MENTAL HEALTH COURT

CITATION:	*Attorney-General for the State of Queensland v* [redacted] [redacted] QMHC 4
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (appellant) **v** [redacted] (respondent)
FILE NO/S:	MHC No. [redacted]
PROCEEDING:	Appeal
DELIVERED ON:	[redacted]
DELIVERED AT:	[redacted]
HEARING DATE:	[redacted]
JUDGE:	[redacted]
ASSISTING PSYCHIATRISTS	[redacted] [redacted]
ORDER:	**Reasons for the decision made on [redacted] <u>allowing</u> the appeal by the AG against the decision of the MHRT (stepping down the respondent's FO to a TSO) and, in effect, re-instating the FO.**
CATCHWORDS:	HEALTH LAW – MENTAL HEALTH GENERALLY – GENERAL LAW AFFECTING PERSONS WITH MENTAL ILLNESS OR IMPAIRED CAPACITY – where the Mental Health Review Tribunal (MHRT) revoked the respondent's forensic order and replaced it with a treatment support order – where the respondent's treating team did not request the 'step down' – where the respondent had not recently been assessed by a psychiatrist prior to the MHRT decision – where the respondent's risk has increased since the step down – whether the forensic order should be reinstated *Mental Health Act* 2016 (Qld), s 442(1), s 450(1)
COUNSEL:	[redacted] for the appellant [redacted] for the Chief Psychiatrist [redacted] (self-represented) for the respondent
SOLICITORS:	The Attorney-General for the State of Queensland for the appellant The Office of the Chief Psychiatrist for the Chief Psychiatrist

Overview

[1] The Attorney-General appealed against the decision of the Mental Health Review Tribunal (MHRT), made on [redacted], to revoke the respondent's forensic order (FO) and to "step it down to" (or replace it with) a treatment support order (TSO) on the same conditions as those contained in the forensic order.

[2] The Attorney-General's appeal was not filed until [redacted] – almost the last day of the appeal period.

[3] The decision of the MHRT was not stayed in advance of the hearing of the appeal. The Attorney-General's application for a stay was refused because *inter alia* her appeal was brought so late in the piece, bearing in mind that her representative appeared at the MHRT hearing in early [redacted].[1]

[4] The respondent is now aged [redacted]. He has a diagnosis of Bipolar Affective Disorder. At the time of the MHRT hearing, he had been on a forensic order for about [redacted].

[5] I heard the appeal on [redacted]. The respondent was self-represented at the appeal although his mother was present to provide him with support.

[6] After considering the evidence, including oral testimony from the respondent's treating psychiatrist, the submissions, and the advice, I allowed the appeal; set aside the decision of the MHRT and reimposed the FO on the same conditions. Whatever might have seemed to be the case at the MHRT hearing when it came to the respondent's mental health stability and the impact of his drug use upon his risk, not long after the stay application was refused, the respondent increased his drug use and suffered a manic episode, thus increasing his risk and warranting the re-imposition of the FO.

[7] My detailed reasons for allowing the appeal follow. My reasons assume knowledge of the operation of the FO review process; the step-down process; and the role of the ARMC and CFOS in risk management.

Reasons

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1 The Attorney-General very properly acknowledged that her delay in bringing the appeal and the fact that it would be heard before the MHRT met to review the TSO told against her application for a stay.

[8] As is well known, an appeal to the Mental Health Court from a decision of the MHRT is by way of rehearing. That is understood in this Court as a rehearing of the matter decided by the Tribunal on the basis of the evidence and other material which was before the Tribunal, and on any other evidence or material placed before this Court on the appeal. It is not necessary for an appellant to show error on the part of the Tribunal to succeed in an appeal – although an absence of error may well tell against the success of an appeal. However, the approach to appeals taken by this Court in this context recognises that mental state and matters relevant to it may change between the decision of the MHRT and the hearing of the appeal from such a decision – as has occurred in the present case.

[9] In re-hearing a matter, this Court asks itself the same question the Tribunal asked. In this case: the relevant question was whether the MHRT ought to confirm or revoke the respondent's FO, and if it decided to revoke it, whether to make a TSO for the respondent instead.

[10] In deciding whether to revoke the FO, the MHRT was required to apply section 442 of the *Mental Health Act* 2016 (MHA), which states in paragraph (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 the other persons or property.

[11] In deciding whether to make a TSO upon the revocation of a FO, the MHRT was required to apply section 450 (MHA), which states in subsection (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.

[12] Obviously, the focus of both decisions is upon the protection of the community from the risk of harm posed by the person, because of their mental condition – in the case of the respondent, his mental illness of Bipolar Affective Disorder.

Material before the MHRT and its decision

[13] In making the decision it made, the MHRT had before it a clinical report dated [redacted]; minutes of a meeting of the ARMC held on [redacted] and a collection of documents known as a dossier. For the purposes of these reasons, I will focus on the most contemporary evidence before the MHRT, namely the clinical report and the minutes, rather than the content of the dossier.

[14] The [redacted] clinical report, by [redacted], the respondent's treating doctor, listed the respondent's risk factors and protective factors. It noted the respondent's ongoing drug use, including methylamphetamine use.

[15] Under the alternative headings "Confirm Forensic Order" and "Revoke Forensic Order", [redacted] wrote (emphasis in original):

> Confirm Forensic Order
>
> **[redacted] has presented with a consistent engagement with the treating team and his risk overall remains stable at baseline in the context of:**
>
> **Forensic Order:**
>
> - [redacted] has reported ongoing amphetamine use; previously [redacted] has stated, *"he would not continue treatment if not on an order".* With the FO, [redacted] will most likely disengage from treatment with increased risk of relapse of psychotic illness thereby increasing risk of harm to himself and others. The FO remains a major part of his treatment and risk mitigation strategy.
> - [redacted] could be stepped down and managed on TSO; however, he is unable to demonstrate continued insight on the need for treatment and the negative impact substances have on his mental state.
>
> Revoke Forensic Order
>
> **Not Currently**

[16] Thus, the respondent's treating doctor was, at best for the respondent, ambivalent about the stepping down of his FO to a TSO in that report. Although, his statement that the FO remained part of the respondent's risk mitigation strategy did not augur well for a step down of the order. Nor did his warning that the respondent was likely to discontinue treatment if taken off an order.

[17] I note that [redacted] was present for the [redacted] meeting of the ARMC, although he had only recently assumed care for the respondent. The minutes note that the forensic liaison officer (FLO) was unable to attend.

[18] The minutes are very brief. Relevantly and importantly though, in response to a prompt asking: "Has the person[']s treatment, care needs, and risk profile determined the possibility of a lower level of management and oversight?", the minutes show a tick in the "no" box and state "Not currently".

[19] The minutes note that a step-down was *not* being considered by the respondent's treating team and for that reason, it had *not* been considered by CFOS.

[20] The minutes record that the respondent breached the conditions of his FO by his ongoing substance use but that he was "reasonably well engaged" in treatment.

[21] The ARMC recommended a medical review with a consultant *as a priority*. Indeed, the committee required review in three months, rather than six, because of the absence of an up-to-date psychiatric review.

The approach of the MHRT

[22] The MHRT proceeded on the basis that the respondent has a diagnosis of Bipolar Affective Disorder which was, at the time of its decision, in remission.

[23] The offences the subject of the reference date from the [redacted]. They include an armed robbery in company from [redacted]; going armed so as to cause fear in [redacted] and possessing tainted property a little later in [redacted]. Thus, the offences were about [redacted] old and the forensic order itself was made about [redacted] ago.

[24] The last record of the respondent offending was in [redacted]. His offences involved theft and drugs. The Tribunal accepted that the administration of depot and other prescribed medications for an extended period had diminished the likelihood of repetition of the acts the subject of the reference.

[25] The MHRT was aware that the respondent is methylamphetamine dependent. The respondent has been a user of illicit substances since his teenage years. Methylamphetamine had been his drug of choice for [redacted]; and he has no intention of ceasing its use. However, there were some indications that he had reduced his drug use around the time of the hearing and that, overall, the respondent's risk was stable

at baseline. The MHRT noted that the FLO confirmed that there were (then) no clinical indications of *increased* drug use or the use of other substances.

[26] Giving weight to the evidence of the FLO, the MHRT proceeded on the basis that the respondent's drug use increased the negative symptoms of his illness *but did not cause an elevation in his mood nor an increased risk to the community*. The reasons do not disclose the qualifications of the FLO. Nor do they engage on the circumstances in which, or the dosage at which, the respondent's use of methylamphetamine might lead to a relapse in the positive symptoms of his illness and increased risk.

