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HARRY v MENTAL HEALTH REVIEW TRIBUNAL AND ANOTHER

Court of Appeal: Kirby P, Mahoney JA and Clarke JA

14-15 December 1993; 31 March 1994

Mental Health — Community treatment orders — Compulsory medication — Mental Health Review Tribunal — Power to make — Whether power exercisable in absence of party — Whether finding that party "mentally ill person" condition precedent — Mental Health Act 1990, ss 51, 57, 59, 119, 131, 133, 274.

B

Mental Health — Mental Health Act — Objects and purposes of legislation — Procedures established by legislation — Duty of advocate for mentally ill person — Mental Health Act 1990.

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Statutes — Construction — Remedial statutes — Objects and purposes of legislation — Procedures established by legislation — Duty of advocate for mentally ill person — Mental Health Act 1990.

Held: (1) (Kirby P dissenting) The Mental Health Review Tribunal has the power to make a community treatment order pursuant to the *Mental Health Act* 1990, s 131, even though, when notice of the proceedings has been given to a party, that party does not appear or is absent from the Tribunal when the order is made. (332C-D, 343B)

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(2) The Tribunal is not required, as a condition precedent to the making of such order, to find that a person is mentally ill within the meaning of the *Mental Health Act* 1900. (329F, 332E, 341F).

Discussion of the objects and purposes of the *Mental Health Act* 1990 and the procedures established by it.

Consideration (by Mahoney JA) of the duty of an advocate appearing for a mentally ill person. (335B)

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Note:
A Digest — MENTAL HEALTH (3rd ed) [5]; STATUTES (2nd ed) [55]

CASES CITED

The following cases are cited in the judgments:

Ainsworth v Criminal Justice Commission (1992) 175 CLR 564.

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B v Medical Superintendent of Macquarie Hospital (1987) 10 NSWLR 440.

Balog v Independent Commission Against Corruption (1990) 169 CLR 625; reversing (1989) 18 NSWLR 356.

BIL (NZ Holdings) Ltd v ERA House Ltd (1991) 23 NSWLR 280.

Bolton Re; Ex parte Beane (1987) 162 CLR 514.

Cameron v Cole (1944) 68 CLR 571.

David by her Tutor the Protective Commissioner v David (1993) 30 NSWLR 417.

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Fitzgerald, Ex parte; Re New South Wales Medical Board (1945) 46 SR (NSW) 111; 63 WN (NSW) 16.

Graham v State of New South Wales (Court of Appeal, 13 October 1989, unreported).

Hawke, Re; Hawke v Hawke (1923) 40 WN (NSW) 58.

John Fairfax & Sons Ltd v Police Tribunal of New South Wales (1986) 5 NSWLR 465.

Kingston v Keprose Pty Ltd (1987) 11 NSWLR 404.

Kioa v West (1985) 159 CLR 550.
Logwon Pty Ltd v Warringah Shire Council (1993) 33 NSWLR 13.
Mabo v State of Queensland [No 2] (1992) 175 CLR 1.
Magor and St Mellons Rural District Council v Newport Corporation [1952] AC 189.
Marshall v Watson (1972) 124 CLR 640.
Metal Manufacturers Pty Ltd v Lewis (1988) 13 NSWLR 315.
R v Forbes; Ex parte Bevan (1972) 127 CLR 1.
R v Hallstrom; Ex parte W [1986] QB 1090.
Rogers v Whitaker (1992) 175 CLR 479.
Smith v Corrective Services Commission (NSW) (1980) 147 CLR 134.
Taylor v Taylor (1979) 143 CLR 1.
Twist v Randwick Municipal Council (1976) 136 CLR 106.
Veen v The Queen (1979) 143 CLR 458.
Veen v The Queen [No 2] (1988) 164 CLR 465.
Walton v Gardiner (1993) 177 CLR 378; affirming (1991) 25 NSWLR 90.
Watson v Marshall (1971) 124 CLR 621.

APPEAL

A community treatment order was made against the appellant. She appealed from that order and also sought a declaration that she had been denied natural justice when the order was made. Hodgson J dismissed her summons and she appealed against that dismissal.

J Basten QC and *I H Wallach*, for the appellant.

S J Gageler, for the respondent.

Cur adv vult

31 March 1994

KIRBY P. This appeal from orders of Hodgson J, in the Protective Division of the Supreme Court, concerns the operation of the *Mental Health Act* 1990 (the Act). The Act is the latest in a series of laws governing mental illness in this State. Those laws trace their origins, ultimately, to the Royal Prerogative which, from feudal times, protected the mentally ill. The original commission issued to Governor Phillip in 1787 contained instructions, enlightened for the time, concerning the application in the penal settlement of the English law on the subject. Since the advent of responsible government, numerous statutes have been enacted, including the *Lunacy Act* 1898, the *Mental Health Act* 1958, and the *Mental Health Act* 1983: see *David by her Tutor the Protective Commissioner v David* (1993) 30 NSWLR 417 at 421.

The present Act is the latest in this series. It is much longer than its predecessors. It contains a number of novel concepts and procedures, relevant to these proceedings. Some of its provisions are said to have been borrowed from the laws of several jurisdictions in the United States. Under one such provision, the appellant was made subject to a community treatment order. This order provides for compulsory medication. The appellant objects to the order. She does so, in this Court, upon two bases.

The first is that there was no power in the Mental Health Review Tribunal (the Tribunal) to make the order in her absence, at least without observing the requirements of procedural fairness which were allegedly denied to her.

A Specifically, the appellant complains that she was given no explicit warning of the risk that, if she did not attend a hearing of the Tribunal, a community treatment order might be made in respect of her, in her absence. Secondly, she complains that, in the circumstances, there was no power in the Tribunal to make a community treatment order in respect of her, because she was not, at the relevant time, a "mentally ill person" within the meaning of the Act, or otherwise qualified for the making of such an order.

B Hodgson J dismissed these complaints. He confirmed the orders of the Tribunal. The appellant has appealed to this Court against his Honour's decision. Named as parties to the appeal are the Tribunal (which submitted) and Dr Matthew Cullen, a psychiatrist (who contested). Dr Cullen is the director of the Eastgardens General Health Centre where the appellant is obliged, by the community treatment order, to undergo her medication. He appeared to support the authority of the Tribunal, and the availability and correctness of its orders in this case.

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A patient with a schizo-affective disorder:

Ms D Harry (the appellant) first came under the notice of Dr Cullen in 1988. He was then working as a registrar at the Prince of Wales Hospital in Sydney. The appellant was admitted to the psychiatric unit of that hospital, where she was cared for briefly by Dr Cullen.

Dr Cullen's next encounter with the appellant was in August 1992. By that D time he had been appointed director of the Eastgardens Centre. He was asked to review the appellant's case, because her "case manager" was concerned that she was failing to take the medication necessary to control her abnormal mental condition. Dr Cullen thereafter became the appellant's treating psychiatrist. From a review of her file, he deposed to an awareness of a large number of admissions of the appellant to psychiatric institutions, dating back to 1979. The number of admissions increased in the period 1989- E 1992. They aggregated to twenty-seven in all. This led Dr Cullen to express the view that the appellant fell into the category of a "revolving door" patient: a view reinforced by his supervision of the appellant and by his view of her "problems in complying with medication, and recognising her condition". Dr Cullen described "revolving door" patients thus:

> "In general these were patients with a mental illness, many of whom I have had direct clinical care of who were able to be treated successfully in hospital under the provisions of the mental health legislation. F However, once they were no longer mentally ill within the meaning of the Act and were released, the patient would often refuse to take any further medication and over a period of time, their condition would deteriorate to such a degree that involuntary admission was again necessary. This sequence of events occurs again and again, with the patient continually being admitted and discharged from hospital and as a consequence, subjected to periods of ill health with significant G disruption and distress."

In his affidavit, read before Hodgson J, Dr Cullen deposed to a diagnosis of the appellant as suffering from "a mental illness known as schizo-affective disorder". This is a "serious relapsing psychotic illness with features of schizophrenia and manic depression. It manifests itself in symptoms such as hallucinations, delusions, mood disturbance and disorganised thinking".

Whilst on medication, the symptoms disappear, and the patient functions normally. Dr Cullen deposed:

> "In relation to Ms Harry I am of the view that it is also a feature of her illness that she lacks insight into her condition, and, in effect, cannot recognise that she is ill or in need of any treatment. This tendency is particularly marked when she has been off medication and is unwell. This has also been a major reason for her failure to comply with treatment. Importantly, when Ms Harry is on medication and well, she is reasonably high functioning, and is able to manage her affairs and person more successfully."

Dr Cullen also deposed to the resistance of Mr Harry to the medication injections, which, she complained, caused side effects. From mid-September 1992, she was erratic in her attendances on Dr Cullen. She largely failed to take her medication. Complaints were received from neighbours about her shouting and screaming late at night, and of threats of violence. It was these complaints which, in January 1993, resulted in the steps taken by Dr Cullen, to have the appellant admitted involuntarily to the Prince Henry Hospital. As a result of a mistake, she was discharged without treatment.

