tribunal's decision was lawful and not discriminatory.
b. section 17(c): involuntary medical treatment without full, free and informed consent – the Tribunal accepted that confirming the treatment authority would require the patient to continue to receive medical treatment that was being given without her full and free consent. However, the Tribunal was satisfied that requiring the patient to receive treatment in these circumstances was lawful and necessary because this was the least restrictive way to provide the required treatment and that the benefits of this treatment outweighed any harm caused by this restriction.
c. section 19: freedom of movement – the Tribunal accepted that the patient's freedom of movement was limited by virtue of the treatment authority with restrictions such as requiring her to be treated as an inpatient with leave into the community only when authorised by her treating psychiatrist. The Tribunal was satisfied this limitation was lawful and necessary because it was the least restrictive way for the patient to receive the treatment and care she required given the evidence provide that this was necessary to address her treatment and care needs, her own safety and welfare, and the safety of others.

d. section 25: privacy and reputation – the Tribunal acknowledged that the patient had a right to keep her life private and that the treatment authority allowed the patient's information to be shared for the purpose of providing treatment and care and Tribunal hearings. However, the Tribunal was satisfied that the continuation of the treatment authority did not unlawfully or arbitrarily interfere with the patient's privacy nor unlawfully attack their reputation.
e. section 31: fair hearing – The patient had the right to have this matter decided by a competent, independent, and impartial tribunal after a fair and public hearing. While this hearing was not public, the Tribunal considered this lawful and appropriate having regard to the provisions of the MH Act and the sensitive nature of the information considered. The Tribunal was satisfied that the patient had a fair hearing because the patient had had access to the written material that the Tribunal relied upon, and also had heard the oral evidence of the treating team. Additionally the Tribunal gave careful consideration of the patient's oral evidence including her views, wishes and preferences.

[30] The HR Act permits limitation of human rights to reasonable limits that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom. Having regard to the nature of the rights limited and the purpose of the limitation, the Tribunal decided that the limitations of the patient's human rights were reasonable for the purposes of the HR Act. In particular, the Tribunal found:
a. the criteria and relevant tests under the MH Act were met such that the Tribunal was required to confirm the treatment authority. Therefore, the Tribunal's decision was lawful and within the jurisdiction of the MH Act.
b. the treatment authority and category had been determined to be the least restrictive way for the patient to receive treatment and care.
c. the limited human rights had been balanced against the risk of the patient suffering serious mental deterioration.

[31] The Tribunal concluded that any limitation of the patient's human rights was therefore justified, and the Tribunal's decision was compatible with the HR Act.

Conclusions of the Tribunal

[32] For these reasons, the Tribunal decided to confirm the treatment authority, inpatient category.

[33] The Tribunal was satisfied that the treatment criteria were met because the patient had a mental illness, did not have capacity to consent to be treated for that illness and, the absence of involuntary treatment is likely to result in her suffering serious mental deterioration. The Tribunal was also satisfied that at the time of the hearing there was no less restrictive way for the patient to receive treatment for her mental illness other than pursuant to a treatment authority.

[34] The Tribunal considered that the patient's treatment and care needs, her safety and welfare, and the safety of others could not reasonably be met if the category of the treatment authority were community. Therefore, the Tribunal confirmed the category of the treatment authority as inpatient category.

Medical 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.