

**In the Appeal of P
an involuntary patient at
Clarendon Community Mental Health**

Reference No: 08-106
Date of Hearing: 9 Jan 2008
Board Members: Ms J Slattery
Dr H Chopra
Dr J Sparrow

Section 14 – Mental Health Act 1986 – s8(1)(c), – Charter of Human Rights and Responsibilities Act 2006 – ss10(b), 32 – risk to self or others – cruel and degrading treatment.

P was a 39 year old man with a mild intellectual disability, a history of polysubstance abuse and a long-standing diagnosis of schizoaffective disorder characterised by delusional beliefs, with some paranoia, aggressive, and aberrant behaviour. He has a long history of relapses and admissions in the context of non-compliance with medication, alcohol and drug abuse. P is both HIV positive and Hepatitis C positive, and also suffers from other sexually transmitted diseases. When non compliant and unwell, he has poor impulse control and he can be very aggressive and sexually disinhibited. Among other things, this leads to accommodation problems, and P being physically assaulted, and putting others at risk both from P's aggressive behaviour and from sexually transmitted diseases.

P's legal representative Ms Shalit submitted to the Board that her client did not meet the criterion as set out in s 8(1)(c) of the Act in relation to P being a risk to himself or others. She further argued that should the Board not accept her argument on the s8(1)(c) criterion of risk, and find that P should not be discharged, then the depot injections should be stopped, as forcing her client to have his medication by injection was in breach of s10(b) of the *Charter of Human Rights and Responsibilities Act 2006* (the Charter). She argued that, for her client, injections constituted cruel and degrading treatment. She said that her client was particularly frightened of injections and that they were painful for him.

Found:

- (1) The Board considered the evidence given at the hearing and in the clinical file in finding that P suffered from a mental illness. His mental illness was characterised by significant disturbance of thought, perception, mood and memory.
- (2) The Board found that P required immediate treatment that could be obtained by P being subject to a community treatment order, and that treatment was required to lessen the ill effects of his mental illness.
- (3) The Board found that due to P's lack of insight into his mental illness and the effect of the medication on his mental state, and his long history of non-compliance with medication and subsequent relapses, he would be at grave risk of relapse if not on a community treatment order. Furthermore, P put other members of the public at risk by his unsafe sexual practices. His generally disinhibited behaviour and poor impulse control when unwell, were also a risk to minors and adults.
- (4) P's clear lack of insight into his mental illness made him unable to consent to the necessary treatment. His long history of relapse due to non-compliance with medication supported this finding.
- (5) The community treatment order was necessary for P to receive adequate treatment for his illness, and that P could not receive treatment in a manner less restrictive of his freedom of decision and action.
- (6) Since its early days, the Board has taken the view that the specific type and mode of treatment provided to an involuntary patient is a matter of clinical judgment that should be determined by the treating team, in consultation with the patient, as part of the treatment planning process (see Dr John Grigor and the Chief General Manager of the Dept of Health MHRB and Mr DWP (1989) 3 VAR 258) In the Board's view, the Charter has not altered that basic position, and the Board has no power to, nor should it, make

treatment decisions in individual cases. However, as a public authority, the Charter will require individual treating teams in area mental health services to take Charter rights into account when making such treatment decisions.

- (7) The Board therefore makes no determination in respect of Ms Shalit's Charter argument, as it is outside the Board's decision-making powers.

Appeal against involuntary status - appeal dismissed.

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

Date of Decision: 9 January 2008

MENTAL HEALTH REVIEW BOARD
STATEMENT OF REASONS FOR THE DETERMINATION

DIVISION:

Clarendon Community Mental Health Clinic

REFERENCE NO:

08-106

DATE OF HEARING:

9 January 2008

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 J Slattery

Community Member: Dr J Sparrow

Psychiatrist Member: Dr H Chopra

ATTENDANCES: At the hearing of the Board on 9 January 2008:

Patient: P

Doctor: Dr AB

Case Manager CD

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

DETERMINATION OF THE BOARD:

The Board was satisfied that the continued treatment of P as an involuntary patient subject to a community treatment order was necessary.

The Board therefore confirmed the community treatment order.

The appeal of P was therefore dismissed.

DATE OF THE BOARD'S DECISION:

9 January 2008

EFFECT OF THE BOARD'S DECISION:

That P continues to be treated as an involuntary patient subject to a community treatment order.

INFORMATION CONSIDERED BY THE BOARD:

1. Clinical file of P.
2. Report on Involuntary Status dated 4 January 2008 prepared by Dr AB and presented to the Board.
3. Treatment Plan of P dated 4 January 2008, prepared by CD and presented to the Board.
4. Oral evidence at the hearing.
5. Appeal of P, dated 11 December 2007 and lodged with the Board on that day.

