New South Wales
Supreme Court

CITATION :	**S v South Eastern Sydney & Illawarra Area Health Service and anor [2010] NSWSC 178**
HEARING DATE(S) :	27 November 2009 Orders made 16 December 2009
JUDGMENT DATE :	12 March 2010
JURISDICTION :	Equity Division Protective List
JUDGMENT OF :	Brereton J
DECISION :	Although some community treatment order was appropriate and necessary, the particular community treatment order made was not the least restrictive alternative consistent with safe and effective care. Appeal allowed, and community treatment order set aside.

CATCHWORDS :	MENTAL HEALTH – community treatment order – depot anti-psychotic by IMI - appeal from decision of Mental Health Review Tribunal – nature of appeal – hearing de novo – whether plaintiff likely to relapse into active mental illness order not granted – where plaintiff likely to become non-compliant and relapse if no order made, but likely to comply with alternative less restrictive order - whether no other care of less restrictive kind consistent with safe and effective care is appropriate and reasonably available, and that plaintiff would benefit from order as least restrictive alternative consistent with safe and effective care – where less restrictive alternative appropriate and reasonably available and consistent with safe and effective care though perhaps not optimal
LEGISLATION CITED :	(NSW) Mental Health Act 1990, s 24 (NSW) Mental Health Act 2007, Part 3, Division 1, s 51
CATEGORY :	Principal judgment
PARTIES :	S (plaintiff) South Eastern Sydney & Illawarra Area Health Service (first defendant) Mental Health Review Tribunal (second defendant)
FILE NUMBER(S) :	**SC** 2009/40
COUNSEL :	Mr G Niven (plaintiff) Mr R Weinstein w Mr R Bhalla (defendants)
SOLICITORS :	Legal Aid NSW (plaintiff) Crown Solicitors (defendants)

IN THE SUPREME COURT
OF NEW SOUTH WALES
EQUITY DIVISION
PROTECTIVE LIST

BRERETON J

Friday, 12 March 2010

2009/40 S v South Eastern Sydney and Illawarra Area Health Service and Anor

JUDGMENT

1 **HIS HONOUR**: On 22 July 2009, the second defendant Mental Health Review Tribunal made a community treatment order under (NSW) *Mental Health Act* 2007, s 51, in respect of the plaintiff S, requiring him to attend a specified hospital operated by the first defendant Area Health Service on alternate Thursdays between the hours of 11 am and 2 pm to receive injections of Risperdal Consta, an anti-psychotic depot medication for treatment of schizophrenia, for a period of six months expiring on 21 January 2010. By summons filed on 19 August 2009, Mr S appeals against that order. The tribunal filed a submitting appearance, and the contradictor was the Area Health Service, upon whose application the order was made.

History

2 A diagnosis of “a low grade schizophrenic illness” in respect of Mr S seems first to have been made in November 1991, following an incident which resulted in his being charged with arson (the prosecution did not proceed). The following does not purport to be a complete summary of his subsequent psychiatric history, but sufficiently identifies the history of his illness and, significantly for the issues that will emerge, of his compliance with medication and previous community treatment orders.

3 In November 1997 Mr S presented to a mobile treatment team with some psychotic features. In January 1999, he was taken by police to the hospital, following an incident with a neighbour, and a description by his father of “bizarre behaviour”. He was assessed by Dr Cedric Bullard, who described “delusional/paranoid ideation”. The doctor recorded that Mr S did not want

to come to hospital, but agreed that he currently needed some help for his mental state. He was discharged on 10 February 1999, with a diagnosis of an underlying paranoid illness.

4 In May 1999, police requested that he be admitted to a psychiatric hospital pursuant to (NSW) *Mental Health Act* 1990, s 24, upon the belief that he had recently attempted or was likely to attempt suicide or cause serious bodily harm. On 21 May 1999, he was referred by his father to a mobile treatment team and seen on a home visit, when he was described as "non-compliant with medications … responding to auditory hallucinations … very reluctant to accept any form of treatment or assistance … has no understanding of budgeting/payment of bills".

