THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO YOUNG AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 14 JUNE 2022	Mental Health Review Tribunal

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

FORENSIC REVIEW:	LUCAS s 46(1) Review of forensic patients *Mental Health (Forensic Provisions) Act 1990*	**[2018] NSWMHRT 3**
TRIBUNAL:	Ms Maria Bisogni	Deputy President
	Dr Rob McMurdo	Psychiatrist
	Dr Meredith Martin	Other Member
DATE OF HEARING:	April 2018	
PLACE:	Mental health facility	

REASONS

1. The case of Mr Lucas was reviewed under the provisions of section 46(1) of the *Mental Health (Forensic Provisions) Act 1990* (the Act) on [date].

TRIBUNAL REQUIREMENTS

2. This is a review pursuant to section 46(1) of 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.

3. 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. No notice of an application for leave or release was provided to the Tribunal prior to this review.

4. 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 Act 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) …
   (e) …

BACKGROUND

5. This was an early review requested by Ms Sinclair of the Mental Health Advocacy Service. The Annexure shows that Mr Lucas was last reviewed by the Tribunal on [date], at which time no change was sought to the Tribunal's order that he be detained at A Hospital, as soon as a bed becomes available, and that in the interim he remain detained at [a correctional facility].

6. There was an email from Ms Sinclair to Dr A and Dr B dated [date], indicating that she was seeking an order for Mr Lucas' transfer to A Hospital "forthwith or within three months".

7. There was not an updated medical report from Dr C. However, there was his report in relation to Mr Lucas' last hearing. Dr C also gave evidence by telephone.

8. After oral evidence was given at the hearing, the Tribunal adjourned the hearing, and requested an updated report from Dr C and written submission from Ms Sinclair. The Tribunal indicated that the panel members would confer after receipt of that material, before making its determination. Dr C provided a report and Ms Sinclair provided a written submission. The panel reached its determination on [date].

9. The Tribunal had a letter by Dr D, addressed to the Tribunal's President, Richard Cogswell advising of the state of bed availability in Forensic Mental Health Network. Dr D related that:

> "patients requiring these beds were prioritised on the basis of 'clinical and legal needs by the NSW Forensic Patient Flow Committee'; the Network has 'limited bed availability and is at full capacity'";
> and that

"In practice over the last two years there has been an average of 15 male patients and 6 female patients per year admitted to the Forensic Hospital. This leads to an estimate of waiting time for the first 15 male patients on the waiting list being up to one year."

ATTENDEES

10. Mr Lucas attended the hearing and was represented by his lawyer, Ms Brae Sinclair of the Mental Health Advocacy Service. Also, in attendance were:
    - Psychiatrist (by telephone);
    - Clinical Nurse Consultant;
    - Mother, and
    - Aunt.

PRESENT CIRCUMSTANCES

Ms Sinclair's submissions

11. In summary, Ms Sinclair's oral and written submissions were that Mr Lucas should have a time limited order as he had exceptional circumstances. Mr Lucas had gained significant weight in custody, ([details of weight gain] after he was commenced on Metformin); he had protracted court hearings in relation to his fitness to be tried and his NGMI finding was not made until [year] although he had already been in custody since [date], without appropriate care; he had ongoing depressive symptoms; he was using illicit substances in custody; he has no access to psychological, drug and alcohol treatment or vocational rehabilitation; and it was his first time in custody. Ms Sinclair stated that neither Dr C or the Tribunal should take into account the policy of the Bed Flow Committee waiting list; and that the Tribunal's determination should be based on a consideration of its governing legislation.

12. Ms Sinclair's written submission included a table of three other NGMI forensic patients who had been transferred to A Hospital on time limited orders over the last 12 months. Ms Sinclair submitted that in each case the Tribunal had found 'exceptional circumstances' and that Mr Lucas' case was also exceptional. Ms Sinclair emphasised the following were factors that the Tribunal should take into account: Mr Lucas' ongoing diversion of medication; his onerous incarceration (by being moved to correctional facilities at [locations], some on multiple occasions); and that the longer than usual time it took for the 'resolution' of his court case.

