Statement of Reasons

Matter:	Treatment Support Order Review
Attendees	
Patient:	Attended
Nominated Support Person:	Attended
Psychiatrist:	Attended
Case Manager:	Attended
Decision:	The Treatment Support Order is Confirmed. The Category of the Treatment Support Order is Community. The Conditions of the Treatment Support Order are attached An authorised doctor may amend the person's Treatment Support Order to reduce the extent of treatment in the community received by the patient.

The patient is a young man with an established diagnosis of Schizoaffective Disorder. The patient was recently placed on a Treatment Support Order following the Mental Health Court finding that he was of unsound mind when he committed the index offence to which this order pertains. The patient is currently managed in the community.

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 a person's treatment support order.

Clinical Report

The patient received the clinical report and was present at the hearing and confirmed he had received and read the report.

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.

- ***mental state and psychiatric history***

The clinical report stated that the patient has a diagnosis of Schizoaffective Disorder characterized by affective-psychosis symptomatology. He first presented to Child and Youth Mental Health Services at the age of 16 when he was treated for First Episode Psychosis. The diagnosis was subsequently changed to Bipolar Affective Disorder and then to Schizoaffective Disorder given his ongoing symptoms and limited response to treatment.

The patient has had several admissions to hospital with break through symptoms including manic and acute psychosis, agitation, restricted affect, mild thought blocking and reduced functioning.
In oral evidence the Treating Team reported that there was no evidence that the patient was using alcohol or illicit substances.

At the hearing the patient expressed his understanding of his mental illness as Schizoaffective disorder, Bipolar Affective Disorder and Schizophrenia, with a lot of high highs and overactive thinking that causes psychosis.

The treating psychiatrist attended the hearing and reported that the patient continued to experience residual negative symptoms of Schizophrenia. He reported the patient requires significant support to maintain adherence to his medication and is currently treated with a combination of anti-psychotic medications and mood stabilizers.

The Clinical Report states that the patient's vulnerabilities and future risks are likely to increase, including an increased risk of sexual violence, if he disengages from treatment or is non-adherent to his prescribed medication.

The Tribunal accepted the patient's psychiatric history, including the increased risks with treatment non-compliance and his propensity for sexual violence when unwell.

- **social circumstances, family and social support**

The patient was admitted to the Community Care Unit (CCU) and at the time of the hearing continued to reside in the unit receiving treatment, rehabilitation and support.

In oral evidence the treating team confirmed that the discharge process is continuing, with the possibility that the patient would be discharged into accommodation in the community within the next six months if suitable accommodation can be found.

The Clinical Report states that the patient is well supported by his father and has regular contact with members of his family. He currently benefits from a high level of supervision and support and he engages well in the rehabilitation program in the CCU, regularly attending morning meetings and group activities. While he is able to attend to his activities of daily living (ADLS) the clinical report confirms that he requires additional support and life skills to successfully transition to independent community living. The treating psychiatrist confirmed in his oral evidence that the patient participates well in social activities at the CCU and that he functions at an acceptable level.

At the hearing, the patient reported that he plays sport on the week-ends, enjoys gaming with friends and has a NDIS package with support workers who take him to exercise physiology, church, shopping, and on social outings 3 times a week. He is keen to get a driving license and gain some work experience and is undertaking a course in computer programming. The patient confirmed his interest in finding work as a manual labourer, packing shelves, or in government. In his oral evidence, the case manager reported that the patient aspires to find employment.

The patient stated that he visits his father's house 2-3 times per week and spends time with his siblings and that the victim of the index offence lives elsewhere.

- ***response to treatment and care and the person's willingness to receive appropriate treatment and care***

The patient has been managed in the community and inpatient settings in various contexts since his initial contact with mental health services. The written evidence reports a failure to achieve a significant response to treatment with ongoing profound negative symptoms of his mental illness impacting on the patient's insight and judgement.

The clinical report states that the patient has a history of non-compliance with prescribed antipsychotics. He is responsible for initiating his own medication while in the CCU and is required to notify the treating team when he has taken his medication. At the hearing, the patient stated that the medication helps with his mania, but that he would like to come off Sertraline in the future and to stay on the Lithium and Abilify. He thinks he will have to be on medication for about 10 years and was able to identify some early warning signs which would indicate he is becoming unwell.

The patient acknowledged that he sometimes forgets to take his medication, and that when he tried to come off the medication in the past that he had suffered a relapse. At the hearing, the treating psychiatrist confirmed that need for ongoing monitoring of the patient's compliance with treatment. The clinical report states that the patient's vulnerabilities and future risks are likely to increase if he disengages from treatment or is non-adherent to his prescribed medication.

The patient provided evidence at the hearing that he would like the non-contact condition to be changed as it affects him 'because of the stigma'. The patient's father also expressed his concerns

about the stigma and having to tell people that his son cannot be around children and that 'it has been a long time'.

In his oral evidence the treating psychiatrist reported on the importance of working closely with the patient, his family and his support workers for a slow transition back into the community to assess what he can tolerate, to ensure he remains compliant and to monitor access to the victim of the index offence. Written evidence in the clinical report states that risk would increase significantly with an increased risk of sexual violence in the context of a deteriorating mental state.

The Tribunal carefully considered the patient's history of non-compliance with medication and his view about coming off medication and that he sometimes forgets to take his medication. The Tribunal formed the view that the patient's understanding of his mental illness and the risks associated with non-adherence were not fully formed, and his willingness to receive appropriate treatment and care is reliant on the protective structure and support of the CCU.

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

The patient was charged with Indecent Treatment of Children Under 16, Child under 12 years.

The clinical report and the ARMC minutes recommended that the treatment support order be confirmed. In their oral evidence, the treating team recommended no change to the current conditions and restrictions of the order which would enable discretion to progressively transition the patient out of the CCU with the support of the community team and NDIS workers. The treating psychiatrist stated in his oral evidence that the patient required a slow transition out of the CCU into the community and the need to monitor his mental state and ensure compliance with medication.

Based on the evidence, the Tribunal concluded that while the patient's participation in rehabilitation was progressing, that the treatment support order provided him with the protection he needs to continue his recovery in the safe and secure environment of the CCU. The patient continues to experience negative symptoms of his mental illness and his oral evidence demonstrated partial insight in his mental illness, the early warning signs, and the consequences of ceasing medication. Historically, the patient has been non-compliant with treatment and has suffered a deterioration of his mental state and impaired judgement which led to the index offence. The index offence was serious in nature and involved significant and ongoing trauma for the victim.

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

There is no victim impact statement before the Tribunal.

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

Is the treatment support 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?

In relation to the matters to which the Tribunal must have regard, the Tribunal was unable to establish where victim was residing or the level and nature of contact between the patient and the victim. The clinical report states that victim lives with the family and that the patient visits the household

frequently on leave and continues to interact with the family. In his oral evidence the patient reported that he visits his father's house 2-3 times a week but that the victim lives elsewhere. The patient's father reported that there is some contact between the patient and the victim, but that it is infrequent. He later stated that the victim 'comes home occasionally' but only when the patient is not there.

The patient and his father stated in their oral evidence that they would like the non-contact condition to be changed because of the associated stigma. The ARMC minutes confirm that the patient's father questions the need for supervised contact between the patient and the victim. The patient's father reported that the victim is also experiencing some stigma from the offence, but that it had only been a few years and she may want to see the patient again 'sometime in the future'

The clinical report states that the Community Forensic Service (CFOS) had accepted a referral for a sexual violence risk assessment, noting that the patient is extremely sensitive about his index offence and may have difficulty coping with the interview. Oral evidence provided by the treating team confirmed that a referral for counselling or therapeutic interventions related to the index offence had not yet occurred as "they did not feel the patient was ready". In his oral evidence, the patient's case manager also reported that COVID had limited access to the specialist skills required to assess risk and explore the impact of the offence on the victim with the patient.

The clinical report states that the risk relating to his index offence needs to continue to be proactively managed. While the patient currently resides in an accommodation facility, is participating well in activities, and has the support of family and NDIS support workers, he continues to require additional support and life skills to successfully transition to independent community living. At the hearing the treating psychiatrist cautioned the need for a slow and careful transition back into the community and the need to monitor treatment compliance and access to the victim.

The patient and his father raised the issue of the impact of stigma and questioned the need for the non-contact condition. The treating team expressed reluctance to explore the therapeutic interventions recommended by CFOS owing to the patient's sensitivity to the issue, his lack of readiness to engage and the specialist skills that would be required to assess risk and provide counselling.

The Tribunal found the evidence with respect to the ongoing risk and safety to the community persuasive. The patient suffers from a mental condition and has ongoing residual symptoms, he has a history of noncompliance with medication and continues to require prompting to take his medication, and there is a history of him becoming unwell if untreated. When the patient is unwell his risks are likely to increase, including the risk of increased sexual violence when he is non adherent to prescribed medication. At the time of the index offence, the patient was suffering a psychotic relapse against a background of 4-6 weeks of medication non-compliance which impaired his judgement.

Despite the ongoing trauma experienced by the victim through evidence that she is still unable to see or talk to the patient, the patient is seeking a removal of the non-contact condition. The Tribunal was of the view that the patient had a very poor understanding of the experience and the impact of the index offence on the victim, and that he did not demonstrate insight into the risks of medication non-compliance on future offending. The treating team and the ARMC state that the risk relating to the index offence needs to continue to be managed and CFOS recommendation for assessment of the risk of sexual violence and therapeutic interventions have not yet been enacted.

