THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO MR MURRAY BY THE PRESIDENT OF THE TRIBUNAL ON 24 APRIL 2018

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:	**Mr Murray** **32nd Review**

s 46(1) Review of forensic patients
Mental Health (Forensic Provisions) Act 1990

TRIBUNAL:	**Richard Cogswell SC**	**President**
	Raphael Chan	**Psychiatrist**
	Diana Bell	**Other Member**
DATE OF HEARING:	**24 April 2018**	
PLACE:	**Hearing Room 2, Mental Health Review Tribunal**	
APPLICATION:	**Unconditional release**	

DECISION

Having reviewed Mr Murray on 24 April 2018 pursuant to sections 46 and 47 of the *Mental Health (Forensic Provisions) Act 1990*, the Tribunal orders that Mr Murray be unconditionally released.

Signed

His Honour Judge Richard Cogswell SC
President
Dated this day

REASONS

This is the 32nd review of Mr Murray who is currently released to the care of [X Community Mental Health Service] on an order of the Tribunal made in 2017. Mr Murray's treating team is seeking unconditional release at this review.

BACKGROUND

In 2000 the District Court found Mr Murray not guilty by reason of mental illness of several charges of robbery armed with an offensive weapon, robbery armed with a dangerous weapon and intent to commit robbery armed with an offensive weapon. Mr Murray was ordered to be detained. In reaching its decision in this matter, the Tribunal has had regard to, and accepts as accurate, this background information which is maintained by the Tribunal's registry.

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 Act 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 set out in section 40 of the Act and 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) *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, and*

(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 the documents listed in the Forensic Patient Exhibit List dated 24 April 2018.

ATTENDEES

Mr Murray attended the hearing and was represented by Ms Emma Bathurst Counsel, Ms Kate Boyd, Solicitor and Ms Jennifer Darmody, Solicitor. Also in attendance were:

- Dr A (by telephone), Consultant Forensic Psychiatrist;
- Dr B (by telephone), Clinical Nurse Consultant;
- Dr C (by telephone), Consultant Psychiatrist;
- Ms Georgia Lewer, Counsel for the Minister for Mental Health;
- Ms Gillian Buchan, Crown Solicitor's Office for the Minister for Mental Health;
- Dr D, Psychologist and Case Manager from Community Mental Health Service;
- Support person;
- Mother, and
- Stepfather.

PRESENT CIRCUMSTANCES

Notice of Intent

There is a Notice of Intent signed by Kathryn Boyd, Mr Murray's solicitor. It is dated 27 March 2018 and seeks unconditional release for Mr Murray.

Reports

There is a joint report from Dr C, Consultant Psychiatrist and Clinical Director of Mental Health Drug and Alcohol at Y Hospital and Dr D, Psychologist and Care Coordinator at X Community Mental Health Service. The report is dated 19 March 2018.

They refer to diagnoses of Mr Murray's file which include Antisocial Personality Disorder, Severe Polysubstance Use Disorder (complicated by atypical seizure symptoms), Substance Induced Psychotic Disorder (in remission) and Major Neurocognitive Disorder due to multiple aetiologies (traumatic brain injury). They refer to Mr Murray's conditional discharge into the community on 4 December 2017 and his twice daily visits from the X Community Mental Health Services Outreach Team. They note one

emergency department presentation two days after his release followed by some days as an inpatient at Y Hospital. They refer to the *"context of being found by police displaying confused and agitated behaviours in a school playground"* with fluctuations in consciousness. They believed the behaviour "*be related to the ingestion of unknown substance of abuse"* although that is denied by Mr Murray.

Since then, however, Mr Murray *"has shown good engagement"* with the community health service and treating psychiatrist. They do, however, note that *"the motivation for his attendance and encouragement has been to demonstrate compliance to the Tribunal rather than a genuine desire to engage or a view that this engagement in any way benefits his health or wellbeing."* His drug screens are negative but they "*might not detect atypical synthetic substances of abuse.*" They doubt his attendance at Alcoholics Anonymous meetings. He engaged with X Drug and Alcohol Service "*and requested that a supportive report be written to the Tribunal."* Again, they say that "*the sole motivation for him to have had the assessment was to secure a letter of support for an unconditional discharge*." Mr Murray acknowledged as much as well, by reference to Alcoholics Anonymous attendance.

