In the Appeal of P **an involuntary patient** **at Mid West Area Mental Health Service - Sunshine**	**Reference No:** **Date of Hearing:** **Board Members**:	07-096 10 January 2007 Mr F McCarthy Dr H Chopra Ms T Harper

Involuntary status – Mental Health Act 1986 – s8(1)(d) – consent to treatment – insight

P was diagnosed with chronic paranoid schizophrenia.

P's legal representative submitted amongst other things that s8(1)(d) of the Act was not met. She stated that P now exhibited a considerable degree of insight into his illness. This was set out in Dr SS's report and in P's file. Further, P believed that he suffered a mental illness and was prepared to continue with oral medication. He was able to identify his symptoms of mental illness and could now also recognise symptoms of developing paranoia. P had presented himself to the hospital emergency department seeking help when that occurred on his last two admissions to hospital.

***Found**:*

(1) The Board was satisfied that P appeared to be mentally ill, and required immediate treatment for that illness.

(2) The Board considered that without treatment by way of medication it was likely that a severe relapse of P's mental illness would occur. This would involve a considerable disruption to his life in the community.

(3) Although the Board decided that P required treatment for his illness to prevent deterioration in his mental state, he did not need to be subject to a community treatment order for that treatment to take place. Further, involuntary treatment was not necessary for his health or safety or for the protection of members of the public.

(4) The Board was satisfied that at the date of the hearing, it was more probable than not that P was able to consent to the necessary treatment for his mental illness and had not refused that consent. It was satisfied that it was probable that he would remain compliant with his treatment without the coercion of a community treatment order. The Board was not satisfied that this criterion was met.

Appeal against involuntary status - appeal allowed.

P was represented by Ms P Mutha-Merennege, Mental Health Legal Centre Inc.

Date of Decision: 10 January 2007

MENTAL HEALTH REVIEW BOARD

STATEMENT OF REASONS FOR THE DETERMINATION

DIVISION:

Mid West Area Mental Health Service - Sunshine

HEARING NO:

07-096

DATE OF HEARING:

10 January 2007

PATIENT'S INITIALS:

P

DECISION UNDER APPEAL

Decision of the authorised psychiatrist made under s14 of the Mental Health Act 1986 ("the Act") that the continued treatment of P as an involuntary patient subject to a community treatment order was necessary.

MEMBERS OF THE BOARD:

Legal Member:	F. McCarthy
Community Member:	T. Harper
Psychiatrist Member:	Dr HD Chopra
ATTENDANCES:	At the hearing of the Board on 10 January 2007:
Patient:	P
Doctors:	Dr RA (Consultant Psychiatrist), Dr SS
Case Manager:	DB
Legal representative:	Ms Pasanna Mutha-Merennege, Mental Health Legal Centre Inc., Solicitor Mr G Mukherji, Mental Health Legal Centre Inc Volunteer (with P's consent)
Patient's Partner:	Ms NP

DETERMINATION OF THE BOARD:

The Board was not satisfied that the continued treatment of P as an involuntary patient subject to a community treatment order was necessary.

The Board therefore discharged P from the community treatment order.

The appeal of P was therefore allowed.

DATE OF THE BOARD'S DECISION:

10 January 2007

EFFECT OF THE BOARD'S DECISION:

That P was discharged from the community treatment order. Therefore P ceases to be an involuntary patient.

INFORMATION CONSIDERED BY THE BOARD:

1. Clinical file of P.

2. Report on Involuntary Status dated 3 January 2007, prepared by Dr SS and presented to the Board.

3. Treatment Plan of P dated 7 December 2006, prepared by DB and presented to the Board.

4. Oral evidence at the hearing.

5. Appeal of P, dated 1 December 2006, and lodged with the Board on 1 December 2006.

ISSUES:

Under s36(2) if, having regard to the criteria specified in s8(1), the Board is not satisfied that the continued involuntary treatment of a person as an involuntary patient subject to a community treatment order is necessary, the Board must order that the person be discharged from the community treatment order. Therefore, the Board considered:

1. Does P appear to be mentally ill; and

2. Does P's mental illness require immediate treatment and can that treatment be obtained by P being subject to a community treatment order; and

3. Because of P's mental illness, is involuntary treatment of P necessary for his health or safety (whether to prevent a deterioration in his physical or mental condition or otherwise) or for the protection of members of the public; and

4. Has P refused or is he unable to consent to the necessary treatment for the mental illness; and

5. Can P receive adequate treatment for the mental illness in a manner less restrictive of his freedom of decision and action?