As a result of this evidence, the Tribunal considered the treatment support order, community category continued to be the most appropriate way to provide the patient with treatment and care for his mental

illness and to protect the community and mitigate the risks associated with a deterioration in his mental state in the community.

The Tribunal therefore confirmed that treatment support order (community category), and determined that an authorised doctor may amend the treatment support order to reduce the extent of treatment in the community received by The patient.

Category and conditions of the treatment support order

The Tribunal heard that the treating team and the ARMC recommended no change to community category of the Treatment Support Order or the four current conditions and restrictions of the order. In his oral evidence, the treating psychiatrist stated that the conditions of the order continued to be appropriate and necessary.

The patient continues to require the rehabilitation and support services of the CCU (Condition 1), with for a slow and careful transition back into independent community living likely in the next 6 months.

While the patient was reported to be compliant with follow up appointments, and engaged well in CCU programs and activities, there had been some issues with his medication compliance (Condition 2). The patient confirmed that sometimes he forgets to take his medication and acknowledged that when he tried to come off the medication in the past that he had suffered a relapse.

In both the written and oral evidence, the treating team confirmed that the patient was not driving a motor vehicle (Condition 3) but had expressed interest in getting a license. The patient stated that he would like to get back to driving but didn't pass his practical test and cannot drive at the moment due to the medication.

Under the current conditions the patient must not have unsupervised contact with children under the age of 16 unless approved in writing by the treating psychiatrist (Condition 4). The Tribunal heard inconsistent evidence with respect the level of contact that the patient has with the victim, though the evidence suggests it is likely that some contact is continuing to occur. The treating psychiatrist gave evidence at the hearing that maintaining the condition of non-contact is a matter of safety and cautioned the need to monitor treatment compliance and contact with the victim. The treating psychiatrist. stated that he was waiting on the outcome of the Violence Risk Assessment and Management Framework (VRAM) and CFOS input into the conditions, particularly the condition of no unsupervised contact with children.

The Tribunal considered the evidence of the treating psychiatrist and the case manager, and the patient's view of on the non-contact order, and the reports of the ongoing impact on the victim. On balance the Tribunal accept the specialist medical opinion that the four conditions remain unchanged.

CONDITIONS

1. That the patient reside at the Community Care Unit.
2. That the patient comply with all appointments for follow up and prescribed treatment, including the taking of prescribed medication and undergo random tests for those medications, as required by the treating psychiatrist.
3. That the patient may drive a motor vehicle if permitted to do so by the treating psychiatrist.

4. That the patient must not have unsupervised contact with children under the age of 16 unless approved in writing by the treating psychiatrist

The Tribunal held the view that risk management and mitigation would continue to be facilitated by maintaining the same level of clinical oversight of the patient in addition to keeping the same conditions currently attached to the Treatment Support Order and that the risk relating to the index offence would need to continue be managed.

Human Rights

The Tribunal acknowledges the Human Rights Act 2019. In particular, the Tribunal considers that the following human rights under that Act are potentially engaged and limited by the Tribunal decision:

- Section 15 Recognition and equality before the law
- Section 17(c) Medical treatment without consent
- Section 19 Freedom of movement
- Section 25 Privacy and reputation
- Section 31 Fair Hearing

The Tribunal was satisfied that the patient's right under section 31 was not limited given he had received the relevant material according to the statutory timeframes, and attended the hearing to express his views, wishes and preferences.

The Tribunal accepted that the patient is receiving medical treatment given without his consent limiting his rights under sections 17(c), 15, 19 and 25. Notably, the patient presents a risk of non-compliance and relapse due to the lack of fully formed insight into the benefits of treatment and is required to receive treatment for his mental illness and to manage risk, though is currently treated in the least restrictive manner in the community. Confidential health information in the documentation before the Tribunal was shared, but the patient was present at the hearing and his privacy protected by the confidential nature of the hearing.

The Tribunal is satisfied that these limitations are lawful, proportionate to the circumstances and compatible with the Human Rights Act. The Tribunal reached this decision because of the risk associated with a deterioration in the patient's mental state secondary to not having his mental illness adequately treated. The Tribunal therefore considered that the patient's history and the risks of further deterioration necessitate the provision of ongoing treatment without his full consent.

Conclusions of the Tribunal

The Tribunal accepts that the patient is well supported by the treating team, the community care unit rehabilitation program, and his NDIS support workers and family. The Tribunal accepts that the patient is engaging well in CCU activities and programs, cooperating with the treating team and functioning at an adequate level.

However, on balance, the Tribunal was satisfied that the patient demonstrates limited insight into the impact of his actions on the victim of the index offence and accepted the opinion of the treating team that the patient continues to suffer residual symptoms, has a history of treatment noncompliance and relapses, and when unwell and poses a risk to the safety of the community, including the risk of increased sexual violence.