The opinion of the X Community Mental Health Service is that "[patient] *presents with a long-term significant risk of relapse into substance use.*" This is "*likely* [to] *lead to an increased risk for serious medical episodes (seizures) and potential for loss of life."* He has recently exited the HASI support program "*and currently has minimal community based supports*." As a voluntary patient, the team thinks that *"he would cease all contact with his support services, including* [X Outreach Team]*."* There would therefore be no active follow-up or monitoring of his wellbeing and substance use and risk.

On the other hand *"there has not been any level of community based support identified that could suitably mitigate* [patient's] *substance use."* He is seen twice a day and even in a high secure facility his substance use could not be managed effectively. Abstinence from substances *"must be managed independently*" and *"would only truly be effective if he shows the willingness to engage voluntarily".* While under the care of X Community Mental Health Service, "[patient] *has demonstrated no features of a psychotic illness or major mood disorder outside the context of substance use*."

The treating team supports the unconditional release application despite "*concerns regarding the ongoing risk in relation to substance use and the potential for medical episodes or death*". The grounds of support are "*that he does not present with symptoms of an enduring mental illness."* The treating team's opinion is that "[patient's] *problematic behaviours are related to his poor insight and impulsive nature, this in turn leads to his increased risk of use of substances, medical episodes and high risk of mortality*." They note the reference in the Tribunal's last reasons to the behaviour of concern being "*related to a condition acquired since the index events".*

There is a report from Dr E, Consultant Psychiatrist. It is dated 10 April 2018. It seems that Dr E was qualified for an opinion about Mr Murray rather than being a treating psychiatrist. He interviewed Mr Murray in his rooms on 26 March 2018. He noted the context of "*his desire for unconditional release*".

Dr E notes that Mr Murray "*said he has not used illicit drugs since* [the index event] *but has used phenobarb which he got online to help sedate him.*" Dr E noted the traumatic brain injury from the 2011 car accident and *"the key deficits … around frontal lobe injury which have led to marked impulsivity, poor judgment and a degree of mood dysregulation."* He noted the multiple diagnoses from Dr F's reports. He notes *"from the correspondence that* [patient] *does not satisfy the criteria for a mood or psychotic disorder*" but that his *"key deficit is related to the brain injury leading to impulsivity and poor judgment."* He adds: "*This does not reach the threshold of a mental illness in the legal or medical definition."*

He expressed the opinion that "[patient] *does clearly suffer a traumatic brain injury associated with frontal lobe deficits which are primarily related to poor impulse control, worsened further by use of prescription drugs.*" His "*insight around the broad significance of this injury remains mixed, but he does display insight into the reasons for his prescribed treatment and has a clear desire to cooperate with suggested treatments."* Mr Murray *"satisfies the criteria for polysubstance abuse*" but psychiatrically "*he does not display any signs of a clear mood or psychotic illness*." Mr Murray "*does not in my opinion pose a threat either to himself or others*." He "*retains some significant vulnerabilities as a result of his traumatic brain injury,"* but "*these do not meet the test in the mental health legislation for someone requiring an ongoing restrictive treatment order to avoid harm to themselves or others.*" Dr E says he is "*in agreement with the treating team that an unconditional release is appropriate.*" He notes Mr Murray's agreement to cooperate but that his "*insight with regards to the impact of his traumatic brain injury remains mixed and he requires ongoing disability input."*

There is a report from Mr Murray's treating neurologist, Dr G. It is dated 16 April 2018. Dr G thought that Mr Murray's "*attacks … probably were not epileptic, rather being an unusual reaction to stimulant drugs taken for ADHD*". The EEG "*single sharp wave*" was "*probably related to an injury incurred to his brain in a car accident.*" The "*anti-epilepsy drugs that we tried did not prevent his attacks which always included deep unconsciousness but sometimes included violent struggling as he came out of the attack."* He noted the last attack was around 23 May 2017 and that Mr Murray "*has remained since then on Lamotrigine 20 mgs daily".* Dr G does not want to change that medication "which is his only drug and which suits him quite well." The examination was normal and Dr G's opinion from *"the neurological point of view"* is that Mr Murray "*is doing well and doesn't need more supervision, thinking here of yearly visits to myself, than anyone else with well controlled episodes as he has."* Mr Murray is "*quite capable of independent living from the neurological point of view*."

