Court of Appeal
Supreme Court

New South Wales

Case Name:	Z v Mental Health Review Tribunal
Medium Neutral Citation:	[2015] NSWCA 373
Hearing Date(s):	20 November 2015
Decision Date:	1 December 2015
Before:	Basten JA at [1]; Bergin CJ in Eq at [43]; Emmett AJA at [171]
Decision:	(1) Grant the applicant leave to appeal from the judgment in the Equity Division given on 28 September 2015. (2) Allow the appeal and set aside the order dismissing the appeal under s 163 of the Mental Health Act 2007 (NSW). (3) Remit the matter to the Equity Division. (4) Pursuant to the Court Suppression and Non-publication Orders Act 2010, prohibit the disclosure of information tending to reveal the identity of the applicant, including by disclosure of information which might indirectly lead others to identify the applicant.
Catchwords:	MENTAL HEALTH – community treatment order – application granted by Mental Health Review Tribunal – appeal to primary judge under s 163 of the Mental Health Act 2007 – whether primary judge conducted a de novo hearing to decide whether community treatment order should be made – whether primary judge made required findings under the Act
Legislation Cited:	Court Suppression and Non-publication Orders Act

	2010 (NSW), ss 6, 7, 8 Mental Health Act 1990 Mental Health Act 2007 (NSW), ss 4, 12-16, 19, 27, 35, 47, 51, 52, 53, 54, 150, 162, 163, 164; Ch 3, Pt 1 Supreme Court Act 1970 (NSW), ss 75A, 101
Cases Cited:	Burnett v Mental Health Tribunal [1997] ACTSC 94 Harry v Mental Health Review Tribunal (1994) 33 NSWLR 315 Maviglia v Maviglia [1999] NSWCA 188 McD v McD [1983] 3 NSWLR 81 Pollard v RRR Corporation Pty Ltd [2009] NSWCA 110 Re S-C [1996] 1 All ER 532 Wyman on behalf of the Bidjara People v State of Queensland [2015] FCAFC 108
Texts Cited:	National Judicial College of Australia, Oral Decisions – Delivering Clear Reasons, (August 2011)
Category:	Principal judgment
Parties:	Z (Appellant) Mental Health Review Tribunal (1st Respondent) Attorney-General of New South Wales (2nd Respondent) Northern Sydney Local Health District (3rd Respondent)
Representation:	Counsel: Z (in person) K Richardson (2nd and 3rd Respondents) Solicitors: Crown Solicitor for New South Wales (2nd and 3rd Respondents)
File Number(s):	2015/291241
Decision under appeal:	
Court or Tribunal:	Supreme Court of New South Wales
Jurisdiction:	Equity – Protective List
Citation:	[2015] NSWSC 1425
Date of Decision:	28 September 2015

Before:	Young AJ
File Number(s):	2014/348589

[Note: The Uniform Civil Procedure Rules 2005 provide (Rule 36.11) that unless the Court otherwise orders, a judgment or order is taken to be entered when it is recorded in the Court's computerised court record system. Setting aside and variation of judgments or orders is dealt with by Rules 36.15, 36.16, 36.17 and 36.18. Parties should in particular note the time limit of fourteen days in Rule 36.16.]

HEADNOTE

[This headnote is not to be read as part of the judgment]

The applicant, Z, appealed to the Court of Appeal from the ex tempore decision of the primary judge on 28 September 2015, in which his Honour dismissed Z's appeal in respect of a Community Treatment Order made by the Mental Health Review Tribunal under the *Mental Health Act* 2007 on 3 June 2015.

Z raised 15 grounds of appeal, including in particular that there had not been a *de novo* hearing and that the primary judge had misapplied the provisions of s 53 of the Act under which a Community Treatment Order may be made by the Tribunal.

Held (Basten JA and Emmett AJA; Bergin CJ in Eq dissenting), allowing the appeal:

The primary judge erred in failing to conduct a new hearing and instead reviewing the decision of the Tribunal: [28]-[30]; [33]; [178]-[179].

The primary judge did not make the findings required by the statutory tests contained in s 53 of the Act in respect of making a Community Treatment Order: [31]-[35]; [177]; [180]-[181].

JUDGMENT

1 **BASTEN JA**: The applicant, Z, has been diagnosed as suffering from paranoid schizophrenia (a diagnosis Z does not accept). The applicant has, in the recent past, been detained in hospitals as an involuntary patient, pursuant to the *Mental Health Act 2007* (NSW). On 3 June 2015 the Mental Health Review

Tribunal made a community treatment order, requiring Z to attend at a community health centre, in part for medication administered by depot injection on a monthly basis.