Under s35A, the Board must review the patient's treatment plan to determine whether:

1. The authorised psychiatrist has complied with s19A in making, reviewing, or revising the plan (as the case may be); and

2. The plan is capable of being implemented by the approved mental health service.

DISCUSSION:

Background

P was a 34-year-old man diagnosed with chronic paranoid schizophrenia with affective symptoms. On 1 December 2006 he lodged an appeal with the Mental Health Review Board, which stated:

> "I do not meet the 5 criteria under s8(1) of the Mental Health Act".

Submissions on behalf of P

Ms. Mutha-Merennege submitted that the criteria in s8(1) (c), (d) and (e) of the Act were not met. She stated that P now exhibited a considerable degree of insight into his illness. This was set out in Dr SS's report and in P's file. Further, she said that P believed that he suffered a mental illness and was prepared to continue with oral medication. He was able to identify his symptoms of mental illness and could now also recognise symptoms of developing paranoia. Ms. Mutha-Merennege stated that P had presented himself to the hospital emergency department seeking help when that occurred on his last two admissions to hospital. She stated that P was compliant with his oral medication. He had been compliant since March 2006. P had found that he suffered fewer side-effects from the oral medication and this was a factor in his compliance with his medication.

Ms. Mutha-Merennege stated that P was not a risk to himself or to others. There had been past forensic issues but these had occurred some time ago in 2002 when P was under considerable stress following his marriage breakdown and problems concerning contact with his children. Ms. Mutha-Merennege said that P would attend the clinic as required and would discuss issues he might have with his case manager. She stated that P had settled down to a more stable personal life for the last 12 months. She drew the Board's attention to the Board's decision in *Re the Appeal of* 03-057 [2002] VMHRB 11 wherein the following appeared:

> "...it is important that the criterion of capacity to consent be viewed realistically and not at a level which is impossible of attainment by a person with a mental illness. Insight is a spectrum with many aspects to it. The acquisition of mature understanding by a patient and by their family about mental illness, its symptoms, its consequences, its relapse signatures and appropriate measures to reduce the likelihood of its recurrence is part of an ongoing process of psycho-education (see *Re the Review of* 01-039 [2000] VHMRB 1). ... Moreover, insight is not a statutory end in itself although undoubtedly its acquisition and escalation are pertinent both to capacity to consent and to the likelihood of ongoing compliance with clinically recommended pharmacotherapy and with treatment generally."

Ms. Mutha-Merennege also drew the Board's attention to a report dated 3 March 2006 prepared by Dr SB of the Mid West Area Mental Health Service, which contained the following:

> "P has partial insight, is compliant with his oral and intramuscular medication. ... He is currently on a CTO (Community Treatment Order) and has been compliant with his oral medication over the last

few months. His mental state has been stable during this time and he feels that things are going well for him."

Evidence of treating team

Dr SS, in his report to the Board, provided the following information:

- P had a current diagnosis of a chronic paranoid schizophrenia characterised by a significant disturbance of thought, perception and mood.

- That diagnosis was supported by P displaying delusional symptoms of persecution. When he was unwell P had complained of security companies and police trying to poison his drinking water. During his admission in 2002 he believed that gas was being put through the vents at the High Dependence Unit causing him considerable paranoia, fear and agitation. More recently he had complained of elaborate schemes to keep his children from him and that police and staff were discriminating against him as he was a Negro. P had several admissions to psychiatric units between 1993 and 2002. He had exhibited inappropriate and dangerous behaviour including running naked through streets and pouring petrol over wood in a petrol station with the intention of killing himself and others. P had been on a community treatment order and depot medication since his discharge from the Sunshine Adult Acute Psychiatric Unit in 2002.

- P was last seen by the consultant psychiatrist on 6 November 2006. On that occasion he was casually dressed, tidy and clean and maintained good eye contact. His mood was described as being euthymic. P's affect was reactive and he exhibited no psychotic symptoms or suicidal ideation. He was sleeping well and had a good appetite. At that time it was agreed that administration of depot Risperdal Consta would be ceased and P would be medicated orally with risperidone, 5 mg at night.

