THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO MR POWERS AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 21 DECEMBER 2018

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

CIVIL REVIEW:	**Mr Powers**	
TRIBUNAL:	**Maria Bisogni**	**Deputy President**
	Uldis Bardulis	**Psychiatrist**
	Diana Bell	**Other Member**
DATE OF HEARING:	**24 May 2018**	
PLACE:	**X Hospital**	
APPLICATION:	**Further involuntary patient order**	

DECISION

The Tribunal was satisfied on the entirety of evidence that the requirements under s 38(4) of the *Mental Health Act 2007* ("the Act") had been satisfied. Mr Powers is a mentally ill person and there is no other care of a less restrictive kind, that is consistent with safe and effective care which is appropriate and reasonably available to him. Accordingly, he is to remain detained as an involuntary patient at X Hospital for further observation and treatment. He is to be next reviewed on or before 6 December 2018.

BACKGROUND

1. On 6 September 2018, Mr Powers, an involuntary patient detained at X Hospital, was brought before the Tribunal under s 37 of the Act for a determination as to whether he was a mentally ill person under s 38(4) of the Act.

2. According to the information before the Tribunal, Mr Powers was admitted to the X Hospital on after having been scheduled under the Act at another Hospital.

3. Prior to his scheduling, Mr Powers was a forensic patient who had served a limiting term for a charge of recklessly causing grievous bodily harm.

4. Mr Powers had also been charged a number of counts of sexual assault.

5. As is required under the *Mental Health (Forensic Provisions) Act 1990*, Mr Powers' fitness to be tried was periodically considered by the Tribunal. Twice in 2016, the Tribunal determined that he was unfit to be tried. Subsequently, Mr Powers was found fit to be tried following Court reports by two psychiatrists. The Director of Public Prosecutions decided not to retry Mr Powers in respect of the charge, thus ending his limiting term and status as a forensic patient.

6. Mr Powers, during the period of his incarceration, was detained at a number of correctional centres. This was interspersed with treatment at a Hospital under s 55 of the *Mental Health (Forensic Provisions) Act 1990* and treatment in the Mental Health Screening Unit, at a Correctional Centre. In December 2016, the Tribunal made an order for Mr Powers' transfer to a correctional centre when a bed became available. He was discharged from Y Hospital and transferred to the W Correctional Facility.

7. Mr Powers' mental health inquiry was held on 7 June 2018 and the Tribunal determined that he was mentally ill, and an involuntary patient order was made until 6 September 2018.

Evidence from written reports and oral evidence at the hearing

[*The Tribunal documented detailed written and oral evidence from Mr Powers, his treating team and brother about his diagnoses, criminal record, drug and alcohol use. It also considered the limited mental health and community services and supports that had been offered for his mental illness and substance use issues both in the community and custody.*]

Questions by Mr Powers' lawyer

8. Mr Powers' lawyer, Mr Davis, asked Dr A when was the last occasion that he had seen symptoms with respect to Mr Powers as described under s 4 of the Act. Dr A said that he thought it was "a few months back". Dr A said that there had not been any overt positive signs of schizophrenia

recently, but there were still symptoms more consistent with the damaging impact of negative thought processes. Dr A described Mr Powers' as having had experiences of delusional content.

9. Asked by Mr Powers' lawyer if there was any indication of symptoms coming to the fore in more recent times, Dr A stated that being in a high security facility itself had an antipsychotic effect and that what was hoped was that Mr Powers could maintain his stability in a less secure environment. However, if there were signs of those concerns coming through which have historically led to serious sexual and physical violence, then the situation required that those concerns be addressed "quite expeditiously".

10. Dr A was asked by Mr Powers' lawyer if there was a nexus between those symptoms and offending or if Mr Powers posed a "different risk". Dr A's response was that he understood from the medical reports and police reports that 'there was some relationship between alcohol and a disruptive mental state'. It was hard to say to exactly what extent his behaviour was formed from his historical schizophrenia. Dr A stated that it was clear that when Mr Powers came off his depot in prison, he had become quite unwell and those similar themes had come out again.

