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.

Matter:	Forensic Order Review
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Forensic Liaison Officer:	Attended
Attorney-General's Representative:	Attended (via telephone)
Decision	
Date of decision:	
Decision:	The Forensic Order is CONFIRMED. The Category of the Forensic Order is COMMUNITY. The CONDITIONS of the Forensic Order are attached. The Tribunal approves 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.

The patient was placed on a Forensic Order after being found of unsound mind in relation to charges of murder and attempt to murder. The victims of the murder charges were her family members. The circumstances are set out in the treating psychiatrist's report. The Mental Health Court found the patient of unsound mind in relation to the offences and made a Forensic Order.

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 received the clinical report and her legal representative was satisfied she had had adequate opportunity to read the report.

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

The history of the patient's psychiatric illness and treatment is set out in detail in the clinical report, to which all parties have access. That history demonstrates the seriousness of her illness, her response to treatment, the time over which she has been accepting of treatment, her level of insight into her treatment needs and the supports necessary to achieve her current stability.

Her first episode of involuntary treatment was after the index offences. The treating psychiatrist's assessment of her mental state, and in oral evidence at the hearing, was that she had no positive symptoms, and had not changed clinically. Her case manager found similarly, and noted that her

judgement was fair, and her insight was developing. The patient did not disagree that she had a mental illness, or that she needed medication. The Tribunal accepted the evidence of the treating team that the patient had a long-standing diagnosis of paranoid schizophrenia, and that her mental state was stable and had been for an extended period.

Any intellectual disability

There was no evidence that the patient had an intellectual disability.

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

The evidence was that the patient is strongly connected to her extended family and her Aboriginal culture. She said she has had family visit her frequently. The patient's oldest child had a number of overnights stays with the patient at the time of the hearing. The patient had also had a visit to family for approximately one week (followed up by mental health locally). The treating team liaise with the local mental health team, elders, and the patient's family and supports there so she can participate in important events.

The patient's children were being cared for by a family member.

The patient has been participating in literacy and numeracy classes, although she said she may not continue them. A support worker would see the patient six days per week assisting her with craft, art and activities. She also had assistance with cleaning. She used public transport to go to the supermarket. She has a Department of Housing unit and would like her oldest child to live with her. The forensic liaison officer said this proposition would be discussed with the treating team.

The treating team indicated they were working with the patient on some health issues. They encourage her towards the GP and the supports available, though at times she lacked motivation. The Tribunal found the patient was well supported in the community with good links to family and culture available to her.

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

The evidence was that the patient was accepting of treatment and took her medication without prompting. The clinical report noted she had a good understanding of her medication and need for treatment. She did not indicate any disagreement about this at the hearing. She had weekly contact with her case manager, or at other times as needed. She had contact with the forensic liaison officer approximately six-weekly. She had random urine drug screening every few months (all negative) and ongoing psychoeducation and input into her recovery plan. She engaged with her NDIS support workers, who direct her towards interests in the community.

In light of the evidence that the patient is stable mental state without any delusional or psychotic symptoms noted, her engagement with treatment and rehabilitation, the assessment that her judgement is fair and her insight developing, lack of any aggressive behaviour or agitation for an extended period, lead the Tribunal to conclude that the patient has had a good response to her continuing consistent treatment and rehabilitation program.

If relevant, the person's response to previous treatment in the community

The patient was not treated in the community prior to becoming an inpatient. During the early years of that treatment, she struggled to maintain a consistent acceptance that she had a mental illness and needed treatment, and also struggled with feelings of hopelessness. This affected her commitment to being engaged with the treating team. There have been issues with non-compliance with treatment in the past, some substance use, and there was some aggression, and the exercise

of poor judgement. However, her mental state and acceptance of treatment had essentially been stable for 9 years. Since being in the community, including when visiting family, she had been compliant with treatment.

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

The circumstances surrounding the alleged offences are set out in summary in the clinical report and in the report to the Mental Health Court contained in the forensic dossier. As all parties have access to that material, I do not propose to set the circumstances out in detail.

In summary, the offences occurred when the patient was living with a fluctuating number of family members, including a number of children. Her mental illness was first diagnosed at the time of the index offences. The evidence suggests the patient was likely psychotic for some weeks prior to the index offences, and possibly longer. Certainly, at the time she was reviewed after the offences, she was experiencing auditory hallucinations of a persecutory nature amongst other positive symptoms of her diagnosed illness, paranoid schizophrenia.