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 39 year old man with a mild intellectual disability, a history of poly substance abuse and a long standing diagnosis of schizoaffective disorder characterised by delusional beliefs, with some paranoia, aggressive, and aberrant behaviour. He has a long history of relapses and admissions in the context of non compliance with medication, alcohol and drug abuse. P is both HIV positive and Hepatitis C positive, and also suffers from other sexually transmitted diseases. When non compliant and unwell, he has poor impulse control and he can be very aggressive and sexually disinhibited. Among other things, this leads to accommodation problems, and P being physically assaulted, and putting others at risk both from P's aggressive behaviour and from sexually transmitted diseases.

P has had multiple failed placements at boarding house accommodation largely due to his behavioural disturbances and deteriorating mental state when non compliant with medication. P was in a relationship which has now ended. He now lives at the Hub in Melbourne, as a temporary measure, but he still visits his former partner D, in Mornington for about three or four days per week. D appears to be P's only stable social contact. P's mother and three sisters appear also to be intellectually disabled. P has not had any contact with them for some years. He sees

his father regularly. P has been referred to Warringa for long term placement and to Fairfield House for regular respite.

P has also been repeatedly assaulted due to his sexually disinhibited conduct away from his accommodation. When unwell and misusing alcohol and illicit substances, he also puts himself and others at risk by having unprotected sex.

Submissions on behalf of P

Ms Shalit submitted to the Board that her client did not meet the criterion as set out in s 8(1) (c) of the Act in relation to P being a risk to himself or others. She argued that P was now well and free of symptoms of his mental illness. P is aware that he needs medication, and he instructed her that he would take oral medication as prescribed, keeping himself and others safe from any ill effects of his mental and physical illnesses. Ms Shalit argued that in the event that the Board found to the contrary, in that her client exhibited behaviours which may endanger himself, he should still be discharged. She argued that as her client had an intellectual disability and that he was a heavy alcohol user, it was not possible for the Board to say that his aberrant behaviours were attributable to his mental illness, as they were attributable to either his intellectual disability or his alcohol consumption, and therefore the Board must discharge him.

Ms Shalit further argued that should the Board not accept her argument on the s8(1)(c) criterion of risk, and find that P should not be discharged, then the depot injections should be stopped, as forcing her client to have his medication by injection was in breach of s10(b) of the *Charter of Human Rights and Responsibilities Act 2006* (the Charter). She argued that for her client, injections constituted cruel and degrading treatment. She said that her client was particularly frightened of injections and that they were painful for him. Ms Shalit then quoted s32 of the Charter as enabling the Board to take into account international instruments and decisions. Ms Shalit cited *Ireland v UK*. (18 January 1978) Series A No 25 of the European Court. Ms Shalit was unable to produce a copy of the decision, or where it may be found in hard copy. She referred only to handwritten notes which she said she had made from the internet. Ms Shalit quoted the European Court as saying that:

“ Degrading treatment could be constituted by treatment which arouses in the victim feelings of fear anguish and inferiority, capable of humiliating and debasing them.”

Ms Shalit claimed that as P felt debased and humiliated, the injections were degrading treatment, and consequently the administration of depot injections constituted a breach of the Charter. Ms Shalit also said that as the injections hurt P, the depot injections were an unacceptably cruel treatment, the ill effects of which outweighed any beneficial effect they may have for her client.

Evidence of P

P gave evidence that he was now well, but that he would take oral medication if told by a doctor to do so. He said that he was frightened of injections and that they hurt. He gave no indication that he suffered any other adverse feelings except the fear when he had an injection. He said that he had the injections in the arm, and he did not like them.

P said that he was well now, and that even though he had consumed lots of alcohol and marijuana at Christmas, he had not been aggressive as he was now better. He said he has 12 pots of Carlton draft, as he will tonight, but he does not get drunk or violent now, it just helps him to sleep. P spoke of his 15 year old “best mate, C.” He shares some bongos of marijuana with him and drinks lots of “VBs” (beer).

When asked about his living conditions, P said that he was awaiting allocation of a flat on his own. He said he wanted privacy. Currently he had boarding house accommodation, but visited his ex-partner D in Mornington, and stayed with him 3 or 4 nights a week. He said that at D’s place, P also had a good time with his other “very best friend B, who is 13 years old.” B comes to visit P when B’s mother and D (P’s ex partner) are at work. B’s mother and D are workmates. P describes B as loving him very much too and how B says to P “I love you D, I really love you.” The Board did not question P further about his relationship with the two minors.

