Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to the section 756 of the *Mental Health Act 2016*. The patient and person 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:	Treatment Support Order Review
Attendees	
Patient:	Attended
Support person:	Attended
Psychiatrist	Attended
Case Manager:	Attended
Decision	
Decision:	The Treatment Support Order is confirmed - community category with attached conditions
Treatment Support Order	
Category prior to this review:	Community
Documents before the Tribunal at hearing:	Clinical report Dossier Written submissions from the patient

The patient is a 37-year-old man who was made subject to a forensic order by the Mental Health Court on around 10 years ago in respect of a charge of assault occasioning bodily harm. The Tribunal revoked the forensic order about one year ago and made a treatment support order. This was a periodic review of the treatment support order. The patient confirmed he had received a copy of the clinical report within statutory timeframes. He also provided undated submissions to the Tribunal, which were considered.

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.

Matters to which the Tribunal must have regard

The Tribunal had regard to the factors in section 464 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 was a 37-year-old man who lived independently. He self-managed his National Disability Insurance Scheme (NDIS) package and supports and finances. He had limited social contact, other than online friends and sporadic involvement with his family.

In his written submission the patient described his hallucinations. In another submission he stated his delusions.

At the hearing, the patient presented and represented himself well. He told the Tribunal that he had been medicated his whole life, the treatment support order was necessary, but he believed he was mature enough to contribute to society. He did not dispute the contents of the clinical report, but he did not like the medication.

According to the clinical report, the patient first presented to mental health services early this century, with multiple admissions since then, often in the context of medication non-adherence or drug use. He had a diagnosis of schizoaffective disorder, with various symptoms. Between 2004 and 2013 he had more than 10 admissions. He also had lengthy admissions in 2013/14 and 2016 and brief admissions in 2021 and 2022.

According to the report there was a history of non-compliance with treatment. However, more recently, the patient engaged willingly with the treating team, and attended all appointments without prompting. At the hearing, the treating team confirmed that the patient's mental state had been relatively settled and he continued to self-manage his NDIS plan, finances and GP appointments. However, even with a depot, the patient continued to experience residual symptoms. The patient also sought assistance from the treating team when his symptoms increased or distressed him.

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

The patient was charged with assault occasioning bodily harm. The circumstances of the offence were considered. While the index offence occurred some time ago, it was a serious offence, resulting in harm to the victim.

Summary of evidence and findings

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?

At the hearing the patient told the Tribunal that he had been medicated his whole life, the treatment support order was necessary, but he believed he was mature enough to contribute to society. However, he did not like the depot medication.

According to the clinical report and at the hearing, the doctor recommended continuation of the treatment support order. He told the Tribunal that the Assessment and Risk Management Committee (**ARMC**) also recommended continuation of the treatment support order. This was because the patient had only recently been stepped down to a treatment support order and needed a longer period of stability of his mental state. The doctor noted that while the patient was doing well, he continued to experience regular exacerbation of his symptoms, which waxed and waned. The doctor acknowledged that the patient disagreed with treatment. However, was of the view that it was the best treatment for his patient, as the patient was not able to tolerate other medication due to side effects.

The doctor confirmed that the patient was no longer using substances, was a very religious man and had come a long way in ten years.

The case manager said the treating team had recently sent a letter to National Disability Insurance Agency (**NDIA**) requesting an increase in support hours for the patient. The patient was yet to see an occupational therapist for a functional assessment as funding had not been resolved. The treating team supported an increase in support hours for the patient to assist him particularly when his symptoms increased and became distressing.

Findings

The patient understood he had an illness and described some of his symptoms in his submissions. Based on the clinical history and professional opinion of the doctor, the Tribunal accepted that the patient suffered from schizoaffective disorder. The Tribunal found that the patient had a mental illness as defined by s10 of the Act.

The Tribunal accepted that the patient's mental state had been more settled with less frequent admissions. The Tribunal accepted that there were no illicit substance concerns, and that the offence was some time ago and that the patient engaged well with the treating team and was help seeking when his symptoms increased or distressed him. These factors weighed in the patient's favour.

However, the Tribunal accepted that the patient continued to have residual psychotic symptoms which required increased support and assistance from the treating team. Both the patient and the treating team wanted the patient's NDIS support hours increased to assist him, particularly at these times also. However, this had not yet been obtained.

Given the patient's other limited supports, the Tribunal accepted that an increase in NDIS supports was required to better assist him to manage residual symptoms and to mitigate risk to the community.

