Mental Health
Tribunal

Level 30
570 Bourke St, Melbourne
Victoria 3000 Australia

T +61 3 8601 5270
F +61 3 8601 5299
T 1800 242 703 (Toll-free)
E mhrb@health.vic.gov.au
W mhrb.vic.gov.au

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Mr David Crofts
23 Brisbane Street
Berwick VIC 3806

Copy via email: david.crofts@gmail.com

Dear Mr Crofts

MENTAL HEALTH TRIBUNAL HEARING – 4 SEPTEMBER 2015

Please find enclosed the Tribunal's Statement of Reasons for its decision in this matter.

Yours sincerely

Grace Horzitski
Legal Officer

Mental Health Tribunal

STATEMENT OF REASONS

1. DETAILS OF THE HEARING

At the time of hearing, DC was subject to a Community Treatment Order and was being treated at the Casey Community Clinic.

As DC's current Treatment Order is due to expire on 10 September 2015, the authorised psychiatrist applied to the Tribunal to make a further Treatment Order.

On 4 September 2015 the Tribunal conducted a hearing to determine whether to make a Treatment Order or whether DC should become a voluntary patient. The hearing was held at Casey Hospital.

The division of the Tribunal conducting this hearing comprised:

Legal Member:	Ms E. Montgomery
Psychiatrist Member:	Dr P. Roy
Community Member:	Ms V. Spillane

Attending the hearing were:

Dr AY (DC's consulting psychiatrist)
Dr AB (DC's treating doctor)
AMZ (DC's case manager)

DC did not attend the hearing

DC's UR number: 355101

2. INFORMATION PROVIDED TO THE TRIBUNAL AT THE HEARING

The Tribunal received the following evidence at the hearing:

(a) A report on DC's compulsory treatment prepared by Dr AB and dated 28 August 2015 and approved by Dr AY and dated 31 August 2015 ("the Report").
(b) DC's clinical file.
(d) Oral evidence was provided by Dr AY, Dr AB and AMZ.

This statement of reasons is not intended to be a detailed record of all the material provided or issues discussed in the hearing. The evidence accepted and relied upon by the Tribunal to reach its conclusions and final determination is identified in Part 4.

3. ISSUES UNDER CONSIDERATION

Pursuant to section 54(5) of the *Mental Health Act 2014* ("the Act"), the Tribunal must conduct a hearing to determine whether to make a further Treatment Order or revoke the current Treatment Order.

If the Tribunal is satisfied that all of the treatment criteria in section 5 of the Act apply to DC, the Tribunal must make a Treatment Order and also decide the length of the Treatment Order and whether it is for treatment in the community or in hospital. The section 5 criteria are attached to this statement.

If the Tribunal is not satisfied that each of the treatment criteria in section 5 apply to DC, the Tribunal must revoke the current Treatment Order. DC cannot be treated compulsorily if the Treatment Order is revoked.

In accordance with the *Charter of Human Rights and Responsibilities Act 2006* ("Charter") the Tribunal must give proper consideration to relevant human rights in making a decision.

4. APPLYING THE TREATMENT CRITERIA IN SECTION 5 TO DC

Determining whether the treatment criteria in section 5 applied to DC required the Tribunal to reach a conclusion in relation to the following questions.

(a) Does DC have mental illness?

Under section 4(1) of the Act, mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. At the hearing, the Tribunal had regard to the considerations in section 4(2) (section 4 is attached to this statement).

DC has been diagnosed with paranoid schizophrenia and has a long history of compulsory mental health treatment in the public mental health system. According to the Report, DC's illness is characterised by thought disorder, delusions, paranoid ideas, irritability, agitation and disorganisation.

On 7 August 2015 DC attended a clinical review with Dr AY. However, Dr AY gave evidence that at the appointment DC refused to discuss his mental state. Dr AY told the Tribunal that DC was an intelligent man who *enjoyed discussing philosophical issues and was opposed to the compulsory mental health treatment*. Dr AY said that DC had at least two websites where he was active in communicating his opposition to the public mental health system. Dr AY said that DC is unwilling to engage with his mental health treatment and when DC's mental health deteriorates, his hostility towards mental health services and clinical staff increases.