The Board asked P about the severe injuries he had suffered when he had been assaulted. He said that he had been bashed once by a group of what he termed as “poofter bashers”. On

another occasion recently he had looked under the door of a public toilet and the occupant had punched him.

When questioned by the Board, P said that he would take pills if he had to, but would not have injections. He said that he did not have a mental illness, but he did have a mood disorder. The Board questioned P about the entries in the clinical file that he believed that his mates had killed 380,000 people. He said that he did not think that now, and that this was a bit silly. He was equivocal as to whether he still believed that the Navy guys were deliberately infecting the Army guys with HIV. He said he knew that because an old boyfriend of his was an army guy.

When asked why he was having the Zuclopenthixol depot injections, P replied that his boyfriend wanted him to have them. P said that his state of mental health had nothing to do with his prescribed medication.

Evidence of treating team

Dr AB gave evidence to the Board that P has a long history of Schizoaffective illness, characterised by delusional beliefs, hallucinations, disordered thought, aggression and poor impulse control. He has had multiple admissions in the context of non-compliance with medication and deterioration of his mental state. When unwell, P's paranoia, aggression, violence and sexually inappropriate behaviour worsened. He became loud and threatening, especially to those at his shared housing. He yelled and broke windows and became frightening, responding to the hallucinatory voices he heard. His insight into the effects of his behaviour decreased and his alcohol and drug use sometimes increased. There had been times when the deterioration in mental state was unrelated to drug and alcohol abuse and solely related to non compliance with medication. P's poor impulse control and behaviour had resulted in him being asked to leave a succession of rooming house placements. The service was having difficulty finding suitable places for P to live. Due to his sexually inappropriate behaviour with strangers when unwell, P had been bashed and put in fear of his life.

The treating team were very specific that when mentally unwell, P engaged in unprotected sex, as well as other inappropriate sexual behaviour. Although P was less sexually inhibited than the norm, due to his intellectual disability, his risk taking behaviour and inappropriate behaviour increased when unwell. This had been observed on the ward following periods of non-compliance and relapse. Given P's status of being HIV positive, Hepatitis C positive and also infected with other sexually transmitted diseases, this was both a risk for him, and for his sexual partners.

Because of the overall deterioration of P's mental state and increase of positive symptoms, P's medication had been increased from 50mg of depot Zuclophenthixol to 250mg each fortnight. There had been an improvement in P's mental state without any negative symptoms from the increased medication.

The movement of P between Melbourne and D's home in Mornington at variable times each week made it difficult for the team to actually find P when he failed to present for the depot injections. The existence of the community treatment order was the only way the medication could be adequately delivered. P's insight into his illness created a situation where he could not consent to medication, nor could he be relied upon to take oral medication. His movements were very difficult to track, making daily supervision of oral medication impossible in practical terms. In any event, the team had now achieved a medication regimen which was controlling the symptoms without side effects.

The team acknowledged that P appeared to be afraid of injections and that he complained that they hurt him. P had refused to have the injections anywhere but in his arm. At this site the injection was slightly more painful than injections into the usual more muscular area.

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 given at the hearing and in the clinical file in finding that P suffered from a mental illness. His delusional belief system had been established by the evidence. His mental illness was characterised by significant disturbance of thought, perception, mood and memory.

Accordingly, this criterion was met.

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 found that P required immediate treatment that could be obtained by P being subject to a community treatment order, and that treatment was required to lessen the ill effects of his mental illness.

Accordingly, this criterion was met.

3. Section 8(1)(c)

Because of P's mental illness, is involuntary treatment of SW 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 found that due to P's lack of insight into his mental illness and the effect of the medication on his mental state, and his long history of non-compliance with medication and subsequent relapses, he would be at grave risk of relapse if not on a community treatment order. On relapse, P was at risk of being assaulted due to his inappropriate behaviour and at risk of infection with more sexually transmitted diseases. His risk of losing further housing because of the behaviour he exhibits when unwell also puts him at risk of homelessness.

Furthermore, P put other members of the public, adults and possibly minors, at risk by his unsafe sexual practices. His generally disinhibited behaviour and poor impulse control when unwell, was also a risk to minors and adults. P's evidence raised a probable risk to others, including the minors he spoke of his best friends whose company he loved. The combination of alcohol, illicit drugs and an increase in P's sexually inappropriate behaviour, if not compelled by the community treatment order to take his medication created a substantial risk to others.

Accordingly, this criterion was met.

4. Section 8(1)(d)

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

P's clear lack of insight into his mental illness made him unable to consent to the necessary treatment. His long history of relapse due to non-compliance with medication supported this finding.

Accordingly, 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?

