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 (disability) review
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Registrar:	Attended
Case Manager:	Attended
Attorney-General's Representative:	Attended
Other attendees:	Support worker attended
Decision	
Date of decision:	2021
Decision:	The forensic order is revoked.

The patient was found to be unfit for trial on a permanent basis by the Mental Health Court for charges of stalking, common assault, wilful damage, commit public nuisance and possession of knife in public and placed on a forensic order. This was a periodic review of the forensic order, which had been previously adjourned.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the *Mental Health Act 2016* (**Act**) that are relevant when the Tribunal reviews of a person's forensic order.

Clinical Report

The patient received the clinical report within statutory timeframes and the Tribunal was satisfied that it was explained to him.

Matters to which the Tribunal must have regard

The Tribunal had regard to the factors in section 432 of the Act as follows.

The relevant circumstances of the person subject to the order

In reaching a decision, the Tribunal had regard to the patient's relevant circumstances.

The patient has an intellectual impairment and a diagnosis of schizophrenia. The patient lived with family until approximately ten years ago when his family could no longer give him full-time support. He lives in a Department of Housing unit which he shares with another person. The patient is supported 24 hours by an NDIS provider. The patient told the Tribunal that he gets on with his flatmate and his support workers. He liked to go to the shops and other outings with his support workers. He did his chores around the house, such as mowing and cleaning. Sometimes his flatmate got on his nerves but, then he would talk to his support workers about how he felt. He did not take drugs and cannot recall the last time he had alcohol, but it was some time ago. The patient agreed that the medication helped with his sleep and voices. The patient said he heard the voices a month ago, though he did not hear them now.

The clinical report sets out a history of the patient's care and support. According to the report, the patient was diagnosed with intellectual impairment with psychosis. The patient had described auditory hallucinations and he was commenced on medication. The medication improved his mental state which resulted in better sleep and improved behaviour. The patient was placed on a treatment authority due to lack of capacity to consent to treatment. The patient has limited capacity to complete his activities of daily living on his own, however, he was well supported by support workers in those activities as well as daily cleaning and other daily activities. A positive behaviour support management plan was also in place.

The patient is an Indigenous man. He enjoys attending Indigenous men's group. He has strong connections to Indigenous elders and as role models with prosocial activities. He spends time with his family by mutual agreement. He visited and stayed a week with his family during holidays.

The patient's support worker described to the Tribunal the patient's daily activities and the significant improvement in the patient's behaviour in the last few years. Seven to eight support workers, three of whom were female workers, supported the patient, who also taught him how to act around females. The patient had good rapport with the support workers. The patient attended three group activities a week and got along well with everyone, both female and male. The activities included bowling, cooking classes, fishing group, BBQs and meals out. If there were any issues that distressed the patient, he would talk with his support workers.

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

The Mental Health Court found the patient was of unfit for trial on a permanent basis in respect of charges of stalking, common assault, wilful damage, commit public nuisance and possession of knife in public.

The circumstances of the offences are set out in the dossier. In summary, the patient approached the complainant and struck up a conversation. On several other occasions after that, the patient followed the complainant and would stare at her and approach her, and at one stage, jumped out of the bushes at her.

On one occasion, the patient suddenly became verbally abusive in relation to his carers and stood up and punched two holes in the wall. When his carer asked him to go to his room he punched the carer in the chest and pushed her backwards. On another occasion, the patient behaved in an erratic and violent way and used a large stick to smash windows of an amenities block.

On yet another occasion, the patient had an argument with a neighbour and brandished a knife. The Tribunal considered the offences were serious. However, the length of time passed since the index offences weighed in favour of revoking the forensic order.

Any victim impact statement given to the Tribunal under section 155 or 742 of the Act relating to the relevant unlawful act

Not applicable.

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

Not applicable.

<u>Summary of evidence and findings</u>

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 team recommended revocation of the forensic order. The patient's legal representative submitted that the forensic order ought be revoked because there was overwhelming evidence that the risks had been significantly reduced since the index offence, there had been no further offending, it had been eight years since the forensic order and the patient had significant NDIS support and he would still be the subject of a treatment authority.

The Attorney-General's representative submitted that the forensic order ought be confirmed because a treatment authority was inadequate to protect the community. It was submitted that the patient needed the structure and oversight of a forensic order to mitigate the risks and that there was evidence of poor impulse control without clinical oversight.

The Tribunal accepted the treating team's evidence that the patient had an intellectual impairment of mild mental retardation and also suffered from schizophrenia. The Tribunal therefore finds that the patient had a mental condition as defined in the Act.

