Mark up by Anne Miles URN 2198898 to specific claims. See full Tribunal Response and facts to negate 'delusions' here including details of compensation claim likely: https://www.annemiles.com.au/qld-anne-miles/

mrt
Mental Health Review Tribunal

Name: MILES, Anne **DOB:** 04/12/1964 **CID:** 1028163

CLINICAL REPORT - TREATMENT AUTHORITY REVIEW

A Clinical Report must be received by the Tribunal at least **7 Days** prior to the hearing.

Person's details

Given Name Anne — Family name MILES

Pronouns She, Her, Hers, Herself

Date of Birth 04/12/1964 — CIMHA No 1028163

Authorised Mental Health Service

Gold Coast Authorised Mental Health Service

Summary Recommendations

Unrealistic to continue involuntary hospitalisation without cause - no harm to self or others likely

Treatment authority	Confirm ☑	Revoke ☐
Change conditions	Yes ☐	No ☐
Change extent of treatment in the community	Yes ☐	No ☐

Hearing details

Hearing date: 17/07/2025

Hearing location: GOLD COAST UNIVERSITY HOSPITAL

Person attending hearing: [outline persons attendance and who will accompany him/her]

Treatment Authority details

No reasonable milestones provided as a guide or goals for integration back into the community nor grounds for medications that are not changing facts

Date Made 19/06/2025

Category	Community ☐	Inpatient ☑
Classified patient		Yes ☐
Is Person a serving prisoner		Yes ☐
Specify location		

Note if person absent/AWA, a completed "Written notice of relevant person's absence report" (Form_13) must be provided for there to be no requirement for a completed clinical report (section 730).

Person's access to report

The full contents of the report and attachments has been provided to and discussed with the person in an appropriate way on: 09/07/2025

Does the person have the following? If so, please outline

First signed by:	Discipline:	Date:	Time:
MALETSKY, David	Medical Officer Specialist - Psychiatrist/Consultant Psychiatrist	9/07/2025	10:35

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CLINICAL REPORT - TREATMENT AUTHORITY REVIEW - MHRT

mhrt
Mental Health Review Tribunal

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CLINICAL REPORT - TREATMENT AUTHORITY REVIEW

Advance Health Directive

None

Not provided at this time as I deemed it unnecessary and until police confirm status of case investigation I choose not to put others at risk

Personal Guardian

None

Attorney

None

Parent

I wasn't aware this was available to me

An application for a confidentiality order has been made. Yes ☐ No ☑

Request for confidentiality order Form 4

Treating Team

Authorised Psychiatrist David Maletsky

Registrar /Medical officer (if applicable) AJIT, Akshaya

Case Manager (name and professional stream) and other treating team members

Support persons and organisations

Other (include nominated support persons, legal representatives, non-government agencies etc.)

Diagnosis based on subjectivity without checking facts. Delusion is based on assumptions without checking actual facts. Provided in my support materials to validate.
Anti-pscyotic medication over nearly 12 weeks hasn't changed the facts of my situation which doesn't suggest medication needs tweaking but that I'm being medicated for something I don't have.

Diagnosis of mental illness/provisional differential diagnosis

[Comment on and include, diagnosis, intellectual functioning, literacy and co... where relevant, and issues related to past or current substance use]

Primary F29 Unspecified nonorganic psychosis

Definitive diagnosis remains unclear with differentials including a delusional disorder vs schizophrenia/schizoaffective vs substance-induced (stimulant medication) psychosis

Details of the current mental state assessment

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Mental H

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CLINICAL REPORT - TREATMENT AUTHORITY REVIEW

'ersecutory delusions' assumed without checking facts. Seems unlawful to make a diagnosis without facts. Grandiosity is assumed without checking my actual media profile or qualifications. See links provided to validate these. IBAC case numbers and confirmation provided.

For the purpose of this report, the person was last examined

By: Dr Akshaya Ajit (Psychiatric Registrar) On: 08/07/2025

[If not seen by psychiatrist for the purposes of this report, please note the date that person was last examined by a psychiatrist]

Mediumship is a scientifically and peer reviewed research backed protocol that is defined outside the mental health criteria. Raising it in this context and tone is prejudicial.

appearance: 60F, younger than her stated age, tall medium build, grey h
groomed
behaviour: remained seated, appropriate eye contact and good engage
when beliefs challenged
speech: quite talkative, but normal rate/tone/volume, no pressured spee
mood: subjective "okay"
affect: euthymic and reactive, nil lability evident
Thought form: logical and coherent, no flight of ideas but mild circumstan
Thought content: persecutory delusions and paranoia relating to organise
investigation from "IBAC" and grandiosity re own skills as a psychic/ med
Perception: describe "feeling spirits" due to her psychic mediumship, no o
Cognition: not formally assessed, but appears to be alert and grossly or
Insight: minimal insight regarding illness and need for medication
Judgement: impaired

Reference to lack of 'insight' suggests a lack of self awareness however the opposite is true. I have more insight into what is real and not real than the doctors making assumptions. I'm highly qualified in self development and neuro-linguistics and very self aware.