11. The lawyer of Mr Powers asked Dr A if it was Mr Powers' continuing condition that posed a risk of serious harm to himself or others if he was not detained at the Hospital. Dr A replied that schizophrenia was a relapsing and chronic condition and that Mr Powers "in this high secure setting", was being watched quite vigilantly. Mr Powers was doing very well and while the team had not seen signs of overt schizophrenia recently, if he were suddenly discharged without the right supports he could relapse and that could dispose him to 'risk of violence.' The risk of violence was directly linked to the symptoms that would flow from his deterioration.

Questions from the Tribunal

12. In response to a question from the Tribunal, Dr A said that Mr Powers' remaining in hospital was the less restrictive option consistent with safe and effective care.

13. Asked by the Tribunal to elaborate on the negative symptoms of schizophrenia, Dr A said that these can be constituted by "difficulties in thought processes which relate to insight", including awareness of early warning signs for a relapse of schizophrenia. Issues of ambivalence and lack of engagement on the part of Mr Powers' meant that he required a structured program and staff to help check in on him and make sure things were going well, to make sure he is attending to his medication and to provide him with daily structure. Historically for Mr Powers, a lack of structure has led to boredom which has led to drug and alcohol use and relapse into his illness. Dr A stated that it was a confluence of factors which may come together which could cause a relapse, particularly with the stresses of change. This confluence could lead to relapse and more pronounced symptoms and the more positive signs of schizophrenia.

The submissions of Mr Powers' lawyer

14. Mr Powers' lawyer Mr Davis, made several oral submissions at the hearing. These were supplemented by written submissions sent the day after the hearing. The thrust of the oral submissions was that the 'continuing condition' had to be linked to the symptoms of mental illness under s 4 of the Act and that there must be a manifestation of symptoms in the recent past. Mr Powers' lawyer submitted that Mr Powers had not manifested symptoms for a number of months and there was no indication that they would necessarily occur again.

15. Mr Davis provided a written submission the day after the heading with a cover note stating that one reference he had quoted was not correct. In order to ensure accuracy and assist the Tribunal the document referred to the references made by the lawyer of Mr Powers at the hearing. The lawyer stated that assistance in interpreting the "continuing condition" could be obtained from the wording of s 9(2) the 1990 Act, when the term was first introduced in the following terms: "in considering whether a person in mentally ill, the continuing condition of the person is to be taken into account". Furthermore, in 1997 the term was widened as follows:

> "in considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

16. My Davis also referred to the decision in *Presland v Hunter Area Health Service and Anor* [2003] NSWSC 754 in which Adams J stated that where a continuing condition is to be considered when assessing the question of mental illness

> "the whole relevant clinical condition should be considered, including the distinct possibility that symptoms might only be episodically evident to a greater or lesser degree. Neither s 9 nor s 10 prescribes any artificial chronological limits on what a doctor might or should think is appropriate to take into account."

17. Mr Davis stated that in the absence of further authority and clear understanding as to the meaning and application of s 14(2), reference was made to the following passage from the Second Reading Speech of the Mental Health Bill in 1990:

> "Mr Speaker, the third requirement, that is, the continuing condition of the person, needs some explanation. It is not just the person's condition at the moment of any examination that has to be taken into account in deciding if he is or remains, mentally ill. Fluctuations in the mental state to the person are to be taken into account. Should, at the specific time of examination, the person not manifest one or more of the required symptoms of mental illness, but has done so in the recent past, he may meet the requirements of the definition. This applies at the initial examination at a mental hospital or any subsequent examination."

Legislation

18. The relevant legislative provisions are set out as follows.

19. "Mentally ill person" is defined for the purposes of the Act as follows:

"14 Mentally ill persons (cf 1990 Act, s 9) (1)

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

20. The words "mental illness" referred to in s 14 are defined under s 4 of the Act as follows:

"mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,

(b) hallucinations,

(c) serious disorder of thought form,

(d) a severe disturbance of mood,

(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d)."

21. Section 38 concerns reviews of involuntary patients, with s 38(1) as follows:

"38 Purpose and findings of reviews of involuntary patients

(1) The Tribunal is, on a review of an involuntary patient, to determine whether the patient is a mentally ill person for whom no other care (other than care in a mental health facility) is appropriate and reasonably available."