The treating psychiatrist confirmed to the Tribunal that the patient's mental state was stable, though

the patient did not understand his psychotic illness or the function of medication and was on a treatment authority as a result. The treating psychiatrist said that the patient's life had greatly improved with the NDIS support package in combination with the positive behaviour support plan.

The treating psychiatrist said the patient's behaviours had settled with no concerning behaviours over the last three years, which was due to the positive behaviour support plan as well as the diligence and consistency of the support workers, which provided a stable environment with pro-social appropriate boundaries. The treating psychiatrist confirmed that there were regular discussions about appropriate behaviours and anger control with the patient by the treating team and his support workers. The treating psychiatrist gave evidence that the patient could spontaneously talk about appropriate behaviours around women.

In response to questions from Attorney-General's representative, the treating psychiatrist confirmed that he was aware that the patient had heard voices in the last month and that the patient had some residual symptoms of schizophrenia from time to time. The treating psychiatrist responded to the Attorney-General's representative's questions about the previous clinical report which indicated a moderate risk, poor impulse control, aggression and recommendation to confirm the forensic order. The treating psychiatrist said this was probably more a case of poor report writing than an accurate reflection. The treating psychiatrist said there was some static risk given the historical issues, but the dynamic risk factors were changed and well mitigated. There were no threats to others or self for many years as the patient was in a very stable environment which mitigated the risk. The treating psychiatrist also said while poor impulse control was a static risk factor, the behaviour support plan had addressed these issues and the patient had learned to control his behaviour and aggression. The treating psychiatrist explained that at the last Assessment and Risk Management Committee (**ARMC**) the treating team were not fully aware of the extensive notes taken by the support workers which showed the patient's consistently good behaviour.

The patient's support worker gave detailed evidence of the patient's daily activities and his significant improvement in his behaviour and stability. The support worker told the Tribunal that approximately three years ago, the patient had 20 to 30 support workers who would bombard him with information and not take account of the patient's delayed processing abilities, which would make him angry. Now, the patient had seven or eight workers only involved, including three women, who regularly modelled appropriate behaviour and taught him how to act appropriately around women. The support workers understood the patient's abilities and his delayed processing abilities and implemented his behaviour support plan. The patient had good Indigenous and other workers providing cultural support and role modelling.

The support worker told the Tribunal that the support workers kept detailed progress notes of the patient's progress, outings and any incidents. The support worker had provided only the last two weeks of progress notes as a sample, but there were volumes of it available if needed. The support worker told the Tribunal that any issues were documented and addressed. He said that the last incident was more than three years ago. The support worker told the Tribunal he had observed the patient using the strategies taught to him for anger management. The support worker staff regularly modelled appropriate behaviour and openly discussed this with the patient. There had been no issues with the patient having a dispute with other support workers or the public since the support worker took over three years ago. The support worker said the patient sometimes did not clean his room when asked but this was OK because it was his room. They had no issues with him at outings or not wanting to leave an activity.

The support worker confirmed that the present staff and structure were stable and likely to continue. Further, all staff knew how to manage the patient and his early warning signs and any new staff are trained. The support worker told the Tribunal that he did not believe that revocation of the forensic order would change any arrangements for the patient. The patient engaged appropriately in groups of males and females and talked to his family frequently. There had been no issues of aggression or inappropriate behaviour in the last three and a half years.

The forensic liaison officer told the Tribunal that the patient was very stable, he had a consistent stable structure, there were no issues with female case managers, the last incident had been many years ago and that the dossier reference to cask wine at his family's home was historical as the patient had not consumed alcohol for many years. The treating team had also obtained more recent collateral from the patient's family which also confirmed that there were no issues and that he had grown up to be a nice young man.

Findings

Having heard from the treating team and the patient's lead support worker and for the following reasons, the Tribunal was satisfied that a forensic order was not necessary to protect the safety of the community from the risk of harm.

The Tribunal considered the patient's stable mental state and stable, structured environment weighed in favour of revoking the forensic order. It was evident that the patient lived in very well supported 24 hour supported accommodation. He had very competent, well trained and supportive and stable support workers. It was evident that the patient had a very good relationship with his support workers and was compliant. The support workers were a particularly strong protective factor for the patient. Further, it was evident that the support workers had played a significant role in improving the patient's behaviour and teaching him appropriate behaviours around women, anger management and impulse control.