- P was seen again on 3 January 2007. He was described as being appropriately dressed, well kempt, pleasant and co-operative. He was concerned about access to his children. His mood was euthymic, his affect reactive and his speech relevant and coherent. He exhibited no formal thought disorder, no paranoia or delusions and denied having any perceptual disturbances or suicidal ideas. The report stated " [P's] insight was improved with willingness to take medication and [he] accepted having mental illness and felt sorry for past behaviour when he was ill."

- On 25 August 2005, P had presented to the Sunshine Emergency Department requesting help with paranoid persecutory delusions. He had recently returned from a trip to Nigeria and had probably become non-compliant with his medication. He believed that he was being surveyed by police and exposed to experiments. He was hostile and irritable with pressured speech. He had expressed homicidal intent against the staff and was insightless.

- P's insight had increased recently [14 December 2006] but he had a history of non-compliance and elusiveness towards the service and in the past this had led to a relapse of his mental illness and readmission to hospital. There was a chance that he might again become non-compliant whilst being taken off his community treatment order or being discharged into the care of a general practitioner.

- P had been taken off depot medication since 2 November 2006 only, and it may be too early to comment on his compliance with oral medication in the light of his past history of non-compliance.

The Board drew Dr SS's attention to the issue of informed consent as set out in his report. In answer to the question in the report, "Is the patient capable of giving informed consent to the necessary treatment?" Dr SS marked the answer "Yes". In answer to the next question in the report, "If 'yes', has the patient refused to consent to the necessary treatment?" Dr SS marked the answer "No". In the report he gave the following reasons for the answers – "In his last visit he showed improvement in his insight and appeared to be compliant with oral medication". The Board pointed out to Dr SS the significance of those answers and advised him that if they correctly represented his opinion then it most likely would follow that the criterion in s8(1)(d) of the Act was not met. The chairperson then drew Dr SS's attention to the following passage relating to informed consent, which appeared in the report immediately above the questions referred to:

> "In general terms, to be capable of giving informed consent requires a patient to have a reasonable understanding of the broad nature of his/her mental illness and the need for treatment (based on information provided by the treating team or otherwise available to the patient). It involves making an informed choice, that is, more than mere acceptance (or non-refusal) of, or acquiescence to, treatment offered by the service. (Note the concept "patient insight" is one aspect only of the Board's consideration under this sub-section of the Act)."

Dr SS was again asked in the light of that passage whether he still believed that P was capable of giving informed consent to the necessary treatment, and had not refused to consent to the necessary treatment. Dr SS confirmed the answers, which he has previously given to the Board, as set out above. P's case manager DB advised the Board that he concurred with both answers given to the Board by Dr SS. Dr SS said that his view was shared by the consultant.

The Psychiatric Consultant, Dr RA, then entered the hearing and said that he had not seen Dr SS's report. He told the Board that P's improvement had been a gradual process "until now". He said that from 2004 until the present, P has been able to avoid admission to hospital because he was being treated by way of depot medication. There had been a negotiated agreement with P that depot medication would be stopped and oral medication continued. It had sometimes been "a hassle" to bring P to the Clinic for his depot medication. However, Dr RA described P's current progress as "fantastic". He told the Board that P had received his last depot medication on 6 November 2006, but that a further three months of observed compliance with oral medication by P was necessary before he could be satisfied that P had sufficient insight to ensure future compliance without the coercion provided by a community treatment order. It was Dr R A's opinion that at this stage he could not confidently state that P had sufficient insight to be able to consent to the necessary treatment.

In answer to questions from Ms Mutha-Merennege, Dr RA told the Board that it was his experience that P had relapsed in the past when medication had been switched from depot to oral. This had happened in 2002, 2003 and 2004. He said he needed "enough time" to ensure that this did not happen again. He said that he had known P for five years and was very familiar with his past history. He told the Board that the last time he had seen P was in November 2006, and that he would, personally, review patients only every 3 to 6 months due to the time constraints that he experienced.

Dr RA told the Board that P had been having oral medication since December 2005. When he went to Sydney in 2006, he became non-compliant with his oral medication. He said there was no evidence that P was not taking his oral medication since December 2005 but it was not possible to check whether this was the case. However, P wished to have oral medication because he found depot injections of Risperdal Consta painful. He said that if P were not subject to a community treatment order, the service was prepared to continue to monitor his progress if he undertook to attend appointments.