There is a note from a Community Services Worker with HASI. It is dated 9 March 2018. She has been working with Mr Murray since December last year and he exited from their service on 7 March 2018 *"due to* [patient's] *developed independence and lack of need for our service.*" She noted during the months of supervision that "[patient] *has been independent, mostly relying on the social aspect of the HASI program, interacting with us out of courtesy in his attempts to see if support could be given."* He "*displayed adequate living skills to maintain his tenancy and independence in the community during the past few months"*. Because of his independence *"in addition to Mr Murray's own insistence,* [patient] *has been*

exited from our service, due not fulfilling the requirements of need by HASI." The Community Services Worker thinks that "[patient] *will be able to maintain his tenancy, and the cleanliness of his unit, maintain his social connections, continue to generate and pursue his own goals, and live independently in the community."* She acknowledged these observations "*had been made while* [patient] *is in a period of wellness"*. She is confident he will continue to recover and develop.

There is a report from Dr A, Consultant Forensic Psychiatrist, and Dr B, Clinical Nurse Consultant, both with the NSW Community Forensic Mental Health Service (CFMHS). It is dated 26 March 2018. They noted the file references to some over familiarity and deodorant spray odour in Mr Murray's unit earlier this year. He apparently left the HASI service in order to demonstrate his independence in living to the MHRT. He left Alcoholics Anonymous after a facilitator declined his request for a report for the MHRT. He denied feelings of disinhibition and behaviour of over-familiarity.

The authors observed during a mental state examination that "*Mr Murray continues to evidence poor insight and judgment."* He "*did not appear to appreciate the significance of the multiple factors likely to have contributed leading to his prolonged period of recurrent disturbance of physical and mental health."*

They say that Mr Murray *"meets criteria for Antisocial Personality Disorder"* and he has a major neurocognitive disorder due to a traumatic brain injury and a recurrent delirium *"likely due to multiple aetiologies including epilepsy and use of substances*." He meets "the criteria for Substance Use Disorder (Phenibut)". He is in remission although meeting the criteria for Alcohol Use Disorder, Stimulant Use Disorder and Cannabis Use Disorder. There was one episode of Major Depressive Disorder following the car accident in 2011 but that is in full remission. He has "*evidenced mood disturbance characterised by elevated mood, pressured speech and disinhibited behaviour*." Differential diagnostic considerations *"may include Bipolar Disorder, a substance related and psychotic mood disorder (including Phenibut withdrawal) as well as the possibility of a post-ictal state*."

They think that diagnostic clarification "*will require longitudinal observation*." He has not presented with generalised anxiety symptoms for some two years.

His problem behaviour is a history of reactive aggression. They review his static and dynamic risk factors and factors which "*could precipitate another episode of reactive aggression".* They review his strengths and protective factors. They note his recurrent episodes of altered consciousness associated with medication non-compliance and substance use and underlying vulnerabilities to develop delirium. The car accident left him with structural brain damage. His cognitive performance and EEG suggest deficits and abnormalities respectively and they expressed the view that these "*structural and dysfunctional deficits render him more susceptible to triggers that could then lead to global cerebral dysfunction (seizures, delirium or a combination)."* They say that the "*observation that periods of elevated mood have occurred will require clarification to determine whether such features reflect an underlying mood disturbance or features associated with fluctuations of an organic presentation."* Given his clinical vulnerability, *"there is*

a need for completion of clinical investigations (such as ambulatory EEG) and the need for continuing close clinical observation to ensure that recently reported improvements are maintained."