However, on 24 February 1993 the appellant attended an interview with Dr A Swan, Dr Cullen's registrar. She presented with band-aids strapped across her mouth. She had been walking in the street in this condition, reportedly abusing people nonetheless. She was seen to have lost weight. She was refusing treatment for an abcess to her tooth. On Dr Cullen's advice, Dr Swan, on 24 February 1993, arranged for the appellant to be admitted involuntarily to the Prince Henry Hospital. On 2 March 1993, Mr Andrew George, LCM, pursuant to s 51(3) of the Act, made an order that the appellant be detained in that hospital as a temporary patient until no later than 30 March 1993, for a form of observation, or treatment, or both. It was during the operation of this order that the appellant's case was first heard by the Tribunal on 26 March 1993. The Tribunal then made its first community treatment order. The community treatment order designated the Eastgardens Centre as the agency to implement its order. It ordered the appellant to comply with an attached "treatment plan", and to receive medication and therapy in accordance with the plan. The order was specified to expire on 25 June 1993, that is, within the three months maximum provided by s 131 of the Act.

On 7 April 1993, the appellant, pursuant to s 148 of the Act, applied to the Tribunal for revocation of the community treatment order. The Tribunal heard evidence from the appellant, her case manager, and Dr Swan. In the result, the Tribunal dismissed the application. It confirmed the community treatment order.

According to the evidence, the appellant, whilst subject to the community treatment order, and succeeding community treatment orders, was supplied with the "treatment plan". She continued to resist its obligation. I now reach the point where the first ground of appeal becomes relevant.

The Tribunal proceeds in the absence of the patient:

In the initial proceeding before the Tribunal on 26 March 1993, the appellant was present. She was, at the time, an involuntary patient in a hospital. Her presence was thus effectively under the control of Dr Cullen. In

A the second proceeding on 7 April 1993, she was the applicant for revocation of the community treatment order. She attended to advance her unsuccessful argument. But by early June 1993, the day was approaching when the first community treatment order was about to expire. Accordingly, Dr Cullen made application to the Tribunal for a further community treatment order.

According to Dr Swan, she saw the appellant on 3 June 1993. She discussed her treatment with her, and told her that an application would be B made to the Tribunal to extend the duration of the community treatment order. She informed the appellant that the hearing for this purpose was set down for 24 June 1993. Dr Swan's affidavit, read before Hodgson J, proceeds:

> "Ms Harry initially said words to the effect that 'I will go interstate to avoid the hearing'. Then she said words to the effect that 'It may be to my advantage to attend with a solicitor to plead my cause'. She then said to me 'what course should I adopt?' I said words to the effect that she C should attend the hearing."

On 17 June 1993, Dr Swan saw the appellant again. She reminded the appellant that she should attend the hearing in the following week. Meanwhile, on 11 June 1993, the Tribunal wrote to the appellant, in terms of a letter which was exhibited. The letter informed the appellant of the hearing, which was to take place at the Eastgardens Centre. It advised her that it would be useful to examine the proposed treatment plan in advance of D the hearing, and to discuss it with a case manager. It informed her that she might bring a friend, or "any other support person", to the hearing. Or that she might wish to be legally represented, giving telephone contacts for the Mental Health Advocacy Service. It invited questions to the Tribunal, directed to an identified officer, and a telephone number. It then contained the following caution:

> "It is important that you attend the hearing as the Tribunal is very E interested in hearing you views on the current community treatment order and the need for an extension. In particular, the Tribunal would like to know if you object to the order being extended, and the reasons for your objections. It is also interested in any comments you might like to make on your treatment or care in the community."

Significantly, in the submission of the appellant, the Tribunal's letter did not expressly warn the appellant of the Tribunal's asserted power to deal with her case in her absence, and to make orders, including a community F treatment order, if she did not turn up at the hearing.

That is what happened. The Tribunal convened on 24 June 1993. Its transcript was in evidence before this Court. Dr Swan assured the Tribunal that she had informed the appellant of the hearing, and instructed her to come. As to the community treatment order, Dr Swan stated: "I think it's worked very well, and I think with someone like [the appellant], it should be mandatory. It's the only way that you can [go]."

G Despite the appellant's absence, the Tribunal duly made the further community treatment order in respect of the appellant.

On 22 July 1993, a summons was filed in the Protective Division of the Supreme Court. Pursuant to s 281 of the Act, it sought an order that the community treatment order made on 24 June 1993, in respect of the appellant, be set aside. It also sought a declaration that the Tribunal was not

empowered by the Act to hear and determine ex parte Dr Cullen's application for a community treatment order affecting the appellant. It was this summons which was heard by Hodgson J, and dismissed on 6 September 1993.

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The primary judge's findings:

In his reasons, Hodgson J dealt with the three issues argued before him:

(1) That the Tribunal had no power to make a community treatment order in the absence of the appellant, at least where no specific warning had been given that it might do so;

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(2) That it had no power to make a community treatment order in respect of a person who was not a patient in a hospital, or a "mentally ill person"; and

(3) That the community treatment order was not the "least restrictive" order, consistent with the safe and effective care of the appellant and thus not required in her case.

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His Honour dismissed (3). This Court is not concerned with that point, except as it is relevant to (2). Argument on (2) will be dealt with below.

In resolving (1) adversely to the appellant, Hodgson J accepted that the Tribunal, as a body established by statute with limited powers, would have to find the authority to make orders against the appellant in her absence, either in the express language of the Act, or in the implications necessarily to be drawn from the Act in order to ensure the achievement of its purposes. No express power existed. But his Honour considered that the power was sufficiently to be implied from:

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(a) the obligation imposed, upon an appellant, by s 274 of the Act, to appear before the Tribunal during a hearing of the matter;

(b) the unlikelihood that a party could simply frustrate an application for a community treatment order by absenting himself or herself from the hearing; and

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(c) the general scheme of the Act, and the necessity to ensure that it should operate effectively.

Hodgson J accepted that the rules of procedural fairness (natural justice) had to be observed by the Tribunal. He acknowledged that it would have been "preferable" if the notice contained in the Tribunal's letter to the appellant, concerning the assertion of its power to proceed in her absence, had been more clearly expressed. But he was satisfied by the evidence of Dr Swan, and, apparently, by the failure of the appellant to give evidence to the contrary, that the appellant knew of the hearing, and of the risk that she ran by being absent, viz, that a further community treatment order, or some other order, might be made binding on her.

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The further orders are made:

Following the judgment of Hodgson J, a third community treatment order was made by the Tribunal on 23 September 1993. The appeal to this Court from Hodgson J's orders was lodged on 10 October 1993. At the outset of the hearing of the appeal, the Court raised its concern that the challenge to the validity of the community treatment order, of 24 June 1993, might have become moot by reason of supervening events. Furthermore, the challenge to the order of 24 June 1993, upon the basis that it was made in the absence of the appellant, was not available in respect of the third community

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A treatment order of September 1993. As the Court was informed, that order was made in the presence of the appellant. Thus, the order, current and operative at the time of the hearing of the appeal, was not subject to the attack raised in respect of the community treatment order of 24 June 1993. The Court permitted an affidavit of the appellant to be read, setting out the circumstances of the making of the community treatment order of 23 September 1993. From that affidavit, it appeared that the community B treatment order was valid until 22 December 1993, a date after the hearing in this Court when judgment stood reserved.

The Court is not aware of whether any further community treatment order has been made in respect of the appellant. It was suggested by counsel that some consideration was being given at the time of the hearing to the substitution of a community counselling order in place of the community treatment order disputed by the appellant.

C Notwithstanding these supervening events, both parties urged the Court to determine the issues raised by the appeal. It is the first time that the provisions of the Act have come under consideration in this Court. Each of the points raised is relevant to the administration of the Act, and the powers of the Tribunal. Upon the argument of the appellant, each of the points, if good, affected the validity of the subsequent community treatment orders made in respect of her. Having regard to the wishes of the parties, and the significance beyond the parties of the points argued, the Court permitted the D hearing to proceed. However, it was made plain when judgment was reserved, that no stay having been granted in respect of the orders of Hodgson J, his Honour's determination of the legal position would continue to bind the parties, until this Court decided differently.

The ex parte order was invalid:

The following principles govern the determination of whether the Tribunal E had the power to make the community treatment order in respect of the appellant, notwithstanding her absence from the hearing:

(1) The power to act as it did must be found in the express provisions, or necessary implications, of the Act. The Act should be given a purposive construction to ensure that, so far as possible, its objects are achieved. Those objects include the facilitation of the care, treatment and control of persons who are mentally ill, or mentally disordered, in the least restrictive environment appropriate to their case: see the Act, s 4(1) and s 4(2). In the F modern approach to statutory construction, courts endeavour to avoid an unduly narrow interpretation of the words used by parliament, particularly where a narrow approach would frustrate the achievement of the apparent objects of parliament: see, eg, *Kingston v Keprose Pty Ltd* (1987) 11 NSWLR 404 at 423. But the ultimate duty of the Court remains the legislative text: see *Re Bolton; Ex parte Beane* (1987) 162 CLR 514 at 518; see also *Magor and St Mellons Rural District Council v Newport Corporation* [1952] AC 189 G at 191:

> "… If a gap is disclosed [in the legislation], the remedy lies in an amending Act … [and not in] a … usurpation of the legislative function under the thin disguise of interpretation."