5 In June 1999, he was taken to the hospital by police following aggressive behaviour, hearing voices, and threatening physical harm to his father. He was referred by his father to a mobile treatment team on 6 July and again on 8 August 1999, when it was recorded that he had "never accepted prescribed medication". At a home visit on 27 August 1999, it was recorded that he admitted to not actually having medications for more than five days, and experiencing daily auditory hallucinations: "[S] absolutely refusing to take medication or have treatment of any kind". He was discharged from the care of the mobile treatment team on 13 September 1999 as "impossible to treat, non-compliant with prescribed medication".

6 On 8 October 1999, he presented to the mobile treatment team, requesting help, and he was prescribed treatment "which he then refused". He refused an IMI test dose, but was willing to accept oral medications. After some persistence on the part the mobile treatment team, he was discharged on 6 November 1999, as he was refusing treatment: "[S] refused treatment, he did not see how medication could help him …". On 30 November 1999, he was again taken to the hospital by police after hearing voices, but denied previous mental problems. At a home visit, it was recorded that it was "evident that [S] is going to be evasive and not wanting to take any medication".

7 On 6 January 2000, he attended the hospital's emergency department, complaining of being "hassled by neighbours". He was discharged from the care of the mobile treatment team on 17 February 2000, it being recorded that he "took medication as prescribed for approximately one month … chose not to continue with medication. Refused to keep doctor's appointment".

8 On 17 May 2000, he was referred by a social worker to the mobile treatment team, with "non-compliance issues". On 21 September 2000, police again requested his admission pursuant to s 24, and on assessment by a psychiatric registrar it was recorded that he "appears non-compliant last few months … not willing to take medications as they interfere with his sex drive … has had thoughts of hurting his father but only in the context of fights with him". On 20 December 2000, he was referred to the mobile treatment team by his father, who said that Mr S would not take his

medication and was irritable.

9 On 23 July 2001, he again presented to the hospital emergency department, requesting medication and stating that he had not taken it for a while. On 14 August 2001, he presented yet again to the hospital emergency department, requesting medication. On 1 November 2001, he was again requesting medication.

10 On 15 December 2001, Mr S was admitted to the hospital on a schedule pursuant to *Mental Health Act*, s 21. The admitting note recorded that he "presents with non-compliance, psychosis, ideas of reference, poor social conditions and isolation". He was discharged on 27 December 2001, with a prescription for oral medication of Risperdal 1mg (an oral anti-psychotic of the same chemical formulation as Risperdal Consta).

11 On 4 January 2002, Mr S was taken by his father to the hospital emergency department and assessed by a psychiatric registrar who recorded that he was "non-compliant with meds, very unkempt, lives with father but neither are coping". On 26 February 2002, he presented for an appointment with a registered nurse, who recorded that he had taken his Risperdal only intermittently.

12 On 19 November 2003, Mr S self-presented at the hospital emergency department, with suicidal ideation. On 3 May 2004, he was admitted to the hospital under the *Mental Health Act*. The admitting note recorded "dishevelled, non-compliant with medications … chronically non-complaint with medications". On 6 May 2004, a magistrate made a community treatment order for a period of six months, pursuant to which Mr S received depot medication of 200mg Clopixol Decanoate (a depot anti-psychotic) weekly by IMI, and oral medication as prescribed. A community treatment order for Clopixol 100mg fortnightly (by IMI) was continued for six months on 5 November 2004. On 4 May 2005, a further community treatment order was made for six months, this time for Risperdal Consta 25mg fortnightly (by IMI). On 28 October 2005, a further community treatment order was made for a period of six months, for Risperdal Consta 37.5mg fortnightly (by IMI). On 20 March 2006, Mr S was reviewed by Dr Diana, psychiatrist, who recorded that the Risperdal Consta had been very effective; on 21 April 2006, a further community treatment order was made for six months for Risperdal Consta 50mg fortnightly IMI. That order was extended for another six months on 20 October 2006.