Turning to section 74 of the *Mental Health (Forensic Provisions) Act* they express the opinion that Mr Murray "*suffers from mental conditions of Antisocial Personality Disorder, Substance Use Disorder and Neurocognitive Impairmen*ts." They note that Mr Murray "*has suffered from mental illnesses of depression and substance induced psychosis characterised by a disturbance of mood, delusions and hallucinations*." They express the "*opinion that there are reasonable grounds that care, treatment and control is necessary for his own protection from serious harm and the protection of others from serious harm."* Mr Murray's and the public's safety are "*unlikely to be seriously endangered*" if Mr Murray remains on conditional release "*provided he complies with conditions and adheres to his management plan and the direction of the treating team*." That is the least restrictive environment for his safe and effective care.

However they do not support unconditional release *"at this time*". There has "*been only a relatively short time since his last episode of altered consciousness and mental state instability."* They note the history "*that when* [patient] *evidences such disturbed behaviour, his safety/or the safety of the public has been placed at significant risk*." They say that if Mr Murray is not "*managed with a mandated level of oversight, the risk of harm to self or others remains."* They make recommendations for treatment, placement, restrictions and monitoring.

At the hearing

Mr Murray said that he was good and doing really well. He was in a good place physically and mentally and had a support network which includes his GP, oncologist, neurologist, supporting friend, the drug and alcohol counsellor and his family. Dr C added that he has agreed to see Mr Murray if Mr Murray wants to. Mr Murray said he got on quite well with and was happy to still see him because he was not forced to. He is confident with the Drug and Alcohol counsellor. They are working on his anxiety and she is knowledgeable about his Phenibut.

Dr C was asked if he supported unconditional release. He said that while he has been treating Mr Murray (since December 2017), he has seen no evidence of a functional illness (no psychosis, mood disorder or anxiety). He thought it unlikely that Mr Murray falls within the terms of the *Mental Health Act.* He has seen no deterioration in Mr Murray's mental state. He acknowledges the opinions of Dr A and Dr B but emphasises that he himself has seen no evidence of ongoing mental illness. He is happy to still see Mr Murray who, he says, does not meet the statutory criteria for a mental illness. He accepts he has an historical mental condition and a substance use disorder but has seen no evidence of the use of illicit substances. The traumatic head injury caused a mental condition as well. The urine drug screens have been negative although Dr C acknowledges they cannot pick up synthetic drugs. He is willing to keep seeing Mr Murray but acknowledges that Mr Murray does not think that he suffers from a mental illness and he is unlikely to see the benefit of the consultation.

Mr Murray's Case Manager was asked about Mr Murray's ability to live independently and responded that he needs a strong network. He needs proactive relapse prevention rather than reactive. His Case Manager would like to see Mr Murray continuing with his community supports including his various doctors and counsellors. His more recent interactions have been more meaningful and he is pleased to see Mr Murray seeking help but "*time will tell*".

Dr A noted the recent history of a hospital admission and behaviour and posed the rhetorical question of what is the best way to manage the risk to the community. Dr A thought it was "*quite early*" for unconditional release and some more months were needed.

Dr B said, based on past information, that Mr Murray needed constraint because he was combative when he was in an altered state of consciousness. She noted that kind of presentation at Emergency Departments.

Dr A acknowledged that Mr Murray expressed that he "*would have been dead*" but for the forensic order but that he was still concerned about the effects of the brain injury and Mr Murray's judgment. He thought Mr Murray needed a longer time frame. He was concerned that Mr Murray had stopped the HASI support and really needed to demonstrate that he could cope.

Mr Murray confirmed that his dose of Lamotrigine was 200 mgs rather than the 25 mgs mentioned in the report of Dr E.

Dr A preferred to see if the improved insight carried on for a longer period of time.