2 At the time of the Tribunal's June decision, the applicant had on foot proceedings in the Supreme Court challenging earlier decisions made by the Tribunal; those proceedings were expanded (without demur) to include an appeal against the community treatment order. The proceedings were heard by Young AJ in the Equity Division (Protective List) on 24 and 28 September 2015. On the latter date, the judge dismissed the appeal and delivered ex tempore reasons. The applicant sought leave to appeal from that judgment.

Non-publication order

3 The proceedings in this Court, in accordance with the practice in protective list matters, were conducted in closed court. Further, the parties jointly requested an order under the *Court Suppression and Non-publication Orders Act 2010* (NSW) ("Non-publication Orders Act") prohibiting the disclosure of information tending to reveal the identity of the applicant, which would include non-disclosure of information which might indirectly lead others to identify the applicant.[1]

4 There is an important public interest in ensuring that persons who have been subject to detention or orders for compulsory treatment on the basis of mental illness should be able to exercise statutory rights of appeal without the fear of prejudice or public humiliation which might follow from the disclosure of the person's identity. The *Mental Health Act* reflects that policy in relation to matters before the Tribunal, or any person "involved in" any proceedings under this Act.[2] Consistently with that policy, the Court made an order prohibiting publication of the name of the applicant, or any information tending to reveal the identity of the applicant. The order was made on the basis that the public interest so identified significantly outweighed the public interest in open justice, for the purposes of s 8(1)(e) of the Non-publication Orders Act. (It was not contended that s 162 had that effect of its own force.)

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1 Non-publication Orders Act, s 7.

2 Mental Health Act, s 162(1).

5 The Court reserved its position with respect to the further request by the applicant, that its reasons for judgment not be published. Although that request was based upon the proposition that any disclosure of information concerning the history of the applicant would be likely to reveal the applicant's identity in some circles, that would be an unusual step for the Court to take. The issue raised has been carefully considered in the course of preparing these reasons with the intention that personal information which is not essential to the conclusion reached should not be disclosed. The Court is satisfied that, in the result, such limited disclosure as will occur does not warrant non-publication of the Court's reasons.

6 In making that assessment, it was noted that both the form and the effect of a non-publication order can involve a nuanced exercise. Thus, people with some information about the circumstances of the person concerned will be able to identify the person as the subject of the proceedings more readily than members of the general public with no such information. Accordingly, the scope of any order and its likely effect will need to be assessed on a case by case basis and weighed against the interference with the public interest in open justice referred to in s 6 of the Non-publication Orders Act. In this case the Court should make the following order:

> Pursuant to the *Court Suppression and Non-publication Orders Act 2010,* prohibit the disclosure of information tending to reveal the identity of the applicant, including by disclosure of information which might indirectly lead others to identify the applicant.

Application for leave to appeal

7 The matter came before the primary judge by way of an appeal pursuant to s 163 of the *Mental Health Act*. That right of appeal lay against any determination of the Tribunal made with respect to the appellant. The *Mental Health Act* provides that the appeal is to be "by way of a new hearing and new evidence or evidence in addition to, or in substitution for, the evidence given in relation to the determination of the Tribunal … may be given on the appeal."[3] In determining such an appeal, the Court is given "all the functions and discretions of the Tribunal in respect of the subject matter of the appeal".[4] In

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[3] Mental Health Act, s 164(2).

[4] Mental Health Act, s 164(1).

order to determine an appeal, the Court must identify and be satisfied as to each of the statutory preconditions to the making of a community treatment order and must consider the matters required by the statute to be considered.

8 As there were real questions, acknowledged by the respondent's notice of contention, as to whether the judge had identified the relevant issues and made the necessary findings there should be a grant of leave to appeal pursuant to s 101(2)(r) of the *Supreme Court Act 1970* (NSW).

Issues to be determined by Supreme Court

9 The matters as to which the Tribunal was to be satisfied before making an order are those of which the judge must be satisfied on an appeal. They are set out in the following provisions of s 53 of the *Mental Health Act*:

> **53 Determination of applications for community treatment orders**
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> …
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> (3) The Tribunal may make a community treatment order for an affected person if the Tribunal determines that:
>
> (a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and
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> (b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and
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> (c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.
>
> (3A) If the affected person has within the last 12 months been a forensic patient or the subject of a community treatment order, the Tribunal is not required to make a determination under subsection (3)(c) but must be satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted.
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> (4) The Tribunal may not make a community treatment order at a mental health inquiry unless the Tribunal is of the opinion that the person is a mentally ill person.
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> (5) For the purposes of this section, a person has a previous history of refusing to accept appropriate treatment if the following are satisfied:
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> (a) the affected person has previously refused to accept appropriate treatment,
>
> (b) when appropriate treatment has been refused, there has been a relapse into an active phase of mental illness,

(c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility (whether or not there has been such an admission),

(d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery 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.