13 On 16 April 2007, when advised that the community treatment order would soon lapse, Mr S said that he wanted to present for his injection, and after the order lapsed on 20 April 2007 he continued to attend for injections. Subsequently, he was changed to oral medication, and the dose was later reduced by his general practitioner. On 16 April 2008, at a home visit by Dr Diana and others, it was recorded that he was "at risk of self-neglect … refusing medication". He was scheduled that day by Dr Diana, "making vague reference to suicide … his father reports serious concerns regarding his mental state and disorganised behaviour … mentally ill, at risk from self-

neglect, possible suicide risk, refusing further treatment". A note of 18 April records that he "will continue to refuse to have his depot". On 1 May 2008, a magistrate made a community treatment order for a period of six months for Risperdal Consta 37.5mg fortnightly by depot injection. He received the first injection, after much coaxing, on 5 May 2008, and appears thereafter to have been substantially compliant with the order (the only incidents of non-compliance have been trivial -attending on one occasion four days, and on another occasion one day, late). The community treatment order for Risperdal Consta 25mg fortnightly was continued on 31 October 2008 for a further six months.

14 On 8 April 2009, he was reviewed by Dr Diana, who recorded that he "has little insight into illness. Unlikely to take medication unless by depot and under a legal obligation". The community treatment order for Risperdal Costa 25mg fortnightly was continued for one month on 29 April 2009, for two months on 27 May 2009, and for six months on 22 July 2009, from which order the current appeal is brought.

The order

15 The tribunal's determination of 22 July 2009 was to make a community treatment order in respect of Mr S in the following terms:

> In accordance with the following terms and conditions as set out in the attached treatment plan:
>
> (1) The mental health facility which is to implement the order is: [the specified hospital]
>
> (2) [Mr S] is required to:
>
> · Be present at – "as set out in the attached treatment plan"
> · During the following times – "as set out in the attached treatment plan"
> · And there receive such medication and therapy, counselling, management, rehabilitation and other services provided in accordance with the attached treatment plan approved by this order.
>
> (3) This order is to expire no later than 21 January 2010.

16 The treatment plan referred to in the determination was in the following terms:

> A The health care agency will:
>
> 1 Supervise and administer depot medication as prescribed. Currently this is Risperdal Consta 25mg IMI every two weeks at [the hospital], every Thursday between 11am and 2pm
>
> 2 Arrange for and notify of review appointment with Dr Diana or delegate .

3 Support [Mr S] with other needs where appropriate.

B [Mr S] is required to:

1 Accept all medications as prescribed by Dr Diana or delegate.

2 Attend [the hospital] on the allocated Thursday when Risperdal Consta 25mg IMI is due, between the hours of 11am and 2pm for the purpose of medication administration and discussion with case manager if required.

3 Attend follow up review appointments with Dr Diana or delegate as arranged.

17 The tribunal's decision was a majority one, the lawyer and psychiatrist members concurring in the result, but the lay member dissenting.

The legislative framework for Community Treatment Orders

18 The preconditions and procedures for applications for community treatment orders (CTOs) are prescribed in (NSW) *Mental Health Act* 2007, Part 3, Division 1, and are relevantly as follows:

Part Three – Involuntary Treatment in the Community

Division 1 - Application for and making of community treatment orders

50 Definitions
In this Part:
" *affected person* " means a person for whom a community treatment order has been applied for or made.
"breach notice" – see section 58(3).
"breach order" – see section 58(4).
"director of community treatment" of a mental health facility means a person appointed under section 113 as the director of community treatment of the mental health facility.
"psychiatric case manager" means a person employed at a declared mental health facility who is appointed under section 114 as the psychiatric case manager of an affected person.
"treatment plan" – see section 54.

