THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO MR ALISTAIR DRAPER AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 20 JULY 2017

Mental Health Review Tribunal

This is an edited version of the Tribunal's decision. The patient has been allocated a pseudonym for the purposes of this Official Report

FORENSIC REVIEW: **Alistair Draper**

F0800 - 36th Review

s68(2) Review of person apprehended under s68

Mental Health (Forensic Provisions) Act 1990

TRIBUNAL:	**Richard Cogswell SC**	**President**
	Rob McMurdo	**Psychiatrist**
	Diana Bell	**Other Member**

DATE OF HEARING: **2 May 2017**

PLACE: **Hearing Room 1, Mental Health Review Tribunal**

APPLICATION: **Unconditional Release.**

DECISION

Having determined pursuant to section 43 of the *Mental Health (Forensic Provisions) Act 1990* that neither the safety of Alistair Draper nor that of any member of the public would be seriously endangered by his unconditional release, that an independent forensic psychiatric report is also of that opinion and having regard to the other matters to which sections 43 and 74 refer, the Tribunal determines that Alistair Draper be unconditionally released.

Signed

His Honour Judge Richard Cogswell SC
President
Dated this day

REASONS

This is the 36th review of Alistair Draper who is a forensic patient. In 2017 the Tribunal issued a Section 68 Order for Apprehension for detention in a forensic hospital. Mr Draper's current order for detention is a Section 68 interim order on Adjournment signed by the Tribunal with access to escorted day leave. Prior to the Tribunal issuing a section 68 Order for Apprehension Mr Draper was conditionally released by order of the Tribunal but remained detained in a forensic hospital.

Mr Draper's treating team is seeking unconditional release at this review.

BACKGROUND

Mr Draper was found not guilty by reason of mental illness and was ordered to be detained.

TRIBUNAL REQUIREMENTS

This is a review pursuant to section 46(1) of the *Mental Health (Forensic Provisions) Act 1990* ("the Act"). Under section 46 the Tribunal is required to review the case of each forensic patient every six months. On such a review the Tribunal may make orders as to the patient's continued detention, care or treatment or the patient's release.

The Act has special evidentiary requirements in relation to leave or release which must be satisfied before the Tribunal can grant leave or release. In view of this, the Tribunal requires notice of applications for leave or release to ensure that the necessary evidence is available. This process also enables the Tribunal to provide notice of such applications to the Minister for Health, the Attorney General, and any registered victims who are entitled to make submissions concerning any proposed leave or release. A notice was provided to the Tribunal prior to this review for an application for unconditional release.

The Tribunal must be satisfied pursuant to section 43 of the *Mental Health (Forensic Provisions) Act 1990* that:

(a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and

(b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.

Without limiting any other matters the Tribunal may consider, the Tribunal must consider the principles of care and treatment under section 68 of the *Mental Health Act 2007* as well as the following matters under section 74 of the *Mental Health (Forensic Provisions) Act 1990* when determining what order to make:

(a) whether the person is suffering from a mental illness or other mental condition,

(b) whether there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm,

(c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,

(d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release,

(e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.

DOCUMENTARY EVIDENCE

The Tribunal considered documentary material and reports, an exhibit list of which is held on the Tribunal's files

ATTENDEES

Mr Draper attended the hearing by videolink and was represented by his lawyer of the Mental Health Advocacy Service. Also in attendance were:

- Counsel for the Attorney General;
- Solicitor for the Attorney General.

By videolink from the forensic hospital:

- Consultant Psychiatrist;
- Clinical Psychologist;
- Nursing Unit Manager(by telephone);
- Education Officer;
- Social Worker;
- Occupational Therapist; and,
- 1 observer.

By telephone:

- Consultant Psychiatrist; and,
- Consultant Forensic Psychiatrist;

By telephone from Queensland:

- Cousin.

PRESENT CIRCUMSTANCES

Notice of Intent

The Consultant Psychiatrist, filed a Notice of Intent. It sought unconditional release for Alistair Draper.

Reports

There is a comprehensive medical report from the Consultant Psychiatrist currently treating Mr Draper

She documents Mr Draper's forensic history which includes minor summary offences. The only significant offence is the offence which was the subject of the index event when Mr Draper was charged with an armed robbery.