Section 38 (4) provides:

"(4) If the Tribunal determines that the patient is a mentally ill person and that no other care of a less restrictive kind is appropriate and reasonably available to the patient, the Tribunal must make an order that the patient continue to be detained as an involuntary patient in a mental health facility for further observation or treatment, or both."

Discussion

22. There are two related key questions for determination. The first is whether Mr Powers was a mentally ill person under the Act. If this question is answered in the affirmative, then it is necessary to consider the second key question of whether there is a less restrictive option consistent with safe and effective care, which is reasonably available.

Was Mr Powers a mentally ill person under the Act?

23. The Tribunal was satisfied that Mr Powers met the definition of a mentally ill person under the Act.

24. It was not disputed at the hearing that Mr Powers has a mental illness, namely, schizophrenia characterised by persecutory delusions about women and witchcraft. Nor was it disputed that his condition was likely complicated by cognitive impairment, alcohol and drug misuse and anti-social vulnerability. The Tribunal found that Mr Powers has a condition of schizophrenia that seriously impairs his mental functioning. His medical history and his history of offending support this finding of a mental illness present as required by s 14 of the Act and these histories also provide ample evidence to satisfy the definition of 'mental illness' under s 4.

25. However, Mr Powers' case is made more complex because his treating team conceded that he had not manifested delusional symptoms for a number of months and it could not be said that he was manifesting positive symptoms of a mental illness at the time of the hearing. The Tribunal accepted that Mr Powers' condition had improved with anti-psychotic medication. In recent months there was no evidence of his experiencing persecutory delusions relating to women and witchcraft.

26. The treating team relied upon Mr Powers' "continuing condition" as the basis for his ongoing detention.

27. As pointed out by the lawyer of Mr Powers, the term "continuing condition" under s 14(2) has received little judicial consideration. In construing the term's meaning it is relevant to consider the legislative history of its inclusion in s 9 the 1990 Act, and its amendment in 1997, when the term was expanded to its present wording under the 2007 Act.

28. The term "continuing condition" was introduced for the first time in the 1990 MHA. The 1990 Act was the final outcome of a 1988 Steering Committee on Mental Health (chaired by Ms Anne Deveson) whose task was to review the 1983 MHA. The review was broad ranging and looked at the definition of mental illness, with the final outcome being a broad-based definition of mental illness reliant on symptoms of major psychiatric disorders with psychotic and/or major affective

syndromes (see Dr Peter Shea, "Continuing Condition" (1999) *Defining Madness*, Sydney, Hawkins Press).

29. The inclusion of the term was not a recommendation of the Committee (Dr Peter Shea, op cit.) and it was thought that it was introduced to "deal with" lawyers making submissions at a hearing before a magistrate for a person's discharge based on the lack of symptoms demonstrated on day of the hearing. The inclusion of the term "continuing condition" allowed a doctor to consider the person's retrospective condition in determining if they were a mentally ill person (Dr Peter Shea, op cit).

30. The term was amended and expanded in the 1997 iteration of the Act as referred to by Mr Davis. Minister Refshauge, speaking in the Legislative Assembly on behalf of the then Government, stated that the term was amended to clarify that in assessing a person's continuing condition "regard can be had to the possibility of deterioration, thus allowing preventative action to be taken."

31. This expanded meaning makes it clear that a person's prospective condition is a relevant consideration and is to be taken into account in considering whether they meet the definition of mentally ill. Notably, there is no time frame attached to the re-emergence of symptoms, but the deterioration must be likely (that is, predictable) and the consequences significant. The major mischief to be avoided is the automatic discharge of patients who no longer manifest symptoms under s 4 but who do need further care, treatment and control to prevent deterioration in their mental state.