(6) The Tribunal must not specify a period longer than 12 months as the period for which a community treatment order is in force.

(7) In determining the duration of a community treatment order, the Tribunal must take into account the estimated time required:

(a) to stabilise the condition of the affected person, and

(b) to establish, or re-establish, a therapeutic relationship between the person and the person's psychiatric case manager.

10 Not all of these provisions were applicable in relation to the applicant. For example, (3A) was not applicable because the applicant had not been the subject of a previous community treatment order. It is relevant, however, because it raises a question as to whether, to be the subject of a community treatment order, the person must be suffering from a mental illness.

11 A similar issue arises from subs (4). Arguably that was not engaged in the present case because the Tribunal was not conducting a "mental health inquiry". That term is defined to mean an inquiry pursuant to s 34(1) with respect to a person detained in a mental health facility. It is required to be undertaken as soon as practicable after admission to the facility.[5] Section 53(4) is consistent with the requirement that if, on a mental health inquiry, the Tribunal is not satisfied that the person is a "mentally ill person" the Tribunal must order that the person be discharged from the mental health facility. Only if satisfied on the balance of probabilities that the person is a "mentally ill person" does the Tribunal have power to order either that the person be detained, discharged into the care of the person's primary carer or be subject to a community treatment order.[6] For reasons which will be noted below, the non-engagement of this provision is a matter of some consequence and was in dispute.

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5 Mental Health Act, s 27(d).

6 Mental Health Act, s 35(5).

12 Accepting for present purposes that subss (3A) and (4) were not engaged, it is apparent that the Tribunal (and hence the Court on appeal) must be satisfied that the terms of subss (3) and (5) are otherwise fulfilled. These matters require both a methodical analysis of past circumstances and an assessment of the professional evidence as to the effect of particular treatment and the consequences of its refusal. Relevant considerations are set out in s 53(2) of the *Mental Health Act*. Apart from the catch-all requirement to consider "any other information placed before the Tribunal",[7] the only consideration relevant to the present applicant was "a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order".[8]

13 The Tribunal, and therefore the Court, is required to consider carefully the nature and content of a proposed treatment plan, first in order to be satisfied that no other care of a less restrictive kind would be appropriate, and also to determine that the proposed care would benefit the affected person. Furthermore, an assessment must be made of the matters identified in subs (7) to determine the appropriate duration of a community treatment order.

14 Dealing with the historical matters, the first step was to identify that the affected person had been previously diagnosed as suffering from a mental illness. The second step was to determine whether, presumably following diagnosis, particular treatment had been prescribed. The third step was to be satisfied that the treatment was "appropriate". The fourth step was to identify a "refusal" to accept that treatment.

15 Those four elements in subs (3)(c) are expanded upon in subs (5). Step five required a finding that there had been "a relapse into an active phase of mental illness". There is some awkwardness in identifying the precise scope of that step: it appears to require a period during which the treatment was administered with beneficial results, followed by a relapse.

16 Step six may involve a further qualification of step five: although a "relapse" suggests a "mental or physical deterioration", as provided in subs (5)(c), the deterioration must be sufficient to justify involuntary admission to a mental

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7 Section 53(2)(d).
8 Section 53(2)(a).

health facility. That in turn would appear to require consideration of the factors set out in Ch 3, Pt 1 including the requirement that an authorised medical officer be of the opinion that the person is "a mentally ill person or a mentally disordered person", amongst other criteria.[9]

17 The final step, step seven, requires a finding, hypothetically, that care and treatment following involuntary admission could have resulted in at least an amelioration of the debilitating symptoms or prevention of deterioration in the condition of the person.[10] No doubt if the person has already had treatment and has suffered a relapse on its cessation, the conclusions required in step seven will follow relatively easily in most cases from the earlier findings.

Proceedings before the Tribunal

18 While this appears to be a scheme of some complexity, one would expect it to involve a reasonably familiar routine for the Mental Health Review Tribunal. Although the Act does not appear to require it,[11] the Tribunal as constituted to consider the applicant's case had three members, including a legal practitioner (presiding) and a psychiatrist.