The Tribunal was particularly impressed with the evidence provided by the support worker who had close contact and knowledge of the patient's abilities, situation and management. The support worker was a particularly impressive and credible witness. While only two weeks of progress notes was provided to the Tribunal, we accepted the support worker's evidence that the observed and documented evidence of the patient's behaviours showed that there had been no concerning behaviours for more than three years. The Tribunal considered the lack of reoffending or concerning behaviours weighed in favour of revoking the forensic order.

The Tribunal noted that the ARMC minutes discussed the possibility of revoking the forensic order after review of the patient's behavioural journal. After receipt of the behavioural journal, the treating team and forensic liaison officer recommended revocation of the forensic order. The Tribunal accepted the treating psychiatrist's evidence that having now reviewed the behavioural journal that the treating team were satisfied as to that documentary evidence, which confirmed that there were no concerning behaviours for the last three years.

The Tribunal accepted the treating psychiatrist's evidence that there were no concerning behaviours for over three years due to the positive behaviour support plan and the diligence and consistency of support workers who provided a stable environment with pro-social appropriate boundaries. The Tribunal accepted that the treating team and the support workers had taught the patient (and he had learned) appropriate behaviour, particularly around women, and the strategies for anger management and impulse control. This was further evidenced by his improved behaviour and lack of concerning behaviours for a lengthy period. This weighed in favour of revoking the forensic order.

Having heard from the treating team and the support worker the Tribunal was satisfied that a dossier reference to the patient's family mother buying the patient alcohol was historical and that the patient did not drink alcohol. The Tribunal accepted that the patient did not use illicit substances and did not consume alcohol which weighed in favour of revoking the forensic order.

The Tribunal accepted the treating psychiatrist's evidence and explanation regarding the change in recommendation in the previous clinical report. The Tribunal accepted the treating psychiatrist's evidence that while there were static risk factors, the dynamic risks where no longer evident given

the patient's stable, structured environment and improvement in his behaviours. This weighed in favour of revoking the forensic order.

The Tribunal did not accept the Attorney-General's representative's submissions that there was evidence of poor impulse control without clinical oversight or that risks could not be managed without a forensic order.

On the contrary, the overwhelming evidence was that the patient had learned strategies to cope with anger management and impulse control and the effectiveness of this was evidenced by the lack of concerning behaviours for at least the last three years. The treating psychiatrist gave evidence also that the percentage of care given to the patient by the treating team was very low compared to the amount of care provided by the NDIS provider. The Tribunal considered the very competent, stable supported environment in which the patient lived played a significant role in supporting and managing the patient, and the evidence was that this would continue. It was also evident that the patient had a very good relationship with his support workers and was compliant.

The Tribunal noted that the patient was subject to a forensic order (disability) but would continue to remain on a treatment authority given he did not have capacity to consent to treatment for his mental illness. The evidence was his mental state was stable and he was medication compliant. The Tribunal considered management of the patient's mental illness with medication assisted in mitigating risks. However, given his improved behaviour, support networks and compliance the Tribunal did not consider the existence or continuation of a treatment authority was significant, other than providing the legal authority to provide treatment.

The Tribunal accepted that the patient also had strong supportive networks from the support workers as well as Indigenous elders and men's groups and from his family. These were good protective factors, which weighed his in favour.

On the evidence, the Tribunal did not accept that a forensic order was needed to protect the safety of the community.

While the Tribunal accepted that the index offences were serious, the Tribunal also considered that the time that had passed since the index offences weighed in favour of revoking the forensic order.

The Tribunal decided to revoke the forensic order. Given the decision to revoke the order, the Tribunal did not consider the patient's human rights were limited.

Conclusions of the Tribunal

Given the patient's stable mental state, engagement and learnings of appropriate behaviour, the stable, structured, competent support workers and living arrangements, and lack of concerning behaviours the Tribunal was not satisfied that a forensic order was necessary to protect the safety of the community.

For these reasons, the Tribunal has decided the forensic order is revoked.

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).

Below are extracts of sections from the Act relevant to the Tribunal's review of a forensic order.

432 Matters to which Tribunal must have regard

(1) In making a decision under this part in relation to a review of a forensic order (mental health) or forensic order (disability), the Tribunal must have regard to the following:
   (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.

   Examples of decisions in relation to a review of a forensic order:
   - deciding whether to confirm or revoke the order
   - deciding whether to confirm or change the category of the order
   - deciding whether the person is to receive any treatment in the community
   - deciding whether to change or remove a condition to which the order is subject or to impose a condition on the order.