[27] The MHRT acknowledged – but did not respond to – the submissions of the Attorney-General's representative about the need for (before stepping down to a TSO) (a) a consultant's review; (b) evidence over the next reporting period about the step-down; and (c) discussions with the AMRC.

[28] It seems that – in lieu of a more up to date report or consultant's review or input from the ARMC – the MHRT relied upon the evidence of the FLO that the respondent's mental state was consistent with a psychiatrist's assessment performed in [redacted] about his insight.

[29] As I understand its reasons, the MHRT relied primarily upon the respondent's long and successful treatment in the community in stepping down the FO to a TSO.

[30] The MHRT noted that a step-down of the FO to a TSO was *not* supported by the treating team but did not explain why it stood down the order notwithstanding that lack of support. The MHRT said nothing about the minutes of the ARMC in its reasons.

[31] In deciding to step down the FO the MHRT said (my emphasis):

> The Tribunal gave weight to the oral and written evidence of the treating team that [redacted] is reviewed regularly by his case manager, for the purposes of administering his depot. The Tribunal accepted the evidence from the FLO that [redacted] mental state was consistent with the psychiatrist's assessment in [redacted] that [redacted] is insightful, the BPAD was in remission with ongoing methylamphetamine dependence.

> The Tribunal noted [redacted] has used substances, currently methylamphetamine and occasionally cannabis, for most of his adult life. Substance use was noted at the time of his index offences.
>
> In the past his substances use has resulted in family disharmony, particularly with his father, resulting in a DVO. At these times, [redacted] has recognised an increase in his stress, and this has resulted in him self-presenting to [redacted]. Since his last admission, he has not used substances at his parents' home.
>
> **[redacted] is very clear that he will continue to use substances and declines any offer of support to reduce or stop his substance use. However, his substance use has not resulted in increased risks to the community. In the past [redacted] years, he has self-presented to the [redacted] when he has felt 'stressed' by a deterioration in his relationship with his parents.**
>
> [redacted] mother remains at home with him and is familiar with staff from mental health services when they visit the home to administer his depot …
>
> **Therefore**, a treatment support order, but not a forensic order, was necessary according to the test in Section 450 of the Act.

[32] With respect to the MHRT, its statement that the respondent's "substance use has not resulted in increased risks to the community" is at odds with the information about the making of a DVO to deal with the family "disharmony" that flowed therefrom.

[33] With respect, it is of concern that the MHRT's reasons do not address at all the lack of support from [redacted] (and the ARMC minutes) for the step down. Nor do they explain why the MHRT was not prepared to wait three months (or even a month) for further information before deciding to step down the order. In my respectful view, the conclusion that the respondent's drug use, in the context of his Bipolar Affective Disorder, did not increase his risk required up-to-date and persuasive clinical evidence to support it.

[34] But as will emerge, any concerns of mine about the conclusions reached by the MHRT are essentially moot. The respondent's drug use did increase, and along with it, his risk to the community, including his family, not long after the decision of the MHRT was made. But before the respondent increased his drug use, the Attorney-General filed an appeal against the MHRT's decision.

[35] The Attorney-General's grounds are set out in her notice of appeal. I will not repeat them in full in these reasons. Essentially, the complaint from the Attorney-General was around the lack of recent risk assessment to inform the decision of the MHRT; the lack of evidence from the respondent's treating team to inform the decision of the

MHRT and the fact that the step-down of the forensic order to a treatment support order was *not* requested by the treating team, nor was it something raised by the treating team with the ARMC. The Attorney-General argued that there was insufficient evidence before the Tribunal for it to reach a conclusion that a forensic order was no longer necessary. The respondent continued to require a higher level of oversight and clinical management than that provided for by a treatment support order. The Attorney-General submitted that the MHRT should have confirmed the forensic order or, at the least, adjourned the matter for up to a month to allow for a review of the respondent. Of course, these arguments were made by the Attorney-General before the recent increase in the respondent's drug use became known.

[36] In anticipation of the hearing of the appeal, [redacted] prepared a clinical report about the respondent. It is dated [redacted]. Although it has been overtaken by other matters, I will outline its content.

[37] In his [redacted] report, [redacted] noted that the respondent suffered from Bipolar Affective Disorder and was subject to a forensic order. In fact, by the time of [redacted] review, the respondent was subject to a TSO – there being no stay of the MHRT's decision.

[38] After going through the respondent's family circumstances and current living arrangements, [redacted] noted that the respondent had a history of polysubstance abuse, with his primary substance being methylamphetamine. He referred also to the respondent's gambling.