Dr C under cross examination acknowledged that Mr Murray could pose a risk if he was intoxicated and that he needed "*chemical restraint*" in Emergency Departments in the past, although Dr C thought the risk to himself was of greater concern. But the risk is not the result of any mental illness. He acknowledged the relatively short period of time before the proposed unconditional release and that longer would provide a better view but there has been stability over the last six months. He acknowledged that he would be more confident if it was over a longer period of time. He acknowledged the risk of harm to Mr Murray by substance abuse and a risk to others if Mr Murray was abusing substances. It was, he said, a predictive exercise. Mr Murray's history suggested he may relapse but that he is doing a lot to present favourably at the moment. The longer he does that the more confident Dr C would be.

Dr A emphasised his concern about a relapse and his behaviour when unwell in Emergency Departments.

Mr Murray's mother said she had seen a "*complete change*" in her son over the last six months which she had never seen before. She is in daily contact and has seen no evidence of intoxication and he seems to have turned his life around. She has seen a "*new* [patient]". He has done enough time under the forensic order which she thinks was of little use. She supports him. If he stays under the order it will do him more

harm than good because his life is on hold and better treatment might be available elsewhere. The order is holding him back.

Mr Murray's support person referred to Mr Murray's supports within the community and she was reassured also in speaking to him. She thought it unjust that he should stay under the forensic order, indeed possibly illegal. She thinks he presents very little risk to the public.

Dr A thought that a Community Treatment Order would be of no benefit but, more to the point, was not available because Mr Murray does not have a mental illness but a mental condition. A mental illness remains open as a possibility but it is more likely to arise in the context of intoxication. A mental condition is a better description.

Mr Murray's stepfather said it was time to bring an end to the order which his stepson no longer needs. He has strong family support.

Mr Murray acknowledged that the order was originally productive but is now counterproductive. He feels like a child that is being sheltered and wants to be given the opportunity to live his life. He acknowledged that he was using illicit substances during index events and will not go near them again. Phenibut is OK but it affects his seizures and medication. He feels stronger than he has ever been.

Dr A said that the brain injury presented difficulties in decision making and reasoning as well as providing some affective instability. There is a lack of clarity about behaviour coming from the acquired brain injury or the substance abuse. The head injury is likely to contribute to his ability to plan and make decisions.

Mr Murray's Case Manager confirmed that they were not asking for a Community Treatment Order because there was no evidence of mental illness.

Dr A and Dr B did not support the unconditional release because the time frame was too short. They thought Mr Murray needed about 12 months of stability.

Mr Murray's Case Manager could not see any difficulty with a period of 12 months of stability rather than six months but it would provide stress for Mr Murray. They would continue to support him. The twice daily visits from the Assertive Outreach Team have mostly worked out. There are a couple of instances of elevated mood but no significant concerns which needed intervention. His medication is supervised. Observations of behaviour do of course have their subjective elements. There was nothing alarming. They keep a board about their patients documenting concerns but there was nothing alarming concerning Mr Murray.

Mr Murray said his mood fluctuates like any other person's. This does not mean that there is a chemical imbalance.

Dr A and Dr B acknowledged that there is currently a framework of support around Mr Murray. A longer period would be better with relapse less likely. He needs a longer period of stability. They still think he presents a significant risk and a significant clinical concern.

Submissions

The Tribunal received significant assistance from written submissions prepared by Ms Lewer for the Minister and from Ms Bathurst and Ms Boyd for Mr Murray.

Ms Lewer, in her submissions, argued that "*there are a number of cogent factors in* [patient's] *case that warrant the Tribunal adopting a cautious approach to his management and not granting him unconditional release at this time.*"

She argues that the opinion of Dr A and Dr B should be preferred and that even the current report of Dr C and Mr Murray's Case Manager pointed to risks. She pointed to the recency (December 2017) of symptoms of Mr Murray's mental condition and evidence of Mr Murray's mental condition as well as evidence of observations by visiting community workers earlier this year. In particular she pointed to his hospitalisation in December last year. She pointed to the risk Mr Murray poses to himself and to the opinion of Dr C and his Case Manager that there is a *"high risk of mortality".* She points to instances of police removing him wandering through a school in an altered state of consciousness and to the seriousness of the index events.