(2) Subsection (1) does not limit any other provision of this part that requires the Tribunal to have regard to a stated matter

433 When reviews are conducted

(1) The Tribunal must review (a periodic review) the forensic order:
   (a) within 6 months after the order is made; and
   (b) at intervals of not more than 6 months after the review under paragraph (a) is completed.
(2) Also, the Tribunal must review (an applicant review) the forensic order on application by:
   (a) the person subject to the order; or
   (b) an interested person for the person mentioned in paragraph (a); or
   (c) the Attorney-General; or
   (d) if an authorised mental health service is responsible for the person—the chief psychiatrist; or
   (e) if the forensic disability service is responsible for the person—the director of forensic disability.
(3) Further, the Tribunal may at any time, on its own initiative, review (a Tribunal review) the forensic order.
(4) If the Tribunal receives written notice under section 213(3) of the amendment of the forensic order, the Tribunal must review (also a Tribunal review) the order within 21 days after receiving the notice.
(5) This section is subject to sections 434 to 437 and chapter 16, part 2, division 6, subdivision 2.

441 Decisions

(1) On a periodic review of the forensic order, the Tribunal must decide to:
   (a) confirm the order; or
   (b) revoke the order.

Notes:

1 See subdivision 2 for the orders the Tribunal may make if it confirms the order.
2 See subdivision 3 for the orders the Tribunal may make if the order is a forensic order (mental health) and the Tribunal revokes the order.

(2) On an applicant review of the forensic order, the Tribunal:
   (a) must decide whether to make the orders sought by the applicant; and
   (b) may make the orders under this division it considers appropriate.

   Example for paragraph (b):

If an applicant seeks an order changing the category of the forensic order from inpatient to community, the Tribunal may decide not to change the category of the order, but may order that the person have limited community treatment of a stated extent.

(3) On a Tribunal review of the forensic order, the Tribunal:
   (a) must decide any particular matter stated in the notice given under section 439(3); and
   (b) may make the orders under this division it considers appropriate.

442 Requirement to confirm forensic order

(1) The Tribunal must 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.

(2) Also, during any non-revocation period for the forensic order, the Tribunal is taken, for section 443, to have confirmed the order.
   Note:
   The Tribunal must not revoke the forensic order during the non-revocation period for the order. See section 452.

(3) Subsection (2) does not apply if the forensic order is a forensic order (mental health) and the Tribunal decides to revoke the order under section 457.

444 Change or confirmation of category

(1) The Tribunal may change the category of the forensic order.

(2) However, the Tribunal may change the category of the forensic order to community, or confirm the category of the order as community, only if the Tribunal is 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.

(3) This section is subject to section 445.

445 Inpatient category – orders about treatment in the community

(1) This section applies if the Tribunal:
   (a) confirms the category of the forensic order as inpatient; or
   (b) changes the category of the forensic order to inpatient.

(2) The Tribunal must do 1 of the following:
   (a) order that the person have no limited community treatment;
   Note:
   An order made under paragraph (a) may not be amended by an authorised Dr. See section 212(2).
   (b) approve that an authorised Dr under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time:
      (i) authorise limited community treatment for the person, to the extent and subject to the conditions decided by the Tribunal; or
      (ii) change the category of the order to community, subject to the conditions decided by the Tribunal;
   (c) order that the person have limited community treatment:
      (i) of a stated extent; and
      (ii) subject to the conditions decided by the Tribunal, including whether, or the extent to which, an authorised Dr under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may amend the forensic order in relation to treatment in the community.

(3) The Tribunal may make an order under subsection (2)(b) or (c) only if the Tribunal is 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.

(4) In deciding whether the Tribunal is satisfied of the matters mentioned in subsection (3), the Tribunal must have regard to:
   (a) the purpose of limited community treatment; and
   (b) the fact that:
      (i) if an authorised mental health service is responsible for the person—an authorised Dr may increase the extent of treatment in the community for the person only if satisfied of the matters mentioned in section 212(3); or

(ii) if the forensic disability service is responsible for the person—a senior practitioner under the Forensic Disability Act may authorise treatment in the community for the person only if satisfied of the matters mentioned in the Forensic Disability Act, section 20(2).

446 Community category – orders about treatment in the community

(1) This section applies if the Tribunal:
   (a) confirms the category of the forensic order as community; or
   (b) changes the category of the forensic order to community.