32. The only relevant judicial consideration of the term occurred in in *Presland v Hunter Area Health Service and Anor* where Adams J considered the term in reference to s 9(2) of the 1990 Act. His Honour did not narrowly construe the term to apply only to cases where there was a recent manifestation of symptoms. Instead, His Honour considered that the entire clinical picture was relevant. His Honour's formulation accommodates the often unpredictable and nonlinear nature of mental illness and the need to assess each person's individual history and circumstances. His Honour's comments support the proposition that the term 'continuing condition' is not circumscribed by requiring some particular temporal nexus to the person's condition and manifestation of symptoms at the time of the hearing.

33. As the lawyer of Mr Powers correctly conceded in his written submission, the decision in *Presland* established that no arbitrary time limits could be imposed, and each matter would turn on its own facts.

34. The Tribunal is of the clear view that very little, if any, weight can now be attached to the 1988 Second Reading Speech which appeared to suggest that there might be a requirement of a "recent history" of required symptoms in interpreting "continuing condition".

35. One reason for the Reading Speech's diminished significance in this context is that the Minister himself in the preceding sentence stated that "fluctuations in the mental state to the person are to be taken into account". This general, unqualified statement appears at odds with the next comment in the Speech that appears to restrict the ambit of taking into account "fluctuations". This incongruence supports the view that the term was not in fact intended by the legislature to be limited only to cases where there was a recent history of manifesting symptoms.

36. In addition, the application of the accepted principles of statutory interpretation mean that the Tribunal should prefer Adams J's judicial characterisation of the term over the suggested interpretation from the earlier Second Reading Speech, the latter being only a secondary and extrinsic, interpretive source. Second Reading Speeches may be useful aids to statutory interpretation to assist to identify the purpose or object of a statute: *Australian Competition and Consumer Commission v Channel Seven Brisbane Pty Ltd* (2009) 239 CLR 305; 255 ALR 1; [2009] HCA 19; *Re Warumungu Land Claim; Ex parte A-G (NT)* (1987) 77 ALR 27. However, they have subordinate, interpretive value when compared to the intrinsic rules of statutory interpretation used by courts, such as discerning the natural and ordinary meaning of the words.

37. Moreover, any interpretive influence of that earlier Second Reading Speech is necessarily significantly diminished by the fact that the relevant provision was substantially amended in 1997 to give a clearly expanded scope to the term.

38. Finally, it should be noted that the Tribunal is by operation of the doctrine of precedent obligated to follow the reasoning of the Supreme Court of New South Wales and therefore bound to follow Adams J's interpretation of the term.

39. It follows from these findings that it was therefore not necessary for the Tribunal in this case to establish some specific temporal nexus between Mr Powers' last experience of symptoms and his current mental health state and the likely re-emergence of such symptoms.

40. The Tribunal therefore accepts that the continuing condition can be relied upon to detain Mr Powers notwithstanding that he has not, in recent months, manifested any symptoms. What is required to come within the "continuing condition" requirement is not the presence of symptoms at the time of the hearing, but the need for ongoing involuntary care and treatment to prevent the manifestation or re-emergence of symptoms for Mr Powers' protection and the protection of others from serious harm. Mr Powers' extensive psychiatric and criminal history strongly point to a prediction that if discharged without effective support and supervision as was his wish, it would, on the balance of probabilities result in his symptoms remerging and he would put himself or others at risk of serious harm. Whilst it was clear that Mr Powers' delusional ideas had not been observed

for some time prior to the hearing, his overall condition was still one of substantial impairment, owing to his negative symptoms of mental illness, cognitive impairment, low IQ and personality vulnerability.

41. The Tribunal was satisfied that Mr Powers' condition is chronic and relapsing and that he had achieved the remission in symptoms because of his hospitalisation in an intensive environment with considerable supports. Mr Powers' has a clear history of relapse in the context of not taking prescribed medication. The Tribunal accepted the evidence of Dr A and the treating team that Mr Powers' still has negative symptoms of schizophrenia that impact on his insight, mental stability and behaviour. He has continued to experience negative symptoms including lack of motivation which have affected his ability to participate meaningfully in the rehabilitation program. He has a significant drug and alcohol history and has only achieved abstinence in custody. He has ongoing cognitive impairment which may affect his capacity to participate in the Hospital's programs. His understanding of his illness and treatment needs is superficial. He has a long and disturbing record of physical and sexual violence. His past record is a strong indicator of potential, future conduct and this was evident from the HCR risk assessment.