(2) The Tribunal is a creature of statute. It does not have inherent powers. Such powers are confined to the courts established out of the Royal

Prerogative, or, upon one view, to superior courts of record established by parliament: see *Cameron v Cole* (1944) 68 CLR 571 at 586; *R v Forbes; Ex parte Bevan* (1972) 127 CLR 1 at 7; *Taylor v Taylor* (1979) 143 CLR 1 at 16; and *Logwon Pty Ltd v Warringah Shire Council* (1993) 33 NSWLR 13. Nevertheless, as a decision-making body established by parliament, with an important jurisdiction to resolve disputes, and to make orders affecting the health, bodily integrity and liberty of individuals, the Tribunal has, as well as the express powers conferred upon it, implied authority to uphold, protect, and fulfil the function given to it by law: see *John Fairfax & Sons Ltd v Police Tribunal of New South Wales* (1986) 5 NSWLR 465 at 476. These implications would ordinarily extend to powers to conduct proceedings in such a way as to avoid their being rendered a futility at the option of one only of the parties to the proceedings;

(3) In our form of society, an individual is ordinarily entitled to go about his or her affairs without intrusion by the state, or its organs, (such as the Tribunal), or by other individuals, (such as Dr Cullen), however well the latter may be motivated. To justify intrusion into the ordinary activities of the individual, and particularly in a matter so intrusive to the bodily integrity of that individual as to enforce a regime of medical treatment, clear authority of law is needed. The greater the intrusion, the clearer must be the legal authority to support it: see cf *BIL (NZ Holdings) Ltd v ERA House Ltd* (1991) 23 NSWLR 280 at 286; *David by her Tutor the Protective Commissioner v David* (at 431);

(4) It is a well-established principle of statutory construction that laws which infringe upon the personal liberty of the individual must be clearly expressed. If the intrusion is left to implication, it must be necessarily implied. Courts have a natural reluctance to imply a power which is oppressive of the rights of the individual and which parliament has not expressly provided. This is so, even where the absence of the power is extremely inconvenient and discloses an apparent gap in the statutory scheme, which probably needs to be filled by legislation: see, eg, *Marshall v Watson* (1972) 124 CLR 640 at 644. *Marshall* was a case involving the power of arrest and detention of a person in order to convey him to a psychiatric hospital. The High Court unanimously held that, no express or implied authority having been given by the *Mental Health Act* 1959 (Vic), the courts should not provide what parliament had omitted to enact. The history of mental health legislation, not only overseas, has often evinced a vacillation between a paternalistic "treatment" model, and a "due process" model, strictly protective of individual rights: cf *David* (at 422). The present Act contains features of each model. Because of the enactment of so much legislation on the subject, the policy ambivalence which it displays, and the frequent amendment of the legislation soon after its enactment, courts should be wary against filling the gaps which are demonstrated in the operation of mental health legislation. Many reports of official bodies, in Australia and overseas, have demonstrated the way in which mental health law can sometimes be used to control the behaviour of individuals merely to relieve family, neighbours, and acquaintances from their embarrassment, rather than to assist the individuals primarily concerned to be themselves. It is not necessary to go to the mental health laws of Hitler's Germany or Stalin's Russia to be reminded of the potential for misuse, or excessive use,

A of compulsory mental health powers. The courts must be vigilant against such a misuse or excessive use. One way to exhibit this vigilance is to insist that, if parliament is to justify enforced intrusion into the life of an individual, it must do so in very clear terms, and by affording those who assert their authority with very clear powers: see *B v Medical Superintendent of Macquarie Hospital* (1987) 10 NSWLR 440 at 455. This, in effect is what the High Court did in *Marshall*;

B (5) Ambiguity in legislation affecting the liberty of the subject will normally be construed in favour of the person affected: see *Smith v Corrective Services Commission (NSW)* (1980) 147 CLR 134 at 139; *R v Hallstrom; Ex parte W* [1986] QB 1090 at 1104; *Graham v State of New South Wales* (Court of Appeal, 13 October 1989, unreported);

(6) International legal principles governing basic human rights may assist Australian courts in filling gaps in the common law, and in construing ambiguous legislation: see, eg, *Mabo v State of Queensland [No 2]* (1992)
C 175 CLR 1 at 42. As a response to the revelations of medical "treatment" and experimentation in Germany prior to 1945, a number of individual statements of principle have been adopted to govern the conduct of medical practitioners in this and other regards. With one voice, those statements have insisted upon the rule of patient consent. Thus, the Eighteenth World Medical Assembly of the World Medical Association, in Helsinki, Finland, in June 1964, resolved that:

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> "In the treatment of the sick person, the doctor must be free to use a new therapeutic measure if in his judgment, it offers hope of saving life, re-establishing health, or alleviating suffering?
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> If at all possible, consistent with a patient's psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In the case of legal incapacity, consent should also be procured from the legal guardian …."

E Patient consent is the normal pre-requisite to the medical treatment of an individual in this country: see *Rogers v Whitaker* (1992) 175 CLR 479 at 489ff. In this country, as in other civilised countries, enforced medical treatment is thus wholly exceptional, both to ordinary medical practice, and to the legal pre-requisites for lawful medical attendances. The recognition of these facts makes the need for clear authority for providing compulsory treatment all the more plain. It makes the need for a clear statutory warrant for an order
F made in the absence of the party affected (or the giving of clear notice that this may occur) all the more important; and

(7) Where the legislature has expressly provided a power to proceed in a particular way, in making an order of a *less* intrusive character, but has omitted so authorising an order of a *more* intrusive character, in the same way, it will ordinarily be inferred that authority in the latter case has been expressly withheld. In the face of such a juxtaposition of the presence and
G absence of power, a court will hesitate to fill the gap left by parliament with apparent deliberateness.

I now proceed to apply these rules to the present case. I acknowledge, as the High Court did in *Marshall v Watson*, the convenience of permitting the Tribunal to proceed in the absence of the appellant. I accept that it seems doubtful that parliament would have contemplated that a person, already subjected to a community treatment order, could frustrate the continuance

of its regime by the mere expedient of staying away from the hearing of the application for a fresh order. I agree that the scheme of the Act seems to envisage the continuance of community treatment orders in certain cases. I would not construe the powers of the Tribunal narrowly.

But against these considerations, two statutory provisions in the Act drive me to the conclusion in this case similar to that reached by the High Court in *Marshall v Watson*. Parliament has simply failed to provide that the Tribunal can make a community treatment order in the absence of the patient:

(1) The first reason is that s 274(1) of the Act does not expressly empower the Tribunal to deal with the matter in the absence of the person affected, especially where that person does not consent to the Tribunal's so proceeding. In its terms, s 274(1) of the Act requires the appearance of the person before the Tribunal "unless the Tribunal otherwise approves". The word "approves" implies that the patient has sought to be excused from the hearing when the Tribunal gives its approval to that request. This provision falls a long way short of authorising the Tribunal to impose its will upon a patient who, far from seeking "approval" of the Tribunal to be absent from the hearing, objects to the community treatment order, and deliberately absents herself from the hearing; and

(2) Section 119(1) of the Act expressly enacts a circumscribed authority for the Tribunal to proceed to make orders in the absence of the patient where what is involved is the less intrusive community counselling order:

> "119. (1) If an application for or to vary a community counselling order is made to the Tribunal, the affected person need not be present at the hearing of the application if the Tribunal is satisfied that the person has been given reasonable notice of hearing and the person is legally represented at the hearing.
>
> (2) If the affected person is not present at the hearing, any community counselling order made must be made so as to take effect at least 3 days after the hearing."

I find it impossible to accept that parliament left the power to the Tribunal to make the more intrusive community treatment order in the absence of the patient, and without any pre or post condition (save those implied by the common law rules of procedural fairness) when it took such pains to enact, in express terms, a power to proceed as s 119 permits, in the case of the less intrusive community counselling order.

To the suggestion that the absence of power creates a ludicrous situation, the answer comes back that community treatment orders are novel and exceptional to our law. Where the person is in involuntary custody, that person will normally be able to be physically delivered to the Tribunal for the community treatment order to be ordered. Compliance with the community treatment order requires that the person, subject to the order, should attend and accept the treatment. But failure or refusal to comply does not, of itself, constitute a breach of a community treatment order: see the Act, s 137(1). A person affected must be given notice that a further refusal to comply will result in specific action being taken: see the Act, s 137(2)(b). If, following that notice, a further breach occurs, the person affected must be given written notice that he or she is required to attend at a specified place for treatment, and may be compelled by a police officer to attend: see the Act, s 138(1). A further refusal to comply provides the necessary pre-

A condition for an order in writing that the affected person be dealt with in accordance with the notice: see the Act, s 139.

Given these careful protection providing expressly what is to happen to a person who refused to comply with an order, I am forced to the view that it is extremely unlikely that parliament would have had the intention that the Tribunal should have a power by the legislation to make community treatment orders ex parte, without equivalent protections, notices, and B warnings.

