Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to section 756 of the *Mental Health Act 2016*. The patient and persons attending the hearing have been de-identified and, in some cases, may be allocated pseudonyms for privacy reasons. Other details that may lead to the identification of the patient may have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Decision made prior to 1 January 2020 so *Human Rights Act 2019* not applicable

Matter:	Forensic Order Review
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Case Manager:	Attended
Attorney-General's Representative:	Attended
Other attendees:	Patient's wife
Decision	
Decision:	Forensic Order confirmed. The category is community. The authorised doctor may at a future time, change the nature or extent of treatment in the community, received by the patient, to the extent and subject to the conditions decided by the Tribunal.

The patient is a man who was placed on a Forensic Order in respect of charges of attempted murder and acts intended to cause grievous bodily harm. The Mental Health Court found that the patient was suffering from a mental illness which deprived him of the capacity to know he ought not do the acts in question.

Statutory Framework and Issues to be determined by the Tribunal

Set out in Appendix A to these Reasons is a summary of the principal provisions of the *Mental Health Act 2016* (**Act**) that are relevant to the Tribunal's conducting a review of a person's Forensic Order. Further reference will be made to these under "Application of evidence before the Tribunal to relevant provisions".

The issues for determination at the review were:

1. whether the Forensic Order for the patient should be confirmed or revoked;
2. if the Forensic Order is confirmed and the category is inpatient, should limited community treatment be approved for the patient, or should an authorised doctor be able to change the category to community;
3. if the Forensic Order is confirmed and the category is community, should the authorised doctor be able to change the extent of treatment in the community to the extent and subject to the conditions set by the Tribunal;
4. what, if any, conditions should be imposed on the Forensic Order;
5. if the Forensic Order is revoked, is there a further order or authority to be made; and
6. have the person's relevant circumstances been considered, defined in Schedule 3 of the Act as including the following:
    a. the person's mental state and psychiatric history;
    b. any intellectual disability of the person;
    c. the person's social circumstances, including, for example, family and social support;
    d. the person's response to treatment and care and willingness to receive appropriate treatment and care; and
    e. if relevant, the person's response to previous treatment in the community.

Clinical Report

The patient confirmed he had received the clinical report within statutory timeframes.

Summary of evidence and findings

The Tribunal must confirm the Forensic Order if the Tribunal considers the Forensic Order is necessary, because of the person's mental condition, to protect the safety of the community, including from risk of serious harm to other persons or property.

1. The relevant circumstances of the person subject to the order

Mental state and psychiatric history

According to the clinical report, the patient's diagnosis was vascular dementia and recurrent depressive disorder. His first presentation to mental health services was following the offences, where he presented with persecutory delusions. He also had auditory hallucinations, limited food intake and was suspicious of others.

History prior to the offence indicated the patient had experienced a period of worsening depression with social isolation, agitation, irritability and an increase in alcohol consumption. Factors contributing to the onset of the patient's symptoms included a predisposition to psychotic symptoms and

depression due to a head injury many years earlier; occupational, financial and personal stressors and an increase in alcohol consumption with abrupt cessation which lead to symptoms of alcohol withdrawal delirium. The patient was treated with medication. At the time of the offence, the patient was affected by a major depressive disorder with psychotic features.

Approximately 3 years ago, following investigations into his emerging cognitive and physical decline, it was considered that the patient had suffered a stroke and imaging showed evidence of progressive vascular dementia.

The treating psychiatrist told the Tribunal that the patient's depressive symptoms were in remission, despite cessation of medication for three years. However, there had been a dramatic decline in his cognitive function in the last three years due to strokes, vascular dementia or possible Alzheimer's Disease. She stated there was no recurrence of delusional thinking, but episodically he expressed persecutory ideas and was very suggestible to ideas around him. As a result, his mental state needed to be closely monitored.

The patient told the Tribunal that if he became unwell he would ask his wife to take him to the doctor. However, he did not know any warning signs or symptoms of becoming unwell. He did not think he had any mental illness issues.

Social circumstances, including, for example, family and social support

Approximately 2 years ago, the patient has returned to live with his wife. He does not have contact with his wife's extended family. The patient's children live overseas or interstate.

According to the report, the patient lived in his own home with his wife and liked to tend to his garden, attended church and the local shopping centre.

The patient told the Tribunal that his family was 'pretty good' and his memory was ok and he very seldom forgot things. He liked to attend church. His self-report stated he stopped drinking approximately 10 years ago. He was happy to be home with his wife and he had a clear mind. He stated living in a nursing home in the past was a waste of resources and he was not happy with the Public Trustee limiting his money. He liked reading, attending church and visiting friends. A community nurse came to visit.

The patient's wife expressed concern about Public Trustee involvement as a breach of human rights and said it made it difficult to manage their finances and their disputed debt to the nursing home. The treating team noted that the Public Trustee was attempting to resolve a debt with the patient's nursing home by selling an investment property. However, the patient's wife would not agree.