(2) The Tribunal must:
   (a) order that an authorised Dr or a senior practitioner under the Forensic Disability Act must not change the category of the order to inpatient; or
   (b) approve that an authorised Dr under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time, change the nature or extent of treatment in the community received by the person, to the extent and subject to the conditions decided by the Tribunal.

   Example of a change of extent of treatment in the community:
   changing the category of the forensic order from community to inpatient, with or without limited community treatment

447 Conditions

(1) The Tribunal may:
   (a) change or remove a condition to which the forensic order is subject; or
   (b) impose a condition on the forensic order.

(2) Without limiting subsection (1), the Tribunal may impose a condition that the person must not contact a stated person, including, for example, a victim of the relevant unlawful act.

(3) However, the Tribunal may not impose a condition on the forensic order that requires the person to take a particular medication or a particular dosage of a medication.

450 Making of treatment support order

(1) The Tribunal must decide to make a treatment support order for the person if the Tribunal considers a treatment support order, but not a forensic 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.

(2) For making a treatment support order under subsection (1), sections 144 and 145 apply as if:
   (a) a reference in the sections to the Mental Health Court were a reference to the Tribunal; and
   (b) a reference in the sections to the person the subject of the reference were a reference to the person subject to the forensic order.

451 Making of treatment authority or no further order

(1) If the Tribunal considers that neither a forensic order nor a treatment support 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, the Tribunal may:
   (a) make no further order for the person; or
   (b) make a treatment authority for the person.

(2) The Tribunal may make a treatment authority for the person under subsection (1)(b) only on the recommendation of an authorised psychiatrist who considers, after examining the person, that:
   (a) the treatment criteria apply to the person; and
   (b) there is no less restrictive way for the person to receive treatment and care for the person's mental illness.

(3) The treatment authority must state the following:
   (a) the category of the authority;
   (b) the authorised mental health service responsible for the person;
   (c) the nature and extent of any limited community treatment the person is to receive;
   (d) any conditions the Tribunal considers necessary for the person's treatment and care, other than a condition requiring the person to take a particular medication or a particular dosage of a medication.

(4) The Tribunal may decide the category of the treatment authority is inpatient only if the Tribunal is satisfied that 1 or more of the following can not reasonably be met if the category of the authority is community:
  (a) the person's treatment and care needs;
  (b) the safety and welfare of the person;
  (c) the safety of others.
(5) However, if the person is a classified patient, the Tribunal must decide the category of the authority is inpatient.
(6) In deciding the nature and extent of any limited community treatment under subsection (3)(c), the Tribunal must have regard to the purpose of limited community treatment.
(7) If the Tribunal decides the category of the treatment authority is community, the Tribunal must decide whether an authorised Dr may, at a future time, reduce the extent of treatment in the community received by the person.
(8) The treatment authority is taken to be a treatment authority made under section 49 by the authorised psychiatrist mentioned in subsection (2).
(9) Despite subsection (8) and section 413(1), the Tribunal must review the treatment authority:
  (a) within 6 months after the authority is made; and
  (b) within 6 months after the review under paragraph (a) is completed; and
  (c) at intervals of not more than 12 months after the review under paragraph (b) is completed.
(10) Sections 53 and 59 apply to the treatment authority as if a reference in the sections to the authorised Dr were a reference to the authorised psychiatrist mentioned in subsection (2).
(11) As soon as practicable after the treatment authority is made, the authorised psychiatrist mentioned in subsection (2) must decide the nature and extent of the treatment and care to be provided to the person under the authority.

452 Orders with non-revocation period

(1) The Tribunal must not revoke a forensic order under division 4 during any non-revocation period for the order.
(2) Subsection (1) is subject to section 457.

453 Order for person temporarily unfit for trial

(1) This section applies to a person subject to a forensic order if:
  (a) a finding of unfitness has been made in relation to the person; and
  (b) the proceeding against the person in relation to which the finding of unfitness was made has not been discontinued under section 490 or 491.
(2) The Tribunal must not revoke the forensic order unless a treatment support order is made for the person under section 450.
  Note:
  If, on a review under part 6, the Tribunal decides the person is fit for trial, the forensic order ends on the person's appearance at the mention of the proceeding for the relevant offence. See section 497(2).

454 Order for person charged with prescribed offence

(1) This section applies if a forensic order for a person was made on a reference in relation to a prescribed offence allegedly committed by the person.
(2) The Tribunal must not revoke the forensic order unless:
  (a) the person has been examined, under an order made under section 721, by an examining practitioner; and
  (b) the Tribunal has obtained and considered the examining practitioner's written report on the examination.
(3) This section is subject to section 452.