Evidence of P

Answering questions from the Board, P said that he had been medicated both by injections and by tablets for a little more than twelve months. He had been placed on depot medication after his admission to hospital in August 2002. In September 2006 his community treatment order was revoked because he did not attend the clinic for his depot medication.

P said that when he was admitted in 2002 he was not well as he was "still recovering, because of the breakdown of my marriage." He said that he needed treatment because he was mentally ill suffering from paranoid schizophrenia. He thought the medication helped him. P told the Board that he had refused the depot medication because of the "side effects". He said that he slept well and took his tablets "every night". During the Christmas period [presumably in 2006] he went to Sydney to spend some time with his uncle from Scotland who was a doctor. He said that he forgot to take his tablets with him and "missed four or five days but I told my uncle who got me back on my medication. When I returned to Melbourne I re-started my medication" and "I have never missed once". He said he had continued to comply with his oral medication since November 2006 when the depot medication was stopped. He did not think he needed three months "probation". He thought the oral medication produced "minimal" side effects compared with the injections, which interfered with his sight and appetite and gave him the "shakes".

When the Board asked P how long he would need the medication he said he would continue to take the tablets for "two, three, four years". He would take the tablets every night because he needed them "to keep well".

When asked what he would do if he were not subject to a community treatment order and could make all the decisions about treatment himself, P said that he would not reduce the medication because "I feel so well … I feel so great. I am not going to be any better in 6 months than I am now. I wouldn't want to put myself in a position where I would make the decision [to cease medication]. I would never stop until the doctors say so". When the Board asked P whether he thought the medication could be reduced he said that he had, in fact, asked the doctors to increase his oral medication from 4mg to 5 mg daily. He said he would wait "until the doctors decided". He did not see himself "getting off the tablets" and that "I wouldn't take that decision".

In answer to Ms. Mutha-Merennege's questions, P said that he went to hospital himself because he "felt unwell". He said that he could now recognise symptoms of a relapse such as not sleeping well at night and would never wait until he had a "full relapse". He said he was compliant with the medication and felt better mentally since being on oral medication only. He said that he could now understand more about his illness. P told the Board that if he were not subject to a community treatment order he would still be "very happy" to come back for treatment for his own, his family's and his children's sakes. P said that he could see "progress" in his condition. He needed the clinic's help "a great deal". He said, "I want to comply

with treatment. I don't need a CTO to make me comply". He thought the community treatment order restricted his contact with his children.

DECISION:

In order to be satisfied that the continued treatment of a person as an involuntary patient subject to an involuntary treatment order is necessary, the Board must be satisfied that the criteria in s8(1) of the Act have been met. The Board considered each of the criteria in turn.

1. Section 8(1)(a)

Does P appear to be mentally ill?

Section 8(1A) states:

> "Subject to sub-section (2), a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory."

The Board considered the exclusionary criteria in s8(2) and has decided that these were not relevant in this case.

The Board was satisfied that P appeared to be mentally ill. That conclusion was based on the information contained in his clinical file and on the evidence set out above provided by Dr RA and Dr SS. It accepted that the diagnosis of chronic paranoid schizophrenia from which P suffered was characterised by a significant disturbance of thought, perception and mood.

2. Section 8(1)(b)

Does P's mental illness require immediate treatment and can that treatment be obtained by P being subject to a community treatment order?

The word "treatment" is defined in s3 of the Act as follows:

> "treatment", in relation to a mental disorder, means things done in the course of the exercise of professional skills to-
>
> (a) remedy the mental disorder; or
> (b) lessen its ill-effects or the pain and suffering which it causes.

In *Re the Review of RD* (1997) 2 MHRBD (Vic) 425 at 430 the Board discussed what matters should be considered when determining whether immediate treatment was required. These were:

> (a) the likelihood of imminent relapse;
> (b) the possible severity of the relapse; and
> (c) the degree of disruption a relapse would be likely to cause should the patient immediately cease medication.

Dr RA told the Board that on three occasions, in 2002, 2003 and 2004, when there had been attempts to change P's medication from depot to oral, P had become non-compliant and had relapsed quickly and significantly. In view of Dr RA's opinion and the history set out above the Board considered that without treatment by way of medication it was likely that a, possibly, severe relapse of P's mental illness

requiring his admission to hospital would occur. This would involve a considerable disruption to his life in the community.