Last review by Dr Maletsky and Dr Gong (covering registrar) on 03/07/202
appearance: 60F, appearing younger than her stated age, tall medium build, grey hair, dressed in casual clothes, well groomed
behaviour: remained seated, appropriate eye contact and good engagement in review, superficial rapport, became upset at times when discussing antipsychotic treatment and continued hospital admi
speech: quite talkative, but normal rate/tone/volume, no pressured speech
mood: subjectively "flat", objectively somewhat elevated
affect: labile, reactive, mood incongruent
Thought form: logical and coherent, no flight of idea
Thought content: persecutory delusions and paranoia relating to organise
with regards to multiple TV and press interviews relating to her skills as a
review), fleeting vague SI with no plan or intent "do not want to be on this
Perception: describes at times hearing a "voice" due to her psychic mediu
disturbance during review
Cognition: not formally assessed, but appears to be alert and grossly oriented to TPP
Insight: minimal insight regarding illness and need for medication
Judgement: impaired

Reasonable behaviour for someone mediated and locked up unfairly against their will despite voluntary preesntation and willingness to work on appropriate medications

I propose their judgment is impaired and not mine. Using Confirmation Bias to fit their criterial without any fact checking nor any understanding of mediumship outside mental health criteria eg. peer reviewed paper Grof and Grof supplied. Suicidal thoughts due to Sodium Vaporate and Quetiapine side effects and uncharacteristic to me. Once off these medications these thoughts disappeared. Even if there were no facts it is still inappropriate to consider no release into the community. I have the right to maintain my psychic abilities if I choose.

Capacity to consent to treatment

The most recent assessment of cap
Does the person have the capacity t
[Outline the specifics of the capacity
understanding of: illness, nature and
not receiving treatment]

It is the treating team's opinion that A
an illness to demonstrate capacity to
that Anne is suffering from a psychotic illness characterised by persecutory delusions and potential auditory/visual hallucinations, requiring treatment. She continues to strongly hold these beliefs, reporting they have been confirmed via her mediumship abilities. Anne has not been able to demonstrate sufficient understanding of this

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There are many different ways to treat ADHD, PTSD (when required) and Fibromyalgia that do not include stimulants if that was deemed to be a concern. Diagnosis is not based on any factual evidence and I'm being withheld the medications I really need. No consideration to any treatment for ADHD. My emotional disregulation when fearing for my life, and PTSD triggered hasn't been considered as an alternative and viable response to the real life circumstances. The doctors have had tunnel vision on one path only and without facts.

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illness to be able to demonstrate and communicate an understanding of the nature and purpose of treatment, appreciate the risks and benefits of treatment or the consequences of not receiving treatment. She continues to express concern that we are not providing treatment for her ADHD with her prescribed stimulants, and is unable to appreciate that use of these stimulant medications may have precipitated or potentiated psychosis.

Undue bias by The Alfred Hospital throughout this process. I've made a claim that The Alfred has been negligent and possible criminal activity to be investigated. I've complied with all medications other than when the charts had multiple mistakes in them. I feel I'm better at managing the agreed medications than the hospital system.

Current treatment

[Provide details of current medication, other treatments, willingness to receive appropriate treatment, any identified goals for the person and any

Anne remains admitted to the Pandanus Unit at time of writing.

Medication

Upon admission, Anne's sodium valproate was ceased and she was recommenced on Quetiapine with a plan to up-titrate dose

Due to reported side effects, Quetiapine was ceased. A medication review was completed with regards to medications trialled during her period of admission in Victoria

Re-trialling Aripiprazole was discussed however Brexpiprazole was commenced as the team hoped it would have a preferable side effect profile. This was trialled over a period of several days at a dose of 1mg, however was administered inconsistently due to st[illegible] reported that this medication caused her to experience significant depression and requested

Paliperidone was commenced on 3/7

Psychologist never contacted me but I don't believe it will add any value regardless. My case is not about my ability to cope but about facts not being considered. Social worker was insisted on as the doctors keep saying I need to apply for Centrelink when they are ignorant to the process for the self-employed. I am better informed than they are. They treat me like a 'one size fits all' approach in all aspects.

Psychosocial

A referral has been completed to the Social work & welfare worker input h

Support has been offered with regar

DO NOT WRITE

During admission, Anne has expressed her frustration with the treating team regarding her perception of a lack of goals with regards to inpatient treatment

We have communicated our ongoing impression of a psychotic illness that we believe requires adequate treatment

Our primary treatment goal is to establish Anne on a medication regime which she finds tolerable, at which point we believe that continued treatment in th

It is the treating team's plan to refer for

The doctor's only milestones for perceived recovery include (a) stop being a medium (b) have no connection or belief in facts in my real life situation and (c) take the medication they insist on despite the above two points not changing and unchangeable with medications.

There seems to be no likely path to being released or to be taken off medications for psychosis and provided the medications that I really need for ADHD, PTSD (when required) and Fibromyalgia remaing untreated unreasonably.

Even if I am deemed to have psychosis there is no clear pathway to reintegration into the community or future medication plans. I'm advocating for my mental health wellness here but being refused a clear pathway.

Anne has provided the treating team wit

Feel 'normal' - not depressed or a zomb

Maintain a standard of professionalism

Be fully functioning cognitively

Have self respect of my own personality

Be able to make fully informed financial

To be active and fit without being of low

To be productive and multitasking as a

To retain a sense of my individuality and

To feel well in myself moving between

To have fast reflexes to be able to ride

To have a healthy diet with protein with

To sleep 6-8 hours a night

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CLINICAL REPORT - TREATMENT AUTHORITY REVIEW

Risk assessment

Sodium Valporate and Quetiapine induced suicidal thoughts that are uncharacteristic to me. Current medication of Pasperitone is not causing these issues however. Social isolation is caused by being hospitalised and medicated against my will. I'm independent and capable and my introverted lifestyle is being judged as an illness in a prejudicial fashion.

Harm to Self

Static:
Nil known history of self-harm or suicide attempts. History of anxiety and PTSD. Socially isolated.

Dynamic:
At times prior to and during admission has voiced fleeting suicidal ideation, [illegible]
mood. Has not voiced any specif
Noted to be experiencing psycho

I have been doing Arakan Self Defence for about 18 month. There is no rule that says I can't do this as a hobby and to be self empowered as an aging woman. This is prejudicial. They asked about weapons - I have no need for a weapon. I discussed a small wooden stick only and was surprised to learn it was considered a 'weapon'.

Harm to Others

Static:
Nil known history of violence/aggress[illegible] collateral limited)

Dynamic:
Has reported training in martial arts
she did research obtaining weapons
Nil physical aggression or concerns

They are diminishing my real vulnerability caused by being locked up - professional harm, business impacted financially and irrevocably. I will be making a damages claim. See my assessment of potential claim against The Alfred and likely these doctors at the link provided.

Vulnerability

Primary risk concerns relate to vulnerability and risk of harm to reputation

Static:
Anne is socially isolated with no known/reported supports locally on the Gold
familial and other supports, in part secondary to her persecutory beliefs.
Records and collateral indicate a history of bankruptcy in 2022, however Anne
Super since this period.

A 'break through' is perceived as a 'break down' in a prejudicial fashion. My family being cut off was about 5 years ago and irrelevant My children are not fit to be contacted regarding my case - one is on the autism spectrum, the other is a drug addict/sex worker/criminal. I have a right to come to a new city and start a new life if I choose. No bankruptcy claim has ever been lodged. Biased by past incorrect reports.

Dynamic:
Ongoing impaired decision making, although slight improvements noted.
Anne has made serious allegations towards members of hospital staff in Victor
Risk to reputation and further financial loss. Risk of legal ramifications should s
without sufficient evidence. Risk of reprisal shou[illegible]e make allegations or con[illegible]
There is also a foreseeable risk of financial vulnerability, as [illegible]'s life has bee
her persecutory beliefs.

Allegations will be proven by appropriate bodies. This is not their place to judge without facts. Financial vulnerability is due to hospitalisation and impairment from medications not the other way around. My business harm is noted in the links.

Treatment Adherence

Static:
Anne has not demonstrated insight into her illness. Following her recent hospita
ceased her antipsychotic medication Quetiapine, though did seek further review of her sodium valproate through
her GP and the local mental health service.
She has expressed on a number of occasions her concern that antipsychotic medication may interfere with her

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Mental Health

Name: MILES, Anne **DOB:** 04/12/1964 **CID:** 102

CLINICAL REPORT - TREATMENT AUTHORITY REVIEW

abilities as a psychic medium, and has alleged that previous treating doctors hav
prescribed antipsychotic medication with the intention of preventing her from bei
investigate organised criminal activities.

Dynamic:
Anne has generally been adherent to medications prescribed during her current
been occasions where she has declined medication due to concern regarding si
It is believed that she does not demonstrate insight into the benefits of antipsych
role in the treatment of her illness.
She has indicated to the team that if treatment were not enforced under the treat
unlikely to engage in treatment for a psychotic illness as she does not believe sh
There is a highly foreseeable risk of medication non-adherence.

Allegations will be proven by appropriate bodies. This is not their place to judge without facts. I'm clear what is real life experiences, what are facts that are tangible, and what is a psychic reading in this also. It is lawful to begin an investigation based on psychic mediumship. Case precedence can be provided if required.,

Incorrect - I never declined medications on any grounds other than a mistake in the charts. I asked to change medications with the doctors without unilaterally deciding. This is a harmful accusation. I'm very compliant to agreed protocols and better able to uphold them than the hospital.

I definitely will not be taking medications that I don't need. I will take medications that are good for me and improve my well being.

Social circumstances, network and the capacity to support the person

Raised in siblingship of 3 - younger brother and sister
Alluded to difficult family dynamics, 'I was parentified at a young age' looking aft
Christian household
High-achieving and intelligent at school
Trained as a life coach, and many self-help courses
Ran theatre production company at age 21
Previously full-time self-owned marketing business (during which time Anne had PHI), which then went bankrupt
(was on JobSeeker 2022)
Hx of FV for 20yrs from ex-partner - historic and not a current issue for Anne

Some facts are incorrect here although irrelevant to note. Family violence is a current issue related to the crime issues I'm experiencing now. These have been present and recorded for over 27 years.

Witnesses can support this claim of seeing organised crime personnel at my propery and staking out to threaten or harm me. Police were involved and revealed corruption instigating report to IBAC and Vic Police Corruption Board. Facts are available. I haven't 'declined' at all. My plans are pending based on hospitalisation impact and my right to choose.

Accommodation

til the events that
she has not retur

has relocated to
med the treating team that she has paid for 6 weeks of
f her discharge from hospital. She has declined to

I have only used a small portion on business equipment that I've always intended to purchase to allow working remotely and to increase capacity. Nothing is unreasonable and this is a gross exaggeration and assumptions without facts. Spending spree' referred to included a small payment to update my credit card on a phone account $45, and buy one small cable to charge my phone in hospital $20. My online business has been in construction for all this year and is a viable business. Links provided. I am a qualified Business Coach and the costs have been a fraction of usual online business costs because I can do a lot of the work myself. This is an unqualified and prejudicial statement.

I am not homeless. I have a home. I have always had a place to stay or rented. I have a home studio in Melbourne now and pay rent still. This is incorrect and evidence that The Alfred's reports are having undue bias over my diagnosis.

- significant financial stress while in Victoria prior to Alfred admission, has been homeless and temporarily on Centrelink
More recently, managed to gain early access to her superannuation, has already spent a significant proportion to buy new phone, computer and other items.
- concern about spent spree driven by persecutory delusion of her phone and computer being hacked by crime gang
- concern about spent spree driven by increased activity - making a lot of online purchases to set up her medium ship business

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I'm better equipped to look after myself than these doctors and any other family members. Once the facts are reviewed it will become obvious there is no cause for detainment or wrongful medications.

Section 420 Report [Only required for review pursuant to s413(1)(c)]

Would the appointment of a guardian result in a less restrictive way for the patient to receive treatment and care of their mental illness?

Anne has limited support available; there is no available personal guardian, nor is it felt that appointment of a personal guardian would be an appropriate way through which she

I don't drink a lot of alcohol by lifestyel choice anyway, but feel this is inappropriate to enforce in any case. I never use illicit substances of any kind. Listing these in this fashion infers I abuse these when I don't.

Care in the Community and Limited Community Treatment

[Provide details of the arrangements in place for community care, i the patient has utilised in the preceding review period]

LCT conditions ordered by the Court or Tribunal:

LCT conditions authorised by the Doctor:
To not drink alcohol or use illicit substances while on leave To carry a working phone and be contactable To sign in and out; leaving and returning on time

Conditions

[Provide details of the current conditions e.g. intervention programs, driving restrictions, weapons, UDSs, alcohol restrictions, conditions and issues relating to victims or contact with victims. Note persons compliance with conditions]

Conditions ordered by the Court or Tribunal:

Conditions authorised / amended by the Doctor:

My right to be a professional medium is being harmed here by biased and limited diagnosis. I have the right to be independent and an introvert if I want to.

Cultural information [To be completed by the Indigenous support worker or transcultural/bilingual worker]

Cultural Background

Communication / Language barriers
(Interpreter required / type e.g. Auslan etc?)

Cultural support required?

[Provide details of community including networks, community supports, and how they are contributing to the person's rehabilitation and recovery; family including, where applicable, effects of the stolen generation, grief and loss issues, family structure and position of the person within the family; cultural issues impacting on care e.g. need for an interpreter; cultural support being provided; cultural support available]

Cultural Information completed by

Position

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I presented myself to 3 emergency wards between 2019-2022, worried that spiritual experiences were psychosis in the past but turned away due to being 'explained'. This led me to find a psychiatrist who reported 'independent phenomena'. Supplied reports. The Alfred in 2025 went against this history and I've presented a case for possible fraud and negligence to IBAC. I have older diagnosis of PTSD from approx 27 years ago, and ADHD about 2022.

This point is incorrect but depends how Mental Illness is defined in Qld.

Date

Brief history of mental illness

[include relevant dates, description and circumstances of symptoms, ... history of willingness to undertake treatment, response to previous treatme... involuntary treatment details]

Anne has had no prior history of treatment for her mental health in Queensl...
Records received from Victoria inform that she had no history of mental health admissions prior to 2025.
Records indicate a past history of diagnoses including PTSD, depression, anxiety and ADHD, with a medical history of fibromyalgia.

She was under the care of private psychiatrist Dr Mahendra Perera for several years for diagnosis and treatment of ADHD. It is noted that in the correspondence provided to us by Anne, Dr Perera noted in his initial assessment letter that her presentation did sound like a bipolar disorder, however felt that the odds were in favour of ADHD. She was commenced on stimulant medication (initially ritalin, and... taken over by her GP. Anne informs us that Dr Perera has since r...

Police proved to me to be corrupt and not helping me in the crisis. This is evidential and for IBAC to confirm.

Missing person's claim was in Victoria on my instruction to my friend as I had seen organised crime people staking out at my home and had real cause for concern. Missing person's register is crucial for police to begin investigations, otherwise nothing can be done. This was a wise thing to do. I initiated this process and was fully aware. My technology was lost with no phone or computer to contact anyone. The Alfred limited my access to community and police.

Psychiatric Admission Alfred Hospital 20/4/25 - 8/5/25:
Anne was admitted to the Alfred hospital Psychiatric Inpatient Uni... complaint:

Anne is a 60yo woman, previously living in private ... but hom... on 17/04, who supports herself financially with fi... ance work (m... practising as a 'multidimensional oracle medium' for the last 3-4y... an estranged relationship with her family (including her two indep... of victim of violence in past.
Nil MH admits and nil CMI other than 2022 episode (EPS/Navigations; EPS Dx pseudodementia), during which Anne self-presented to ED with MS deterioration (pertaining to financial stressors) but did not engage in longitudinal MHS engagement as her stated goal for SKRC was accessing her superannuation early. Psychiatric Hx of PTSD, depression, anxiety, and ADHD. Medical history of fibromyalgia. Currently supported by her GP, reporting that her previous PP is now retired. Currently on Vyvanse 60mg for ~6/12, having previously been on Ritalin and reboxetine in 2022.
On this occasion, Anne self-presented to ED (after being listed as a missing person by friend in NSW) with concerns about her MH. She has been living on the streets since a reported break-in of her home on 17/04, feeling that she had no one to support her. She reported auditory and visual hallucinations, paranoid/persecutory ideas, and significant psychological distress, self-requesting a MH admission for additional support.

She was admitted to the ward for ongoing assessment and treatment, with a working impression of a first episode psychosis, potentially precipitated/worsened by stimulant medication.
The following is documented in her discharge summary from the hospital regarding her symptoms, diagnosis and treatment during this admission:

- ceased Vyvanse on admission
- period of a weekend without regular charted treatment to provide period of washout of vyvanse + give Anne the opportunity to engage in taking medication voluntarily
- discussion held with Psychiatrist, impression of first episode psychosis. Anne unwilling to take prescribed medication - placed on an AO --> ITTO.
Possible longer standing untreated psychotic illness
This has likely been precipitated/worsened by stimulant/vyvanse and exacerbated by psychosocial stressors and social isolation

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- Anne's primary psychotic illness affecting relationship w children, housing, social life, and engagement with work
- during admission attempts to liaise w GP, unable to co
- symptoms including: Persecutory delusions involving
she is being filmed at home. Pornography and 'sex ring
Anne's child as a victim. Also describes one of her child
that Anne is the person who can uncover all of this, "24
social isolation- Anne feels cannot contact friends + fam
Anne was unable to live at home due to belief being filmed there and persecuted.
- Anne exhibits ongoing signs and symptoms of psychosis, and remains irritated and politely frustrated with respect to her admission, and is in disagreement regarding treating team modality of treatment. She continues to believe that police should be investigating her concerns, and continues to pose a high risk of AWOL, disengagement and non-adherence to treatment given this.
- Attempts to discuss and introduce aripiprazole depot as ongoing treatment on 8/5/25, Anne disagreeing w this treatment. In particularly, Anne concerned about losing her gift as a medium with anti-psychotic treatment.
- in light of ongoing poor sleep introducing melatonin 25mg IR, discussing at this dose not for anti-psychotic properties rather to aid w sleep.

Having this report come up again in this Tribunal Report is further proof that this report has been unduly influencing my diagnosis in Queensland and likely to bias the Tribunal outcomes.

IP Treatment
- Commenced on Risperidone PO, patchy adherence
- ceased risperidone, commenced on aripiprazole on 28/4/25 10mg PO --> attempted increase to 20mg PO, Anne did not want to take this dose, discussed and Anne commenced on 15mg PO aripiprazole on 6/5/25. Aripiprazole moved to nocte dose in setting of Anne experiencing some sedation after taking aripiprazole.
- Melatonin 2mg MR nocte
- Quetiapine 25mg IR nocte -discussing at this dose not for anti-psychotic properties rather to aid w sleep

In documentation provided to the treating team by Anne, she has alleged that her treating psychiatrist from The Alfred was bribed $8,000 to treat her, as well as another (unnamed) doctor from the treating team and the head nurse on the ward. She further alleged that her psychiatrist had been bribed 16 times in total, including occurrences not related to her care. She reports she received this information via a mediumship reading. In her documentation she states *"My reading about my treating doctors is that three of them are being paid $8K each to enforce anti-psychotic medication to prevent my mediumship abilities as a corruption to prevent me supporting the police in a high level crime that I have been inve further offences and put the hospital's repuation at*
She believed that one of the men who had been pe infiltrated the hospital dressed as a cleaner and ent also were on the ward, one as a patient and one as

Note that BIPU released me with no medication orders not noted here.

BIPU and The Alfred failed to provide my report to The Tribunal forcing me to have no record of this clearance on file. This report fails to note that BIPU had a review of the facts of my situation and likely realised their mistake and released me without waiting for the new Tribunal hearing date after postponement. This seems a premeditation.

Psychiatric Admission Broadmeadows Inpatient Psy
Anne was transferred to the Broadmeadows Hospit
remained in the LOW Dependency Unit (LOU) durin
The following is documented regarding her admissio

 # Suspected psychosis
- Hx revisited. Impression of psychotic episode trigged by Vyvanse use (prescribed by pp for ADHD) - ceased during Alfred admission.
- psycho-education around psychosis and role of medication in managing sx of anxiety stemming from paranoia
- Anne reluctant to take medication or up-titrate recommended levels to allow therapeutic effect. Agreeable to trailing sodium valproate after reviewing drug information provided
- Sodium valproate commenced at 200mg BD. up-titrated to 200mg mane / 500mg nocte by the time of discharge
• Quetiapine dose increased gradually - 150mg nocte at the time of discharge. Anne encouraged to work with community team and further titrate medication doses

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- Anne utilised unescorted and escorted leave, denying any safety concerns or paranoia
• At the time of discharge, continues to express concern re c
corruption (believes Alfred team have accepted payment to k
appear to be impacting her functioning to a degree that woul
& discharge planning)

Having this report come up again in this Tribunal Report is further proof that this report has been unduly influencing my diagnosis in Queensland and likely to bias the Tribunal outcomes.

 # MHT hearing
- Anne supported by SW With Advanced Care Plan inde[illegible]ndently prepared supporting documentation for hearing scheduled 20/05/25
- MHT report prepared by Alfred TT and provi[illegible] to Anne on 15/05/25 - Anne sought legal aid
- Hearing adjourned due to clerical error - r[illegible]t sent to MHT late & Anne's documentation missing
- TTO later revoked following discharge planning meeting with Anne & her cousin, David + discussion With DCS (Dr Rudolph)

 # Discharge planning
- Anne's cousin, David originally visited to support Anne during the hearing with plans to take her with him back to QLD where he is based (pending outcome)
- Family meeting 20/5 post hearing (adjourned) with David, [illegible]
- David advocating for discharge, happy to support Anne in
- Anne agreeable with plan and states willing to continue m
supports
- Discharge plan discussed With Dr Dev Rudolph (DCS—N
- Decision to prioritise autonomy, accepting a level of risk
- Note Mental Health Act has no interstate jurisdiction - TT[illegible]
better supported by family
- Family to be provided with triage contact details and instructions around EWSs, when to escalate - discussed with David prior to discharge
- Note risk Of deterioration if Anne becom[illegible]non-compliant leading to symptoms becoming unmanageable (she has expressed concern around medication dampening her
the risk of further estrangement from mental health service
such that when she is made voluntary treatment could be c

This is written as if medication was still ordered and necessary, when it wasn't. I voluntarily continued on Sodium Valporate and presented to Queensland team for review. I was under no orders to take any medication despite how this is written.

No risk of homelessness. I have the means and continue to have a home in Melbourne. This is further evidence of The Alfred's reports impacting my diagnosis.

'Supernatural' is a negative way to address proven mediumship skills as an accurate professional. This is prejudicial.

Impression
First episode psychosis, possibly untreated for ~4 years, m
Risks of harm to self and others low at the time of dischar
supports
Risks of mental state deterioration in tie of psychosocial str
Risk Of medication non-compliance with A[illegible]s expressing concern re medication effects on her supernatural abilities
Vulnerability - risk of homelessness, financial stress - somewhat mitigated with Anne accessing her superannuation & supported by family

Anne's treatment order was revoked on 21/5/25 on the grounds of her relocating to Queensland with her agreeing to continue treatment and to seek help from a psychiatrist in Queensland.

Circumstances leading to the initiation of involuntary treatment

[Significant events and precipitating factors leading to the making of a treatment authority, including details of past involuntary treatment (e.g. previous treatment authorities, forensic order)]

Anne self-referred to the Gold Coast MHS Acute Care team on 6/6/25. Following an initial phone triage she was

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encouraged to present to the Crisis Stabilisation Unit at Robina Hospital to engage in a face to face assessment. On assessment, the following statements were documented by the assessing clinician:

I contacted MH Call today as I have run out of my Sodium Valproate and need scripts.
They then thought it would be good for me to see someone.
I understand how it reads when I talk about being a spiritual medium, but it is real and a gift that I have been working with for a long period of time now.
One of the cases that I have been working on involved undercovering local police corruption and have since reported it to the IPAC.
I also married into a DV situation and he and his family a
I then became so distressed at all these events occurring
thought would happened, was the opposite.
They told me I was being diagnosed with psychosis and an admission to the ward under the MH ACT.
I don't agree with that diagnosis or the treatment that I received and I have since made a complaint about this.
I believe I was actually having a full blown PTSD episode and just needed to be heard and given medication that would have helped me to feel less traumatised.
Upon being discharged, I then headed to Toowoomba with my 1st cousin and was suppose to be staying with him and be linked into the MHS.
However he acted inappropriately toward me, so I l
stay with my eldest son.
I then decided I wanted to be away from Melbourne
having been on the GC before, I decided I would lik
Financially I am okay and have no concerns about
have drawn down on my Super.
Being away from Melbourne right now is what I need, as it was so toxic down there that being away from all of that has allowed me to think more clearly.
*It has also helped that I ceased th*etiapine as it was making me too sedated and unable to think clearly.*
But the Sodium Valproate has been really good. It seems to help with my symptoms of PTSD where I am less up and down. It is easier to now deal with my triggers
presenting to Prince Alfred.
I know it looks strange that I have changed phones
way currently in feeling safe.
I know I have also not provided numbers for any N
have already spoken about when I called 1300 ea
The plan at present is to find either an apartment in
Saturday and will go from there.
I have no concerns for my overall wellbeing right no
decisions that I can make.
I have also given myself a break from my work but am spending time writing.
I am not at risk to myself, am not having suicidal thoughts, plan, intent or wanting to harm anyone.
However I am happy with any follow up support that you may recommend.

IBAC - Independent Board of Anti-Corruption Victoria
Case details provided at links.

Sodium Valporate - never called this 'really good'.
Later it caused proper depression and suicidal thoughts. It worked to reduce anxiety at first but not suitable ongoing with accumulation.

This concept of 'taking a break' is so far from true. I have been impacted extremely hard by The Alfred hospitalisation and medications. This has broken my business and stopped all income streams. I was trying to remain positive in a very stressful situation with a lot of harm to my finances. I discussed how I could fill the time without the ability to work as a side effect of the harm and not an active choice.

Following assessment, a plan was put in place for referral to the community Acute Care Team (ACT) for a period of follow-up and further assessment.

She attended a face to face assessment with an clinician on 10/6/25, with the following documented in the assessment:

continues to express concerns for personal safety in relation to her ex-partners family being involved in crime network
claims her ex-father in-law is head of a crime network which has interests in sex work, reports her youngest son is a sex worker
after she reported her concerns to the police she was admitted to hospital in Victoria (Broadmeadow and Alfred Hospitals) for six weeks

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previous to entering hospital was prescribed Vyvanse to treat ADHD which was ceased on the treating team's
this Mx had contributed to her experiencing a psychosis
feels the doctors had got this wrong and [illegible] diagnosed as be
being in hospital was traumatising and has now made a comp
now feels insecure when discussing her concerns, which she [illegible]
again be admitted to hospital
is currently staying in rented accommodation on the GC and is not wanting to contact her friends or family as she is fearful she will be located by the ex-partners family
has ongoing contact with IBAC who are investigating the crimes she has reported, some in connection with her work as a medium
is concerned about what will happen to her if IBAC do not reach some conclusions about the crimes she has reported
the ongoing stress is contributing to her experiencing low mood, and fleeting suicidal ideation, denies plan or intent
denies any other previous episodes of psychosis or hospital admissions previous to her recent six week admission
was diagnosed with PTSD after experiencing domestic violence perpetrated by her ex-partner
has yet to make contact with her GP to arrange PP, is worried about finding the right Psychiatrist
discussed option of MO review which Anne felt would be helpful

Continues to demonstrate that the Alfred's reports are considered in diagnosis by new doctors. Undue bias.

She had a further clinician assessment on 13/6/25 with s

After being released by BIPU it didn't occur to me that I'd have to revalidate the facts of my situation and prove myself all over again. This doctor never looked at any facts herself before diagnosing and sending me to Gold Coast Uni hospital under orders. She was biased by The Alfred reports only. I voluntarily came to get help from Sodium Valporate side effects of depression. ADHD remained untreated by these teams.