19 The transcript of the hearing before the Tribunal focused almost entirely upon the terms and requirements of the proposed treatment plan. At the conclusion of the hearing, the chairperson gave the applicant an opportunity to say anything before the Tribunal decided whether or not to make the community treatment order and, upon the applicant indicating there was nothing to say, announced that the Tribunal would make the order.

20 A formal document headed "Determination of Tribunal" included the date of hearing, stated that a community treatment order was made, referring to the "attached treatment plan" and noted that the order would expire no later than 2 December 2015. The reasons of the Tribunal were handwritten in three lines and read (so far as legible):

> "The Tribunal is satisfied that the requirements of s 53(3) are met. [The applicant] does not believe [the applicant] has a mental illness and the

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9 Mental Health Act, ss 12-16.

10 Mental Health Act, s 53(5)(d).

11 Mental Health Act, s 150.

> Tribunal is satisfied that without an order [the applicant] will not accept treatment necessary … at risk of relapse."

21 When the appeal came before the primary judge, he noted that the Court had the power to nominate two assessors if thought appropriate to do so.[12] Neither party invited the Court to take that step and the judge declined to do so. Given that the applicant had proffered no expert evidence contradicting the affidavits supplied on behalf of the respondents, the judge may have thought it unlikely that he would need the assistance of a psychiatrist. Given the conclusions reached below it is not necessary to comment further on that course, although the failure to sit with assessors was a ground of appeal.

Judgment below

22 It is necessary then to consider whether, in determining the appeal, the primary judge dealt with issues identified above and made the necessary findings.

23 The judge noted that "the court book contains over 450 pages"; he then stated that he had "read the lot."[13] He described the bulk of the material as "reports" from various health professionals, although a large proportion was better described as clinical progress notes. The judge also identified the applicant's criticism of the accuracy of some of the records, which recorded histories. The applicant complained that errors by way of miscommunication and in observations were uncritically repeated and relied upon. While accepting the possibility of error, the judge found that there were consistencies and a progression in recorded events which were made independently of early records in other institutions.[14]

24 The judge made an express finding that the applicant was suffering from chronic schizophrenia.[15] Whether that was a relevant finding will be addressed below, but the judge appears at first to have considered it was such.[16] The judge also accepted the evidence of Dr Chandrasekera that the treatment given to the applicant under his care was effective and that the symptoms of the illness were diminished. Further he accepted Dr Chandrasekera's evidence

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12 Mental Health Act, s 164(5).
13 Judgment at [6].
14 Judgment at [7].
15 Judgment at [11] and [13].
16 Judgment at [4] issue (5), [5] issue (5) and [14]; cf [31].

that the applicant did not "have a good history of taking medication" (which the applicant did not dispute) and that unless the applicant was "subject to a controlled treatment regime, [Z] would relapse."[17]

25 The judge then dealt with a number of legal issues before returning to the facts. The judge stated at [24]:

> "Thus, so long as there has been a diagnosis of chronic schizophrenia and medical evidence that, unless treated, the condition will no longer lie dormant, and there is some evidence to suggest that a patient will not voluntarily take … medicine, a community treatment order may be made."

26 After referring to earlier authority (not presently relevant) and the provisions of s 51(5) and s 53(3) and (4), the judge accepted that "it is only in respect of a community treatment order sought under s 51(5)(a) that it is necessary to prove that at the time of the order the affected person had a mental illness."[18] The judge continued, noting that "the effect of the Act generally is that it is probably only the case where a person has previously been assessed with a mental illness and there is evidence that continued treatment is necessary to prevent [recurrence] of the symptoms and the person affected has a history of not voluntarily accepting treatment, that the Tribunal would be justified in making such an order." That, the judge said, was this case.

27 The judgment then turned to consider whether certain earlier determinations, which on one view were no longer operative, could be reviewed. The judge dealt with the matter in the following manner at [34]-[37]:

> "[34] The decision of 3 June 2015 was that [Z] needed treatment for … chronic schizophrenia and the minimum appropriate treatment in all the circumstances was the community treatment order that was made. Now the basis of the decision can be found in the evidence of Dr Chandrasekera. At paragraph 25 on page 329 of the Court book Dr Chandrasekera swore:
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> > 25. After Dr Law reported his findings to me on 3 June 2015 I remained of the view that [Z] was suffering from schizophrenia and was a mentally ill person under the Mental Health Act. Although [Z's] symptoms were diminished in comparison to [Z's] symptoms in May 2015 in my opinion, if [Z] stopped the treatment at that time [Z] would likely become unwell again. I formed the view that although [Z] had been under psychiatric care since being admitted to Royal North Shore on 19 April which is nearly seven weeks of care, continuing treatment was necessary to keep [Z] well and prevent, as far as possible, further relapses of [Z's] schizophrenia.

