THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO Mr BRIDGES AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 10 NOVEMBER 2016

Mental Health Review Tribunal

This is an edited version of the Tribunal's decision. The patient has been allocated a pseudonym for the purposes of this Official Report

MENTAL HEALTH REVIEW TRIBUNAL DECISION

CONCERNING: **MR BRIDGES** **MHRT NO: C/ XXXXX**

TRIBUNAL MEMBERS:

Julie Hughes	Lawyer member
Sheila Metcalf	Psychiatrist member
Peter Bazzana	Member

APPLICATION FOR: Section 65 Revocation of a Community Treatment Order

DATE AND PLACE OF HEARING: 16 February 2016 Community Mental Health Facility

DETERMINATION

The Tribunal was not satisfied on the evidence that s65 (3) (a) or (b) of the *Mental Health Act 2007* ('the Act') had been satisfied. There has not been a substantial or material change in the circumstances surrounding the making of the order, nor is there relevant information before the Tribunal that was not available when the order was made on 17 November, 2015. As such, the CTO stands.

BACKGROUND

According to the information before the Tribunal, Mr Bridges was admitted to a mental health facility in April 2015 and was formally discharged on 12 June 2015. The admission was preceded by a first documented episode of mental illness. It would seem that the incident that resulted in Mr Bridges going to hospital was that he was charged with an assault upon his brother. On admission to the mental health facility Mr Bridges was found to be suffering an acute psychosis (*and that in the months prior to the admission there was the presence of auditory hallucinations, persecutory and bizarre delusions, thought alienation, and disorganized thought and behaviour*). Mr Bridges reported having used cannabis, amphetamines and LSD.

Mr Bridges was discharged from the mental health facility on a six-month Community Treatment Order ("CTO") on 12 June 2015. A further six-month CTO was made by the Mental Health Review Tribunal ("MHRT"') on 17 November 2015. The present application is for a revocation of that CTO.

EVIDENCE

Documents available for the hearing were:

1. Letter to the Mental Health Review Tribunal dated 22 January 2016 from Mr Mr Bridges enclosing the following documents in support of an application for revocation of the Community Treatment Order:
    1.1. Report dated 19 January 2016 of an independent psychiatrist, retained by Mr Mr Bridges.
    1.2. Letters by the independent psychiatrist, to Mr Bridges' treating team.
2. Case manager's report dated 29 January 2016.
3. Report dated 15 February 2016 by the Consultant Psychiatrist

The Tribunal also had access to its file which contained documents from previous Tribunal hearings, including those from the last hearing on 17 November 2015, when the current CTO was made.

Evidence of Mr Bridges

Mr Bridges' letter to the MHRT was a frank request for the Tribunal to revoke the order, with the claim that his rights under s68 (e) of the Act, that is, that "people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment and be supported to pursue their own recovery", had "not been upheld". For the most part the letter detailed frustrated efforts by Mr Bridges to obtain his medical records. (The letter concluded with statements that the medication has had horrendous side effects that have prevented Mr Bridges return to his studies and his career, as well as living the life he, his family and friends have wanted for him.)

At the hearing Mr Bridges stated that he understood the importance of taking medication and that he wouldn't stop it "cold turkey". He expressed a preference for mental health management under a private psychiatrists, (whom he had seen since August 2015) and the independent psychiatrist whom he had consulted in recent months and from whom he had obtained a medical report declaiming his present treatment regime. He stated his belief that he had experienced a "one-off manic episode" and that the medication had taken him to a point where he was now numb. He had, he opined, suffered a mental illness, but he was now stabilised by the medication. He expressed his desire to take responsibility for his own mental health and future, and a general preference for the private mental health system over the public system.

Evidence of Mr Bridges' father

Mr Bridges father stated that his views about the benefit of a CTO had changed since the November 2015 hearing. He corroborated his son's accounts about side effects. Further, he stated that the treatment was medication-based only, without intense psychological counselling.

Evidence of the independent psychiatrist retained by Mr Bridges

The independent psychiatrist had not treated Mr Bridges but provided a medical report that the prescribed medication was inappropriate and dangerous and that is should be ceased. The independent psychiatrist had written to Mr Bridges' doctor with a detailed account of numerous side effects reported by Mr Bridges.