51 Community treatment orders
(1) A community treatment order authorising the compulsory treatment in the community of a person may be made by the tribunal or a Magistrate.
Note: Section 56 sets out the matters to be included in the

community treatment orders.
(2) The following persons may apply for a community treatment order for the treatment of a person:
(a) the authorised medical officer of a mental health facility in which the affected person is detained or is a patient under this Act,
(b) a medical practitioner who is familiar with the clinical history of the affected person,
(c) any other person prescribed by the regulations.
(3) An application may be made about a person who is detained in or a patient in a mental health facility or a person who is not in a mental health facility.
(4) An application may be made about a person who is subject to a current community treatment order.
(5) A community treatment order may be made in the following circumstances and may replace an existing order:
(a) following a mental health inquiry,
(b) on a review if a patient by the Tribunal,
(c) on an application otherwise being made in the Tribunal.

52 Notice of applications
(1) The applicant for a community treatment order must notify the affected person in writing of the application.
(2) The notice of the application is to include a copy of the proposed treatment plan for the affected person.
(3) If the affected person is not detained in a mental health facility, the application must be heard not earlier than 14 days after the notice is given.
(4) Subsection (3) does not apply to an application for a further community treatment order in respect of an affected person who is the subject of a current community treatment order.

53 Determination of applications for community treatment orders
(1) A Magistrate or the Tribunal is, on an application for a community treatment order, to determine whether the affected person is a person who should be subject to the order.
(2) For that purpose, the Magistrate or Tribunal is to consider the following:
(a) a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order,
(b) if the affected person is subject to an existing community treatment order, a report by the

psychiatric case manager of the person as to the efficacy of that order,

(c) a report as to the efficacy of any previous community treatment order for the affected person,

(d) any other information placed before the Magistrate or Tribunal.

(3) The Magistrate or Tribunal may make a community treatment order for an affected person if the Magistrate or Tribunal determines that:

(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and

(b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and

(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

(3A) If the affected person has within the last 12 months been the subject of a community treatment order, the Tribunal is not required to make a determination under subsection (3)(c) but must be satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted.

(4) A Magistrate may not make a community treatment order unless the Magistrate is of the opinion that the person is a mentally ill person.

(5) For the purposes of this section, a person has a " *previous history of refusing to accept appropriate treatment"* if the following are satisfied:

(a) the affected person has previously refused to accept appropriate treatment,

(b) when appropriate treatment has been refused, there has been a relapse into an active phase of mental illness,

(c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility (whether or not there has been such an admission),

(d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term

prevention of deterioration in the mental or physical condition of the affected person.

(6) The Tribunal or Magistrate must not specify a period longer than 12 months as the period for which a community treatment order is in force.

(7) In determining the duration of a community treatment order, the Tribunal or Magistrate must take into account the estimated time required:

(a) to stabilise the condition of the affected person, and

(b) to establish, or re-establish, a therapeutic relationship between the person and the person's psychiatric case manager.

54 Requirements for treatment plans under community treatment orders

A treatment plan for an affected person is to consist of the following:

(a) in general terms, an outline of the proposed treatment, counselling, management, rehabilitation or other services to be provided to implement the community treatment order,

(b) in specific terms, the method by which, the frequency with which, and the place at which, the services would be provided for that purpose.

56 Form and duration of community treatment orders

(1) A community treatment order is to:

(a) nominate the declared mental health facility that is to implement the treatment plan for the affected person, and

(b) require the affected person to be present, at the reasonable times and places specified in the order to receive the medication and therapy, counselling, management, rehabilitation and other services provided in accordance with the treatment plan.

(2) A community treatment order ceases to have effect at the end of the period specified in the order or, if no period is specified, 12 months after the order is made.

Note: Section 53(6) specifies that the maximum period for an order is to be 12 months.

(3) A community treatment order has no effect while an affected person is detained in a mental health facility (otherwise than under this Part), or is a voluntary patient.