The treating psychiatrist noted that Mr Draper had been asked to develop his own goals. He "*identified being in a warmer climate and being closer to his family as high priorities, also identifying a desire for employment and intimate relationships to help provide additional stability in his rehabilitation."*

Mr Draper's treating psychiatrist documented the many years of unsuccessful attempted conditional releases, time in the Forensic Hospital, residential drug treatment programs and periods at Bloomfield Hospital. He again breached conditional release last year. His conditional release was reinstated early this year and he absconded two days later.

Since his most recent admission his mental state has remained stable without any evidence of psychotic features. Although he denies thoughts or plans of self-harm or harm to others, his "*insight into his risk for violence is poor and he minimises the impact his illness and personality has on himself and those around him."*

The diagnosis offered by his treating psychiatrist is Bipolar Affective Disorder, Substance Abuse and Dependence as well as narcissistic personality/Cluster B traits.

In dealing with the risk assessment, his treating psychiatrist refers to Mr Draper as "*a 39 year old man who committed a single violent act which resulted in psychological distress but no physical harm, almost 15 years ago."* The event "*occurred in the context of illicit substance use and homelessness*." The major issue over his rehabilitation has been *"his impulsive drug and alcohol use, which has led to sabotage of his recovery goals on a number of occasions*." His treating psychiatrist added that "*good control of his mental illness has not previously been sufficient to ensure good compliance with rules or rehabilitation*." Significantly, his treating psychiatrist offered the opinion "*that the probability of him committing a violent act in the future is low and the gravity of any such act is unlikely to be severe."*

Furthermore, his treating psychiatrist offers this opinion -

> *"He has made minimal progress despite 16 years of inpatient treatment. His risk when he became a Forensic Patient at the age of 23 was related to his personality, drug use and untreated mental illness. The likelihood of him acting recklessly is high (using illicit substances, gambling, infidelity, offending family and friends) but the severity of the subsequent violence is likely to be low."*

His treating psychiatrist refers to this and adds that on each occasion except the first "*the breach was a result of his personality disorder and not his mental illness."* As his treating psychiatrist says, given that Mr Draper's life goals include the continued use of ICE and cannabis, it is "*impossible to reconcile*

conditions of release around these life goals." He will continue to "*fail to take responsibility for his actions and blame others (the forensic system) for each failure."* He will "*therefore not make any progress."* Referring to each episode of absconding and before the index event, his treating psychiatrist said that Mr Draper "*has sought professional help when within the comm*unity." Despite his drug use, non-compliance and alienating himself from social supports, "*he did not commit any violent act.*" She said that Mr Draper *"likes to access help and support on his own terms and he has proved that he does this successfully when required."* She expressed the opinion "*that if he were granted unconditional release he would voluntarily access support around his drug and alcohol issues and his mental health*." This, treating psychiatrist said, "*would reduce his risk*."

Again addressing risk, treating psychiatrist refers correctly to the importance of distinguishing between the likelihood of violence and the gravity of the risk. She adds that "*the gravity of the risk is low*" in Mr Draper' case.

treating psychiatrist says this –

> *"In Mr Draper's case, based on the extensive evidence that we have about his behaviour when he has absconded, we can say with some conviction that if he were to relapse into drug use, fail to take his medication and engage in an itinerant lifestyle, that he may behave recklessly (having unprotected sex, sharing needles, driving intoxicated, alienate his friends and family) but he is unlikely to commit a serious violent act, as he has never done this before."*

Acknowledging that her position is "counter intuitive", treating psychiatrist expresses the view that "*unconditional release in this case may reduce the risk to the community as he is aware that there would not be the safety net of the Forensic system. If he spent all his money irresponsibly, if he committed an offence or used drugs and became mentally unwell*." treating psychiatrist concludes with her opinion "*that his risks could be safely managed without the need for the forensic order and within the civil mental health services and the criminal justice system*." She proposes a management plan for unconditional release noting a return to live with his cousin and seeking local support in the form of drug and alcohol counselling and a general practitioner and community health services and leisure.