WRITTEN EVIDENCE

13. Dr C reported that Mr Lucas' illness has been poorly responsive to treatment and that he has ongoing symptoms in the context of treatment with Clozapine augmented by Amisulpride medication. Mr Lucas "continues to experience ongoing referential auditory hallucinations

which he partly attributes to his illness". He has some depressive symptoms "in the context of his ongoing incarceration". Mr Lucas' Clozapine was increased and he was receiving ongoing psychoeducation on how to distract himself from his ongoing symptoms.

14. Dr C stated that Mr Lucas has a severe mental illness with residual positive symptoms and significant negative symptoms which have been targeted with antipsychotic medication and psychological approaches. Mr Lucas requires multidisciplinary long term psychiatric care and rehabilitation. In view of his ongoing psychiatric symptoms and disabilities, the least restrictive and most appropriate treatment consistent with safe and effective care is for Mr Lucas to be transferred to A Hospital.

15. However, Dr C stated that the Tribunal should consider that Mr Lucas was "appropriate to remain in the waitlist to be transferred to A Hospital when a bed becomes available and to remain in a correctional facility until that time".

16. Dr C's report noted that prior to his [offence] charge, Mr Lucas had not previously been diagnosed with a psychotic illness and that he has a diagnosis of schizophrenia. He has a past history of depression and anxiety and three admissions to B Hospital in the context of thoughts of self-harm. He also has a "significant drug and alcohol history" which was "implicated in the offending behaviour' for which he has not received past treatment. He had reported "abuse and sexual assault as an adolescent".

17. Dr C noted that Mr Lucas' Clozapine blood level suggested that he was "continuing to divert his medication" and it was reduced on [date] and converted to syrup. He continues to accept augmentation of Aripiprazole medication. For depressive symptoms he has been prescribed anti-depressant medication to which he has shown "limited early response". Mr Lucas' weight has reduced with diet and medication and "his metabolic parameters have improved" with these strategies.

18. Assessing Mr Lucas' needs using the DUNDRUM instrument, Dr C said that his score for urgent triage suggested "a low level of urgency for transfer"; and "there does not appear to be any significant clinical factors that should take precedence over non-clinical factors that would warrant more urgent transfer". Dr C further stated that Mr Lucas' "limited compliance with treatment, ongoing illicit drug use, ongoing residual symptoms of psychosis and seriousness of the index event" meant Dr C does not believe he was appropriate for transfer from a high secure to a medium secure setting. Dr C recommended that he be transferred when a bed becomes available.

19. There was a report by an Aboriginal Mental Health Clinician. The Clinician reported that Mr Lucas has said that he is “coping ok, I guess” but has reported feeling somewhat depressed over recent days. The finding of NGMI had made him feel “a little overwhelmed” in regard to this status. Furthermore, he is “particularly concerned about having no actual release date”. The clinician said that Mr Lucas has asked questions about the forensic process and he gave him basic information regarding same. Mr Lucas said that he is aware that there is a long waitlist for a bed in A Hospital and is a “little concerned about this”. The report also noted that Mr Lucas has “good support from his mother, father, brother and aunt”. His mother is trying to secure accommodation in Sydney to remain closer to her son for support. The Clinician expressed the opinion that Mr Lucas “will be suited to remain in a correctional centre until a bed becomes available at A Hospital”.

AT THE HEARING

20. Mr Lucas told the Tribunal that he had lost 30kg but had put on 10kg and had achieved this by not eating chocolate and junk foods. Mr Lucas also said he was experiencing “blackouts like a micro-sleep”. The Clinical Nurse Consultant said that Mr Lucas told him that these experiences were reminiscent of a “petit mal” like in epilepsy. The Clinical Nurse Consultant, in answer to questions from the Tribunal said that this had yet to be investigated. The Clinical Nurse Consultant said that he had only been told about it last week. On further questioning by the Tribunal’s psychiatrist, Mr Lucas said that he had experienced 40 or 50 blackouts over six months for about half a second or less, after which he feels light headed and lethargic.