(4) The fact that an affected person is the subject of proceedings before the Tribunal does not, unless the Tribunal otherwise orders, affect the operation or duration of the community treatment order.

(5) The time for which a community treatment order is in force does not cease to run during any period in which this section provides that it has no effect.

Note: The Tribunal may vary or revoke a community treatment order in accordance with section 65.

19 Section 67 of the Act provides as follows:

67 Appeals

(1) The affected person under a community treatment order made by the Tribunal may at any time appeal to the Court:

(a) if the term of the order exceeds 6 months or no term is specified in the order, against the duration of the order, or

(b) on any question of law or fact arising from the order or its making.

...

20 In addition, s 163 provides:

163 Appeals to the Court

(1) A person may appeal to the Court against:

(a) a determination of the Tribunal made with respect to the person, or

(b) the failure or refusal of the Tribunal to make a determination with respect to the person in accordance with the provisions of this Act.

(2) An appeal is to be made subject to and in accordance with the rules of the Court.

21 Section 164 is as follows:

164 Power of the Court on appeals

(1) The Court has, for the purposes of hearing and disposing of an appeal, all the functions and discretions of the Tribunal in respect of the subject matter of the appeal, in addition to any other functions and discretions it has.

(2) An appeal is to be by way of a new hearing and new evidence or evidence in addition to, or in substitution for, the evidence given in relation to the determination of the Tribunal, or the failure or refusal of the Tribunal to make a determination, in respect of which the appeal is made may be given on the appeal.

(3) The Court is to have regard to the provisions of this Act and any other matters it considers to be relevant in determining an appeal.

(4) The decision of the Court on an appeal is, for the purposes of this or any other Act or instrument, taken to be, where appropriate, the final determination of the Tribunal and is to be given effect to accordingly.

(5) In hearing and deciding an appeal, the Court may be assisted by 2 assessors selected by the Court from the panel

> nominated for the purposes of this Chapter, if the Court considers it appropriate to do so.
> (6) An assessor is to sit with the Court in the hearing of an appeal and has power to advise, but not to adjudicate, on any matter relating to the appeal.

22 It was common ground that, whether brought under s 67 or s 163, by operation of s 164(2) the appeal was by way of hearing *de novo*, and new evidence was tendered by both parties without objection. In addition, all the evidence before the tribunal was before the court. Reasons for the decisions of the tribunal, produced only a few days before the hearing of the appeal, were also before the court for the purpose of informing the court of the tribunal's decision and its reasoning process, but it was common ground that the appellant did not have to establish error and that ultimately it was for the court to make a new decision. For that reason, the defendant, who had sought the community treatment order, was regarded as bearing the onus of proof, and began. At a directions hearing, I decided that it was not necessary for the purposes of this appeal to sit with assessors.

23 The combined effect of s 52(2) (which requires that notice of the application include a copy of "the proposed treatment plan"), s 53(1) (which directs consideration to whether the person should be subject to *the* order – being the order for which application is made under s 51(2)), s 53(3)(b) (which requires that the tribunal be satisfied that there is "an appropriate treatment plan"), s 54 (which requires that a treatment plan outline in general terms the proposed treatment and in specific terms the method frequency and place at which services would be provided for that purpose – presumably, if the order be made); s 56(1) (which stipulates that a community treatment order nominate the facility *that is to implement the treatment plan* and requires the affected person to be present to receive treatment *provided in accordance with the treatment plan*) is that on considering an application for a community treatment order, the tribunal's role is limited to considering whether such an order should be made in terms of the proposed treatment plan or not at all, and the tribunal is not authorised to make a community treatment order otherwise than in accordance with the treatment plan placed before it by the applicant.