Response to treatment and care and the person's willingness to receive appropriate treatment and care

The patient told the Tribunal he thought the Forensic Order was ok but it was controlling him and understood it meant he had to comply with his doctor's directions. He thought he did not have mental illness issues.

According to the clinical report, the patient's anti-psychotic treatment was ceased due to the patient's physical disability and decline in his cognition. The treating psychiatrist confirmed this at hearing.

According to the treating team, the patient's mental state remained stable, although there had been a subtle decline in cognitive function. He had poor insight into his cognitive and functional deficits and need for assistance with daily living, though was cooperative and not impulsive. He had a poor understanding of the risks of recurrence of his illness and restrictions of the Forensic Order. However, he accepted and complied with treatment and had developed a reasonable rapport with the treating

team.

The treating psychiatrist told the Tribunal that the patient's depressive symptoms were in remission but there were episodic persecutory ideas and he was highly suggestible to ideas about issues with finances. He passively accepted treatment and had no insight. The treating psychiatrist noted the patient used to have a warm relationship with his children but had become suspicious when the Public Trustee took control of his finances. The treating psychiatrist told the Tribunal that the case manager reviewed the patient fortnightly. There was a plan in the next 6 months to possibly reduce that, but the team would need to closely monitor the patient's mental state and his Public Trustee issues and vulnerability.

The Tribunal accepted the evidence of the treating team that the patient had depressive and psychotic illness, which was currently in remission. The Tribunal also accepted the treating team's evidence that the patient had vascular dementia with significant cognitive decline in the last 3 years. The Tribunal accepted that the patient required close monitoring as he had episodic persecutory ideas and was highly suggestible to ideas, particularly about stealing and his finances.

The Tribunal finds the patient suffers from a mental illness as defined in section 10 of the Act and therefore he has a mental condition.

It was evident that the patient did not think he had a mental illness and could not describe any signs or symptoms of becoming unwell. Further, he considered he seldom forgot things and minimised his cognitive decline. Given the patient's lack of understanding of his symptoms, illness, early warning signs, the Tribunal finds the patient does not have capacity to consent to treatment.

The case manager was concerned that the patient did not spend as much time with the family as in the past and that the family do not communicate with the treating team about when the overseas family visited. The patient's wife said the family did not tell them when they planned to visit. The case manager noted that one of the patient's children had visited, but the treating team had not been told. The case manager noted the family can be a stressor for the patient. The treating team considered the family needed more psychoeducation about the patient's early warning signs and symptoms.

The Tribunal accepted the case manager's evidence. The Tribunal did not consider the patient's family a protective factor as they had limited contact given their residence overseas and interstate and needed more psychoeducation. While he resided with his wife, it was evident she had little understanding of the risks and needed more psychoeducation. Further, as noted in the clinical report the family did not notice the change in the patient's demeanour or manner in the lead up to the offence. The report also noted the lack of overt expression of emotion and behavioural expression made detection of re-emerging psychiatric illness difficult.

2. The nature of the relevant unlawful act and the period of time that has passed since the act happened

The patient was charged with attempted murder and acts intended to cause grievous bodily harm. The injuries were caused by the patient stabbing two other people with a knife. The circumstances of the offences are described in the medical reports in the dossier. While the index offences occurred nearly 10 years ago, they were very serious offences, resulting in serious injuries. The offences were prescribed offences.

3. Any victim impact statement relating to the relevant unlawful act

No victim impact statement has been provided to the Tribunal.

4. If the Mental Health Court made a recommendation about an intervention program for the person – the person's willingness to participate in the program offered to the person

No recommendations about intervention programs were made by the Mental Health Court.

5. **Is the Forensic Order necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property?**

The Tribunal considered the risks outlined in the clinical report and oral evidence at hearing.

The patient said there was no need to worry as he was an older man, could not work and was always a poor man. He did not understand what the Forensic Order meant, other than that he had to comply with his doctor's directions.

The Assessment and Risk Management Committee (ARMC) and treating team were of the opinion that a Forensic Order was necessary to protect the safety of the community from risk of serious harm.

The evidence was that the patient's mental state was stable and his depressive symptoms were in remission and there had been no breach of conditions. The Tribunal accepted that this weighed in his favour. However, it was evident from the clinical report that there were low to moderate risks of deterioration and psychosis as the patient was no longer on anti-psychotic medication due to side effects and his cognitive and physical decline. The risk of aggression was low in the absence of severe depression or psychosis. However, the lack of overt expression of emotion and behavioural expression made detection of re-emerging psychiatric illness difficult.