There is a report from the NSW Community Forensic Mental Health Service (CFMHS) regarding Mr Draper' proposed unconditional release. It was prepared by a Forensic Psychologist, and a Consultant Forensic Psychiatrist. They too recite Mr Draper'S forensic history. They conclude with the opinion that Mr Draper "*has an established diagnosis of Bipolar 1 Disorder*". They add that he "*presents with problematic gambling"* and met the "*criteria for cannabis and amphetamine dependence*." They also note he "presents with Cluster B personality traits". They add that his "*problem behaviour is best described as reactive aggression."* However they add that the *"reported aggression has been limited to a time when mentally unwell and it does not appear to be a long-standing trait."*

In relation to self-harm they say that Mr Draper *"currently falls into a group of people who cause low clinical concern.*" They say that he "*presents with a high loading of historical factors and a low loading of dynamic factors that are associated with a potential for future episodes of reactive aggression.*" But they add that these factors *"need to be viewed in terms of their specific relevance to Mr Draper' history of violent offending*." They note the context of the index event and his repeated lapse into substance use but add that despite those episodes "*Mr Draper has not perpetrated any further violence and has repeatedly self-presented to emergency services for treatment."*

Significantly the authors expressed this opinion –

> *"As such it is our opinion based on 16 years of monitoring from forensic mental health services, that whilst it is considered that Mr Draper presents with a high risk of relapse into substance use and thus mental instability, the link between this and the serious endangerment of himself or others has not been demonstrated, supporting the view that his risk of violent reoffending is currently low while he remains engaged with treatment."*

They note his mental illness and express the opinion that there are "*reasonable grounds that Mr Draper requires care, treatment and control for his own protection and the protection of others from serious harm."* If inadequately treated, his "*condition is likely to deteriorate and will thus pose a risk to himself and others.*" Nevertheless, they express the opinion that "*on the balance of probabilities, the safety of Mr Draper and/or the public is unlikely to be seriously endangered were he to be Unconditionally Released into the community provided the management plan proposed is adhered to."* They expressed the opinion *"that community placement with a Community Treatment Order is considered to offer a safe and effective level of care of the least restrictive nature and that he requires such care."* They go on to "*recommend a Community Treatment Order to ensure his ongoing compliance with treatment as he transitions into a community placement*."

They support the application for unconditional release and *"recommend that Mr Draper complies with all aspects of a Community Treatment Order that includes the proposed treatment recommendations."* They consider that proposed treatment to be "*of the least restrictive kind to ensure Mr Draper' ongoing compliance with treatment as he transitions into community placement."* They recommend abstinence from alcohol and illicit substances and make a long list of recommendations for Mr Draper as he reintegrates into the community.

There is a report from a Clinical Nurse Consultant. She notes that Mr Draper' *"rapport with staff is superficial and he denies suicidal or homicidal thoughts or intent*." She adds that the treating team has seen no evidence of either. She added that the treating team "*continued to discuss progress and plan the complex and ongoing rehabilitation and recovery care pathway for Mr Draper*."

There is a psychological report (annexing earlier reports) from a Clinical Psychologist. He notes that Mr Draper' "*responses to rehabilitation initiatives are highly questionable"* and so it "*becomes problematic*

when considering what the nature of his discharge journey must be." His final position was to ask the MHRT "*to provide guidance on what Mr Draper' discharge journey needs to include*." In an earlier report the Clinical Psychologist thought that "*an ideal solution is not regrettably available.*" He thought "*the likelihood of his risk profile (regarding his index offence) being elevated to high, is currently unlikely.*" On the other hand, "*his risk profile for drug related offending and vehicle related offences is high."*

A Social Worker provided a report. She supported "*the team's submission for unconditional release.*" She too thought that Mr Draper would understand that there would be no safety net or backing by the forensic system and that it "*will be good for Alistair to make some of his own decisions and to take full responsibility for them*." He has *"shown in the past that he will access support as he needs and as per the detailed medical report the risks associated with Alistair's behaviours can be safely managed within the civil mental health system."*

There is a report from a Diversional Therapist. She too refers to his "*history of absconding*" but that "*he has not reoffended in using violence.*" She *"thought that the probability of him reoffending in the future would be low*." She pointed out that the treating team thought that the absence of a forensic backup *"may activate him to modify his risk taking behaviour, or take greater responsibility for his actions."* She supported the application for unconditional release.