Further, while compliant and well engaged with the treating team, it was evident that the patient had some resistance to his current medication, despite the doctor's view that it was the best medication for him. The Tribunal was not satisfied that without the order patient would be compliant with current treatment.

According to the report, the patient had a history of mental illness with persecutory delusional themes. He had a history of aggression and violence and medication non-adherence.

Further, the forensic order had only recently been revoked and a treatment support order made. The Tribunal agreed and accepted the treating team's evidence that a further period of mental state stability with reduced oversight was needed before consideration of revocation of the order.

The Tribunal considered the patient's illness, including his significant residual symptoms, the need for extra assistance from time to time, and the lack of other supports weighed in favour of confirmation of the treatment support order.

The Tribunal considered the risks were being managed due to the support, monitoring and oversight by the treating team. However, without such clinical oversight and support, the Tribunal considered the risk of significant relapse and consequent harm to the community increased.

The Tribunal also accepted the ARMC and treating team's evidence that the treatment support order was necessary to manage risks at this time.

The Tribunal found the treatment support order was necessary to manage the risks to the community. The Tribunal considered the treatment support order was the least restrictive order which will provide support by the treating team, ensuring the safety of the community through regular contact and monitoring.

Given the severity of the patient's illness, limited supports and the risks he posed when unwell, the Tribunal found a treatment support order was necessary to protect the safety of the community from risk of serious harm.

The Tribunal decided that an authorised doctor may amend the treatment support order to reduce the extent of treatment in the community.

Category and conditions of the treatment support order

The Tribunal found the treatment support order could remain as community category because the patient's treatment and care and the safety and welfare of others could be managed with continued monitoring and supervision by the treating team and with the attached conditions.

The Tribunal considered the accommodation and treatment conditions were necessary to mitigate the risk by ensuring engagement with the treating team, monitoring of his mental state, and to reduce the risk of relapse and consequent harm to others.

The Tribunal considered this was the least restrictive way to protect the safety of the community.

Human Rights

For reasons discussed, the Tribunal found the treatment support order and attached conditions were necessary to protect the safety of the community. In making its decision and the conditions, the Tribunal considered the *Human Rights Act 2019* (**HRA**).

The Tribunal considered those human rights potentially engaged and limited by the Tribunal's decision were sections 17(c), 19 and 31. The Tribunal considered s17(c) of the HRA and accepted that it was limited because the patient may not have capacity to consent to treatment and was being treated for a mental illness. The Tribunal accepted that the patient's freedom of movement (s19) was restricted because condition 1 required that he reside in a place approved by the treating psychiatrist.

Taking into account the following, the Tribunal is satisfied that the limits imposed by the Tribunal's decision are reasonable and justified in accordance with section 13 of the HRA because:

- the criteria of the relevant test for treatment support orders under the Act were met. Given the mental illness and need for treatment, and the risks to others when not treated and unwell, the Tribunal considered requiring treatment, including monitoring by the treating team was reasonable and justified to ensure continued treatment and monitoring of the mental illness and to manage the risks to others. The treatment support order and conditions allowed the treating team to monitor the patient's mental state to avoid the risk of relapse and consequent harm to others. Thus, the confirmation of the order was lawful and within the jurisdiction of the Act
- the order has been determined to be the least restrictive way for the person to receive treatment and care and to avoid risks of harm to others
- the human rights engaged have been balanced against the risk of deterioration of the patient's mental health that is likely to eventuate if he does not receive treatment and care under the order and the risks to the safety of others if not treated, contactable, supported and monitored and supervised
- the Tribunal considered the risks to others outweighed any restrictions on the patient receiving treatment for his mental illness, and freedom of movement.

The Tribunal did not consider the right to a fair hearing (s31) was limited as the patient was present at the hearing and able to speak on his own behalf. The patient had been provided with relevant documentation and the Tribunal was legally constituted. While s31(3) may have been limited because the decision was not publicly available, the Tribunal considered such limitation was reasonable and justified because it was lawful pursuant to the Act and the patient's privacy outweighed publication of an identified decision.

Accordingly, the Tribunal was satisfied the decision, including conditions, was compatible with human rights (s8).

Conclusions of the Tribunal

The Tribunal found that the treatment support order was necessary, because of the patient's mental condition, to protect the safety of the community from risk of serious harm. For these reasons, the Tribunal decided to confirm the treatment support order, community category with the attached conditions. An authorised doctor may amend the treatment support order to reduce the extent of treatment in the community.

Presiding 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 O'Gormange 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 O'Gormange 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.