Ms Lewer further points to "*a poor history of compliance with medication (leading to hospitalisations) and non-compliance with Tribunal orders and treating team directions*." His recent better compliance is motivated by his desire for unconditional release argues Ms Lewer. He lacks insight, and, she argues, "*the removal of all conditions from* [patient] *is likely to result in reduction or cessation of treatment and an associated deterioration of his mental condition with an increased risk* [of] *serious harm to himself and others*." She points to Mr Murray's "*severe substance use disorder*" and links between illicit drugs or non-prescription drugs and mental illness or mental conditions. She says that "*Mr Murray has effectively engaged in no treatment for his substance misuse."* She points to his use of drugs in the hospital ward.

She argues that Mr Murray *"would likely relapse into alcohol and illicit, synthetic and/or prescription drug use*" increasing the risk to himself and others. She argues that he lacks community supports including clinicians in the community. Finally she argues that there is no application for a Community Treatment Order therefore no mandated treatment or supervision which likely means he will choose "*to have no treatment whatsoever*."

At the hearing, Ms Lewer acknowledged the evidence of recent good progress by Mr Murray, but emphasised that the application remains premature. It is too early for the level of confidence needed for release without compulsory treatment. Two major concerns were a lapse into substance misuse and the

possible absence of continuing treatment. She points to Dr C's opinion that Mr Murray is unlikely to see the need to continue to see him including, she argued, his demonstrated animus towards the forensic system. She pointed to the conditional release granted in November last year but then his hospitalisation the following month.

She argued that Dr E did not address the relevant statutory test under section 43 and to the evidence, she argued, that Dr C was in general agreement with Dr A and Dr B regarding the question of risk.

The real issue was risk not whether release was "*desirable*". She pointed to the history of the use of illicit drugs leading to psychosis and the misuse of alcohol leading to the car accident which caused the brain damage. Without oversight, she argued, there is a real chance that Mr Murray will relapse into alcohol and illicit drug use. There is a history of conditional release followed by repeated hospitalisations. More time is needed before there can be a sufficient degree of confidence. She also pointed to a history of deceit and relapse. There is a risk of violence associated with seizures and Mr Murray needing restraint in Emergency Departments.

She argued that Dr A from the CFMHS clearly fell within the required terms of section 74(d) of the Act whereas Dr E did not. She acknowledged that the Tribunal can have regard to Dr E's report but it should be accorded less weight.

In their written submissions, Ms Bathurst and Ms Boyd argued, by reference to section 74(a), that Mr Murray "*is not suffering from a mental illness*" nor taking any medication for such an illness. Although it does not form part of the statutory test for release, the question of whether or not Mr Murray has a mental illness "*is a mandatory consideration in the context of the present application.*" They acknowledge that their client "*does have various mental conditions".* But he has insight and motivation to remain well.

By reference to section 74(b) they acknowledge Mr Murray needs continuing treatment but not control for his own or others' protection from serious harm. They argue that the CFMHS opinion about control is not supported by the evidence which is not sufficient to conclude that their client's unconditional release would seriously endanger the public.

By reference to section 74(c) they argue that there was only one episode of diminished mental health in the last six months and that Mr Murray's condition is "*currently stable*". His neurologist says these episodes are well controlled. Mr Murray is seeking drug and alcohol counselling and they pointed to a report from HASI about Mr Murray living independently.

By reference to section 74(d) they point to Dr E's report. They argue that the brain injury challenges do not mandate restrictive treatment (relying on Dr E) and point to the evidence from Dr C and Mr Murray's Case Manager that the risk of substance abuse arises from his impulsivity. Occasions of elevated mood do not point to a disorder and the need for control.

They argue that there is no proper basis for concluding that Mr Murray's unconditional release will seriously endanger any member of the public and they point to the Tribunal's conclusion to that effect in the context of his conditional release in November last year and argue that nothing has changed since then.