There was a report from an Occupational Therapist. She pointed out that "*Mr Draper has not acted violently or aggressively as a patient on [the] Unit, nor when he has been in the community, both when on approved leave and during periods of absconding."* She added that *"Mr Draper has not harmed himself or others directly when he has absconded or during periods of leave."* She thought his functional capacity and lack of violent offending since the index event met the requirements of section 43 of the *Mental Health (Forensic Provisions) Act.*

There was a letter from Mr Draper's cousin. They had a close relationship growing up and lived together with the family from the age of 16. She lives with her 16 year old son, with whom Mr Draper is close. She pointed out that she has been a support person for him over the last 17 years and that Mr Draper *"has a large support system in [X] with the majority of his family living here and through the relationships he has developed with my siblings and their children*." She said the intention was that *"[Alistair] live with me in the short term to provide him sufficient time to find appropriate accommodation in [X]."* She has found a GP who will bulk bill and support groups nearby. She said she was aware of her cousin's *"medical conditions and I have the ability to identify these in their early stages.*" Being his support person over so many years, "*I have always taken a strong stand and hard line with him.*" There would be "*no tolerance at all when it comes to the use of drugs and alcohol within my home"* and Mr Draper knows that. She pointed out that she directs a childcare centre and that both she and Mr Draper were aware that it would be *"detrimental to my career and to my son if Alistair was to participate in drugs and alcohol while living with me*".

At the hearing

His treating Psychiatrist was asked whether her patient's risk was increasing or fixed over the last five or six years. She said that the risk was static and that the risk of serious harm to the public had not been elevated. It was helped by having the medication in depot form which provided a stable dose. She emphasised the pattern of Mr Draper's behaviour of seeking help in the past. If he reverted to substance use then he was likely to seek help with drug and alcohol counselling. Any unconditional release would involve liaison with local mental health services and a discharge summary.

His treating psychiatrist acknowledged the obvious risks with consumption of illicit substances both from the harmful effects of the substances themselves and the impact of the environment in which they were taken. But again she acknowledged that Mr Draper, based on his past habits, was likely to seek help and treatment.

Asked whether Mr Draper was untreatable in an inpatient setting, his treating psychiatrist did not agree that he would be untreatable but said that there was no benefit in an inpatient setting without access to the community. Treatment does not need to be provided in an inpatient setting.

His treating psychiatrist was further of the opinion that Mr Draper's reckless behaviour was more to do with his personality and issues to do with failing to take responsibility. Behaviour based on personality factors is likely to improve with age. Mr Draper is turning 40 later this year. She expressed it by saying that Mr Draper will pose less risk to the public aged 40 than when he was aged 22.

She said that Mr Draper's mental state had settled quickly after illicit drug taking and the Paliperidone medication helped as a protection against relapse into mania. His mental illness was not very fragile and was well helped by Paliperidone. Indeed she added that if Paliperidone was stopped then it would not lead to an increase in the risk of harm to others. She added that serious endangerment to others was not present in this case. The one violent episode was the index event which caused a psychological but no physical harm and there had been no other instances of violence since then. She thought that a further violent offence was very unlikely.

She said the continued hospital treatment was not adding any value and would not help the risk.

Asked about conditional release as a preliminary step, his treating psychiatrist expressed the opinion that Mr Draper does not require conditions to manage any risk to the community. She emphasised that Mr Draper has breached his conditional release time and again without any risk to the public. His treatment and management can be done by community health services. She expressed the view that on conditional release community mental health support was the most appropriate course.

The Clinical Director agreed with the treating psychiatrist's summation on the question of risk. He thought that the risk to the community was less than the risk to Mr Draper himself. But the risk to Mr Draper

himself was more along the lines of spending money and putting his own accommodation at risk. He referred to an instance of driving under the influence but acknowledged that very many other people posed the same risk.

The independent psychiatrist was asked questions about Mr Draper being released on a Community Treatment Order. He explained that references in his report were not meant to be a proposal for a Community Treatment Order release. A Community Treatment Order would merely add an extra level of certainty.

On the other hand, the treating psychiatrist expressed the view that a Community Treatment Order would still not be justified even if he were to be released within this State. She based this on Mr Draper's history of always voluntarily complying with treatment, the severity of his illness and his good insight.

The Clinical Director did not think that a Community Treatment Order would add value. Mr Draper has not been non-compliant and even if he was breached for drug use he would then be released. A Community Treatment Order would not add to the strength of his treatment.

The treating psychiatrist emphasised that her assessment was not made on the basis that Mr Draper would be released on a Community Treatment Order.