It also noted that P has been receiving treatment over the past year by way of depot medication with Risperdal Consta 12.5 mg fortnightly, and orally with risperidone 5 mg nightly. Since November 2006, the depot medication had been stopped and he has been medicated orally with risperidone 5 mg nightly. The medication provided pursuant to the community treatment order has substantially lessened the ill effects of his mental illness to the degree that led Dr RA to describe P's progress as "fantastic".

The Board was satisfied that this criterion was met.

3. Section 8(1)(c)

Because of P's mental illness, is involuntary treatment of P necessary for his health or safety (whether to prevent a deterioration in his physical or mental condition or otherwise) or for the protection of members of the public?

As set out below, when dealing with the question of insight and consent, the Board accepted P's evidence that he would remain compliant with his treatment. He was very happy with his current medication, being risperidone 5 mg nightly taken orally as he had experienced some problems with depot Risperdal Consta in the past. Accordingly, although the Board decided that P required treatment for his illness to prevent deterioration in his mental state, he did not need to be subject to a community treatment order for that treatment to take place. Further, involuntary treatment was not necessary for his health or safety or for the protection of members of the public.

The Board was not satisfied that this criterion had been met.

4. Section 8(1)(d)

Has P refused or is he unable to consent to the necessary treatment for the mental illness?

The Board has decided in earlier decisions that it was necessary for it to be satisfied on the balance of probabilities that the criteria set out in the Act had been met before it could confirm the patient's treatment as an involuntary patient.

For example in *Re the Appeal of MM* (1987) 1MHRBD (Vic) 1 at 5 the following appears:

> "It is legal truism that the standard of proof normally required in civil proceedings is the balance of probabilities. That is the standard which the Board proposes to apply… Accordingly as the case before us involves, in part, the appellant's right to liberty, the Board must act with much care and caution before reaching a conclusion that we are satisfied on the balance of probabilities that the criteria set out in section 8(1) have been met and that continued detention is necessary."

This view was based on considerable legal precedent. In the Australian High Court case of *Briginshaw v. Briginshaw* (1938) 60 CLR 336 at 347, Latham CJ stressed that in civil matters when applying the ordinary standard of proof (the balance of probabilities) any tribunal should act with much care and caution before finding that

a serious allegation is established. The proof required must satisfy a mind sensible of the gravity of the finding. Dixon J (at 361-362) stated it as follows:

> "Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequences of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal."

In this Appeal, the Board found it useful to consider the view expressed in Phipson on Evidence 14th ed., 1990 (Howard, Crane & Hockley) 78 wherein it was stated that the standard of proof which is generally expressed as proof "on the balance of probabilities" requires a decision to be made in determining if the evidence is such that it can be said that something is more probable than it is not. If the probabilities are equal then it cannot be said that the balance of probabilities have been met.

In the Administrative Appeals Tribunal case of B *v Mental Health Review Board and Dr W* (unreported 28 June 1988), Jones J also considered the applicable standard of proof and stated that:

> "As the authorities make clear, the standard of proof to be applied in proceedings such as these is the civil standard but the degree of persuasion for which the civil standard or proof calls may vary according to the gravity of the facts to be proved...The position can perhaps be summed up in this way: in deciding a matter, the Tribunal or the Board must examine the evidence critically and thoroughly bearing in mind the seriousness of the consequences but in the end only be reasonably satisfied on the balance of probabilities having regard to the evidence it regards as acceptable."

The Board applied the standard of proof enunciated above when it considered what was the appropriate decision it should reach in these matters.

In addition, it was necessary for the Board to consider this criterion with the assistance of decisions made by other divisions of the Board. For example in Re *the Review of MF* [1993] 2 MHRBD (Vic) 81 at 84, the following appeared:

> "The following considerations need to be taken into account when deciding whether there is a substantial risk of non-compliance.
>
> Firstly, non-compliance must be shown to be likely from the patient's immediate past record of treatment or an established pattern of non-compliance.
>
> Secondly, the risk of non-compliance must not be too remote. For example, a stated intention to cease taking medication some time in the future would be too remote to constitute a present risk.

> Finally, even if there is a substantial risk of non-compliance, in order for the criterion to be fulfilled, it must be established that the consequences of non-compliance must be significant, in that it has been demonstrated, on a present admission or in the past, that if the patient does not receive the proposed treatment his or her condition will significantly deteriorate."

In *Re the Review of AB* (1988) 1 MHRBD (Vic) 14 at 17, the Board elaborated upon the requirements for consent stating:

> "...a person is competent, or has the capacity to consent to treatment, when he or she understands the broad nature and effects of the treatment for which consent is sought."

In *Re the Review of CC* (1994) 2 MHRBD (Vic) 182 at 186, the Board dealt with the ability of the patient to consent to the necessary treatment in the following terms:

> "What is required, however, is that the person have a sufficient appreciation of both the illness and its treatment for their decision-making with respect to their condition to be regarded as being founded in reality and reason."

In *Re the Appeal of* 98-035 [1997] VMHRB 18, the Board considered that:

> "...it is more a question of whether a patient has sufficient understanding of the nature and the existence of his or her illness and the connection between the medication and the role that medication plays in keeping that illness at bay or at least in lessening its ill effects or the intensity of its symptoms."

As set out above, Dr SS expressed the view that at the date of the hearing, P had insight into his illness and was not refusing to consent to treatment. When questioned at length by the Board, he maintained that view. Dr RA disagreed, citing previous episodes of non-compliance when P's treatment was attempted to be changed from depot to oral medication. He suggested that even though he regarded P's recent progress as "fantastic" he would prefer to see a further three months of satisfactory compliance with medication by P before he was discharged from his involuntary status. The Board noted that P had received his last depot medication on 2 November 2006 and, at the date of the hearing over two months later, it was reported that P was gaining increasing insight into his illness and that at the date of the Board hearing, he remained compliant with his medication.

The Board also noted the apparent conflict between the views of Dr SS and Dr RA in this regard. Dr RA had, it should be emphasised, through no fault of his own, not seen P since November 2006. In addition, Dr RA told the Board that he had not seen the report prepared by Dr SS before it was presented to the Board. The Board accepted that there were some reservations expressed by Dr SS in his report to the effect that compliance issues in circumstances similar to those now facing the Board had arisen in the past and, perhaps, further time was needed to ensure P's compliance with treatment.

It was necessary for the Board to determine whether P's assurances were "founded in reality and reason" (see *Re the Review of CC* above).

P had been questioned at length by the Board at the hearing of his appeal. The answers which he gave confirmed that he understood the need to continue with his medication and the necessity of complying with the instructions from the treating team even without the coercion of involuntary status. His answers also went some way in indicating that he was able to identify the development of symptoms, which might herald the onset of a relapse in his mental illness. He also told the Board that he had no intention at all of ceasing his medication in the short term or even in "two, three, four years". A further matter was that Dr RA has stated that the last occasion upon which P had suffered a relapse following a change in the method of medication occurred in 2004, more than two years prior to this hearing.

After considering all the matters set out above, the Board was satisfied that, at the date of the hearing, it was more probable than not, that P was able to consent to the necessary treatment for his mental illness and had not refused that consent. It was satisfied that it was probable that he would remain compliant with his treatment without the coercion of a community treatment order.

The Board was not satisfied that this criterion was met.

5. Section 8(1)(e)

Is P unable to receive adequate treatment for the mental illness in a manner less restrictive of his freedom of decision and action?

In view of the findings of the Board with respect to ss8(1)(c) and (d) above, it was not necessary to consider this criterion.

Review of Treatment Plan

In reviewing a patient's treatment plan, the Board must be satisfied that the requirements of s35A(1) of the Act have been met. The Board considered each of the requirements in turn.

1. Section 35A(1)(a)

Has the authorised psychiatrist complied with s19A in making, reviewing or revising the plan (as the case may be)?

The Board was satisfied that the requirements of s19A were met.

2. Section 35A(1)(b)

Is the plan capable of being implemented by the approved mental health service?

The Board considered that the plan was capable of being implemented if P remained an involuntary patient subject to a treatment order but in light of the Board's determination above, there was no need to further consider this requirement.

Therefore, the Board is satisfied that the authorised psychiatrist has complied with s19A in making, reviewing or revising the plan, and the plan is capable of being implemented by the approved mental health service.

As a result, as all the s8(1) criteria were not met, the Board made the determination set out on page 1.