Anne attended an assessment by ACT psychiatrist Dr Bu
assessment:

Reports she wants a review of her medication as she is s
States she has had a lot of life pressures due to other people "thinking I've made it up".
States her ex-husband and his family were involved in sex crimes, "they've filmed me with hidden cameras over the years and put it on porn sites". Knows this through her "medium-ship" powers.
Reported this to police but "they didn't do anything about it" and believes they are involved and so is now going to police corruption - "IBAC". "I've revealed police corruption".
States organised crime bosses then came to her h
relocated to QLD to hide her identity and avoid bei
States she has "facts" that prove her report but wh
is not interested in talking about that. States she do
involved in the aforementioned corruption. She saw the organised crime boss and his brother coming in dressed as a cleaner coming in and talking to staff. Also saw patients carrying weapons that she believes was arranged.
Adamantly declined to discuss anything relating to psychosis and wanting to be prescribed Vyvanse and/or Reboxetine for her mood.
"Suicidal behaviour right now is that I should go home
States she is unable to leave her [illegible] due to fear, "I
anybody". Became tearful at this point, "I've lost ever
Has been managing distress by binge eating (not dor
previously drink). Denied other substance use.
Can see the crime bosses/police hacking her phone so feels she can't contact anybody. Has a "secret phone" that she has given us the number for. Has been mailing her usual phone around the country "as a decoy".
Has been learning martial arts for self-protection. Denied having access to weapons.
Strongly declined for ACT to contact any FOK - declined to provide contact details.
Declined contact with cousin David reporting he made a pass at her that was inappropriate.

I was not leaving the hotel because of depression caused by medications, not because of any concerns for my safety in Queensland at all.

My first cousin said 'Don't be surprised if I kiss you'. I told him that was so inappropriate and chose to leave his care as he was home alone without his wife.

Mood described as "really low", rated 2-3/10.
Affect dysphoric but reactive, appropriately tearful at times.
Reported marked anhedonia.
Hopelessness and helplessness "there is no one who can help me", "a lot of despair".

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Name: MILES, Anne **DOB:** 04/12/1964
CLINICAL REPORT - TREATMENT AUTHORI

Side effect of sodium valproate. Once medication ceased these thoughts stopped. Witnesses and reports available at Gold Coast Uni hospital to this effect.

Reports suicidal thoughts that she has never had before. No specific plan aside from "go home and let them kill me". States if IBAC state they can't help then she would
witness protection.
Disrupted sleep during the night of 2-4 hours, but then
Reduced motivation "I've lost the will to go outside".
Reports concentration and memory have reduced since

I always took the dosage given to me and ordered. I was on voluntary medications and didn't take the dose on the day of admission as it was under review and I had a blood test to check levels. GP advised not to have it on the morning of blood test. This is not factual and biased against me.

Denied any manic symptoms.

States Valproate has helped reduced her anxiety but
fatigued and has also had diarrhoea. A
Consulted a GP today, Dr Waleed Aldeeki at My Doc
today before her morning dose. Provided permission
Has maintained her rental in Melbourne and may retu
list.
Is now paying for her rental unit in Melbourne and
to cover her expenses.

I had just been cleared of all this by BIPU and didn't understand why the nightmare was allowed to keep continuing. I came for medication review and didn't see I needed to rejustify the facts and the release. After weeks and weeks of hospitalisation in an unlawful process it is justified to become agitated.

Anne became agitated when discuss possible diagnosis of psychosis and benefits of re-trialling antipsychotic medication. She was adamant she does not have psychosis and that this diagnosis was made "unlawfully" by doctors in Melbourne who were apart of the conspiracy against her. She declined less restrictive community based treatment options and wished to leave the building. She was informed that she has been placed under the mental health act. PSO was in attendance and she was transported to GCUH via ambulance.

<u>Mental Status Examination:</u>
• Appearance and behaviour: tall medium build, long grey hair tied back, good attention to hygiene, well groomed, appears younger than stated age. Quickly became agitated when discussing psychotic symptoms and wished to leave the review to avoid admission/treatment.
• Speech: slightly increased rate and volume, raised voice when admission discussed
• Mood and Affect: mood described as "really low" and rated 2-3/10. Affect dysphoric but reactive, appropriately tearful at times.
• Perception: nil perceptual disturbances reported or observed
• Thought form/flow: Thought form logical and linear
• Thought content: persecutory delusions regarding her ex-husband, his family and even her sons being involved in sex crimes, uploading pornographic videos of her and organised crime bosses coming to her house to kill her. Persecutory delusions about police and hospital staff being involved, including doctors at the Alfred receiving payments from these organised crime bo
Misidentification symptoms - reports see
and talk with the doctors and saw weapo
see these crime bosses and police hacki
has been mailing her phone "around the country as a decoy" to keep herself safe. Has felt unsafe to leave her current temporary accommodation on the GC due to feeling her life is at risk. Expressing suicidal thoughts with plan to allow these crime figures to kill her if IBAC are unable to place her in witness protection.

No facts reviewed to make this judgement. Subjective, influenced by The Alfred, unlawful.

** Cognition: Alert and orientated*
• Insight and Judgement: Impaired insight, adamantly denied she could be suffering psychosis despite the opinion of a number of mental health professionals. Adamantly declined any antipsychotic treatment, only wanting to be prescribed Reboxetine and Vyvanse. Declined less restrictive community based care. Impaired judgement leading to her becoming homeless then itinerant and without contact with social supports and at significant risk to reputation and financial risk (using super to pay for rental unit in Melbourne, accommodation on GC and other expenses all to avoid crime bosses and police she believes are going to kill her). Anne is suffering from a Mental Illness (Psychosis) and lacks capacity for MH decision making. She is at risk to self (has expressed SI), others (training in martial arts to protect self), vulnerability (has become itinerant through acting on delusions), financial (relying on her super to fund various accommodations) and reputation without assertive treatment.