The Board found that the community treatment order was necessary for P to receive adequate treatment for his illness. As to the issue pursued by Ms Shalit that P should have oral medication rather than injections, from P's evidence and that of the treating team, and from the unfortunate history of rapid relapses due to inadequate medication, it appeared quite clear that P could not be appropriately medicated without depot injections, unless he was to become an inpatient. This was not considered as it was in itself a much more restrictive option, to be used only as a last resort when P's mental state had so deteriorated that he required hospitalization.

Accordingly, this criterion was met.

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 found that there had been compliance with the requirements of s19A in completing the treatment plan.

2. Section 35A(1)(b)

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

The Board found that the plan could be so implemented.

Therefore, the Board was 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.

The Charter and Board Decision Making

Background

The Charter was assented to 25 July 2006 recognising in legislation key civil and political rights and principles. The Charter became fully into operation on 1 January 2008. Under the Charter, a "public authority", which includes the Board when acting in its administrative capacity and all Victorian area mental health services, is required to act in a way that is compatible with human rights and, in making decisions, to give proper consideration to a relevant human right (s38).

In its decision-making role, each division of the Board is a "tribunal" and, as such, is not a public authority and is given two very specific responsibilities under the Charter. First, the Board is required to interpret the Act's provisions, "so far as it is possible to do so consistently with their purpose", in a way that is compatible with human rights (s32). In relation to the Board's decision-making functions under the Act, therefore, the Charter is an interpretive tool which does not affect the validity of the Act, or any provision of the Act, irrespective of its incompatibility with a human right. Secondly, in appropriate circumstances and in accordance with s33 of the

Charter, the Board may refer a question of law that arises and relates to the application of the Charter or a question arises with respect to the interpretation of a statutory provision in accordance with the Charter to the Supreme Court.

It is therefore important for parties to understand that the Board has no power under the Charter to determine the compatibility of the Act, or any provisions of the Act, with the Charter, nor to declare particular decisions or actions to be in breach of specific Charter rights. Save for the s32 requirement in respect of the interpretation of laws, the Charter does not change the Board's substantive decision-making role under the Act.

Dealing with Charter Issues or Arguments

In December 2007, the Board President issued Practice Direction 2007/1, which is posted on the Board's website at www.mhrb.vic.gov.au. This practice direction sets out in detail the Board's requirements for any party who wishes to raise a genuine Charter issue or argument that may affect the Board's decision-making. In the interests of fairness to all parties, and consistency of the Board's hearing practices, all parties are required to comply with the terms of the Practice Direction before the Board will consider and determine Charter issues or arguments.

Raising Charter Issues or Arguments in Hearings

In this case, Ms Shalit purported to raise on P's behalf a Charter argument relating to the mode of treatment P is currently receiving from the area mental health service. She did this without reference to the Practice Direction, which requires pre-hearing notification to the Board and other parties of the issues and/or arguments, together with details of their basis and supporting material.

Except as indicated above, the Board cannot, and will not, deal with Charter arguments without due regard to their impact on other parties involved in the hearing, and in other cases listed at the same Board sitting. Therefore, strict compliance with the terms of the Practice Direction is required.

Consideration of Ms Shalit's Argument

On behalf of P, Ms Shalit argued that the use of depot medication given by way of injection is a breach of one of the Charter rights established in s10, in that P's acknowledged fear of injections, which hurt P when given, was evidence of it being a cruel and degrading treatment practice. She purported to support this view by reference to an international decision, a copy of which could not be provided to the Board at the hearing.

Dr AB gave evidence to the effect that, other than his expressed fear and the pain on entry of the injection into P's arm, the current medication has provided considerable improvement to P's mental state and functioning without any obvious side-effects. Despite suggestions from the treating team to reduce the pain by giving the injection in a more muscular site than the arm, P has refused to consider other injection sites.

Since its early days, the Board has taken the view that the specific type and mode of treatment provided to an involuntary patient is a matter of clinical judgment that should be determined by the treating team, in consultation with the patient, as part of the treatment planning process (see Dr John Grigor and the Chief General Manager of the Dept of Health MHRB and Mr DWP (1989) 3 VAR 258) In the Board's view, the Charter has not altered that basic position, and the Board has no power to, nor should it, make treatment decisions in individual cases. However, as a public authority, the Charter will require individual treating teams in area mental health services to take Charter rights into account when making such treatment decisions.

The Board therefore makes no determination in respect of Ms Shalit's Charter argument, as it is outside the Board's decision-making powers.

As a result, as all the s8(1) criteria were met and the treatment required for P can be obtained through him being subject to a community treatment order, the Board made the determination set out on page 1.

Dated the 7th day of January 2008.

FOR THE MENTAL HEALTH REVIEW BOARD