The independent psychiatrist agreed that there was no change in his risk assessment of Mr Draper if there was no Community Treatment Order. He emphasised that the question of serious endangerment was not the main point. There was no suicide risk and all the clinicians agreed that there was no risk to the public. He said what was at the heart of the unconditional release application was the view that the public was not seriously endangered. He acknowledged some risk of self-harm by indifference or recklessness but queried the magnitude of the resulting harm. There are numerous episodes of illegal drug taking in his past and although all his relapses were assisted by drugs, there were other occasions when the use of drugs produced no relapse. It was important to take into account the pattern of Mr Draper's behaviour before and after the index event. Of all the relapses, none was associated with any violence, reckless behaviour or endangerment to himself or the public. Looking at the index event, it was affected by his mental illness and intoxication. He was impressed by Mr Draper's own reflections on the event and his remorse. He pointed to the absence of criminogenic history and behaviour and attitudes. He was of the view that Mr Draper is not an habitual criminal. Over the last 16 years Mr Draper has had plenty of exposure and opportunity to commit acts of violence but it has not happened. Over that time the risk of such an event being repeated has become reduced, perhaps to the point of absence. As he said, the risk of repetition was very high the day after the index event but has changed over 16 years with Mr Draper's behaviour and attitude. The index event could be described as bizarre and connected with delusions and driven by financial need.

Mr Draper's cousin was asked how she would cope if there was a problem. She emphasised the importance of family support and mental health services. She said he had lots of family support and has had contact with Mr Draper's mother.

Finally, Mr Draper himself said that the traffic incident involved him being pulled over for a U turn and making an admission to the police about drug use some weeks before. The charge of driving under the influence of drugs was later dropped through lack of evidence. There is documentary evidence to support that.

Submissions

Counsel for the Attorney General referred to her written submissions dated 1 May 2017. She made the additional submission that she would take instructions about the enforceability of a NSW Community Treatment Order interstate. She urged the Tribunal to act with caution pointing out that usually patients were not unconditionally released without at least six months of conditional release beforehand. She said there is evidence of high risk behaviours (drug taking) and pointed out what that can do to Mr Draper and the community. She pointed out the number of relapses to do with drugs and alcohol and leading to chaotic behaviour.

Mr Draper's solicitor, referred the Tribunal to section 53(3A) of the *Mental Health Act* and argued that a Community Treatment Order would not be available in this case. Her client is suffering not so much from mental illness as a substance abuse problem. She pointed out that her client in those circumstances is insightful, follows directions and turns up to hospital. Prior history demonstrated that he survives the risks associated with substance abuse. He has never been in an intensive care unit or presented at hospital with broken bones and there has never been any application for a Financial Management Order despite his gambling habit. She pointed out that the only evidence of violence was the index event itself and that the risk was reduced by her client's increasing age with the risk changing for the better. How he behaved when absent without leave was not criminally violent in nature. She argued that pursuant to section 43(b) of the *Mental Health (Forensic Provisions) Act* her client "*does not require care*." She argued that there was no risk of serious endangerment to her client or members of the public by his proposed unconditional release.

Consideration

This is a case that poses an apparent conundrum. A man with a history of regular breaches of conditional release, usually involving drug taking, is now asking for unconditional release. The answer to the apparent conundrum lies not in summary dismissal of the application as fanciful nor in granting the application because he has exhausted his treating team's efforts in managing him. The answer (to grant or to refuse the application) lies in the careful addressing of the questions posed by the legislation relevant to such an application.

The legislative questions

As counsel for the Attorney General has pointed out in her written submissions (1 May 2017), after our review under section 46 of the Act we may make an order as to Mr Draper's "*continued detention, care or treatment in a mental health facility"* or his "*release (either unconditionally or subject to conditions)"*. Because the application is for Mr Draper' release, the "*Tribunal must not make an order"* for his release "*unless it is satisfied, on the evidence available to it"* of two things. The first is that "*the safety of the patient or any member of the public will not be seriously endangered "* by Mr Draper's release. The second is that *"other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available"* to Mr Draper or that the Mr Draper "*does not require care."* Those requirements come from section 43 of the Act.

If we make an order for Mr Draper's unconditional release, he will no longer be a forensic patient, as Counsel points out (section 51). If he ceases to be a forensic patient, Mr Draper "*must be discharged from the mental health facility"* in which he is detained (section 54).