Such a construction of the scheme of the legislation is by no means irrational. The objects of the legislation lay stress (as do the Second Reading Speeches of the ministers, produced during argument) upon the purpose of parliament to shift the emphasis in mental health care to informal and voluntary procedures, rather than involuntary treatment: see also the Act, s 4(1)(c). The Act carefully imposes time-limits upon the duration of orders C such as community treatment orders. Clearly, it does so out of respect for the civil rights, dignity, and self-respect of the patient, and having regard to the wholly exceptional character of enforced medication in a society such as ours. It is at least open to argument that parliament's purpose was that if, following an initial community treatment order, a person should not wish to continue under that regime, it should be left to that person's choice. If, subsequently, in the "revolving door" conduct of a patient, fresh grounds D were established to warrant involuntary detention, such an order could be sought. If the pre-conditions were made out, it could be made. To require this is not such an astonishing demand. Out of respect for the rights, dignity and self-respect of alleged criminals, many with established records of anti-social conduct, our law has rejected notions of preventative detention. It has done so even in the case of individuals who may appear to present a grave danger to society: see *Veen v The Queen* (1979) 143 CLR 458 at 469; *Veen v The Queen [No 2]* (1988) 164 CLR 465 at 477. It is not immediately E apparent why a lesser protection to the rights, dignity and self-respect should be afforded to a person who has committed no crime, but is said to need a community treatment order for his or her own protection. Not for what has been done, but for what might, without the community treatment order, occur in the future.

If parliament intended that the Tribunal should have the power to proceed to make the more intrusive community treatment order in the absence of the F patient, it would have expressly afforded the power to do so as it did for the less intrusive community counselling order. Not having done so, it is not for this Court, "under the thin disguise of interpretation", to fill the gap left by parliament, with apparent deliberateness.

I would therefore declare that the community treatment order made by the Tribunal on 24 June 1993 was invalid. Not having been made in the presence of the appellant, and no authority having been conferred on the G Tribunal to make such an order in her absence, it was thus made without authority. As its validity was the pre-condition to the validity of the community treatment order made on 23 September 1993, it, too, must fail.

This conclusion strictly relieves me of the necessity to decide the second argument advanced for the appellant under this heading. This was that, if the Tribunal had power to make the order, it was obliged to do so following a

clear warning concerning the consequences of non-attendance: cf *Kioa v West* (1985) 159 CLR 550 at 585.

With Hodgson J, I agree that it would have been desirable for the Tribunal's notice to the appellant to warn her, in clear terms, of the risk which she ran that an order might be made in her absence. However, I would not have been inclined to differ from Hodgson J's conclusion that, the combination of the letter sent, and the reported conversations with Dr Swan, together with the absence of evidence from the appellant herself, would permit an inference to be drawn that, in this case, the appellant was sufficiently aware of the risk which she was running by staying away. To these considerations would have to be added the appellant's long experience with succeeding mental health laws, and her unsuccessful attempt in April 1993 to escape from the community treatment order, made initially in her presence. As, however, I have concluded that the power to proceed, as it did, was denied to the Tribunal by the Act, it is unnecessary, in my conclusion, to explore the issues of procedural fairness at any greater length.

Dr Cullen finally urged that the orders made in the absence of the appellant were not void, but merely voidable. I doubt this. As no authority existed for the making of them, they were prima facie a legal nullity. But assuming that they were voidable, the appellant has, from at least April 1993, made it plain that she wishes to be free from the intrusion of community treatment orders. She did not ask to be excused from the hearing of the Tribunal. She has contested these proceedings. There is no reason why, if the community treatment orders were voidable, this Court should not, in the circumstances, set them aside. To uphold the law and to limit unlawful intrusions of authority into the life and person of the appellant, there is every reason why the Court should afford her the relief sought.

"Mental illness" is not a pre-requisite to a community treatment order:

It is unnecessary for me to go further. However, in deference to the argument of the parties, and the importance of the matters raised, I will express briefly my views on the second matter argued. It afforded an alternative basis by which the appellant attacked the community treatment order made in respect of her.

Her argument was that the community treatment order of 24 June 1993 was made by the Tribunal without satisfying itself that the appellant was a "mentally ill person", within the meaning of that term, in s 9 of the Act. In the absence of such a finding, it was argued, the Tribunal lacked the power to make such an order.

In support of this argument, the appellant pointed out that the Tribunal was not responsible, under the scheme of the Act, for the initial involuntary admission of a mentally ill person to a hospital. Its jurisdiction extended to a "temporary patient" in involuntary detention, in respect of whom the medical superintendent sought an order continuing the detention: see the Act, s 56(1). Such a person might then continue to be detained as a temporary patient, or as a "continued treatment patient", either pursuant to an order made under an inquiry, or pursuant to s 56, or s 58 of the Act, both of which require that the patient be "brought before the Tribunal". Where the Tribunal does not order the continued detention of the patient, it is empowered to make an order for care "of a less restrictive kind". However,

A that order is not defined in either s 57(4) or s 59(4). Each of those subsections is in precisely the same terms:

> "(4) If the Tribunal does not determine that the patient is a mentally ill person or is of the opinion that other care of a less restrictive kind is appropriate and reasonably available to the patient, the patient must be discharged from the hospital in which the patient is detained."

If the Tribunal does not order continuing detention (by inference upon the B ground just stated), it is empowered to make a community counselling order, (by s 118(1) of the Act), or a community treatment order (by s 131 of the Act). If the community treatment order is made, it may be repeated: see the Act, s 131(2A).

Hodgson J rejected the contention for the appellant that, under s 131(1) of the Act, the Tribunal had to be satisfied that the person was a "mentally ill person". The subsection reads:

> C "(1) The Tribunal may, on the application of the medical superintendent of a hospital or on reviewing the case of a patient under Part 3 of Chapter 4, make a community treatment order for implementation by a health care agency in relation to a person who is a temporary patient or continued treatment patient in a hospital."

In support of her argument, the appellant relied upon s 131 (2A) inserted by the *Statute Law (Miscellaneous Provisions) (No 2) Act* 1990. That Act inserted in s 131 the following provision (relevantly):

> D "(2A) Before the expiration of a community treatment order affecting a person, the Tribunal or a Magistrate may, on the application of the Director of the health care agency responsible for implementing the community treatment order, make a community treatment order for implementation by a health care agency in relation to the person."

The reason behind this amendment does not emerge from the explanation given by the minister introducing it. All he said was (*Hansard*, Legislative E Assembly, 21 November 1990 at 10198): "... The status of persons able to make an application for a further community treatment order is also defined."

The appellant's argument went thus. A pre-condition to detention at a hospital is that a patient must be a "mentally ill person", or a "mentally disordered person": see the Act, ss 21(1)(b), 28, and 29. A person, once admitted, must be brought before a magistrate as soon as practicable: see F the Act, s 38(1). If the person ceases to be a mentally ill person, he or she must be released: see the Act, s 40(1) and s 52(1). A magistrate can make a community treatment order, but only if satisfied that the person is a mentally ill person:

> "51.(1) If, after holding an inquiry, a Magistrate is satisfied that on the balance of probabilities a person is a mentally ill person, the Magistrate must take the action set out in subsection (2) or subsection (3).
>
> G (2)The Magistrate may order the discharge of the person to the care of a relative or friend who satisfies the Magistrate that the person will be properly taken care of or order such other course of action in respect of the person (including a community treatment order) as the Magistrate thinks fit.
>
> (3) If the Magistrate is of the opinion that no other care of a less

restrictive kind is appropriate and reasonably available or that for any other reason it is not appropriate to take the action set out in subsection (2), the Magistrate must direct that the person be detained in, or admitted to and detained in, a hospital specified in the direction for further observation or treatment, or both, as a temporary patient for such period (not exceeding 3 months) as the Magistrate, having regard to all the circumstances of the case, specifies."

By way of contrast, if the Tribunal determines that the patient is a "mentally ill person", it must consider whether care of a less restrictive kind than detention is appropriate: see the Act, s 57 (3). If it is not, detention will continue. If, however, the Tribunal is not satisfied that the patient is mentally ill, or is satisfied that a less restrictive care is appropriate, the patient must be discharged. This appears from s 57(4) of the Act:

> "(4) If the Tribunal does not determine that the patient is a mentally ill person or is of the opinion that other care of a less restrictive kind is appropriate and reasonably available to the patient, the patient must be discharged from the hospital in which the patient is detained."

The appellant's argument was essentially that, because a magistrate can only make a community treatment order if satisfied that the person to be subjected to it is a mentally ill person, pursuant to s 133(1)(a), it is unlikely that such a pre-condition would not also exist in the case of the Tribunal.

In its reasoning of 24 June 1993 in this case, the Tribunal itself faced up to the legal curiosity:

> "The juxtaposition, in s 133(1)(a), of the condition precedent for a magistrate's community treatment order that the magistrate would otherwise make an order in respect of the person under s 51(3) (such an order requiring the person to be 'a mentally ill person'), on the one hand, and the condition precedent for a Tribunal community treatment order set out in the immediately following s 133(1)(b), that the Tribunal is satisfied, to put the matter colloquially, that the patient would, if such an order were not made, otherwise become a "revolving door" hospital patient, on the other, quite clearly indicates in the Tribunal's mind that, for a Tribunal community treatment order, it is not necessary that the affected person is currently "a mentally ill person" as defined by the Act … Parliament must have been aware that the Tribunal's jurisdiction to make a community treatment order only arises after a period of compulsory hospitalisation ordered by a magistrate under the Act has commenced, and in some cases, after such a period, the additional periods of community treatment under previous community treatment orders, have commenced. Parliament obviously had in mind a scheme which allowed compulsory treatment of mentally ill people in the community to prevent such people from becoming 'mentally ill persons' thus inviting the possibility of a return to hospital, with concomitant detention and compulsory treatment."