24 The issues for the tribunal, and now for the court, are:

> · Whether no other care of a less restrictive kind (than that provided for by the order), consistent with safe and effective care, is appropriate and reasonably available and whether Mr S would benefit from the order as the least restrictive alternative consistent with safe and effective care (s 53(3)(a));
> · Whether a declared mental health facility has an appropriate treatment plan for Mr S and is capable of implementing it (s 53(3)(b)); and
> · Whether Mr S - having within the last twelve months been the subject of a community treatment order - is likely to continue in or

relapse into an active phase of mental illness if the order is not granted (s 53(3A)). As Mr Weinstein for the Area Health Service submitted, I accept that as Mr S had been subject of a community treatment order within the preceding twelve months, neither the tribunal nor the court was required to determine that he has a previous history of refusing to accept appropriate treatment. Nonetheless, the presence or absence of such a history must inform whether there is a likelihood of relapse, and at least be a relevant factor in considering whether, as a matter of discretion, a compulsory community treatment order should be made, if all the pre-conditions for such an order are otherwise satisfied.

Mr S requires anti-psychotic medication

25 The evidence previously summarised plainly establishes that Mr S suffers from chronic schizophrenia and at times is affected by delusions of a persecutory kind. It also establishes that anti-psychotic medication is of benefit to him, and has assisted greatly in controlling his illness. During the period of the community treatment orders, his psychotic symptoms have been markedly reduced, and his capacity for independent living has demonstrably increased. The benefit of the anti-psychotic medication is attested by Mr S's acknowledgment that he has "heard the voices" less frequently while he has been on the community treatment orders, that during that period he has become more independent (although he does not necessarily attribute it the medication), and that save for interference with his sexual function, the injected depot medication has no side effects of significance, and indeed less side effects than oral medication.

26 Despite occasional denials in the past that he suffers from schizophrenia or requires anti-psychotic medication, in his evidence before me, which I think he gave with great frankness, Mr S said (in cross-examination):

> Q You agree, don't you, that you think you require treatment for your illness with medication, right?
> A Yeah listening to Dr Diana in these hearings has sort of swayed me to that realisation, yeah, yeah, I suppose, yeah.
>
> Q That you need to take medication because of your illness?
> A Supposedly, yes.
>
> Q It makes you feel better than not having the medication, right?
> A I don't know about that because to be totally honest with you, I can't notice a difference; to be quite honest I can't notice a difference.

27 There is no doubt that Mr S needs anti-psychotic medication. The fundamental issue is whether that must be pursuant to a community treatment order, or whether he can be left to take it voluntarily; and if under a community treatment order, whether it must be by way of depot injection.

Does a mental health facility have an appropriate treatment plan (s 53(3)(b))?

28 The matters so far mentioned show that Risperdal Consta is effective and beneficial treatment for Mr S, with minimal side effects (less than the oral alternative). It was not suggested that the hospital was not a declared mental health facility (or part of one), nor that it was incapable of administering the treatment plan; indeed the last several years since a community treatment order was first made in respect of Mr S demonstrates that capability.

29 I am therefore satisfied that the treatment plan for Mr S under the community treatment order is an appropriate one, and is capable of implementation by the hospital (and/or the Area Health Service), as it has been in the past. It follows that I am satisfied of the matters referred to in s 53(3)(b).

Is Mr S likely to relapse if the order is not granted (s 53(3A))?

30 Although - because Mr S has been the subject of a community treatment order within the last 12 months – neither was the tribunal nor am I required to make a determination that he has a previous history of refusing to accept appropriate treatment, it is a precondition to making a community treatment order that the tribunal, and now the court, be satisfied that he is *likely* to continue in or to relapse into an active phase of mental illness if the order is not granted. The medical evidence – particularly that of Dr Diana – explains that if Mr S were to cease to take medication, his condition would deteriorate, not necessarily immediately but after perhaps four to six weeks. Thought disorder would increase, and he would likely experience an increased incidence of auditory hallucinations and persecutory delusions, with a consequent impact on his independence. The medical evidence also suggests that it would take him many months of treatment to recover from any such deterioration to the condition which he has presently reached. Resolution of this issue is therefore primarily informed by an evaluation of whether Mr S would be compliant with a regime for medication other than pursuant to the order. This requires consideration both of the situation that there be no order at all, and of that that there be a “less restrictive” order, in circumstances where, in his oral evidence, Mr S assured me that, if afforded the opportunity of taking oral medication rather than IMI depot medication, he would definitely take it.