Without limiting other matters, section 74 of the Act provides that "*the Tribunal must have regard"*, relevantly to this case, to four matters. The first is whether Mr Draper "*is suffering from a mental illness or other mental condition"*. The second is "*whether there are reasonable grounds for believing that care, treatment or control"* of Mr Draper "*is necessary"* for his "*own protection from serious harm or the protection of others from serious harm".* The third is Mr Draper's "*continuing condition … including any likely deterioration"* in that condition "*and the likely effects of any such deterioration".* The fourth is a report by a forensic psychiatrist not involved in treating Mr Draper as to Mr Draper's condition and whether his safety or the safety of any member of the public "*will be seriously endangered"* by Mr Draper's release.

Relevant to the question posed by section 43 of the Act about whether anyone's safety will be "*seriously endangered"* Counsel reminds the Tribunal of the decision of the Court of Appeal in *Attorney General for the State of New South Wales v XY* [2014] NSWCA 466. The Tribunal accepts Counsel's statement of the effect of that decision in this case that *"the Act implicitly requires a risk assessment, and that such risk assessment involves weighing two factors: first, the likelihood of the relevant risk eventuating; and, secondly, the magnitude of harm which would result in such a case."*

Section 43 considerations

Almost all the evidence points away from Mr Draper's safety or the safety of any member of the public being "*seriously endangered"* by Mr Draper's release. Pointing to Mr Draper's behaviour in the past, the opinion of his treating psychiatrist is that the probability of him committing a violent act in the future "*is low and the gravity of any such act is likely to be severe".* Although "*the likelihood of him acting recklessly is high",* the *"severity of the subsequent violence is likely to be low."* She adds that Mr Draper "*is unlikely to commit a serious violent act, as he has never done this before."*

The independent psychiatrist, says that the risk of self-harm on the part of Mr Draper is of "*low clinical concern".* Although referring to reactive aggression, the independent psychiatrist places weight on Mr Draper's history and the context of the original event. In a cogently expressed opinion "*based on 16 years of monitoring from forensic mental health services"*, he says that the link between the high risk of Mr Draper returning to substance use "*and the serious endangerment of himself or others has not been demonstrated."* That supports the view "*that his risk of violent reoffending is currently low while he remains engaged with treatment."* He concludes that "*the safety of Mr Draper and/or the public is unlikely to be seriously endangered"* by his unconditional release. It is important to note a proviso to the independent psychiatrist's opinion that "*the management plan proposed is adhered to."*

The Clinical Psychologist expresses a qualified opinion. A high risk offence such as the index event "*is currently unlikely"* although he is at high risk of drug-related offending. One other qualified opinion is the social worker who thinks that Mr Draper's "*behaviours can be safely managed within the civil mental health system."* Other health workers point to Mr Draper' non-violent behaviour when he has been at large.

The risk seems to be, according to Mr Draper's treating psychiatrist, reckless behaviour rather than violence. She attributes that to Mr Draper's personality. It seems to the Tribunal that if the risk is the result of personality rather than mental illness or a mental condition then the Tribunal would not be authorised to detain Mr Draper.

The Clinical Director agreed with the Treating Psychiatrist.

The independent psychiatrist's qualification about a treatment plan was explained during the hearing to mean that his opinion was not dependent on Mr Draper being on a Community Treatment Order. That would "*merely add an extra level of certainty."* The treating psychiatrist made it clear that her opinion was not based upon a Community Treatment Order. The Clinical Director agreed. The Independent Psychiatrist added that there was no change in his risk assessment if there is no Community Treatment Order.

The Tribunal must base its decisions "*on the evidence available to it".* The evidence referred to above, in the Tribunal's opinion, points overwhelmingly to the public's or Mr Draper's safety not being seriously endangered by his release.

Does Mr Draper require care any longer? The nature of the care in question, in the Tribunal's opinion, must be related to why he is in detention. He is in detention because he was found not guilty by reason of mental illness of the charge he faced. Orders for detention (which can be made under section 39 of the Act by the Court or under other provisions by the Tribunal) are not made on the basis of a criminal offence but by reference to Mr Draper's mental illness. The Tribunal must always have regard (section 74) to whether a person "*is suffering from a mental illness or other mental condition".* Hence the Tribunal

expects that any requirement for care provided for by section 43(b) must be related to Mr Draper's mental health.