21. Mr Lucas said he could not be sure if Clozapine was making him better or not. It keeps him sedated and it slows his thoughts down. Since the reduction in dose Mr Lucas has had weight loss and more energy so is able to exercise more.

22. Dr C was concerned about the blackouts described by Mr Lucas and said he needed a medical review “sooner rather than later”. Dr C imagined that a review could take place on an emergency basis. The change of medication was to balance the sedation with the auditory hallucination and weight gain.

23. Dr C also confirmed that he had reduced Clozapine and introduced Abilify medication, which was weight neutral. As a result, Mr Lucas has had a significant weight loss in the last few months.

24. Dr C said that the main reason Mr Lucas needs to go to A Hospital is the severity of his illness. The [correctional centre] is not resourced for his treatment. Mr Lucas needs drug and alcohol intervention. However, he does not need to be transferred to A Hospital for the medical

investigation of blackouts. Whilst Mr Lucas needed to go to A Hospital it was not urgent. There are people who had been in the queue longer than Mr Lucas.

25. Asked if there was anything in Mr Lucas' case that meant he should have priority to go to A Hospital, Dr C said there were no acute or psychiatric issues "to put him higher on the list than others". Mr Lucas is doing relatively well. He does have chronic issues that need to be treated but no acute issues to warrant transfer. Mr Lucas is not overwhelmed.

26. Asked by the Tribunal's psychiatrist if Mr Lucas has had a full medical workup, Dr C stated that Mr Lucas needs to be referred for a brain scan and ECG and also a cardiologist for Clozapine monitoring. These investigations can be done relatively quickly once he has been medically assessed. There is a GP on site.

27. The Tribunal asked if there had been any cognitive testing. Dr C stated that there had not been any and he thinks that it would be done in the context of rehabilitation at A Hospital. Furthermore, these tests are more accurate once pharmacotherapy has been exhausted. Mr Lucas was last reviewed in the last two weeks and is usually reviewed every four to six weeks.

28. The Clinical Nurse Consultant confirmed that Mr Lucas is number 11 on the list for A Hospital. The Clinical Nurse Consultant gave an undertaking that he will get a GP to do a medical assessment and arrange for an ECG.

29. Mr Lucas' mother and aunt expressed concern about the time Mr Lucas would wait for transfer to A Hospital and the effects of medication. The Tribunal requested that the Clinical Nurse Consultant facilitate a family meeting, so these issues could be discussed. Mr Lucas' mother was not sure if the medication was doing its job.

30. The Tribunal asked Dr C to address Mr Lucas' continuing condition and likely effects of any deterioration, noting that Dr C had previously given evidence that Mr Lucas' condition had stabilised and that he was clinically stable. Dr C's evidence was that Mr Lucas' current placement was appropriate. Asked about the least restrictive option consistent with safe and effective care, Dr C's opinion was that it was the least restrictive environment comparable to A Hospital.

Ms Sinclair's questions of Dr C

31. Ms Sinclair asked Dr C whether a custodial place was the right place for treatment to occur. Dr C's response was that the appropriate place is A Hospital but that it was reasonable for

Mr Lucas to be in the [correctional centre] unit until a bed becomes available. In terms of equity for people waiting, Dr C's clinical view was that he could not see anything in Mr Lucas' presentation that would mean that he should leapfrog anyone. Furthermore, if Mr Lucas' was clearly unwell or at risk he would certainly be asking the panel to consider transfer.