Dr AY told the Tribunal that two other appointments were made with DC on 14 and 24 August 2015. According to the clinical notes in DC's file and evidence during the hearing by Dr AB and AMZ, at these appointments DC was reported to be irritable, un-cooperative, angry, loud, verbally abusive and verbally aggressive and it was not possible to discuss or assess DC's mental state. Due to DC's hostility and past aggression towards mental health staff, all appointments with DC are conducted in the presence of a security guard or another clinician.

In the absence of any evidence to the contrary from DC, the Tribunal was persuaded by the information in the Report and the evidence presented by the treating team at the hearing that DC has mental illness characterised by a significant disturbance of thought and mood. Accordingly, the Tribunal was satisfied that DC has mental illness as defined in section 4(1) of the Act and found that the requirements of section 5(a) are met.

(b) Because of DC's mental illness, does he need immediate treatment to prevent serious deterioration in his mental or physical health or serious harm to DC?

Under section 6 of the Act, treatment is defined as things done to the person in the course of the exercise of professional skills to remedy the mental illness or to alleviate

the symptoms and reduce the ill effects of the mental illness (section 6 is attached to this statement).

The Report states that DC requires immediate treatment to prevent serious deterioration in his mental and physical health and serious harm to another person.

At the hearing and in the Report it was Dr AY's evidence that DC requires ongoing psychotropic medication as well as assertive community engagement and support to prevent further serious deterioration in his mental state. According to the Report, when DC relapses he becomes disorganised, threatening and assaultive in his behaviour towards others and is *particularly hostile towards those providing his mental health treatment*.

Dr AY told the Tribunal that he had concerns that in recent weeks DC's mental state had seriously deteriorated. DC was observed to be increasingly irritable, had been verbally aggressive including frequent use of abusive language and had made threats towards clinical staff and was increasingly un-cooperative in his engagement with mental health services. Dr AT said that these behaviours were characteristic of deterioration in DC's mental state.

At a meeting on 28 August 2015, Dr AY discussed with DC's family the symptoms that the treating team had observed and reported in their recent interactions with DC. According to Dr AY, DC's mother and sister said that they could not corroborate the observations of the treating team or any signs of deterioration in DC's mental state. However, they informed him of the profound stress the family was currently experiencing as DC's father was acutely unwell and terminally ill with cancer. Dr AY told the Tribunal that DC's mother and sister reported that DC was co-operative and extremely helpful at home and that DC had a critical role to play in caring for his father. Due to concerns about the enormous personal stress on DC in relation to his father's declining health, and the fact that these stresses were likely to intensify in coming weeks, despite the fact that DC's family had not observed signs of deterioration in his mental health at home, DC's family nevertheless supported the treating team's application for a further Community Treatment Order.

The Tribunal notes that in the Report the treating team argues that DC requires immediate treatment to prevent serious deterioration in his physical health. However there were no details in the Report or evidence provided at the hearing in relation to how immediate treatment would prevent serious deterioration in DC's physical health.

In relation to DC's need for immediate treatment to prevent serious harm to another person, Dr AY told the Tribunal that prior to DC's last admission to hospital he had been verbally and physically aggressive including assaulting a police officer. On 13 May 2015, DC was brought to the Emergency Department at Casey Hospital after *he assaulted a member of the police force during a welfare check*. AMZ said that a police officer had been kicked by DC and it was this assault that had led to the Police taking him to the Emergency Department for an assessment of his mental state. According to the Report, at the time of his admission DC *expressed that his GP and the mental health services were plotting against him* and *had delusions that his bones were being removed.*

In the Emergency Department, DC *caused considerable damage to the* [assessment] *room and had to be transferred to seclusion*.

During the hearing Dr AB commented that DC could have seriously injured himself or a member of staff during his violent outburst. A *Code Black* was called in response to DC's behaviour which included *marked property destruction and threatening behaviour*. The damage caused in the Emergency Department of the hospital is reported to have cost $30,000 to repair.