The patient was placed on a Forensic Order by the Mental Health Court after being found of unsound mind in relation to all charges. At the time of the review, it was eleven years since the index offences; the offences are prescribed offences under the Act and are of the most serious of offences. The evidence before the Tribunal was that she had had only one incident since then, a charge of common assault, following an assault on a co-patient. She received a good behaviour bond and fine.

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

The Tribunal considered principles pertaining to victims contained in s6 of the Act. It considered the serious nature of the offences and the catastrophic and enduring impact on the families and communities associated with the victims, and on the community generally.

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

The MHC did not make any recommendations about intervention programs.

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 treating psychiatrist said he had looked after the patient for about eighteen months. He said that, in the context of the patient being well, the risks were minimal. If she had a psychotic relapse, given the unique cluster of circumstances he thought it unlikely the index offence would be repeated, despite a relapse. He opined a Treatment Support Order may be appropriate for the patient but would like to see the progress of the patient's oldest child's involvement with the patient over the next twelve months before recommending it. He was not a forensic psychiatrist and would be seeking forensic specialist input on that issue. The forensic liaison officer said he had known the patient since her transition from the inpatient unit. He noted that there had been no indication that CFOS had considered a Treatment Support Order, and neither had the Assessment and Risk Management Committee (**ARMC**), at which CFOS was represented.

The treating psychiatrist said he had skimmed a recent CFOS report (not before the Tribunal) and there were no concerns. The forensic liaison officer said he had not seen it, but no concerns were raised at the ARMC.

Asked about any stressors in her life, the patient said her family staying was not too stressful. She

had complained to the Department of Housing about a neighbour. She said she enjoyed visiting family but was happy to return home. The forensic liaison officer said that the patient had coped with a number of significant losses in her life and had not been destabilised. The team tried to provide additional supports at those times, and the patient had sought help appropriately at times. The forensic liaison officer said that there had been no issues in terms of the patient's visits to family.

With respect to substance use, the treating psychiatrist said urine drug screens were random and there had not been a positive one. It was also noted that the patient had not expressed any interest in illicit substances, although she had asked the approval of the treating team to request the Tribunal if she could have an alcoholic drinks from time to time. The clinical report noted this required further discussion within the team.

Recommendation of the treating team:

The clinical report and the oral evidence indicated that preventing any relapse of psychotic symptoms was crucial to the management of risk. There were good supports in place for the patient, and although she was accepting of treatment, the Forensic Order continued to be necessary to ensure maintenance of the stable status quo and, as doses of medication had been missed in the past, to manage the risks of inconsistent treatment.

Submissions:

The Attorney-General's representative submitted that the Forensic Order should be confirmed. The patient's legal representative submitted that the Forensic Order should be confirmed.

The Tribunal's decision:

The Tribunal accepted the evidence that the patient had been assessed as low risk across all domains in the risk screen completed (attached to the clinical report). Ultimately, the evidence to the Tribunal was that although the patient had gained some insight over the last few years, it required further development. The risks of medication non-compliance and substance abuse would increase, and could result in self harm, and depressive and psychotic relapses.

There were no submissions to the Tribunal that the Forensic Order should be revoked, and neither was there evidence to support revocation. The Tribunal found that the Forensic Order ensured necessary support and monitoring for the patient, without which she was at risk of becoming non-compliant with all her treatment and of relapsing into substance use, causing a deterioration in mental state and potential for aggression. Given the catastrophic outcome of the index offences, ensuring stability in her mental state was key to the safety of the community, and to the patient's own safety. The risks of harm required the confirmation of the Forensic Order.

6. In considering category and conditions, is the Tribunal satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of harm to other persons or property?

With respect to the category of the Forensic Order, the recommendation of the treating team, and the submissions of the parties were unanimous that the category should remain community. The legal representatives agreed that nothing in the *Human Rights Act 2019* (**HRA**) changed the balance in the risk considerations for the community.

There was no evidence before the Tribunal that there was an unacceptable risk of harm to the community in the Tribunal confirming the category as community, given the time since the offences and the patient's extended period of stability, her acceptance of treatment and strong supports in the community. The Forensic Order and the NDIS package provided sufficient supports for the patient in the community. There was no evidence that she needed inpatient care, or risk management in an

inpatient situation. This is the least restrictive option under the Act whilst managing the risks.