These remarks were unnecessary to the Tribunal's conclusion in this case, because it went on to say:

> "In any event … we determine on the evidence for us that [the appellant] was, at the time of the making of this renewed community treatment order, in any event, 'a mentally ill person', taking into account her 'continuing condition' under s 9(2) of the Act."

A This conclusion on the part of the Tribunal, an expert body with specialist membership and other forensic advantages, has never been set aside. It renders the debate on this point concerning the Tribunal's powers moot in this case. However, as both parties desired the opinion of the Court, on whether the establishment that the patient was "a mentally ill person" was a pre-condition to an order by the Tribunal under s 131(1), it is appropriate to offer this opinion.

B Hodgson J determined this point against the appellant. He found that nothing in the terms, legislative history, or context of s 131 (2A), required that the person, made subject to an order, must be "a mentally ill person" at the time the order was made.

I acknowledge the curiosities in the inter-relationship of the powers of the Magistrate and the Tribunal pointed to by the appellant. I accept that in the Second Reading Speech supporting the introduction of s 131(2A), nothing was said which suggested that the intention of the new subsection was to
C extend the class of persons who would otherwise be the subject of orders under s 131. As will be obvious from what I have already said in respect of the first ground of appeal, I approach the Act, as the appellant urged, prepared to resolve ambiguities in the pre-conditions for the making of a community treatment order, with its potentially intrusive consequences, in a way favourable to the liberty of the individual potentially subject to it. I also accept that, as a practical matter, the occasions on which the Tribunal would
D see a person who did not satisfy the definition of "a mentally ill person", would be rare. This is because the Act imposes on the medical superintendent, who did not consider a person to be mentally ill, the duty to discharge that person. Accordingly, such a person would not ordinarily be brought before the Tribunal. In such a case, no community treatment order would therefore be made.

However, the language of s 131(2A) is clear enough. In it, I perceive no
E relevant ambiguity. In s 35 of the Act, it is made clear that the community treatment order has a maximum duration of three months. Yet there is no limit in the number of community treatment orders that may be made in relation to a person. The practical limitation is that imposed by s 133(1)(c) of the Act. The Tribunal must, on each occasion that it contemplates a community treatment order, be satisfied that the person would benefit from the community treatment order as the least restrictive alternative, consistent with safe and effective care.

F I therefore see nothing in s 131 that requires that the Tribunal must be satisfied, at the time of making an initial community treatment order (s 131(1)), or subsequent community treatment orders (s 131(2A)), that the person affected is "a mentally ill person".

This construction is also compatible with the purposes of the community treatment order. These include an assurance as to the provision of medication, without which the patient would be "a mentally ill person", but
G with which the patient will be able to function in the community. Reinforcement for this view of the meaning of s 131 is found by reference to s 142 and s 143 of the Act. These provisions show that, where a community treatment order is made, a person may remain subject to the community treatment order without being "a mentally ill person": see also s 148 and s 149 of the Act, which contain no requirement for the revocation of a

community treatment order, where a person is found not to be "a mentally ill person". A

Although the legislation is complex and wordy, and the matter is not beyond argument, I am not persuaded that Hodgson J erred in the construction which he gave to the Act on this point.

Conclusion and orders:

The result is that, in my view, only upon the first ground argued is the appellant entitled to succeed. For the contesting respondent, it was put that if it so concluded, the Court should follow the course approved by the High Court of Australia in *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564 at 581, and provide relief by way of a declaration: the course approved by the High Court in that case. That is what the Court should do. I will fashion a declaration accordingly. B

I therefore favour the following orders:

(1) Appeal allowed; C

(2) Set aside the order of Hodgson J, of 6 September 1993;

(3) In lieu thereof, declare that the first respondent may not proceed to make a community treatment order in circumstances where the person in respect of whom the order is sought:

(i) does not attend the hearing; and

(ii) has not sought, or consented to the Tribunal's proceeding in his or her absence, which course the Tribunal has approved. D

(4) Order the respondent to pay the appellant's costs of the proceedings in the Protective Division and in the Court of Appeal; and

(5) The respondent should have, in respect of the costs of the appeal a certificate under the *Suitors' Fund Act* 1951.

MAHONEY JA. In this proceeding the Court is asked to determine the validity or effectiveness of a community treatment order made in respect of Denise Elizabeth Harry on 24 June 1993. I agree with Kirby P and Clarke JA that, in the special circumstances of this case, the Court should determine the issues posed. E

I have the advantage of reading the judgments of Kirby P and Clarke JA. What their Honours have said enables me to go directly to the main question which the Court is asked to decide: (1) whether the Tribunal was deprived of power to make the order it did because Ms Harry refused to attend the Tribunal; and (2) whether the Tribunal's power to make the community treatment order existed only if Ms Harry was, or was then found to be, "a mentally ill person" within the *Mental Health Act* 1990. F

In order to understand the terms of the Act and the issues which have arisen from it, it is necessary to refer to the facts of the present case. They have been detailed by Kirby P and Clarke JA. I shall refer to what, in my opinion, are the most significant aspects of them.

Unfortunately Ms Harry suffers from what one of the doctors describes as a schizo-affective disorder. It is recurring illness: from time to time she becomes better or worse. She is subject to manic depression. It is a psychotic illness. The significance of this is, as I think the Court may know, that a psychotic illness involves, in general terms, gross impairment in reality testing, the individual incorrectly evaluating the accuracy of his or her perceptions and thoughts and making incorrect inferences about external G

A reality, even in the face of contrary evidence. Ms Harry's symptoms and her conduct from time to time have indicated that her condition is of this kind. Her symptoms and her conduct from time to time can properly be described as bizarre, being dangerous to herself and disturbing to others. The nature of these is detailed in the evidence. It is not necessary to repeat it.

It is however, important to understand the effects which her illness has in relation to her acceptance of treatment for it. When she takes the medication B prescribed for her condition, she is, it has been said, "reasonably high functioning and is able to manage her affairs and person more successfully". However, her condition leads her to lack insight into it and in effect she cannot recognise that she is ill and in need of treatment. Accordingly, as appears from her history, if she is not supervised and properly motivated, she tends not to take her medication. This brings on the signs and symptoms of her condition and over a period of time without medication her condition deteriorates. Her condition becomes such that, for her safety and well-being, C it is necessary to treat her and, at least on occasions, to take her into hospital and treat her. She has been described for this reason as "a revolving door patient". She has been in and out of hospital on, it has been suggested, some twenty-seven occasions.

1. The effect of an order made in the absence of Ms Harry:

The argument in this regard originally suggested two things: that the D Tribunal had no power to make an order "ex parte"; and (if it did) that what it did in this case involved a denial of natural justice to Ms Harry.

The use of "ex parte" in the argument and in the grounds of appeal is ambiguous. It is necessary to draw distinctions. Two kinds of cases are to be distinguished: one where no notice of the proceeding has been given to a party yet the Tribunal proceeds with the hearing and makes an order; and one where, although notice of the proceeding has been given to a party, that E party does not appear or is absent from the Tribunal when the order is made. The term "ex parte" is ordinarily applicable to a case of the first kind.

The present case is one of the second kind. The application made to the Tribunal was an application for a community treatment order made, as the notice of appeal asserts, under s 131(2A) of the *Mental Health Act* 1990. It is not clear what, if any, procedural formalities have been established for the hearing of an application for a community treatment order, whether under F this provision or otherwise. But the argument has proceeded on the basis that, considering substance rather than formalities, Ms Harry was given notice that an application for a community treatment order was to be made in relation to her, that the notice indicated that it would be heard at a specified place and time, and that the notice was given to her in sufficient time to allow her to attend. Hodgson J found that a letter of 11 June 1993 advised her of the application for a further community treatment order and contained the following sentences:

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> "It is important that you attend the hearing as the Tribunal is very interested in hearing your views on the current Community Treatment Order and the need for an extension. In particular, the Tribunal would like to know if you object to the order being extended and the reasons for your objection."

His Honour accepted that earlier, on 3 June 1993, she had been told by

the psychiatrist responsible for her care that the community treatment order would be heard on 24 June, that she said she would "go interstate to avoid the hearing"; that later she said, "It may be to her advantage to attend with a solicitor to plead her cause"; and that the psychiatrist told her "that she should attend the hearing". This advice was repeated to her on 17 June 1993. It is not clear precisely why she decided not to attend.

A

There is no doubt that the application was intended to be one to which she was a party, that she was properly notified of the hearing of it, and that the reason why she did not attend was probably that she had decided not to.

B

In these circumstances, it is not necessary to determine the circumstances in which a tribunal will make an order which is, in the proper sense, ex parte. I would be loath to conclude that it could not, in some circumstances, make an order even though the patient had not been informed of the application. It is possible to imagine medical emergencies in which it would be necessary for the patient's own health or, it may be, safety that an order be made: cf s 201. But it is not necessary to determine that matter: I express no opinion upon it. As I have said, this is not, in that sense, an ex parte matter.

C

Therefore, to succeed on this argument, it is necessary for the appellant Ms Harry to show that the Tribunal has power to make a community treatment order only while the patient remains before the Tribunal. It would appear to follow from such a submission that, if the patient left the presence of the Tribunal during the hearing or remained outside, she could thereby deprive it of power to make such an order: cf s 119. There is, in my opinion, nothing in the Act which requires such a conclusion. I do not think it is so.

D

2. Must the patient be "a mentally ill person"?

It was submitted that, as a condition of its power to make a community treatment order or, in effect, to continue the operation of a community treatment order which is due to expire by the making of another community treatment order, it is necessary that the patient be at that time a mentally ill person within the Act or that the Tribunal find her to be so. There are at least two reasons why, in my opinion, this is not so.

E

First, I do not think that the terms of the legislation, properly construed, so require. I agree generally with what has been said in this regard by Kirby P and Clarke JA.

Secondly, so to construe the legislation would, in my opinion, be to make more difficult the attainment of the purpose of it. It has long been accepted that, in determining what a statute means, a court should determine what is the mischief which the statute was passed to remedy; determine the remedy or means chosen by the statute to remedy that mischief; and construe the statute accordingly: *Metal Manufacturers Pty Ltd v Lewis* (1988) 13 NSWLR 315 at 325-326.

F

In drafting this statute, the legislature was concerned with, inter alia, two associated mischiefs. First, the reconciliation of personal freedom and the need for treatment. As a matter of general principle, a person should not be forced to accept medicine or treatment, even though it be for her own good. To do so is an infringement of her personal freedom. If she is to be treated, prima facie she may be treated only if and as far as she consents to be treated. There are, of course, exceptions to this general principle: it is not necessary to pursue the detail of them. But in the application of the general

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A principle and the exceptions to it, problems arise. A person who needs treatment may not have the capacity or judgment to give consent to the treatment she needs. An hallucinating or potentially suicidal patient may need to be treated even if she does not consent. In such a case, the duty of the community to care for one who cannot care for herself may, in appropriate circumstances, have to take precedence over personal freedom: public morality (or charity) prevails over justice. Accordingly, there must be B a basis for deciding whether justice or charity is to prevail and in what circumstances it is to do so. It was the purpose of the legislation so to provide. It provided the safeguards of scrutiny by medical attendants, by a magistrate and by a tribunal.

There is also the problem which arises from uncertainty as to the person's true mental state. It is not always possible to say whether the person is mentally ill or, for example, merely eccentric, and (if mentally ill) whether C she is ill to such a degree that treatment needs to be given against her will. Diagnosis may often be difficult. If attended with doubt, respect for the patient's personal freedom (or fear of the legal consequences) may result in treatment not being given when in fact it is needed. The present legislation was intended to provide means by which those who must make such diagnoses, and would be liable in law if treatment was given when it was not justified, can form a calm judgment and do what is necessary in the patient's interest. Their judgment is to be scrutinised and, if proper, supported by the D magistrate or the tribunal.

The present legislation should be construed in such a way as, consistently with its terms, will provide a solution to each of these problems. The operation of legislation of this kind and the remedies which it has provided have developed over the years. Originally, the only, or substantially only, remedy was to commit the patient to a mental institution. The patient could then be kept in custody and treated without consent. As the concepts of law E and psychiatry developed, new remedies were evolved. The law allowed treatment of voluntary patients, day patients and the like and made statutory provision for what in such cases could be done. But, in general, the right to treat without consent was related to treatment in or by reference to a hospital.

This leads to the second problem. As, I think, the law is entitled to know, treatment in the context of an institution gives rise to special problems. The F institutionalisation of psychiatric patients may have detrimental effects upon them or at least upon some of them. The fact that a person was in a hospital, particularly one described as a mental hospital, could apply a stigma. And, in addition, the routines of such an institution, the effects of institutionalisation, could themselves cause damage to the mental condition of the patient. As I think the Act indicates, it was desired to do two things: to provide means whereby treatment could be administered to a person needing it outside an G institution and without the effects of institutionalisation; and to provide it in circumstances in which, if necessary, the treatment could be supervised and/or given without a fully articulated or informed consent.

It was in the context of problems of this kind — the “consent” problem and the “institutionalisation” problem — that the legislative provisions for community treatment orders, and for the lesser community counselling order, evolved. It is not necessary to pursue the incidents of community

treatment order and community counselling order procedures. It is sufficient to recognise that they provide methods of treatment outside institutions in circumstances in which compulsion or pressure may be used where necessary to ensure that the therapy is accepted.

I have, in referring to these matters, used language and terms which to an extent are not fully accurate and what I have said would, in a fully detailed statement, require qualification and correction. But what I have said sufficiently indicates the mischief to which the present legislation was directed.

It follows from what I have said as to the purposes of the legislation that the terms of it will best achieve those purposes if so construed that: a patient can receive treatment — if necessary, have treatment given to her — where it is sufficiently clear that the treatment is necessary notwithstanding the absence of an articulated consent; and that can be effectively achieved outside a hospital context.

What is involved in the present case, and cases of this kind, is the reverse of the ordinary situation. In the ordinary situation, the patient is ill and the treatment is necessary to make her well. In cases such as the present, the patient is (temporarily) well and the treatment is necessary to prevent her becoming ill. In a sense this is an infringement of her liberty. If she is well she can give proper consent. But her judgment is such that she cannot do so effectively. In such a case, the legislation is best construed so that that can be done even if she does not consent but actually opposes the treatment. At one extreme there is the case where the patient has the capacity and judgment to decide what is in her own best interest; at the other extreme, she does not know what is in her interest and is not able to articulate it. In the extreme cases, the position is clear. But between the two there is a wide penumbra and one of the main purposes of the legislation is to enable a decision to be made as to the administration of treatment where these things are not so clear.

I am conscious of the possibility of abuse. Treatment is not to be forced on a patient against her will merely because it will be good for her, even if well meaning and caring professionals think it is so. But there comes a time when it should be given, when if treatment is not given, there will be unacceptable damage to her. It is the function of the procedures provided by the legislation to safeguard against abuse. But the possibility of abuse should not lead to the legislation being so restrictively construed that, where treatment is needed, it cannot be given. The safeguard against abuse in the present legislation is the provision of procedures, of tribunals and, if necessary, of court procedures for ensuring that the treatment will not be administered where, as far as examination of her condition can ensure, it is not necessary or warranted. The court should give a beneficial and purposive construction to them; it should not give them a restricted construction merely because they may infringe her personal liberty.

The desirability of treatment outside the context of a mental hospital reinforces the view that a community treatment order may be made or renewed even though the patient is presently not in a mental hospital and is otherwise not a mentally ill person. Stated broadly, the contrary view would involve, at least in a substantial number of cases, that to make a community treatment order, or another community treatment order, it would be

A necessary that the patient be allowed to become a mentally ill person. This construction would, I think, defeat the purpose of the legislation.

3. General observations:

In view of what has been said, during argument and otherwise, it is proper to add two things. First, the Court has been pressed in argument with the need so to interpret the Act that it does not unnecessarily infringe the liberty of the subject. As I have indicated, it is proper that such a principle be
B observed: see, eg, *Balog v Independent Commission Against Corruption* (1990) 169 CLR 625 at 635-636; (1989) 18 NSWLR 356 at 372 et seq; *Re Hawke: Hawke v Hawke* (1923) 40 WN (NSW) 58; *Watson v Marshall* (1971) 124 CLR 621. But it is equally necessary to have in mind what the liberty of the subject involves. The recognition of liberty is not the end but the beginning of the problem: at least it is so in cases such as these, where there are competing values. Liberty has limits: it does not exclude the proper
C protection of other values and interests. The much cited *Universal Declaration of Human Rights* accepts that, in the exercise of her rights and freedoms, everyone is subject, though subject only, to "such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society" (art 29(2)), see also the *International Covenant on*
D *Economic, Social and Cultural Rights*, art 4. I do not doubt that the proper protection of the mentally ill is no infringement of such rights and freedoms.

Courts are conscious of the harm that has been done to those in need of such care, in the past: see *Ex parte Fitzgerald; Re New South Wales Medical Board* (1945) 46 SR (NSW) 111; 63 WN (NSW) 16; and in more recent times; see the *Chelmsford Hospital* experience; *Walton v Gardiner* (1993) 177 CLR 378; affirming (1991) 25 NSWLR 190. But here, the plain purpose of
E the legislation is to ensure that liberty does not lead to, for example, suicide. This must be borne in mind in deciding what influence the liberty of the subject is to have in the construction of this legislation. As I have said, I am conscious that such powers may be abused. But the remedy against such abuse lies rather in the exercise of vigilance than in so construing powers as to make them potentially inadequate for their purpose.

Secondly, it is proper to refer to the procedures which safeguard the
F exercise of power over mentally ill persons. This Act, as did earlier Acts, establishes procedures whereby the condition of those to whom the statutory powers are to be applied can be monitored to ensure that they are and continue to be in need of the statutory constraints. It is proper that these things be monitored and that the courts and the tribunals ensure that the statutory requirements are satisfied. But that does not mean that the duty of an advocate appearing for a person before such a tribunal is, as it has been said, "to get his client off". The duty of an advocate for a mentally ill person
G has always been a delicate one. An advocate must ensure that the law is observed and that the protections provided for his client are available to her. But to negate the application of beneficial powers for mere technical deficiencies may do damage to the client. It may be necessary, in an appropriate case, to consider whether, for example, the failure to observe legislative provisions of this kind invalidates what is done by a tribunal or

constitutes merely an irregularity. The advocate's position is the more difficult when his client is, or is to be presumed to be, of insufficient capacity to give instructions. It is proper to record that, in the present case, Mr Basten QC has, of course, properly discharged his duty. A

In my opinion the appeal should be dismissed with costs.