Evidence of the Community Case Manager

The report of the Case Manager, dated 29 January, 2016, gave the rationale for the application of the original CTO and for continuation of same:

1. " Poor/superficial insight into his mental health diagnosis, which is viewed by his preoccupation with his medication, obsessions with acquiring his clinical notes due to belief that people have falsified information within and his ongoing need to challenge his diagnosis via alternative psychiatrist (3 to date) opinions. As well as his desire to acquire a trial off medications further identifying his poor insight to his diagnosis.
2. High risk of disengagement with the treating team if not treated on a CTO resulting in noncompliance of medication causing a strong risk of relapse which in turn could cause psychological harm to others due to his delusions of erotomania and physical harm to others as he assaulted his brother due to delusions...

   Having Mr Bridges under a CTO is the least restrictive form of safe and effective care in order to ensure ongoing mental stability and minimize physical and psychological harm to others. Mitchell has no insight into the incidents that led to his admission and continues to exhibit psychotic projection in the surrounding incidents…"

Further, the report detailed the seriousness of the symptoms that led to the 2015 mental health admission, and the resultant police charges that flowed from acting upon the delusions present at the time.

In oral evidence, the case manager reported that nothing material had changed in terms of the circumstances that were present at the time of making the CTO in November 2015. She reported a lack of willingness to engage in any conversations about modifications to medications, unless they involved cessation of medication.

Evidence of the Consultant Psychiatrist

The report of the Consultant Psychiatrist outlined the treating team's belief that Mr Bridges has poor insight into his mental illness and continuing condition, and the belief that without an order he would be non-compliant with the medication regime.

Although Mr Bridges reported to the Consultant Psychiatrist that there had been minimal illicit drug use leading up to his hospital admission, this is at odds with what Mr Bridges told the treating team at the time. the Consultant Psychiatrist explained that medication reduction was offered to Mr Bridges in August 2015

because of the side effects he reported. Although the reduction was made, it became necessary to increase the dose in November 2015 because he was exhibiting signs of relapse after the dose was reduced. A switch to a different medication had been offered in December 2015, but this was declined. The report concluded:

> "…During follow up Mr Bridges has sought to delay his depot injections and has showed little insight into his worsening of symptoms when the dose was reduced. He has also been seeking alternate opinions to support his request to have his diagnosis reviewed and medication stopped. The treating team believes there is considerable risk of relapse if the CTO is discontinued due to Mr Bridges' poor insight. He has a continuing condition with high risk to others when unwell."

At the hearing, the Consultant Psychiatrist stated his concern about Mr Bridges' continuing condition, and considered that the same risks remained as when the CTO was made. It was his view that Mr Bridges had an enduring mental illness rather than a drug induced psychosis or transient psychosis. It was also his view that a depot medication was necessary given Mr Bridges' professed belief that he did not want to take the medication, and given his lack of insight into his condition. The Consultant Psychiatrist stated that, although it was not uncommon for psychiatrists to have different opinions, the independent psychiatrist was forming an opinion based on retrospective information given by Mr Bridges. Medication changes had been offered to Mr Bridges, but he would not agree to them because he wanted to be off medication.

When asked by the legal representative whether the written evidence of the independent psychiatrist, or hearing from Mr Bridges and his father indicated a change of circumstances, the Consultant Psychiatrist replied that the thing that had changed was the family's views on treatment.

REASONS FOR DECISION

The matter of a proposed revocation of a CTO is dealt with under s.65 of the Act.

Section 65(3) provides:

> s65 (3) An application may be made only if:
>
> (a) there has been a substantial or material change in the circumstances surrounding the making of the order, or
>
> (b) relevant information that was not available when the order was made has become available.

The matter before the Tribunal is not an appeal against the making of the CTO. Such an appeal would be heard by a different mechanism (s 67) and in a different forum, namely, the Supreme Court of New South Wales. This is an application for *revocation* of a CTO.

The Tribunal may revoke an order on an application that is validly made under s.65 of the Act or on its own motion (s.65 (1)). The question arises as to standing to make the application, and the applicant, Mr Bridges, has such standing in accordance with s65 (2) (a) as the "affected person".