They say the suggestion of misuse of aerosol cans is not soundly based in evidence. They argue that he is not at sufficient risk himself because the last seizure was in August last year and he has the support of family and friends. His living conditions have been satisfactory over the last six months. Even if he lapsed into substance abuse it does not follow that it would produce a real risk to the community because "[patient] *has not committed any crimes since 2011 (and the index offences occurring some 20 years ago), notwithstanding deteriorations (and subsequent recoveries) in his mental health since that time."* He has willingly engaged with his medical practitioners and has another appointment with the drug and alcohol counsellor. He has no desire to change his medication regime and has engaged with home visits which can be quite onerous. Mr Murray's continued adherence to his medication regime and avoidance of substances "*can be achieved through appropriate engagement with and monitoring by his general practitioner, psychologist and neurologist*" who are all available to him. He can still also obtain support from the Community Mental Health Service. He has enough insight to keep himself safe.

At the hearing, Ms Bathurst argued that her client has no current mental illness. He may have a mental condition from the brain injury in 2011 but this was not associated with the index events. He has shown a lot of insight despite "*ticking the boxes*". He has used the services he has been offered and is ready to move forward. The hospitalisation in December 2017 was an isolated event and drug screening has been negative.

Ms Bathurst acknowledged that the highest she could put Dr E's qualifications under section 74(d) was that the Clinic where he practises has a forensic unit.

There has been no risk to the public over the last six months and the Tribunal was satisfied on the last occasion that there was an insufficient risk to refuse a conditional release. The index event was some 20 years ago and the only other suggestion is some violent interaction with another patient recently. Conditions are not necessary to protect their client or the public from serious danger to their safety.

His support network will ameliorate any risk of a seizure while living alone. She pointed to the letter from the Community Services Worker of HASI and Mr Murray's Case Manager's evidence that most of the last few months have been without incident. Observations by visitors can be subjective. She pointed to the evidence of Dr C and Dr G and his support person who supported her client's conditional release.

She pointed to her client being at the end of his tether and pointed to the evidence demonstrating, in accordance with section 43(b) of the Act, that "*other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available*" to her client.

Consideration

Current treating psychiatrist Dr C and case manager both support unconditional release. It is fair to say their reasoning is qualified and they are not completely confident, but they appear to remain committed to that position.

Dr E supports unconditional release.

Neurologist Dr G says that Mr Murray does not need supervision "*from a neurological point of view".*

However Dr A and Dr B do not support unconditional release at this stage. They maintain their support for conditional release.

Turning to the matter for the Tribunal's consideration posed by section 74(a) of the Act, the diagnoses of Dr A and Dr B do not include any mental illness. Also, Dr D is of the view that Mr Murray's condition "*does not reach the threshold of a mental illness in the legal or medical definition"* and Dr C and Mr Murray's Case Manager say that "*Mr Murray has demonstrated no features of a psychotic illness or major mood disorder outside the context of substance use*."

The Tribunal is comfortable in concluding that Mr Murray does not currently suffer a mental illness.

However Drs A and B diagnose "*the mental conditions"* of Antisocial Personality Disorder, Substance Use Disorder and Neurocognitive Impairments. It seems clear to the Tribunal that it was the traumatic brain injury from the car accident in 2011 that has produced *"marked impulsivity, poor judgment and a degree of mood dysregulation*" (Dr E) and "*poor insight and impulsive nature*" (Dr C and Mr Murray's Case Manager) and made Mr Murray "*more susceptible to triggers that could lead to global cerebral dysfunction*" (Dr A and Dr B).

The Tribunal is of the opinion that the impulsive and problematic behaviour demonstrated by Mr Murray for some years now is clearly more related to his brain injury (and perhaps underlying personality). These are mental conditions.

Mr Murray was found not guilty by reason of mental illness in 2000 and referred to the Tribunal. Since that finding, Mr Murray's mental illness has effectively come into sustained remission (although liable to provoked re-emergence). During Mr Murray's detention as a forensic patient he suffered an acquired brain injury in a car accident. That produced a mental condition resulting in the impulsivity and poor judgment and other symptoms described by the doctors. Those symptoms have resulted, it seems clear

to the Tribunal, in increased risk-taking behaviour including aggravating a pre-existing drug abuse condition. The danger posed by Mr Murray to himself and others is related to drug taking and risky disinhibited behaviour.