CLARKE JA. On 24 June 1993, the Mental Health Review Tribunal (first respondent), constituted under the *Mental Health Act* 1990 (the Act), made a community treatment order under s 131 of the Act in respect of the appellant. She then appealed from that order and at a later stage amended the summons by which she had appealed by including a claim for a declaration that the first respondent had denied her natural justice in making the order in her absence. B

Her appeal and additional claim for relief were heard by Hodgson J who ordered that the summons be dismissed, rejecting both the claim that there had been a denial of natural justice and the other grounds of appeal relied upon. The appellant has now appealed to this Court and has, in essence, raised two substantive points. First she has submitted that the first respondent had no power to proceed to make the order in her absence. It was, she said, void. Secondly, she contended that in so far as she had not been found to be a mentally ill person by the first respondent it did not have power to subject her to a community treatment order. C

Although in a sense it is more appropriate to deal with the former submission at the outset there are reasons of convenience which lead me to deal first with the second submission. Before dealing with the detail of the submission, however, there are two preliminary matters which I should mention. The first is that the community treatment order which is the subject of the appeal was expressed to expire on 23 September 1993. Obviously that date has passed and it could be said that the present proceedings are academic. Notwithstanding, another community order was made on 23 September 1993 which was expressed to expire on 22 December and it is possible that there will be a further community treatment order made. In the circumstances the parties have submitted that the point at issue is of such importance that the court ought to deal with it in order that any further application for a community treatment order be considered in accordance with the legal principles laid down by this Court. In so far as the validity of the community treatment order made in September depends upon the earlier order which is the subject of the appeal it is, in my opinion, desirable that we accede to the requests of the parties. D E F

The second point that should be mentioned is that, although the first respondent did conclude that a community treatment order may be made in respect of a person who is not “a mentally ill person” it nonetheless decided that the appellant was such a person at the time of the making of the order. Despite this finding it was accepted during the hearing of the appeal before Hodgson J, which was an appeal by way of an new hearing (s 284(2) of the Act), that the appellant was not then “a mentally ill person” and his Honour, nonetheless, ruled against the appellant on the point. In those circumstances, and because the question is considered an important one for the administration of the Act, I have reached the conclusion that this Court ought to deal with it. G

A The objects of the Act are set out in s 4(1). In broad terms they are to provide for the care and treatment of persons who are mentally ill, or mentally disordered, through community care facilities and hospital facilities and to ensure that they are given an opportunity to have access to appropriate care, while at the same time protecting the civil rights of those persons. This is made clear by s 4(2) in which there is an expression of the intention of parliament that the provisions of the Act be interpreted so that:

B "(a) persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given; and

(b) in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances."

C

An important feature of the Act was the introduction, for the first time, of a provision facilitating the supply of treatment to persons who are able to live at home under community counselling orders and community treatment orders. The mischief that was sought to be dealt with by these provisions was best described by the second respondent, Dr Cullen, who said that prior to

D the new Act there were no options for compulsory treatment of patients outside involuntary admission to a psychiatric hospital. This had, according to the second respondent, limited the options available to clinicians who were required to deal with a small but significant number of patients who fell into the category of what is colloquially known as "revolving door" patients. These are patients with a mental illness who are able to be treated successfully in hospital but who, once they were no longer mentally ill and

E were released, would often refuse to take medication with the consequence that their condition might deteriorate to such a degree that involuntary admission was again necessary. As the second respondent said: "This sequence of events occurs again and again with the patient continually being admitted and discharged from hospital and as a consequence subjected to periods of ill health with significant disruption and distress."

In the second respondent's opinion the appellant was a "revolving door"

F patient. She is a woman in her thirties who has been diagnosed as having a schizo-affective disorder, a serious relapsing psychotic illness with features of both schizophrenia and manic depression which is, at least in its active stages, a condition which satisfies the definition of mental illness as set out in Sch 1 of the Act.

She has been hospitalised on about twenty-seven occasions with a poor compliance record in respect of both medication and follow-up between admissions. On each occasion her condition has responded to treatment in

G hospital but following discharge non-compliance with medication has generally led to a relapse which has led to her re-admission to hospital.

On 24 February 1993, the appellant was admitted, once again, to hospital. It is unnecessary to detail her appearance and behaviour at that time for they are both fully documented in the judgment of the President. On 2 March, she was taken before a magistrate who directed that she be detained in

hospital as a temporary patient until no later than 30 March 1993. Before that date a community treatment order was made by the first respondent expressed to expire on 25 June 1993. The appellant sought the revocation of that order on 7 April 1993 but her application was rejected. On 24 June 1993, the community treatment order, which is the subject of the appeal, was made which was expressed to continue until 23 September 1993 when, as I have already pointed out, a third order was made. A

Mr J Basten QC, senior counsel for the appellant, submitted that the first respondent was not empowered to make a community treatment order in the absence of a finding that the appellant was a mentally disabled person at that time. Such a finding was, he contended, a condition precedent to the making of the order. A consideration of this submission, although it raises a relatively narrow point, requires some understanding of the working of the Act. Part 2 of Chapter 4 deals with involuntary admission to hospitals. In summary it provides that a person may be taken to and detained in a hospital on the certificate of a medical practitioner provided a number of conditions are satisfied. As soon as practicable after that person's arrival at the hospital he or she is to be examined by the medical superintendent and in the event that the superintendent does not certify that the person is a mentally ill, or a mentally disordered, person the detention must, subject to an exception not presently relevant, be brought to an end (s 29). If the medical superintendent certifies that the person is a mentally ill person, or a mentally disordered person, then he or she must cause the person to be examined by another medical practitioner who if he, or she, is of the same opinion must so advise the medical superintendent. If that examiner reaches a contrary opinion then there is provision for a further examination by a medical practitioner and if both are of opinion that the person is not a mentally ill person, or a mentally disordered person, the detention must, subject to the same exception, be brought to an end. Where both the medical superintendent and the additional examiner reach the conclusion that the person is, for example, a mentally ill person the medical superintendent is required to bring the person before a magistrate as soon as practicable (s 38). B C D E

That magistrate is obliged to hold an inquiry and if, after holding that inquiry, the magistrate is satisfied that the person is a mentally ill person then he or she is obliged to act in accordance with s 51(2) or s 51(3). If the conclusion of the magistrate is that no other care of a less restrictive kind is appropriate and reasonably available then he or she must direct that the person be detained in hospital for further observation or treatment as a temporary patient for up to three months. F

If, however, a magistrate is not satisfied that the person is a mentally ill person the magistrate must order that the person be discharged from hospital but may make a community counselling order in respect of that person (s 52(3)).

Section 56 and s 57 are of particular importance. The former provides that if it appears that a temporary patient will, immediately before the expiration of the period of detention, continue to be detained in hospital after the period has expired the medical superintendent is required to cause the patient to be brought before the first respondent. This must occur as soon as practicable before the expiration of the stated period. Pursuant to s 57 the G

A Tribunal is charged with the duty of determining whether the patient is a mentally ill person. If that is the determination then where the first respondent determines that no other care of a less restrictive kind is appropriate and reasonably available to the patient it must determine whether the person should be detained further in hospital as a temporary patient or a continued treatment patient. Section 57(4) is of special importance and I set it out:

B "If the Tribunal does not determine that the patient is a mentally ill person or is of the opinion that other care of a less restrictive kind is appropriate and reasonably available to the patient, the patient must be discharged from the hospital in which the patient is detained."

Community treatment orders are dealt with in Part 3 of Chapter 6 and in particular s 131 which provides that the first respondent may, on the application of the medical superintendent of a hospital, "… make a community treatment order for implementation by a health care agency in C relation to a person who is a temporary patient or continued treatment patient in a hospital". The conditions precedent to the making of such an order are set out in s 133 which relevantly reads:

"(1) The Tribunal or Magistrate may not make a community treatment order in respect of a person unless:

(a) in the case of an order made by a Magistrate, the Magistrate would otherwise make an order in respect of the person under D section 51(3) (Result of finding that person is mentally ill); and

(b) the Tribunal or Magistrate is satisfied that subsection (2) applies or that the person has been for the first time diagnosed as suffering from a mental illness by a psychiatrist or a medical practitioner appointed under section 123; and

(c) the Tribunal or Magistrate is satisfied that the affected person would benefit from the order as the least restrictive alternative E consistent with safe and effective care; and

(d) the Tribunal or Magistrate is satisfied that a health care agency has an appropriate treatment plan for the affected person and is capable of implementing it.

(2) This subsection applies if:

(a) the affected person has previously refused to accept appropriate treatment; and

F (b) when appropriate treatment has been refused, there has been a relapse into an active phase of mental illness; and

(c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to hospital (whether or not there has been such an admission); and

(d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery G from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the affected person."