[39] He discussed his several admissions to mental health units over the years, the most recent being his admission from [redacted] to [redacted]. His note of that admission is as follows:

> Admitted as father put out a DVO and suspicion of hypomanic episode with ongoing substance abuse. Sodium Valproate ceased following this admission.

[40] On mental state examination, [redacted] observed no psychomotor disturbances. He considered the respondent to demonstrate good rapport and good eye contact. His speech was spontaneous, and of normal rate and tone. His slight slurring and mumbling speech was most likely a pre-existing speech deficit.

[41] The respondent described his mood to [redacted] as flat – which was incongruent with his affect as he was reactive. Other than his frustration regarding the forensic order, [redacted] found no evidence of major depression nor mania nor hypermania nor psychosis during his review.

[42] [redacted] explained that the respondent was aware of the upcoming appeal to the Mental Health Court. He noted the respondent's frustration at the impact of involuntary orders on his life and the way in which he considered those orders to significantly disrupt his ability to live. The doctor noted that there was minimal reflection on the part of the respondent about his own contribution to his current circumstances. The doctor discussed the respondent's drug use and noted that he was "pre-contemplative" in terms of his readiness for change. The respondent told [redacted] that he did not go out looking for drugs but only used when he could afford it. He demonstrated to [redacted] an intellectual understanding of the risk of relapse of bipolar psychosis with methylamphetamine use and explained that, for that reason, he was moderating his use.

[43] Of particular relevance to this appeal is [redacted] recommendation about a step down to a TSO. As at [redacted] was of this view:

> On the balance of probability, [redacted] level of risk can be clinically managed under a Treatment Support Order (TSO), which can provide adequate oversight of his treatment and mitigate the risk associated with his mental illness. If Her Honour confirms the TSO, the ARMC, which involves participation of Community Forensic Outreach Service (CFOS), will continue to provide additional clinical oversight of his treatment. He will also continue to have periodic reviews by the Mental Health Review Tribunal (MHRT).
>
> The TSO with the current conditions will ensure that he remains engaged with his treatment team. Furthermore, his risk of future violence is also mitigated by his stable living environment, although [they] maybe imperfect, the additional requirements of the existing DVO may serve as deterrent for him to comport himself at home. He is supported by his family, particularly his mother, who has previously facilitated his admission.

[44] Notwithstanding those statements the doctor concluded his report with the following:

> Given the history of multiple criminal charges, longstanding history of poor compliance with medical reviews and his ongoing methylamphetamine addiction, her Honour may consider confirming the Forensic Order rather than revoking the order.

[45] Viewing his [redacted] report as a whole, it could not reasonably be said that [redacted] supported the respondent's step down to a TSO. He was, at best for the respondent, again ambivalent about it. If the TSO were confirmed, he and the treating team would do their best to ensure that the respondent was adequately supported but he recognised, even before the respondent increased his drug use, that this court might, in effect, confirm the FO given the matters referred to in paragraph [44] above.

[46] On [redacted], the respondent self-presented to the emergency department of the [redacted] asking to see the mental health team and reporting feelings of mania due to excessive drug use. He had used methylamphetamine on the day of his presentation and his use was confirmed by a urine drug screen. His own suspicion of a manic episode was confirmed by the mental health assessment team, and he was admitted to the mental health unit. During his admission he disclosed further methylamphetamine use. Indeed, on the evidence before me, he was using while in hospital.

[47] [redacted] saw the respondent in hospital on [redacted]. The respondent told him that he had been smoking methylamphetamine on a daily basis in the days leading to his hospital presentation. There had been an escalation of his longstanding conflictual relationship with his father, and he no longer wished to stay at home.

[48] The respondent was reviewed again on [redacted]. By that date, he had returned to baseline. There were no overt signs of psychosis. However, he remained pre-contemplative regarding his methylamphetamine use.

[49] [redacted] prepared another report dated [redacted]. In that report, under the heading "Risk Assessment" he said:

> Given [redacted] increased methylamphetamine use, recent manic episode, loss of stable accommodation, and reduced parental support, his overall risk level has increased compared to when the previous report was provided. Clinically, his risk can be managed under a Treatment Support Order (TSO). However, his ongoing substance use, which breaches the Forensic Order (FO) along with his current elevated risk state, supports the continuation of the Forensic Order.

[50] The doctor went on in that report to outline appropriate conditions of the forensic order.

[51] In his oral evidence, [redacted] said that – whatever the order, his team's goal was to mitigate the risk posed by the respondent's illness. Because his risk had recently increased, they had increased his supports.

[52] As I have already explained, on an appeal from a decision of the Mental Health Review Tribunal this Court is to consider matters as at the date of the hearing. As confirmed by [redacted] in his oral evidence, there has been a recent elevation in the risk posed by the respondent which, in my view, no longer makes the step-down of his forensic order to a treatment support order appropriate. The Attorney-General argued that the MHRT's conclusion that the respondent's drug use might not increase his risk may well have been valid for modest methylamphetamine use, but the respondent's use (say, a small amount once a fortnight) was greater than that at the moment. The respondent missed his scheduled [redacted] review, which meant that when the matter was considered by the MHRT in [redacted], the respondent had not been seen since [redacted]. For that reason, the ARMC requested an urgent review, but that did not occur before the MHRT hearing.

[53] The respondent, who was self-represented at this hearing, was not in a position to make arguments in support of the maintenance of the treatment support order. Very properly, [redacted] for the Attorney-General imagined the sorts of arguments that the respondent would have had made on his behalf if he were legally represented. They included an argument that he had been on a forensic order for a very long time and that he took himself to hospital when he was concerned about an elevation in his risk.

[54] [redacted] himself said to the Court that he followed the arguments made by the Attorney-General. He invited the Court to make whatever decision was thought best for him. He said the FO did not really change his life – apart from the fact that it prevented him from working (at least interstate). He understood that the FO gave his treating team "more power" when it came to managing him than a TSO did. He said he really did not want to waste any more time on the matter because he did not really wish to be at Court anyway.

The advice of the assisting clinicians

[55] [redacted] advised me that it did not seem like the ARMC were seeking to revoke the forensic order prior to the MHRT making that decision; nor did the ARMC have sufficient information. [redacted] had not been reviewed by a psychiatrist for a significant amount of time. A risk assessment by one person was not as valuable as risk assessments across various points in time, such as might have occurred had there been a psychiatrist's review or input from the ARMC for the MHRT to consider.

[56] On the issue of current risk, [redacted] advised me that there had been a considerable increase in it over the past couple of months. The respondent's current living arrangements, ongoing drug use; and the revocation of the FO, led to an unsettled situation and the respondent's recent instability.

[57] He acknowledged the respondent's frustration at being on the FO for [redacted]. He observed that there was little evidence to suggest that there had been plans made to address the respondent's frustration or his step-down to a TSO. He advised me that whilst a TSO provides significant "powers" to the respondent's treating team, successful transition to a TSO required *a process.* It ought not to be thought of as a one-off guillotined act.

[58] [redacted] advised me that I ought to allow the appeal and reinstate the FO.

[59] [redacted] agreed. She advised me that it would be appropriate to reinstate the forensic order on the basis of the respondent's multiple risk factors for offending behaviours. These included his offending history; his history of major mental illness with bipolar disorder; his history of substance use and non-compliance with medication; his unemployment problems; and the problems in his relationships, particularly with his father.

[60] In [redacted]' view, the risks are now higher than what they had been in the recent past. That was because of a recent increase in the dynamic risk factors for offending, namely, the respondent's recent manic episode; the recency of his substance abuse; and the ongoing instability in his social situation, including projected changes to his accommodation.

[61] On the issue of future clinical assistance, she advised that involvement of the ARMC with input from the Community Forensic Outreach Service would help to manage risk, particularly with the current instability.

My conclusion

[62] As I said at the hearing, having regard to the material and the evidence before me, the submissions of the parties, and the advice of the assisting psychiatrists, I allowed the appeal and, in effect, reinstated the respondent's FO.

[63] I did so primarily because of the evidence before me about the recent increase in the respondent's risk.

[64] Regardless, I did not consider the evidence before the MHRT sufficient to enable it to reach the conclusions it did about the appropriateness of the respondent's step down to a TSO.

[65] With respect to the approach of the MHRT, I gave great weight to [redacted] advice that a step down from a FO to a TSO was something which ought to occur in the context of planning by the treating team, over a period of time, and in the context of contemporary risk assessments from a variety of sources.

[66] However, as I've said several times, matters well overtook the decision of the MHRT. On the (limited and dated) evidence before it, it seems it could not have anticipated that the respondent would return to daily ice consumption leading to an increase in his risk, which meant that a step down to a TSO was premature.