The category was confirmed as community. The Tribunal approved that a doctor may change the nature or extent of treatment in the community in the future should that be necessary.

With respect to conditions on the order, in relation to the patient's oldest child, the patient said she would like to be able to live with that child. The treating psychiatrist said the obvious fact was that the patient's oldest child would soon be 18. He acknowledged he had never met the patient's oldest child. The patient's risks were low across all domains, there were no issues with her engagement with the mental health service and her treatment adherence. She was abstinent from all illicit substances. The treating psychiatrist said that the restrictions concerning the patient's oldest child showed an extremely cautious approach by the Tribunal. He said the condition relating to the patient's oldest child's overnight visits were no longer relevant.

The forensic liaison officer said that the treating team was not proposing any change to the conditions. The team would need to go through a process including a discussion at the ARMC, and there had been no discussion of changes in the conditions. He had longitudinal knowledge about her. He had met the patient's oldest child but that was some time ago. There could possibly also be a discussion with the independent CFOS psychiatrist who wrote the CFOS report before a recommendation came from the treating team.

The patient's legal representative raised the issue of the patient having unsupervised contact with her other children. The concerns relating to all the children and supervision stemmed largely from their emotional well-being and that of the patient given the relatively small amount of time they had spent together.

The forensic liaison officer said he would like to have the same process for unsupervised contact for the patient's oldest child to occur with the other children. Attempts had been made to address this issue over the years. There would need to be a meeting of key stakeholders, including the children and their primary carer, so a plan could be developed through the approved processes for changes in treatment in the community. He noted this had been raised in the hearing and not with the treating team, and that the Tribunal process focused the patient on her plans in her discussions with her legal representative rather than her discussing with the treating team what the patient would like to happen. The question of unsupervised time with the other children had not been raised with the treating team or raised with the ARMC. He would want to do more work and make a recommendation about suitable conditions.

<u>Submissions:</u>

The Attorney-General's representative submitted the conditions should remain unchanged.

With respect to extending the patient's access to the oldest child's, the Tribunal process should not be used instead of the treating team's own discussions and the ARMC's consideration of the team's proposals. The evidence of that process should be before the Tribunal. The unsupervised contact between the patient's oldest child and the patient was approved last year and had only occurred very recently, so there was more scope for that contact to occur. It would be premature to approve changes today given the seriousness of the offences.

There had been less contact with her other children than with her oldest child so the situation could not yet be assessed. The treating team indicated it had not been made aware of these requests prior to today's hearing. Risk assessment and planning would be required before any extensions of unsupervised contact could occur. Discussions with the children and other stakeholders had not been undertaken, and the recent CFOS report and safety plan should be before the Tribunal before it made this decision.

The patient's legal representative said the Mental Health Court was silent in regard to any contact between the children and their mother. He referred to the treating psychiatrist's statement that the Tribunal had taken a conservative approach in the past. Contact between the patient and her children had been restricted to occurring in the presence of a responsible adult. The treating psychiatrist had also said there was low risk, and the same unique constellation of events in relation to the index offence would be unlikely to recur. It was time for critical reflection on the conditions in regard to cultural kinship connections. He submitted the most appropriate response was to introduce a similar condition for the other children as for the patient's oldest child. The treating team would be providing a complete safety plan and the treating psychiatrist would have overview of approving in advance contact for the other children. He submitted that the condition limiting the patient's oldest child's contact with the patient should be removed up until the time her child turned 18.

Decision:

With respect to the patient's request that the supervision condition for her oldest child be changed so that her child be able to live with her, the Tribunal noted that the patient was unsure if her child wished to do so. The unsupervised overnight leave for the patient's oldest child had been granted, and she had only recently exercised it. The treating team had not had the opportunity of speaking with the patient's oldest child to find out her response to that leave and were not in fact aware it had taken place. The question of the patient's oldest child living with the patient required significant further investigation.