32. Ms Sinclair asked if Justice Health and Forensic Mental Health Network (the Network) policy was taken into consideration in his treatment of Mr Lucas. Dr C said yes, that he does have some constraints but that his ethics were the clinical treatment of each patient in the context of limited resources in the system. It was not ideal for any patient to be treated in a custodial setting. If A Hospital was twice the size, then it would be best, but it is not so and therefore a waiting list based on number of days waiting is equitable. Fundamentally, there are limited resources for people like Mr Lucas. Patients go onto the waiting list when they are found unfit for trial.

33. Ms Sinclair asked why Mr Lucas' antidepressant medication had been changed. Dr C's response was that Mr Lucas was on Mirtazapine which is weight gaining. Dr C considered that Mr Lucas' depression was not biological but more reactive to his custody. In answer to questions as to how long it took for Mr Lucas to respond, Dr C said that he was slow to respond and then he had gradually improved over the last two months. He does not have a significant response to Clozapine, but that response can occur for up to two years after its introduction. Asked if he was vulnerable by Ms Sinclair, Dr C said that Mr Lucas could be vulnerable like any other patient in the [correctional centre] unit but there was no evidence of his being bullied or stood over in the system.

DETERMINATION

34. The Tribunal was persuaded on all the evidence that Mr Lucas should have a time limited order. Dr D's letter to the Tribunal's President makes it clear that Mr Lucas could be waiting another year for a bed at A Hospital. The Tribunal considers that Mr Lucas has high needs that would be more adequately treated at A Hospital. Moreover, he has been incarcerated for close to three and a half years without access to the range of treatment that he will require if he is to recover. The Tribunal considered that it was appropriate that he should be moved to A Hospital, earlier than the foreshadowed 12 month period.

35. Having said this, the Tribunal also records that it is cognisant of the Network's challenges in trying to provide timely treatment to forensic patients. Dr C in his evidence described the difficulties he faces as a clinician by having to abide by the Networks' policy of having to allocate limited resources; and he observed that this would not be a problem if there were sufficient beds. Ideally, all forensic patients found to have not been responsible for a criminal

offence due to being mentally ill, who would benefit from care and treatment in a hospital, should have immediate access to such care.

36. The Tribunal recognises that it is the task of the Network to prioritise patient movement in accordance with their policy position as a way of fairly allocating treatment based on clinical and legal need. However, the Tribunal generally may only have regard to policy unless "there are cogent reasons to the contrary". A cogent reason for departing from a policy is that its application would result in an injustice (*Re Drake and Minister for Immigration and Ethnic Affairs (No 2)* (1979) 2 ALD 634 (*Drake No 2*)) (Brennan J)). In this case, the Tribunal considered that strictly applying the Network's policy to Mr Lucas would result in an injustice.

37. That is not to say that the Tribunal can make decisions in a vacuum, without regard to practical realities. Section 47 confers a flexible and discretionary power on the Tribunal as to whether or not it makes orders for a patient's care, treatment and detention. In *A (by his tutor Brett Collins) v Mental Health Review Tribunal, (No 4)* [2014] NSWSC 31 Justice Lindsay considered at length the nature of the Tribunal's powers under s 46 and s 47 [83, 100] and found the Tribunal's power of "review" under section 46, was for the purpose of "whether to make any (and, if so, what) orders under s 47…". However, His Honour also held that the word "may" in s 47 "imports a discretionary value judgement, but not an unfettered discretion" [106]. In short, "may" in section 47 does not mean "must" [106]. Having said that, it is also clear that the Tribunal's discretion is "guided, at least", by the statement of objects in section 40 of the Act, the s 68 statement for care and principles, "as well as constrained by the matters" set out in section 74 of the Act [111].