The Tribunal is satisfied that the patient's treatment and care needs are currently being well managed under the treatment support order and that risk management and mitigation would continue to be facilitated by maintaining the same level of clinical oversight and that the conditions currently attached to the order are necessary and appropriate.

For these reasons, the Tribunal decided to the confirm the treatment support order (community category), and subject to the same conditions as were previously attached to the order. An authorised doctor may amend the person's treatment support order to reduce the extent of treatment in the community received by the patient,

Member

APPENDIX A

Statement of the law regarding Treatment Support 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).

464 Matters to which tribunal must have regard

(1) In making a decision under this part in relation to a review of a treatment support order, 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 order was made because a forensic order (mental health) for the person was revoked and the Mental Health Court made a recommendation in the forensic order about an intervention program for the person — the person's willingness to participate in the program if offered to the person.

   Note:
   See section 450 for when the tribunal, on deciding to revoke a forensic order (mental health) for a person, may make a treatment support order for the person.
   Examples of decisions in relation to a review of a treatment support 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.

465 When reviews are conducted

(1) The tribunal must review (a periodic review) a treatment support 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) a treatment support 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 chief psychiatrist.

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

(4) If the tribunal receives written notice under section 217(3) of the amendment of a treatment support order, the tribunal must review (also a tribunal review) the order within 14 days after receiving the notice.

(5) This section is subject to sections 466 to 469 and chapter 16, part 2, division 6, subdivision 2.

472 Decisions

(1) On a periodic review of a treatment support 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 it revokes the order.

(2) On an applicant review of a treatment support 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.

(3) On a tribunal review of a treatment support order, the tribunal:
   (a) must decide any particular matter stated in the notice given under section 471(3); and
   (b) may make the orders under this division it considers appropriate.

473 Requirement to confirm treatment support order

(1) On a review of a treatment support order, the tribunal must confirm the 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, the tribunal must confirm the treatment support order if:
   (a) a finding of unfitness has been made in relation to the person; and
   (b) the person has not been found fit for trial on a review of the person's fitness for trial under chapter 12, part 6; and
   (c) the proceeding for the relevant offence has not been discontinued under section 490 or 491.

475 Change of category to community

If the category of the treatment support order is inpatient, the tribunal must change the category of the order to community unless the tribunal considers that 1 or more of the following can not reasonably be met if the category of the order is community:
   (a) the person's treatment and care needs;
   (b) the safety and welfare of the person;
   (c) the safety of others.

476 Community category – deciding whether authorised doctor may reduce treatment in community

(1) This section applies if:
   (a) the category of the treatment support order is community; or
   (b) the tribunal changes the category of the treatment support order to community under section 475.

(2) The tribunal must decide whether an authorised doctor may, under section 216(1), amend the person's treatment support order to reduce the extent of treatment in the community received by the person.

477 Inpatient category – limited community treatment

(1) This section applies if the category of the treatment support order is inpatient.

(2) The tribunal may approve limited community treatment, or an extension of limited community treatment, for the person.

(3) In deciding whether to approve or extend limited community treatment under subsection (2), the tribunal must have regard to the purpose of limited community treatment.

(4) If the tribunal approves or extends limited community treatment under subsection (2), the tribunal must also decide whether an authorised doctor may, under section 216(1), amend the person's treatment support order to reduce the extent of treatment in the community received by the person.

478 Conditions

(1) The tribunal may:
   (a) change or remove a condition to which the treatment support order is subject; or
   (b) impose a condition on the treatment support 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 treatment support order that requires the person to take a particular medication or a particular dosage of a medication.

480 Change of category to inpatient

(1) This section applies if the category of the treatment support order is community.

(2) The tribunal may change the category of the order to inpatient, but only if the tribunal considers it is reasonably necessary for an authorised doctor to examine the person in order to review the person's treatment and care needs.
   Note:
   Under section 216, the authorised doctor who examines the person may change the nature or extent of the person's treatment in the community.

(3) If the tribunal changes the category of the treatment support order under this section to inpatient, the tribunal may authorise an authorised person to transport the person to an inpatient unit of a stated authorised mental health service.

(4) For subsection (3), an authorised person may transport the person to an inpatient unit of the stated authorised mental health service.
Note:
For the powers of an authorised person when detaining and transporting a person, see chapter 11, part 6, division 5.

483 Making of treatment authority or no further order

(1) 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) 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.

(6) If the tribunal decides the category of the treatment authority is community, the tribunal must decide whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.

(7) The treatment authority is taken to be a treatment authority made under section 49 by the authorised psychiatrist mentioned in subsection (2).

(8) Despite subsection (7) 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.

(9) Sections 53 and 59 apply to the treatment authority as if a reference in the sections to the authorised doctor were a reference to the authorised psychiatrist mentioned in subsection (2).

(10) 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.