The evidence from the treating psychiatrist and the forensic liaison officer was that they were not aware of the patient's requests, as she had not raised it with them. Consequently, the issues relating to contact with the children had not been discussed within the team or with the ARMC. There was a very recent CFOS report which the forensic liaison officer was yet to review. The Tribunal anticipated that a change may be feasible to the conditions, however, today, important information as to safety planning, and general management of risks, for both the patient, and for the children, was not before the Tribunal. Nor had the treating team gathered that information as yet. The children would need to be consulted and have support towards the goal of improving their relationship with their mother. The Tribunal decided there was insufficient evidence to support a change in the conditions at this time.

Human Rights Considerations:

Submissions:

The Attorney-General's representative submitted the HRA did not change the test to be applied by the Tribunal in balancing the community interests, risk and the rights of the patient, citing the decision of *Nigro v Department of Justice.*

The patient's legal representative referred to the HRA principle in relation to Aboriginal and Torres Strait Islander peoples, and the protection of families, and submitted the Tribunal should not limit that right unless in accordance with s13. He referred to both the patient's cultural ties and her relationship with all her children. Her rights should not be limited unless there was risk, and the response to the risk should be a proportionate response.

He submitted there should be a condition allowing for gradual contact with the other children, and an opening up of unsupervised contact with the patient's oldest child. The condition providing for limitations on unsupervised contact with the patient's oldest child should be removed now, as she will attain her majority soon. Prompted by the Tribunal to consider the requirement in s26 of the HRA that children should be provided with the protection that is in their best interests, he said there was nothing in his submissions contrary to that.

Tribunal's consideration of Human Rights

The Tribunal acknowledges the HRA. In particular, the Tribunal considers that the following human rights are potentially engaged and limited by the decision of the Tribunal: sections 17(c),19,25,26,28. Section 31 is also engaged however the Tribunal is satisfied it is not limited given the patient attended the hearing, received the relevant material according to the statutory timeframes, had legal representation at the hearing, and received the decision of the Tribunal immediately.

The Tribunal is also satisfied that the limitations on the patient's human rights as a result of its' decision are lawful, proportionate to the circumstances and compatible with the HRA. The Tribunal reached this decision because:

- the criteria of the relevant tests under the Act were met and thus the confirmation of the authority was lawful and within the jurisdiction of the Act
- the order, category and conditions have been determined to be the least restrictive way for the patient to receive treatment and care
- the aim of the limitations is to ensure the patient receives appropriate treatment for her diagnosed mental illness, and to ensure the community is protected from the risk of harm. The evidence was that the patient's stability and her ability to spend time in the community are a direct result of her carefully managed treatment and support as provided under the Forensic Order and the conditions, and therefore the limitations achieve their purpose
- the human rights engaged have been balanced against the risk to the community, and to the patient's health and wellbeing that is likely to eventuate if the patient does not receive treatment and care under the order.

In relation to the particular submissions made by the patient's legal representative:

The Tribunal accepts that section 28 (cultural rights for Aboriginal and Torres Strait Islander peoples) and section 26 (protection of families and children, with added protection for children according to their best interests) are relevant to the Tribunal's decision, and the impact of the Tribunal's decision on the patient's Forensic Order and conditions is to limit the rights. The Tribunal is satisfied the limitations are reasonable and justifiable. The limitation requiring a responsible adult to be present and approved by the treating psychiatrist when the patient is with children, or travels to see family, is intended to allow for contact with the patient's family when she wishes, whilst managing any risks and providing protection and support to children. The treating psychiatrist may expand the category of approved persons if that inhibits the occurrence of these visits. The evidence to the Tribunal was that there were practical challenges limiting the visits, outside of the conditions. The conditions achieve their purpose; there have been a number of visits and no concerns have been raised. The condition strikes a balance between the patient's rights, and those of her family to be with her and have opportunities for developing kinship ties and connecting with her culture, whilst also encompassing the requirement in section 26 that decisions about children are made in their best interests.

Accordingly, the Tribunal is satisfied that the limitations are reasonable and demonstrably justified, and that its decision is compatible with human rights in accordance with section 8 of the HRA.

Conclusions of the Tribunal

The Tribunal acknowledges that the patient is making progress in her rehabilitation. As canvassed above, the evidence was unanimous that at this point to maintain the patient's current enjoyment of her life in the community, and to protect the community, the support and monitoring required under the Forensic Order remained necessary. Maintaining the community category is the least restrictive way of the patient receiving the required treatment.

The Forensic Order was confirmed, community category, and conditions of treatment in the community were attached to the order.

Presiding 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.