31 Like many schizophrenics, Mr S has limited insight into his illness, with the result that at times he has not accepted that he suffers from schizophrenia (propounding on occasion that he suffers from bi-polar illness), and has sometimes disputed that he needs anti-psychotic medication. The history summarised above indicates that when he has not been under the compulsion of a community treatment order he has at times in the past become non-compliant with prescribed medication.

32 Mr S conceded that there were occasions in the past, when he was on oral medication, that he missed taking medication for a couple of days, but

not that he had ceased taking it for weeks or months. Following the expiry of the previous community treatment order in April 2007, he remained voluntarily on depot injections, and then changed to oral medication, on which he remained about a year. The side effects of the medication initially prescribed were, in respect of his sexual function, unacceptable to him and he was changed to another, but his general practitioner (probably at Mr S's request) reduced the dose, to a sub-therapeutic level, with a concomitant decline in his mental state and function. Mr S maintained that, at the time of his subsequent deterioration in April 2008, he was then taking his medication, but that "life pressures" impacted on him in a manner which caused the deterioration; this explanation was not disproved. Indeed, during the last week before the hearing of the appeal, his condition deteriorated somewhat with a number of life events, although he remained on medication in accordance with the community treatment order. Mr S also denied having asserted that he did not need medication, would not take it, and wanted to see what would happen if ceased medication completely. Nonetheless, having regard to the whole of his history, and to the typical reluctance of schizophrenics to remain on their medication, I am satisfied that unless he is under a legal obligation to take medication, it is likely that sooner or later he will become non-compliant and subsequently relapse into an active phase of mental illness.

33 However, it does not follow that he would not comply with a "less restrictive" community treatment order, such as one that required him to take oral medication and submit to regular review. Despite his limited insight into his illness, Mr S has substantially complied with the community treatment order since it was made. Indeed, a number of features of the evidence point to him as being compliant with legal obligations, particularly when the consequences of non-compliance have been explained to him.

34 Moreover, if IMI medications were ceased and not replaced with oral medication, signs of deterioration would likely appear in six to eight weeks. If he was on oral medication, depending on the dose, deterioration might become apparent in a few weeks. The significance of this is that if he is under regular review, non-compliance with medication would become apparent at a sufficiently early stage that there could be an intervention.

35 Although Dr Diana and the case worker Mr Roper expressed the view that Mr S was not likely to be compliant with oral medication, I am unpersuaded that this is so, if he is under a legal obligation to take the medication. His history is one of compliance with treatment orders when there is a legal obligation. Even when there was not, and when he was on oral medication in 2007 - 2008, he continued to take that medication, albeit at a sub-therapeutic level after his GP reduced it. In my view, if under a legal obligation to take oral medication and submit to regular review, it is likely that he will comply, and that any non-compliance would be detected at an early enough stage to permit intervention before serious relapse.

36 It follows that while I am satisfied that, unless he is under a legal obligation to take medication, it is likely that sooner or later Mr S will

become non-compliant and subsequently relapse into an active phase of mental illness, I am not satisfied that such a relapse is likely if a “less restrictive” order, permitting oral as an alternative to IMI medication and providing for regular review, were in place.

Is the order the least restrictive alternative consistent with safe and effective care (s 53(3)(a))?

37 While Mr S’s preferred position is that there be no community treatment order at all, his alternative position was that he should be permitted a trial of oral medication in lieu of IMI depot medication.