Dr AY told the Tribunal that DC's admission to hospital had included periods in seclusion due to his irritability, verbal aggression, verbal threats to staff and unpredictable

behaviour. On 2 July 2015, after a six-week inpatient stay, DC was discharged from hospital on a Community Treatment Order.

In the absence of evidence to the contrary, the Tribunal was persuaded by the evidence of the treating team that because of DC's mental illness, he requires immediate treatment in the form of ongoing antipsychotic medication to prevent serious deterioration in his mental health, satisfying section 5(b)(i) of the Act. However, due to an absence of evidence, the Tribunal was not persuaded that DC requires immediate treatment to prevent serious deterioration in his physical health.

The Tribunal was also persuaded by the evidence in the Report and by the treating team at the hearing regarding DC aggressive and unpredictable behaviour prior to his admission and during his stay in hospital from 13 May to 2 July 2015, that DC requires immediate treatment to prevent serious harm to another person satisfying section 5(b)(ii) of the Act.

(c) Will the immediate treatment be provided to DC if he is subject to a Treatment Order?

Dr AY told the Tribunal that the immediate treatment that DC has been prescribed is a long-acting injectable anti-psychotic medication (Flupenthixol depot, 40mg) on a fortnightly basis. In addition, DC continues to require assertive outreach to encourage him to attend appointments for the administration of his depot or for scheduled reviews. Dr AY noted that recent clinical reviews had not been successful in assessing DC's mental state.

The Tribunal accepted the evidence of the treating team that the immediate treatment DC requires is anti-psychotic medication to prevent serious deterioration in his mental health, together with community engagement and support. On the basis of the evidence, the Tribunal was persuaded that immediate treatment would be provided to DC if he was subject to a Treatment Order. Accordingly, the Tribunal was satisfied that the requirements of section 5(c) applied to DC.

(d) Are there less restrictive means reasonably available to enable DC to receive the immediate treatment?

For the reasons that follow, the Tribunal concluded that there are no less restrictive means reasonably available to enable DC to receive the immediate treatment and, accordingly, the Tribunal was satisfied that section 5(d) applied.

The Tribunal accepted the evidence in the Report and by the treating team that DC's strong preference was to be a voluntary patient. According to the Report, DC managed well in the community from 2005 to 2013 and had no admissions during this time. DC lives next door to his parents in a property owned by his family. Understandably, DC's father's terminal illness has created enormous stress on DC and his family. During the hearing, Dr AY acknowledged the important role DC played in caring for his father, who was terminally ill, and in supporting his mother. It was also Dr AY's evidence to the Tribunal that in the context of the profound stress relating to his father's terminal illness, DC's risk of relapse was high.

In the Report and at the hearing, Dr AY expressed concerns that in the absence of a Treatment Order DC would cease taking his medication, which was necessary to prevent serious deterioration in his mental health. Dr AY told the Tribunal that DC objected to his compulsory mental health treatment and was consistently unwilling to engage in discussions about his treatment. Dr AY reiterated that in the weeks before the hearing the treating team arranged three appointments with DC and one family meeting in an effort to engage with DC and to understand his treatment preferences. Dr AY told the Tribunal that DC's refusal to discuss his mental state and confrontational behaviour with clinical staff during the appointments had made it impossible to adequately assess DC's mental state. Dr AY added that in the past arrangements had been made to treat DC in a less restrictive manner including transferring his care to his general practitioner. Dr AY

gave evidence that under such arrangements DC had pressured his general practitioner to reduce the dose of his depot medication, which would occur, resulting some weeks later in DC suffering relapse and requiring an admission to hospital.

In reaching its decision, the Tribunal considered the assertive follow up that was necessary by the treating team to ensure that DC had his fortnightly depot and attended his appointments. The Tribunal also took into account the challenges of engaging DC in his treatment and placed positive weight on the fact that the treating team had made three appointments and adopted different approaches to encourage DC's participation. The Tribunal considered that the steps taken by the treating team reflected the mental health principles in section 11 of the Act.