In challenging the making of a community treatment order Mr Basten submitted that, in so far as it is only temporary patients, or continued treatment patients, in a hospital who may be subjected to a community

treatment order and as those persons could not have been detained in hospital unless they had been mentally ill persons, it is clear that the first respondent may only make a community treatment order in respect of mentally ill persons. He supports that submission by reference to s 8 which defines a person, relevantly, as a mentally ill person for the purpose of the involuntary admission or detention of the person in a hospital or in determining whether the person should be subject to a community treatment order. There would, he contends, have been no need to refer to community treatment orders in s 8 unless it was a condition of the making of such an order that the relevant person was a mentally ill person.

Mr Gageler, counsel for the second respondent, submitted that the Tribunal was not bound to find that the person under consideration was "a mentally ill person" before making a community treatment order in respect of that person. He pointed out that the legislature had, in s 133, set out the conditions precedent to the making of such an order and there was no mention in that section of the condition precedent upon which the appellant relied. In his submission where the legislature had gone to the trouble of setting out all the criteria that need to be satisfied then there is little room for the implication of another criterion for the making of the order.

This is, as it seems to me, a powerful argument and it is reinforced by reference to s 133(1)(a) which makes it plain that a magistrate, as opposed to the Tribunal, may make a continuing treatment order only if he or she has determined that the person concerned is a mentally ill person.

Mr Basten accepted that, superficially at least, these were factors strongly in favour of Hodgson J's conclusion that a finding by the first respondent that the person was a mentally ill person was not a condition precedent to the making of a community treatment order. He did, however, submit that the Court should not treat the terms of s 133(1)(a) as supportive of the argument as the subsection did not expressly condition the making of an order by a magistrate on such a finding. Rather it was concerned with the provision of an alternative to a detention order under s 51(3) of the Act.

Mr Basten's major submission was that the Act was structured in a way that supported the conclusion that it was necessary to find that the person was a mentally ill person before either ordering his or her detention or making a community treatment order in respect of that person. He referred the Court to s 8 which provides a definition of "mentally ill person" only for the purposes of the involuntary admission to, or detention in, hospital and the making of community treatment orders (the general definition of "mentally ill person" is in s 9). He then referred to s 57 and its requirement that the Tribunal determine whether a patient is a mentally ill person and if so whether there was other care of a less restrictive kind which was appropriate and reasonably available to the patient. In so far as it is only where there is no such other care available that the Tribunal makes a detention order it is clear that where the relevant other care is available the Tribunal would be required to consider making one of the two available less intrusive orders, that is, community counselling orders and community treatment orders. Furthermore, s 57(4) requires the Tribunal to discharge a patient from hospital if it does not determine that the patient is a mentally ill person.

Turning to s 131 he drew the Court's attention to the fact that a

A community treatment order could only be made by the Tribunal in respect of a person who is "a temporary patient or continued treatment patient in a hospital". This was important, in his submission, because a person could only become a temporary patient, or continued treatment patient, upon a finding by either a magistrate or the first respondent that the person was a mentally ill person. This was a pointer to the fact that community treatment orders, unlike community counselling orders, could only be made in respect of such B persons and he added that s 133(3)(a) and s 133(3)(b) were consistent with this approach.

In the context of the legislative scheme to which I have already referred Mr Basten made four substantive points. First he submitted that a continuing treatment order involves the compulsory administration of treatment, such as drugs, which compulsion may be enforced by apprehension without warrant, detention in hospital and the administration of treatment (s 137 to s 142).

C Secondly, where such intrusive orders are available the liberty of the subject is at stake and any ambiguity attaching to the pre-conditions for such an order should be construed in favour of the subject: *Graham v State of New South Wales* (Court of Appeal, 13 October 1989, unreported); *Smith v Corrective Services Commission (NSW)* (1980) 147 CLR 134 at 139.

Thirdly, it is clear that the regime of "less restrictive kinds" of care established by the Act is intended as an alternative to detention in hospital. This desirable policy would be undermined, in his submission, if the less D restrictive orders were to be available generally in circumstances where the pre-condition of detention, namely, that the person is a mentally ill person, had not been satisfied.

Fourthly, the clear time limitation imposed on orders is designed to limit the length of involuntary treatment so that it does not continue for an indefinite time once a person has been found to be a mentally ill person. He supported those submissions by pointing to a practical consideration, that is, E that the first respondent would be unlikely to encounter many patients who were not mentally ill persons. The reason for this is that it is only if the medical superintendent believes that the temporary patient should remain in detention after the expiry of the period that he or she would cause that patient to be brought before the Tribunal. If the medical superintendent were of opinion that the temporary patient was no longer mentally ill then, clearly enough, he or she would discharge the patient.

F There is some force in these submissions although the last-mentioned one involves assumptions which I would not be prepared to make. Nonetheless, I have concluded that his Honour was correct and the first respondent is not required, as a condition precedent to the making of a community treatment order, to find that a patient is a mentally ill person. I have reached these conclusions taking into account the two factors referred to by counsel for the first respondent and which I mentioned at the commencement of the discussion of this point and the structure of the Act, particularly in so far as G it represents a legislative response to the problem of patients who may cease to be mentally ill under the influence of treatment but remain in danger of suffering a relapse if released into the community and failing to continue medication.

"Mental illness" is defined in Schedule 1 of the Act to mean a condition which seriously impairs the mental functioning of a person *and* is

characterised by the presence of one or more of a number of specified symptoms. Although the underlying condition may remain after treatment the disappearance of the symptoms will, arguably, lead to a conclusion that the person is no longer suffering from a mental illness. In addition, if, as a result of treatment, there are no longer grounds for believing that care, treatment or control is necessary to protect that person, or other persons from serious physical harm or, in a specific situation to protect that person from serious financial harm or serious damage to his or her reputation, then that person would not fall within the definition of a mentally ill person in s 9.

Notwithstanding the medical superintendent may feel that if the person is released unsupervised into the community he or she may fail to continue medication and as a result become once again a mentally ill person requiring further hospitalisation. The terms of s 133(2) would indicate that this is one of the problems for which community treatment orders were designed. That subsection enables, subject to compliance with the other stated conditions in s 133, a community treatment order to be made in respect of a person who has previously refused to accept appropriate treatment and has, as a consequence, had a relapse into an active phase of mental illness which has been followed by mental or physical deterioration justifying involuntary admission to hospital where care and treatment following that admission resulted in an amelioration of the debilitating symptoms of the mental illness. Nothing in the terms of the subsection suggest that the person, who is under consideration for the making of a community treatment order, must at that time be "a mentally ill person". On the contrary the structure of the subsection strongly implies that the person under consideration will have benefit from treatment in hospital and recover from, or at least had an amelioration of, the debilitating symptoms which led to the finding that the person was a mentally ill person. Of course, the person may still be suffering from symptoms and therefore still a mentally ill person but that would not necessarily be so for s 133(2)(d) includes cases in which the person has recovered from the symptoms of the mental illness. Such a person would not, or arguably would not, continue to be a mentally ill person.

The scheme is a beneficial one which conforms with the expressed object of the Act which is to ensure that persons receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given and its effectiveness would be seriously undermined if a community treatment order could only be made in respect of mentally ill persons. Although a magistrate can only make such an order in the case of a mentally ill person the reason why this should be so, and the same condition not imposed upon the making of an order by the first respondent, is to be found in the different roles played by each. The magistrate is concerned to determine whether someone involuntarily detained in hospital is a mentally ill person and to ensure that that person is discharged if he or she is not, albeit under a community counselling order (s 52(3)). The first respondent, on the other hand, is concerned with regular reviews of persons detained in hospital or under community treatment orders. It is required to consider the condition of the person at the time when consideration is being given to whether that person should be released into the community.

Finally, the terms of s 131(2A), which was introduced into the Act by

A amendment shortly after the Act itself was enacted, enable the first respondent (and, curiously, a magistrate) in effect to continue a community treatment order. This subsection conveys a suggestion that there should not exist the condition precedent for which the appellant argues. In my opinion Hodgson J was correct and the first respondent may make a community treatment order in respect of a person, provided that the criteria in s 133 have been satisfied, whether or not the person is a mentally ill person.

B **Procedural justice:**

The argument presented by the appellant had many problems, not the least of which was that if it were correct a person could defeat the proper administration of the legislation simply by declining to appear before the Tribunal when consideration is being given to the making of another community treatment order. It is, however, unnecessary to dwell upon those problems, in my opinion, for three reasons. First, the Act provides for an appeal by way of a new hearing before the Supreme Court (s 284) and in which the Court has all the functions and discretions which the Tribunal C enjoyed. I would conclude in these circumstances that the principles expressed in *Twist v Randwick Municipal Council* (1976) 136 CLR 106 should be applied. Secondly, there is nothing to be found in the Act which supports the view that the Tribunal cannot proceed ex parte. Indeed s 274(1) would strongly suggest that it can. Thirdly, the appellant was, in my opinion, given adequate notice and the evidence supports the conclusion that she was well aware of the alternatives available to her. On the latter two aspects I agree with the reasons of Hodgson J.

D In my opinion the appeal should be dismissed with costs.

(By majority)
Appeal dismissed with costs

Solicitor for the appellant: *T Murphy* (Mental Health Advocacy Service).

Solicitor for the respondent: *K Crawshaw* (Department of Health).

E R J DESIATNIK,
Barrister.

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