38 The same medication (Risperdal) – or an alternative anti-psychotic – can be administered orally by daily doses, rather than fortnightly by injection, producing the same effects. There is nothing to suggest that oral medication is any less effective as a treatment, apart from questions of compliance. For reasons already explained, I am unpersuaded that Mr S would be non-compliant with an oral regime if under the compulsion of a community treatment order. Regular supervision would permit early detection of any deterioration so as to permit prompt intervention to avoid serious relapse. Indeed, on many occasions over the years, when he has been in a state of mental distress, Mr S has brought himself to the attention of the community health team. When something goes awry, he realises there is a problem, even if he cannot articulate it. When he has had relapses, he has frequently self-presented in a community setting or to the emergency department.

39 That is not to say that oral medication is necessarily the optimal treatment for him. On his own evidence, he appears to experience fewer adverse side effects with the IMI depot medication than with oral medication, and there is impressive evidence that the IMI depot medication works well for him. If the question for me were the medical one of which course of treatment is best suited to his circumstances, I have little doubt that I would conclude that it was fortnightly IMI depot injections of Risperdal Consta.

40 But that is not the legal question: to uphold the community treatment order, I must be satisfied that no other care of a less restrictive kind consistent with safe and effective care is appropriate and reasonably available, and that Mr S would benefit from the order as the least restrictive alternative consistent with safe and effective care. “Appropriate and reasonably available” treatment does not connote the very best treatment. So long as the alternative is appropriate and reasonably available and is consistent with safe and effective care, it matters not that it may not be the most desirable course of treatment. In my view, a treatment plan that afforded Mr S the option of oral or IMI depot medication - together with regular (say monthly) supervision and review in a mental health facility to monitor his condition, welfare and compliance – is appropriate (though perhaps not optimal) and reasonably available, would be a less restrictive alternative to one providing only for IMI depot medication, and would be consistent with safe and effective care.

41 It follows that I am not satisfied that the particular community treatment order that was made is the least restrictive alternative consistent with safe and effective care.

Conclusion

42 For the foregoing reasons, on 16 December 2009 I announced my conclusions as follows.

43 There is no doubt that Mr S needs anti-psychotic medication. I am satisfied that the treatment plan for Mr S under the community treatment order is an appropriate one, and is capable of implementation by the hospital (and/or the Area Health Service), and thus of the matters referred to in s 53(3)(b). I am also satisfied that unless he is under a legal obligation to take medication, it is likely that sooner or later he will become non-compliant and subsequently relapse into an active phase of mental illness. However, I am not satisfied that such a relapse is likely if a “less restrictive” order, permitting oral as an alternative to IMI medication and providing for regular review, were in place. In my view, a treatment plan that afforded Mr S the option of oral or IMI depot medication – together with regular (say monthly) supervision and review in a mental health facility to monitor his condition, welfare and compliance – is appropriate (though perhaps not optimal) and reasonably available, would be a less restrictive alternative to one providing only for IMI depot medication, and would be consistent with safe and effective care. It follows that I am not satisfied that the particular community treatment order that was made is the least restrictive alternative consistent with safe and effective care.

44 Accordingly, while I am satisfied that a community treatment order is appropriate, I am not satisfied that the order made by the tribunal is the least restrictive alternative consistent with safe and effective care. No alternative treatment plan, for an order of the type which I would consider appropriate, was before the tribunal, nor is one before me. In those circumstances I do not think that I can substitute such an order, there being no relevant treatment plan. I must allow the appeal, and leave it to the Area Health Service to make a further application to the tribunal supported by such a treatment plan.

45 I therefore allowed the appeal, and made the following orders:

> (1) Order that the community treatment order made on 22 July 2009 be set aside.
> (2) Dismiss the application for the community treatment order.

46 Having heard counsel then on the question of costs, and having regard primarily to the protective nature of the proceedings and the jurisdiction, reinforced by the circumstance that the plaintiff’s success was only partial (in the sense that his primary case, that there was no justification for any community treatment order failed), I made no order as to costs, to the intent that each party bear its own costs.

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