38. It should also be noted that the section 68 statement of principles for care and treatment, which apply equally to forensic patients implicitly recognise that there may be limitations or constraints in their application (section 76). Section 68 is in the following terms:

> *"It is the intention of Parliament that the following principles are,* ***as far as practicable****, to be given effect to with respect to the care and treatment of people with mental illness of mental disorder…"*

39. This reasoning of a broad discretion exercisable by the Tribunal under section 47 goes against Ms Sinclair's oral submission that the Tribunal was compelled to make an immediate or three month order for Mr Lucas' transfer to the Forensic Hospital and that the Network's waiting list and Mr Lucas' priority on that list were irrelevant considerations. As His Honour added in the above case, it was Parliament's intent

"to leave to the Tribunal, upon the conduct of a s46 review, scope to give effect, by a process of reasoning applied to investigation of facts and due consideration to the legislation's purposive element, to its view the justice of the particular case."

40. His Honour also noted, relevantly, the importance of the Tribunal consulting 'the subject matter, scope and purpose of its governing legislation' because of the

"(a) high level of abstraction of the objects, principles and factors identified in the purposive provisions affecting it;

(b) the broad nature of a s 46 "review", incorporating a need to consult the availability of alternative arrangements for the care and treatment of a forensic patient; and

(c) the need, in an appropriate case, to have regard to a range of purposive provisions, not limited to s 68 of the Mental Health Act and ss 70 and 74 of the Mental Health (Forensic Provisions) Act' [112 and 114]."

41. In other words, it is for the Tribunal to decide what factors it may take into account in the exercise of its discretion. In making its decision, the Tribunal considered Mr Lucas' recent history of illness, his current functioning and response to treatment and the urgency with which he requires immediate access to care and treatment at A Hospital. In approaching the case in this way, the Tribunal gives effect to the objects and purpose of the Act as they apply to Mr Lucas' current circumstances.

42. In this case, the Tribunal was persuaded that Mr Lucas' mental state had improved at the [correctional facility] with medication (despite his diversion of medication, which was addressed by using syrup). There was no evidence that he was expressing the frank psychotic symptoms which he had displayed after his incarceration for the index event. However, the Tribunal considered that Mr Lucas' distinct "care and treatment" needs could not, in the long term, be satisfactorily addressed at the [correctional facility]. Mr Lucas has a severe illness, schizophrenia, which was diagnosed for the first time around the time of the index event for which he has not had treatment in the past; clearly it was in evidence at the time of the index event. Mr Lucas was found NGMI of [offence]. Whilst there is evidence that he has partially responded to treatment for his illness, it is concerning that he has developed depressive symptoms which to date have not responded to treatment. It is immaterial that these symptoms are considered to be a reaction to his confinement. Mr Lucas also is not in a setting that can provide him with any support for his ongoing drug use. His dramatic weight gain was also a matter of concern. Mr Lucas has a supportive family who are justifiably concerned about his ballooning weight, depressive symptoms and ongoing drug use. He has a trauma history. Another factor of considerable weight was Mr Lucas' detention in custody for almost three and a half years without access to care. He has improved sufficiently to be able to benefit from the

programs at A Hospital which is equipped to address his illness in a holistic way. Dr C's evidence was also to the effect that Mr Lucas would receive optimal care and treatment for his condition at A Hospital. There was no doubt that Mr Lucas and his family were also concerned about the lengthy wait in obtaining a bed at A Hospital. The order will provide a degree of certainty.

43. The Tribunal did not accept Ms Sinclair's submission that the Tribunal should find that Mr Lucas had "exceptional circumstances". Nor, did the Tribunal consider it relevant or helpful to compare Mr Lucas' case with the factual circumstances of three other forensic patients. The Tribunal's decision stands on the assessment of the merits of Mr Lucas' individual circumstances that compel this outcome.

44. The Tribunal has in the past as a courtesy given some warning to the Network about its intention to make a time limited order. However, the Tribunal considered in light of the delay in Mr Lucas accessing appropriate care that to do so in this case would cause further unacceptable delay.

45. Accordingly, the Tribunal orders Mr Lucas' transfer to A Hospital within six months of the signing of this order.

Signed

Maria Bisogni
Deputy President

Dated this day