The Tribunal must be satisfied that his behaviour will not seriously endanger his or the public's safety (section 43(a) of the Act).

It is apparent to the Tribunal that having more time (for example another 6 or 12 months) is unlikely to produce a change in Mr Murray's underlying conditions. They are related to a brain injury.

Danger to Mr Murray himself is by misadventure (accidental overdose or an accident occurring whilst he is under the influence of illicit substances). The Tribunal acknowledges that Mr Murray is obviously behaving appropriately at present because he is motivated to secure unconditional release from the Tribunal. Even given that, he has good family support and support from a friend, all of whom attended the Tribunal hearing and demonstrated their support. He himself said that he has a support network which includes his GP, oncologist, neurologist and a drug and alcohol counsellor as well as his family and friend. The Tribunal thinks it reasonable to conclude that any erratic or inappropriate behaviour of Mr Murray is likely to be noticed by his family and friends who will remind him of his need to see his GP or drug counsellor. There are also available to him his neurologist and of course hospital emergency departments which Mr Murray has used regularly before. In other words, care of a less restrictive kind consistent with safe and effective care is appropriate and reasonably available to Mr Murray (section 43(b) of the Act). It must also be borne in mind that the Tribunal granted conditional release in November last year. Mr Murray was given supervision but only by visits from the community team twice a day and his own safety has not been seriously endangered since then (section 43(a) of the Act). Although Dr C and Mr Murray's Case Manager refer to a high risk of mortality, Mr Murray has been an illicit substance user for some time. Continued use will put his safety in some danger but his own experience and survival over years will mitigate that danger so that it drops below serious.

The Tribunal is also satisfied on the evidence that an unconditional release of Mr Murray will not pose serious endangerment to the safety of the public. The index events were some 20 years ago and the only evidence of criminal behaviour since then was the drunk driving resulting in his accident in 2011. Again this (drink driving) is obviously a potential danger, but the risk to the public is no greater than that posed by all the other members of the community who drive under the influence of alcohol or illicit drugs. Drink driving has been detected only once over the years. The Tribunal notes the intended deterrent effect of conviction and losing of licence in ameliorating risk. Mr Murray has demonstrated some aggression in emergency departments, again, probably no more than other drug addicted patients. Such behaviour occurs in the presence of professionals trained to anticipate it. In other words there are risks to the safety of the public but they are significantly and sufficiently ameliorated by these circumstances.

Clearly Mr Murray has mental conditions but risks associated with those conditions have not become apparent over the last six or seven months.

The problem behaviour (mostly related to brain-injury-induced impulsivity) produces no greater public danger than that generated by thousands of other members of the community with drug or alcohol problems.

Considering the opinion of Dr A and Dr B (the persons qualified under section 74(d)), they were comfortable with a conditional release because Mr Murray's and the public's safety are unlikely to be seriously endangered "*provided he complies with conditions and adheres to his management plan and the direction of the treating team*". But it must be borne in mind that his opportunity to misbehave has existed for close on 24 hours a day on conditional release. It is acknowledged that his good behaviour is no doubt driven by his desire for unconditional release but, again, any misbehaviour is likely to pose no greater risk than the community currently faces. The Tribunal acknowledges that there has been a relatively short period of stability but thinks that any further period is unlikely to improve Mr Murray's prospects or risk to himself or others. There is a concern, as Ms Lewer points out, of a lapse into substance misuse but the subsequent risks to himself or the public are no greater than those posed by other illicit drug users. Again, the Tribunal thinks that more time is not going to make any difference.

The Tribunal accepts the submissions of Ms Bathurst and Ms Boyd that Mr Murray clearly needs continuing care and treatment but not control for his or others' protection from serious harm (section 74(b) of the Act). Mr Murray's continuing condition is unlikely to change and will deteriorate with illicit drug use (section 74(c)) but the effects of the deterioration do not warrant ongoing control under the Act.

Signed

His Honour Judge Richard Cogswell SC
President
Dated this day