The treating psychiatrist believed the patient's mental state required close monitoring because of the patient's episodic persecutory ideas and being highly susceptible to stresses around finances. While his mental state was currently stable, the treating team were of the opinion that the continued intensity and nature of the patient's concerns about his finances and the intentions of others required ongoing monitoring, given the prominence of his delusional concerns about theft of his assets at the time of the index offence.

Given the patient's lack of insight, his stressors and episodic persecutory ideas, the Tribunal accepted that close monitoring of the patient's mental state for early warning signs of depression and psychosis was needed.

The patient also had limited ongoing family support and family tensions. Further, the treating team were of the view that the patient's wife's anxiety also required observation and containment as it impacted on the patient's stress and perceptions.

The treating psychiatrist told the Tribunal that the patient's wife was unable to understand the role and reason for management of finances by the Public Trustee.

The treating psychiatrist noted while the index offence was nearly 10 years ago, it was a serious offence and the patient had no insight and he was not likely to gain any insight due to the progress of his dementia. The treating psychiatrist noted with vascular dementia there was also an increase in the possibility of a relapse. It was also important to monitor the patient's mental state as anti-psychotics had been ceased. The treating psychiatrist was concerned about the patient's suggestibility and his family and financial distrust issues, which were similar to the issues which led to the index offence.

The Tribunal noted the ARMC did not support revocation of the order or stepdown of the order at this time. The ARMC noted there was ongoing tension with the family in terms of finances. The treating psychiatrist also stated the Community Forensic Outreach Service (CFOS) meeting did not support a stepdown at this time as there were ongoing financial stressors and concerns by the wife which impacted on the patient and his susceptibility to persecutory ideas.

The patient's legal representative submitted the patient wanted more control and was not happy with the Forensic Order. In the past he had accepted his diagnosis, although he did not at hearing. In the past, the patient said he would remember his condition, but he did not at the hearing. The patient considered his mind was clear and had no health concerns. He exercised, read books and newspapers and always went out with his wife. The patient's legal representative submitted it was open to confirm the Forensic Order on the evidence.

The Attorney General's representative submitted the Forensic Order was necessary to mitigate the risk of harm to the family and to the community. It was submitted the conditions could remain the same, but it was open to delete the condition about illicit substances as that had never been a problem.

While the offence was 10 years ago, the Tribunal considered the patient's violent unpredictable attacks when unwell weighed in favour of confirming the Forensic Order.

Further, it was evident that the patient had no insight into his illness or early warning signs and the family had little ability to detect his early warning signs. His family also had limited understanding of the patient's warning signs and it was difficult to detect his deterioration. The Tribunal considered the lack of insight and difficulty in detecting a change in his mental health weighed in favour of confirming the Forensic Order.

With the cessation of medication, his cognitive decline with vascular dementia and risks to others when unwell, the Tribunal accepted that the patient's mental state required monitoring.

The patient's mental state was stable with depressive symptoms in remission and he accepted treatment which weighed in favour of revoking the Forensic Order. However, the Tribunal was concerned that the patient had episodic persecutory ideas and was still highly susceptible to stressors and ideas of distrust around his family and financial situation, which was similar in the lead up to his index offence. Also there had been further cognitive decline with vascular dementia, which increased the risk of relapse.

The Tribunal finds that close monitoring of the patient's mental state was necessary to detect deterioration of his mental health or increase in persecutory ideas or relapse. The Tribunal accepted that without such close monitoring that there was a risk of undetected relapse, which would pose a significant risk of harm to others. The Tribunal accepted that mental health deterioration or increase in persecutory ideas for the patient increased the risk of him causing harm to others.

The Tribunal did not consider there was a less restrictive way to manage the risks.

The Tribunal was of the view that the Forensic Order was necessary, because of the patient's mental condition, to protect the safety of the community from risk of serious harm.

Category and Conditions

The Tribunal considered the regular reviews by the treating team and the patient's passive compliance, his stable mental state and supervision by his wife was sufficient to demonstrate that there was not an unacceptable risk to the safety of the community and thus allow treatment in the community at this time.

The Tribunal accepted that the patient had no illicit substance history and as such no condition about that was necessary. Otherwise the conditions attached were necessary to ensure the risks were managed in the community, and that treatment in the community did not pose an unacceptable risk.

Conclusions of the Tribunal

Given the patient's lack of insight into his mental illness and symptoms, the unpredictable nature of the very serious offence, his continued episodic persecutory ideas, financial stressors and cognitive decline the Tribunal finds that the Forensic Order is necessary, because of his mental condition, to protect the safety of the community, including his family, from risk of serious harm.

For these reasons, the Tribunal has decided to confirm the Forensic Order – community category. Further, the Tribunal approved that an authorised doctor may at a future time change the nature or extent of treatment in the community, received by the patient, to the extent and subject to the conditions decided by the Tribunal, as attached.