42. The Tribunal accepted Dr A's concern that any precipitous discharge to an environment that was unsupported, was likely to result in the re- emergence of symptoms, violent conduct and a return to prison or hospital. The Tribunal agreed with the view of Dr A that the removal of Mr Powers from a high secure facility should only be attempted with a very measured and comprehensive discharge plan in place that takes into account his mental illness, comorbidities and vulnerabilities. A failure to ensure such planning is utilised would more likely than not result in a relapse of his symptoms. Given also his history of physical and sexual assaults, there is the real likelihood of his posing a risk of serious harm to himself and/or others. The continuing condition involves a prediction on the likely result of a patient's discharge. The Tribunal was satisfied on the evidence available, and particularly from Dr A, that there was a significant link between Mr Powers' psychotic experiences and his past acts of physical and sexual violence.

No less restrictive option consistent with safe and effective care, that was appropriate and reasonably available.

43. Considering the events that led to the imposition of Mr Powers' limiting term, his lengthy history of mental health treatment, his history of serious offending behaviour, and his array of mental health issues and vulnerabilities (including his ongoing impaired insight into his illness and his previous longstanding sporadic compliance with treatment), the Tribunal was satisfied that there was no less restrictive option consistent with safe and effective care, that was appropriate and reasonably available. Accordingly, the Tribunal was satisfied that at present, Mr Powers' remains in the least restrictive environment consistent with safe and effective care. This environment is currently necessary to prevent a significant risk of serious harm to himself and others.

44. The Tribunal was satisfied that the treating team had begun the process of carefully and comprehensively considering alternative options and pathways.

45. Mr Powers' complex presentation and history of sexual offending were significant obstacles to acceptance by medium and low secure units, and there was no less restrictive alternative at this time other than ongoing care and treatment at the X Hospital.

46. The Tribunal was satisfied on all the evidence available, that without proper supervision and control, Mr Powers was likely to relapse into positive symptoms of schizophrenia, with potentially catastrophic consequences.

47. Whilst Mr Powers stated that he could reside with his mother if discharged, it was clear that this was not a practical or safe option.

48. Moreover, Mr Powers' brother was very much in support of ongoing care and treatment and careful discharge planning for his brother. His evidence was that his brother had not had the kind of assessment and care opportunities that had now been made available at the Hospital. He welcomed the continuing input of the treating team. The provisions allow for patients to have the benefit of a "stepped", incremental approach to discharge in order to test their readiness for discharge and for patients such as Mr Powers to be the subject of comprehensive discharge planning to prevent deterioration in their mental states.

49. It was also clear that Mr Powers' cognitive impairment has reduced his capacity to engage in rehabilitation at the Hospital and was at least a contributing factor as to why he had been rejected by one medium secure unit.

50. The Tribunal supported the treating team's efforts to explore less restrictive options, and it agreed with the treating team's emerging view that the only viable option would be a community placement with "wrap around" supports as Mr Powers was unlikely to be accepted by medium or low secure units because of his cognitive impairment and history of sexual violence. The Tribunal also endorsed the view that the supports being considered would need to be comprehensive and well thought out.

51. The Tribunal was satisfied that any discharge without the kind of support described by Dr A and other members of the multidisciplinary team, would result in Mr Powers' mental state deteriorating and as a consequence, he would pose a likely risk of serious harm to himself and/or others.

52. Mr Powers' psychosocial needs are great and the Tribunal considers that the treatment plan put in the alternative, that is, for discharge to the community with the support of the NDIS and a

Community Treatment Order, would be the very minimum required to try to prevent a relapse of his illness.

53. Mr Powers faces many challenges due to his impairments arising from his numerous mental health issues. He has achieved a level of stability in a highly regulated and contained environment. Any transition to less restrictive care, whatever form that might ultimately take, must be designed to prevent a relapse of his illness and to prevent serious harm to himself and others and the commission of further offences.

Signed:

Maria Bisogni
Deputy President

Dated: