

**In the Appeal of P
an involuntary patient at
Peninsula Health**

Reference No: 07-128
Date of Hearing: 27 Mar 2007
Board Members: Ms D Saunders
Dr T Gidley
Dr D Sisely

Section 14 – Mental Health Act 1986 – s8(1)(c) – protection of members of the public – risk – definition.

P was a 72 year old man with a 20 year history of mental illness. His diagnosis at the time of the Board hearing was bipolar affective disorder. P was admitted to hospital as an involuntary in-patient for a period of 5 weeks in August 2006 and was subsequently discharged onto a community treatment order. P was treated with depot medication administered by his general practitioner. Of particular relevance was that P's wife (AB) was also a patient of the service being treated on a community treatment order. Her treatment included maintenance electroconvulsive therapy (ECT).

The treating team for P argued that P interfered with his wife's treatment and for this reason was an involuntary patient for protection of members of the public (and other reasons in relation to each of the s8 criteria). Ms Shalit submitted that the central issue was the issue of risk posed by P. She submitted that, in view of the assessment of Dr CD, that there was no risk to P's health and that the only risk was the one to his wife in that it was the treating team's view that when unwell, P interfered with his wife's treatment of maintenance ECT. She submitted that P disputed such interference and stated that while he was opposed to the treatment for his wife, at the time of the hearing he had a different view and supported her in such treatment. Further, she stated that AB's doctor says the relationship between AB and P was advantageous.

Found:

- (1) P appeared to be mentally ill, and he required immediate treatment for his illness that could be obtained on a community treatment order.
- (2) A decision to make a person an involuntary patient has serious consequences for the person's liberty in that their freedom of movement and freedom of choice is restricted. P was on a CTO and is mandated to attend for depot medication that his psychiatrist decides that he must take, the administration of which his psychiatrist authorises. The Board turned its attention to the meaning of protection of the public in this instance, based on this consideration. The Board considered previous Board decisions (99-467 [1998] VMHRB 15 (13 November 1998) and MW [1987] VMHRB 3 (10 December 1987)), as well as the second reading speech for the Mental Health Bill 1985 (Vic).
- (3) In consideration of the intention of Parliament, and the principles contained in the previous Board case law, the Board in this case formed the view that the "protection of members of the public" requires that the public be likely to suffer significant physical or psychological injury or impairment.
- (4) The evidence concerning P was that, when he was unwell, the risk he posed to the public was that he interfered with his wife's maintenance ECT. The Board had been informed that AB (P's wife) was also on a CTO and therefore subject to treatment prescribed by her psychiatrist and administered under his or her authority. The Board considered that the treatment for AB was likely to be managed by such an arrangement and with the operation of the Act in relation to that treatment. There was no other evidence presented to the Board that P posed a risk to the public at large or that any member of the public was likely to suffer significant physical or psychological injury or impairment. Therefore, the Board was not satisfied that because of P's mental illness, involuntary treatment was necessary for the protection of the members of the public.
- (5) The Board did not consider the remaining criteria under the Act.

Appeal against involuntary status - appeal granted.

P was represented by Ms B Shalit, of the Mental Health Legal Centre

Date of Decision: 27 March 2007

MENTAL HEALTH REVIEW BOARD
STATEMENT OF REASONS FOR THE DETERMINATION

DIVISION:

Peninsula Health - Peninsula CMHS

REFERENCE NO:

07-128

DATE OF HEARING:

27 March 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: Ms D Saunders

Community Member: Dr D Sisely

Psychiatrist Member: Dr T Gidley

ATTENDANCES: At the hearing of the Board on 27 March 2007:

Patient: P

Wife of P: AB

Doctor: Dr CD

Case manager: EF

Legal representative: Ms Barbra Shalit, of the Mental Health Legal Centre

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:

27 March 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 12 March 2007 prepared by Dr SF and presented to the Board.
3. Treatment Plan of P dated 15 January 2007, prepared by EF and presented to the Board.
4. Oral evidence at the hearing.
5. The appeal lodged on behalf of P by his legal representative dated 7 March 2007.¹

ISSUES:

Under s36C(2), if the Board is satisfied that a person subject to a community treatment order does not satisfy the criteria specified in s8(1), the Board must discharge the person 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 making P subject to a community treatment order; and
3. Because of P's mental illness, is involuntary treatment of P subject to a community treatment order 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 is a 72-year-old married man with a twenty-year history of a diagnosis of a mental illness. He was first seen by a psychiatrist, Dr Y approximately 20 years ago when he was diagnosed with paranoid psychosis. His current diagnosis is bipolar affective disorder. In August of 2006 he was admitted to Frankston Hospital as an involuntary patient for five weeks then discharged on a community treatment order ("CTO"). He was treated with depot medication administered by his general practitioner. Of relevance to this case was that P's wife, AB, is also a patient at the community health service and subject to a CTO under the Act. AB's treatment includes maintenance ECT. It was argued by the treating team for P that he interferes with his wife's treatment and for this reason is an involuntary patient himself for protection of members of the public (and other reasons under the criteria).

Submissions on behalf of P

Ms Shalit outlined her instructions that P does not agree that he has a mental illness, therefore he sees no need for treatment. Ms Shalit stated that P had been seeing Dr Y for about twenty years and stopped seeing him in 2006. However Ms Shalit indicated that he had no treatment between

¹ The letter requesting the appeal hearing was not seen by the Board on the day of hearing.

2003 and 2006. She stated that her instructions were that P is able to manage himself. She stated that he is agreeable to attending at the clinic for monitoring, and in addition, his wife's case manager visits their home on a weekly basis.

Ms Shalit submitted that the central issue is the issue of risk posed by P. She submitted that in view of the assessment of Dr CD, that there is no risk to P's health and that the only risk is the one to his wife in that it was the treating team's view that when unwell, P interfered with his wife's treatment of maintenance ECT. She submitted that P disputes such interference and states that while he was opposed to the treatment for his wife, he now has a different view and supports her in such treatment. Further, she stated that AB's doctor says the relationship between AB and P is advantageous.

She submitted that ss8(1)(c) and (e) were not established and the Board should discharge P from involuntary status.

On the question of the "protection of members of the public", Ms Shalit submitted that it was not Parliament's intention that a person could be detained as an involuntary patient because they interfered with the treatment of someone else. She submitted that the "risk to others" under the Act is something greater than an inconvenience to others or one, which creates an administrative convenience for treating another person. She also submitted that AB is on a CTO and subject to requirements under the Act and as such, this ensures she receives the treatment that she needs.

Evidence of P

P agreed that Ms Shalit had presented his views. He also stated he did not believe he had a mental illness and that if it was his choice he would not take medication though he would see his general practitioner. He also said that while he had concerns about the ECT for his wife, he agreed about four months ago that it was appropriate. He said he was supportive of his wife and wanted to put things in order because he was now over 70 years old.

Evidence of treating team

The Report on Involuntary Status stated that P was admitted involuntarily in August 2006. The symptoms at that time were described as: "hypomania - irritable, hostile, verbally abusive, threatening, rapid pressured speech; expressing multiple bizarre ideas about mental illness and "cures" for it."

The Report stated that on 19 March 2007 he was seen by a psychiatrist at which time he was pleasant, cooperative, but attributing multiple physical symptoms to his psychiatric treatment. It was also reported that (he) denies any need for psychiatric treatment other than Mogadon.

The Report identified the risk either to P or to others as being the "risk of non treatment is P's case revolves primarily around the risk of his significantly jeopardising his wife's ongoing treatment issues." The Report described that P when he was unwell, actively interferes with the treatment of his wife, who is also a patient at the same service and in receipt of maintenance ECT. It is for this reason the Report stated that P is considered a risk to her.

In so far as is relevant for determining whether or not P has refused or is unable to consent to treatment it was reported that P "denies he has an illness thus lacks capacity to provide informed consent as he fails to accept a basic fact upon which the need for treatment is predicated". On the question of whether treatment could be obtained in a less restrictive manner the Report stated that P does not accept the need for treatment.

The case manager, EF, stated to the Board that her current assessment of P was that he was more settled on medication; he was not as aggressive or as grandiose. She also stated that when AB was in hospital for treatment of her mental illness, P had been refused permission to visit his wife.

Other evidence

P provided to the Board two letters that he had from many years ago concerning his referral from an ear, nose and throat surgeon, whom he had been seeing for a hearing problem, to Dr Y (for psychiatric treatment). He told the Board that at the time he had been suffering tinnitus.

DECISION:

In order to be satisfied that the continued treatment of a person as an involuntary patient subject to a community 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 has considered the exclusionary criteria in s8(2) and has decided that these were not relevant in this case.

The Board considered the evidence put before it, as discussed above and determined that P appears to be mentally ill, in that he has in recent months exhibited symptoms of his diagnosed illness – bipolar disorder. The Board accepted the evidence of Dr CD and the case manager EF that in the past P has presented as irritable, hostile, verbally abusive, (and with) rapid pressured speech.

2. Section 8(1)(b)

Does P's mental illness require immediate treatment and can that treatment be obtained by making P 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.

The Board accepted the evidence of the treating team that P now presents as pleasant and cooperative. This was also noted by the Board in the hearing. The Board was of the view that this is likely to indicate P's responsiveness to treatment for his mental illness. P has been receiving treatment for about six months. The Board was satisfied that P's mental illness requires immediate treatment that can be obtained while he is subject to a community treatment order.

3. Section 8(1)(c)

Because of P's mental illness, is involuntary treatment of P subject to a community treatment order 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?

The Board considered the evidence of Dr CD that except for P's interference with his wife's need for maintenance ECT, P would not fit the criteria under the Act.

A decision to make a person an involuntary patient has serious consequences for the person's liberty in that their freedom of movement and freedom of choice is restricted. P is on a CTO and is mandated to attend for depot medication that his psychiatrist decides that he must take, the administration of which, his psychiatrist authorises.