There is evidence that Mr Draper requires ongoing care. His treating psychiatrist thought that the antipsychotic medication afforded a protection against relapse into mania. His mental health was well supported by the Paliperidone. The independent psychiatrist was of the view that Mr Draper still requires care.

Is there then available to Mr Draper "*other care of a less restrictive kind, that is consistent with safe and effective care"* and is such care appropriate? Again the evidence here points to a pattern of behaviour on the part of Mr Draper. As his treating psychiatrist said, he is familiar with the hospital and community mental health systems and readily falls back on them. When he has been at large and in breach of his conditions, he turns up at such facilities in order to seek help. The services of those facilities have been effective in the past. They are reasonably available in Australia. It therefore seems to the Tribunal that although Mr Draper requires ongoing care for his mental illness, that care is reasonably available to him within the community or at public hospitals and that he is likely to resort to it. The care provided is appropriate.

Section 74 considerations

By reference to section 74, it is clear from the psychiatric opinions that Mr Draper suffers from a Bipolar Disorder as his main mental illness. He also has a Substance Dependence and Cluster B personality traits.

Although Mr Draper requires care and treatment (which can be provided in the community) control of him, based on the evidence, is not "*necessary"* for his "*own protection from serious harm or the protection of others from serious harm'.* His risk to others is assessed as being low. There appears to be a sound basis for that assessment, namely his behaviour over the last 16 years both in detention and at large, uninfluenced and influenced by illicit drugs.

Mr Draper's mental illness will continue. His illness will deteriorate if he resorts to illicit drugs. But soundly based on past performance, he is likely to seek appropriate help in that event. Indeed his treating psychiatrist acknowledged that although the Paliperidone helped Mr Draper's mental illness, if it was stopped it would not lead to an increase in the risk of harm to others.

The independent psychiatrist supports the diagnosis referred to above and expresses the opinion that the safety of Mr Draper or any member of the public will not be seriously endangered by his release.

Although the proposed unconditional release of Mr Draper is, as his treating psychiatrist acknowledges, counter-intuitive, it seems to the Tribunal that almost all of the available evidence points one way on the critical legislative issues.

Despite many episodes of drug and alcohol abuse and absconding, there is no history of other significant criminal activity or aggressive behaviour. The only risk of harm is resumption of illicit drug use. He has done that a lot over the years but has not attracted attention from law enforcement agencies except for a drug driving charge which was dismissed without evidence.

The Tribunal was somewhat concerned with the circumstance that the treating team has sought only very limited leave for Mr Draper but has also applied for his unconditional release. This is part of the conundrum. It is probably a realistic acknowledgement of the failure of a process of conditional release but also the need to prepare Mr Draper for unconditional release. As has been pointed out, those failures are related to his personality rather than his mental illness.

The Tribunal considered conditional release on the understanding that a further breach would result in Mr Draper being housed in another facility. There are two problems with this. The first is that realistically Mr Draper is likely to breach the conditions, despite the consequences. The second is that the breaches would be unrelated to his mental health condition. The choice remains of leaving Mr Draper in indefinite detention (because of the real likelihood of any conditional release being breached) or unconditional release into the community. The tests provided by the legislation are all fulfilled in Mr Draper's case. He will be yet another drug addict in the community, like many others. Like many drug addicts, he will pose very limited threats to himself or others, apart from the impact of the drugs on himself. Mr Draper has a track record of resorting to the public health system to deal with the impact of these breaches will have on his mental health. That is available and an appropriate resort.

The Tribunal thought that the ideal solution would be to release Mr Draper on a Community Treatment Order. However, as Counsel for the Attorney General points out in her written submissions dated 12 May 2017, Mr Draper is likely to relapse with or without a Community Treatment Order. A Community Treatment Order, in the Tribunal's view, would serve little utility in Mr Draper' case. Not only that, he proposes to move interstate and, for the reasons Counsel points out, it does not seem that a NSW Community Treatment Order could be enforced interstate. The more realistic course is that proposed by his treating psychiatrist that she would speak to the community mental health team where Mr Draper is likely to be living and advise them of his move into their jurisdiction.

CONCLUSION

The Tribunal finds that Mr Draper meets all of the legislative requirements for the proposed unconditional release and will order that.

Signed

His Honour Judge Richard Cogswell SC
President
Dated this day