Legal Member

APPENDIX A
Statement of the law regarding Forensic Orders

The main objects of the *Mental Health Act 2016* (**Act**) are set out in section 3(2) and must be achieved in the way outlined in sections 3(2) and 3(3).

Chapter 12, Part 4 addresses the Mental Health Review Tribunal's (**Tribunal**) review of Forensic Orders (Criminal Code). The Tribunal must, within 21 days of receiving notice of the making of a Forensic Order (Criminal Code), conduct a hearing. At the hearing, the Tribunal must make a Forensic Order (mental health) unless the Tribunal considers:

(a) the person has an intellectual disability but does not have a dual disability; or
(b) the person has a dual disability but does not require treatment and care for their mental illness.

On the making of a Forensic Order (mental health) or Forensic Order (disability), the Forensic Order (Criminal Code) ends.

Section 433 provides that the Tribunal must conduct a **periodic review** of the Forensic Order –

(a) within 6 months after the order is made; and
(b) at intervals of not more than 6 months.

The Tribunal must also review the Forensic Order on application (an **applicant review**) by the forensic patient, an interested person for the patient, the Attorney-General, the chief psychiatrist or the director of forensic disability. Section 433(3) provides that the Tribunal may, on its own initiative, review a Forensic Order (a **tribunal review**).

Section 432(1) provides that the Tribunal must have regard to the following when reviewing a Forensic Order (mental health) or Forensic Order (disability):

(a) the relevant circumstances of the person subject to the order;
(b) the nature of the relevant unlawful act and the period of time that has passed since the act happened;
(c) any victim impact statement given to the Tribunal under section 155 or 742 relating to the relevant unlawful act;
(d) if the Mental Health Court made a recommendation in the order about an intervention program for the person – the person's willingness to participate in the program if offered to the person.

Section 438 provides that an application for an applicant review must state the orders that are sought and such order/s must be an order mentioned in Division 4 or 6 and are subject to any non-revocation period that may have been made by the Mental Health Court under section 137 (as required by section 442).

Section 441(1) provides that on a periodic review, the Tribunal must decide to confirm or revoke the Forensic Order for the patient. Section 441(2) provides that on an applicant review, the Tribunal must decide whether to make the orders sought and may make orders under Division 4 that it considers appropriate. Section 441(3) establishes that on a tribunal review, the Tribunal must decide any matter that was stated in a notice given under section 439(3) and may make orders under Division 4 that it considers appropriate.

Section 442 requires the Tribunal to confirm the Forensic Order if the Tribunal considers the order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property. Also, during any non-revocation period for the Forensic Order, the Tribunal is taken to have confirmed the order.

If the Tribunal confirms the Forensic Order, the Tribunal may change the category of the Forensic Order. However, the Tribunal may change the category of the order to community only if satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

Under section 445, if the Tribunal confirms the category of the Forensic Order as inpatient or changes it to inpatient, the Tribunal must:

- order that the person have no limited community treatment; OR
- approve that an authorised doctor or senior practitioner may authorise limited community treatment to the extent of, and subject to, the conditions decided by the Tribunal OR change the category of the order to community; OR
- order that the person have limited community treatment of a stated extent and subject to conditions.

Limited community treatment may only be approved or ordered if the Tribunal is satisfied there is not an unacceptable risk to the safety of the community arising from the person's mental condition.

Section 446 provides that if the Tribunal confirms the Forensic Order as community category or changes the category to community, the Tribunal must order that an authorised doctor or senior practitioner must not change the category to inpatient OR approve that they may at a future time or extent of treatment in the community to the extent and subject to the conditions of the Tribunal.

Chapter 12, Division 5 (sections 452 – 455) establishes that the Tribunal must not revoke a Forensic Order:

- during any non-revocable period of the Forensic Order;
- while a person remains unfit for trial (temporarily), unless the Tribunal makes a Treatment Support Order for the patient under section 450
- for Forensic Orders of patients charged with prescribed offences, the Tribunal must not revoke such a Forensic Order unless the Tribunal has obtained and considered an independent report.

If the Tribunal decides to revoke a Forensic Order (mental health), the Tribunal may make a Treatment Support Order or Treatment Authority for the patient if the Tribunal considers that a Treatment Support Order or Treatment Authority is necessary to protect the safety of the community, including from risk of serious harm to other persons or property. However, the Tribunal may only make a Treatment Authority for a patient on the recommendation of an authorised psychiatrist that the treatment criteria apply to the patient and that there is no less restrictive way for the person to receive treatment and care.

For a person who has a dual disability and is subject to a Forensic Order (mental health), if the Tribunal is satisfied the person no longer requires involuntary treatment and care for their mental illness. The Tribunal must revoke the Forensic Order (mental health) and make a Forensic Order (disability) for the person (section 457).

If the Tribunal decides to revoke a Forensic Order (disability), no further order may be made.