When considering an application made by a person with standing to do so, the focus of the enquiry is to determine the appropriateness or otherwise of revoking the CTO by considering whether there has been either:

> substantial or material change in the circumstances surrounding the making of the order; or where there is relevant information before the Tribunal that was not available when the order was made. (see s65 (3) extracted above).

Therefore, the function of the Tribunal in determining such an application is, to apply the law as laid out in s65. It is not to enquire as to the probity of the original order on a matter of law. It is to consider whether there has been significant or material change in circumstances, or whether new, relevant information has come to light, such as would justify revoking the order.

The written evidence of the independent psychiatrist was extensive and, in addition to the commentary on Mr Bridges' diagnosis and the unsuitability of the prescribed medication, there was a great deal of literature about drug products, psychiatry literature, and comparisons between standards applied between the United States of America and Australia.

The Tribunal considered and weighed all of the evidence and determined that there was not such a change in circumstances or revelation of new information, as contemplated by s65. The Tribunal accepted the evidence proffered by the case manager and the treating psychiatrist that there has been no amelioration of the risk (of rapid deterioration in mental state without a CTO) that existed at the time the order was made on 17 November 2015.

Mr Bridges is clearly an intelligent man who does not believe he has an enduring mental illness. He is also a young man, quite rightly, desperate to continue in his recovery journey to achieve a fulfilling and rewarding life and career. He disputes any diagnosis that accords with the existence of an ongoing problem, preferring the view that he experienced a "one-off" psychotic mania which has now resolved. He bitterly opposes ongoing treatment, particularly within the public health system, and is very much against the coercive powers behind a CTO.

On the evidence, it is possible that modifications to the treatment regime might cause a reduction or cessation of the many medication side effects reported by Mr Bridges. It would seem, however, that Mr Bridges is unwilling to engage in the process of experimenting with different medications under the guidance of his treating psychiatrist. A reduction in the dose of the present medication resulted, in the view of the treating team, augmentation of worrying symptoms of mental illness, such that the dose was returned to its original level.

These matters are significant, and it is clear that they need to be resolved within the treatment regime. However, the specific diagnosis or the details of medication regime are not matters for the Tribunal. The

job of the Tribunal in making a CTO is, in essence, to determine whether the CTO would be beneficial to the person, but benefit of itself is insufficient. The CTO must represent the least restrictive alternative that is consistent with safe and effective care. The treatment plan proffered by the treating team, then, must be appropriate and capable of implementation. Further, it essentially considers whether, subsequent to a diagnosis of mental illness, the affected person has a history of refusing to accept appropriate treatment and such refusal has caused deterioration in mental state that either required a hospital admission, or could have required such admission (s53(3) *MHA*).

The role of the Tribunal in an application for revocation of a CTO, as already outlined, is to assess whether there has been material or significant change in the circumstances surrounding the making of the order, or whether there is now relevant information before the Tribunal that was not available at the time of the original hearing. The Tribunal must confine itself to these matters.

Consideration of the evidence presented at the hearing does not convince the Tribunal that these conditions of revocation have been proved on the balance of probabilities. The Tribunal prefers the evidence of the treating team over that of the independent psychiatrist. The Tribunal accepts that Mr Bridges is very unhappy with his treatment, and the Tribunal sympathises with his position and that of his family. Whether or not the pharmacological regime is optimal is clearly a matter for earnest review, and needs to come about through the collaborative efforts of the treating team, Mr Bridges, and his very supportive family. The focus of a recovery-oriented approach to mental health was been embedded in the *Mental Health Act* (NSW) amendments of 2015. The principles for care and treatment in the *MHA* (s68) have been sharpened to make plain the heightened clinician focus on the individual's recovery by taking into account various considerations. In particular the clinician is to support the person to pursue their own recovery, and to make every effort to obtain the person's informed consent when developing treatment and recovery plans, monitoring a person's capacity to consent and supporting those who cannot.

Clearly, there is a tension between a treating team that persists in its clinical view that ongoing treatment is necessary, and a person who believes that there is no need for ongoing treatment. It may be that it is possible for the treating team to afford Mr Bridges, at some time in the future, the dignity of risk associated with the less restrictive form of treatment of accessing private sector health services. This will, undoubtedly, be part of the ongoing therapeutic dialogue between Mr Bridges and the treating team.

Signed:

Julie Hughes, Chairperson
Dated: 25 May, 2016