Dr CD stated that P is not a risk to himself - involuntary treatment of P subject to a CTO is not necessary for his health or safety. The issue was therefore, whether or not treatment is necessary for the protection of members of the public. As Ms Shalit submitted, it is necessary to consider the intention of Parliament in reaching the meaning of the words.

In the second reading speech for the Mental Health Bill 1985 (Vic) (Hansard, Legislative Assembly, 30 May 1985, 926–927), Mr Roper MP noted that:

[T]he Bill specifies a series of criteria for involuntary admission. These can be summarised as being that the person needs to be detained for urgent treatment for mental illness in the interests of his or her health or safety, or for the protection of others. ...

The criteria for involuntary admission have been drafted with a great deal of care. The government makes no apology for the fact that they are expressed narrowly and will be more limited than those applying under the existing legislation. This is not only consistent with the principle of the least restrictive alternative, but emphasises that involuntary admission has serious consequences and should be contemplated only as a matter of last resort".

A mentally ill person may be admitted and detained involuntarily only when his or her behaviour is sufficiently harmful either to himself or herself or to other people.

The above Bill was subsequently withdrawn and the Mental Health Bill 1985 (No 2) was introduced. In the second reading speeches for the revised Bill (Hansard, Legislative Assembly, 28 November 1985, p2612), Mr Roper MP noted that the criteria in the new Bill omits the capacity to admit or detain a person "for the protection of members of the public".

Despite this, Mr Roper MP then reintroduced "for the protection of members of the public" (Hansard, Legislative Assembly, 19 March 1986, 399):

During the second-reading debate honourable members raised the issue of persons who are dangers not only to themselves but also may be dangers to others and suggested that the Bill may have left out something that was needed to provide protection to members of the public.

I should emphasize that this provision is not meant to be seen in the traditional sense, where often people with a mental illness have been put away behind large walls, barbed wire and large moats. That is not what we are talking about, we are talking about instances where a person may, *because of a mental illness, become a danger to other members of the community without necessarily being conscious of it* (emphasis added).

The Board in 99-467 [1998] VMHRB 15 (13 November 1998) considered the meaning of "protection of members of the public" where a patient, an elderly woman had a fixed belief that a surgeon was controlling her behaviour in her own home such that she was thinking of moving interstate. She had persistently sent letters of complaint about the surgeon. The majority of the Board found, that writing letters of complaint was not (on the evidence available) anything more than annoying and time wasting.

In the matter of MW [1987] VMHRB 3 (10 December 1987) where it was argued that the patient had caused psychological harm and stress to her neighbours, the Board found that the phrase "protection of members of the public" applies when a member or members of the public are likely to suffer an injury including any significant impairment of mental, physical or emotional health whether permanent or of a temporary nature.

The Board, therefore, found that the phrase did not apply in respect of mere nuisance or irritation caused to members of the public. The Board in MW adopted the following non-exhaustive list of questions to be considered:

- What conduct will this person probably engage in as a result of his or her mental illness?
- How persistent or intense is such conduct likely to be?
- In what circumstances is such conduct likely to occur?
- Who is likely to be affected by such conduct?
- How are such people likely to be affected?
- How long is the person likely to engage in such conduct?

In MW the Board summarised the test to be applied in considering the phrase "protection of members of the public":

- A person who appears to be suffering from a mental illness, engages in conduct or represents such a burden to care for, that significant injury is likely to be caused to a member or members of the public as a result of that conduct or the giving of that care;

- Injury includes any significant impairment of mental, physical or emotional health whether permanent or of a temporary nature.

How and when and in what circumstances the phrase “for the protection of members of the public” applies, necessarily involves some prediction as to the future and an anticipation of the degree of risk that the public may face. The Board considered the view expressed in 99-515 [1999] VMHRB 1 (5 January 1999) that:

A person should be detained for protection of members of the public if, by reason of their mental illness, there is a significant risk in the short or medium term that they will commit an act or omission likely to lead to a significant risk of serious physical harm to another person.

In consideration of the intention of Parliament and the above principles, the Board in this case formed the view that “protection of members of the public” requires that the public be likely to suffer significant physical or psychological injury or impairment.

The evidence concerning P was that when he was unwell, the risk he posed to the public was that he interfered with his wife’s maintenance ECT. The Board had been informed that AB was also on a CTO and therefore subject to treatment prescribed by her psychiatrist and administered under his or her authority. The Board considered that the treatment for AB was likely to be managed by such an arrangement and with the operation of the Act in relation to that treatment. There was no other evidence presented to the Board that P posed a risk to the public or that any member of the public was likely to suffer significant physical or psychological injury or impairment. Therefore, the Board was not satisfied that because of P’s mental illness, involuntary treatment was necessary for the protection of the members of the public.

Accordingly, the criterion was not met. As a result, the Board did not consider any further criteria.

Because P was discharged from his involuntary status, the Board considered that it was unnecessary to consider the Treatment Plan.

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

Dated the 30th day of April 2007.

FOR THE MENTAL HEALTH REVIEW BOARD