The Tribunal accepted that DC was currently managing his illness in the context of extremely stressful circumstances. The Tribunal took into account that in the past DC had difficult experiences on the inpatient ward and consequently his engagement with clinical staff was often fraught. The Tribunal also considered the evidence of DC's mother and sister that they had not observed symptoms of deterioration in his mental health in the context of the family home. Nevertheless, the Tribunal accepted and was persuaded by the evidence of the treating team, that in the absence of a Treatment Order it was unlikely that DC would continue to receive the immediate treatment that he required and that this would be seriously detrimental to his mental health. The Tribunal was satisfied that there was no less restrictive means reasonably available to enable DC to receive the immediate treatment and, accordingly, the requirements of section 5(d) were met.

5. DETERMINATION

As it was satisfied that each of the treatment criteria in section 5 of the Act applied to DC, the Tribunal made a Treatment Order in the terms specified in Part 6 below.

Having determined that all the criteria in section 5 of the Act applied to DC, the Tribunal was satisfied that while the Order engaged and limited DC's rights to privacy, liberty, freedom of movement and freedom from medical treatment without consent, those limitations were lawful and reasonable.

6. TREATMENT ORDER

Pursuant to section 55(1) of the Act, if the Tribunal is satisfied that the treatment criteria apply, the Tribunal must determine the duration of the Treatment Order and whether it should be a Community Treatment Order or an Inpatient Treatment Order. The Tribunal must also have regard to the circumstances in section 55(2).

The Tribunal was satisfied that the immediate treatment that DC requires can be provided in the community and therefore made a Community Treatment Order for 52 weeks.

In determining the duration of the Order, the Tribunal considered evidence regarding DC's poor engagement with the community mental health services and recent efforts to assess his mental state and to engage him in discussions about his treatment. The Tribunal also took into account evidence that DC's family supported the treating team's application for a further Community Treatment Order and that they would continue to support the treating team to engage with DC in this setting. The Tribunal considered that 52 weeks was an appropriate period for the treating team to assertively engage with DC, monitor his mental state and in the context of the stressful period ahead surrounding his father's health, provide him with support in the community.

Date of determination: 4 September 2015.

Ms E Montgomery
Presiding member, on behalf of the Tribunal division.

Date: 28 September 2015.

Note: Pursuant to section 194 of the *Mental Health Act 2014*, the name and other details of a person who is the subject of a proceeding before the Tribunal must not be published unless the written consent of the President has been obtained. If publication is sought, consent in writing from the patient must first be obtained.

Section 4 What is mental illness?

(1) Subject to subsection (2), mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

(2) A person is not to be considered to have mental illness by reason only of any one or more of the following—
- (a) that the person expresses or refuses or fails to express a particular political opinion or belief;
- (b) that the person expresses or refuses or fails to express a particular religious opinion or belief;
- (c) that the person expresses or refuses or fails to express a particular philosophy;
- (d) that the person expresses or refuses or fails to express a particular sexual preference or sexual orientation;
- (e) that the person engages in or refuses or fails to engage in a particular political activity;
- (f) that the person engages in or refuses or fails to engage in a particular religious activity;
- (g) that the person engages in sexual promiscuity;
- (h) that the person engages in immoral conduct;
- (i) that the person engages in illegal conduct;
- (j) that the person engages in antisocial behaviour;
- (k) that the person is intellectually disabled;
- (l) that the person uses drugs or consumes alcohol;
- (m) that the person has a particular economic or social status or is a member of a particular cultural or racial group;
- (n) that the person is or has previously been involved in family conflict;
- (o) that the person has previously been treated for mental illness.

(3) Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.

Section 5 What are the treatment criteria?

The treatment criteria for a person to be made subject to a Temporary Treatment Order or Treatment Order are—

(a) the person has mental illness; and

(b) because the person has mental illness, the person needs immediate treatment to prevent—
- (i) serious deterioration in the person's mental or physical health; or
- (ii) serious harm to the person or to another person; and

(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

Section 6 What is treatment?

For the purposes of this Act—

(a) a person receives treatment for mental illness if things are done to the person in the course of the exercise of professional skills—
- (i) to remedy the mental illness; or
- (ii) to alleviate the symptoms and reduce the ill effects of the mental illness; and

(b) treatment includes electroconvulsive treatment.