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Name: MILES, Anne **DOB:** 04/12/1964
CLINICAL REPORT - TREATMENT AUTHORITY

Melbourne psychiatrist Dr Perera had a very robust process of diagnosis over several months. The Alfred diagnosed psychosis after 30 mins and called him a quack without knowing who he was or reading his reports. This has then been a domino effect into all other treating teams in a prejudicial manner.

Impression
Anne is a divorced 60-year-old female presenting with psychosis, having been diagnosed with FEP in May 2025 during an involuntary MHU admission in Victoria. There is documented concern that her symptoms had onset approximately 4 years ago but had been untreated and then exacerbated by commencement on Vyvanse 6 months ago. She describes a range of persecutory delusions involving her ex-husband, sons, organised crime bosses, police and Alfred Hospital staff. Acting on these delusions has resulted in itinerancy, loss of social supports and financial risk. She has been poorly compliant with medication on discharge and is experiencing a deterioration in MSE with worsening psychotic and mood symptoms and new onset suicidal ideation. She lacks insight into the nature of her symptoms and requires treatment under the MHA.

Anne was transported to the Gold Coast University Hospital and admission to the acute adult psychiatric inpatient unit was facilitated.

Recommendation and reasons

Treatment Authority	Confirm ☑	Revoke ☐
Change conditions	Yes ☐	No ☐
Change extent of treatment in the community	Yes ☐	No ☐

Reasons

Provide a summary of recommendations including likely risks if the person were not on a treatment authority, available. For inpatients, why is a community based Limited Community Treatment (LCT) is authorised, day, days per week and overnight leave (conditions rationale/clinical indications if proposing any

I believe they can't diagnose properly because I don't fit their criteria and medications are not working. True life and real experiences cannot be medicated away.

They talk about 'bizarre' as a subjective statement without facts. Their own values and life experiences flavour their impressions and don't allow for individuality.

They call me delusional despite facts being provided about my many qualifications, media exposure, lifestyle choices and life experiences.

Anne has been diagnosed with a major mental illness (currently unspecified), which has been confirmed on have been involved in her treatment since the initial hospital in Victoria in April 2025. Anne presents with nature, at times bordering on bizarre. She has continued to openly voice many of these beliefs over the past two and a half months since her initial hospital presentation.

Anne continues to lack capacity to consent to treatment and disagrees that she is experiencing symptoms understanding of this illness to be able to demonstrate purpose of treatment, appreciate the risks and benefits treatment. The treating team believe that this is in interfere with her abilities as a psychic medium. She treatment for her ADHD with her prescribed stimulant medications may have precipitated or potentiated

I will definitely decline medications that I don't need but definitely want my real mental health issues to be addressed that are currently left untreated. If any medications seem to improve my quality of life then I'm open to continuing, however so far they only make my life worse by a large scale to the point of depression and suicidal ideation otherwise uncharacteristic.

My private psychiatrist has retired now and I need a new one with capabilities in all my areas of concern and with an undestanding of consciousness technologies like mediumship and up to date on the latest science.

In the absence of involuntary treatment, it is believed her views on treatment clear in that she does not requires treatment for this. In the continued absence mental state deterioration.

The current treatment regime continues to be viewed as the least restrictive option available. At time of writing, Anne continues to require inpatient treatment to allow us to establish her on a tolerable medication regime, at

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This suggests a possible outpatient option might be possible despite the form suggesting no change and to retain me in hospital against my will. This is contradictory.

No clear pathway to 'recovery' has been detailed.

which point continued treatment in the community setting will be considered and pursued. Anne has limited support available; there is no available personal guardian, nor is it felt that appointment of a personal guardian would be an appropriate way through which she may receive treatment at this time.

It is our view that continued treatment under the Treatment Authority is required to ensure that Anne continues to receive adequate and effective treatment for her mental illness.

Human Rights Considerations

The *Human Rights Act 2019* recognises that all individuals in Queensland have human rights. It requires public entities to act and make decisions in a way that is compatible with human rights. Clinicians may be asked to provide evidence in relation to any human right that is limited and why any limitation is demonstrably justified.

Documents annexed

Report **MUST** be signed by the Treating Psychiatrist /Senior Practitioner

Report prepared by (name, designation)	Initially drafted by Dr Gong (Psychiatric Registrar, covering for Dr Ajit) Further updated and completed by Dr Maletsky (Psychiatrist)

Mental Health Act 2016
Section 413 When reviews are conducted

(1) The tribunal must review (a ***periodic review***) a treatment authority—
  (a) within 28 days after the authority is made; and
  (b) within 6 months after the review under paragraph (a) is completed; and
  (c) within 6 months after the review under paragraph (b) is completed; and
  (d) at intervals of not more than 12 months after the review under paragraph (c) is completed.

(2) Also, the tribunal must review (an ***applicant review***) a treatment authority on application by—
  (a) the person subject to the authority; or
  (b) an interested person for the person mentioned in paragraph (a); or
  (c) the chief psychiatrist.

(3) Further, the tribunal may at any time, on its own initiative, review (a ***tribunal review***) a treatment authority.

(4) If the tribunal receives written notice under section 210(3) of the amendment of a treatment authority, the tribunal must review (also a ***tribunal review***) the authority within 14 days after receiving the notice.

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