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[17] Judgment at [11].

[18] Judgment at [31].

> 26. Schizophrenia is a chronic mental illness which is characterised by periods of relapse on a background that the patient's cognitive function will also decline over time. As at 3 June 2015 [Z] had a relapsing chronic condition, as evidenced by documented relapses, requiring hospital presentations since 2012 each with persecutionary [sic] delusions.
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> 27. Schizophrenia affects a person's thoughts, perceptions and mood in a manner that can lead to poor social, occupational and emotional functioning. If schizophrenia is not treated a patient will be much more likely to have future psychotic relapses and those psychotic relapses are likely to be more severe… Hence without adequate pharmaceutical treatment and support [Z] would be chronically unwell and impaired in the above domains. With treatment and support, the symptoms can be managed and can attain a greater degree of function which would be impossible without treatment. Although schizophrenia cannot be cured it can be managed well with appropriate treatment.
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> 28. I formed the view that if [Z] did not take a prescribed anti-psychotic medication, that [Z] would be at real risk of a deterioration of [Z's] mental illness and at risk of the harms described above.
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> [35] Now [Z] cross-examined Dr Chandrasekera. [Z] did put to him that a lot of the material he had read was non-verified assertions from family members and put to him that he could not be satisfied of the so-called facts which they alleged. Dr Chandrasekera's answer to that was, whilst that might be true up to a point, he himself had had one on one sessions with [Z] for a period of over a month and was satisfied with his diagnosis. Dr Law gave similar evidence.
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> [36] … [Z] had been under the care of Dr Chandrasekera and his colleagues for some months and that the evidence of Dr Chandrasekera really should be accepted and that that was the evidence on which the Tribunal made its decision, that is that in all the circumstances it would be best to infringe [Z's] civil liberties to the extent of ordering the treatment under the community treatment order.
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> [37] I have to decide the matter on the balance of probabilities. I would have liked to have thought about it a bit more, but for reasons I have outlined it seems to me that in the absence of any particular medical evidence produced by [Z] and on the background, that there is some material to justify the view that [Z] is a person who is unwilling to accept that [Z] has schizophrenia, that on the balance of probabilities the order made by the Mental Health Review Tribunal was the correct one for it to make."

28 There are, with respect, difficulties with this reasoning. First, the passage starts by identifying the decision of the Tribunal of 3 June 2015 and concludes by saying that "it seems to me that … the order made by the Mental Health Review Tribunal was the correct one for it to make." That is language consistent with reviewing the decision of the Tribunal, not the language of conducting a new hearing and determining each statutory precondition afresh.

29 Secondly, even that exercise seems to have been based on a false premise, namely that articulated in the second sentence set out above, stating that "the

basis of the decision [that is the Tribunal's decision of 3 June 2015] can be found in the evidence of Dr Chandrasekera." If the statement were taken literally, it was incorrect. Dr Chandrasekera's affidavit was dated 10 August 2015 and thus post-dated the decision of the Tribunal. Further, the affidavit made clear that Dr Chandrasekera did not himself provide evidence to the Tribunal, either by way of a report or orally. (A report was prepared for the Tribunal by Dr Law.) The alternative reading of that passage in the judgment is that the decision of the Tribunal could *now* be justified by reference to the evidence of Dr Chandrasekera. However, that reading would also reveal error of the kind noted in respect of the previous sentence in the judgment, namely that the exercise being undertaken was a review of the decision of the Tribunal, rather than the making of a fresh determination.

30 Thirdly, as to [36], the respondent contended that the passage should be read as a finding that the evidence of Dr Chandrasekera was accepted and the conclusions he reached adopted as those of the Court. Once the grammatical infelicities are ignored (by removing the word "that" each time it appears after "and") two problems remain. The first is that, again, it is said to be the evidence on which the Tribunal made its decision and is thus expressly not adopted as the basis for findings by the Court. Further, the reference to evidence of Dr Chandrasekera is, presumably, to that which the judge had just set out at [34] of his reasons. But if that were the case, Dr Chandrasekera did not express his opinions in terms of the statutory tests identified above, even if that evidence might provide a basis for satisfying some of those steps in the requisite reasoning process.

31 Thus, Dr Chandrasekera's quoted evidence referred to "documented relapses, requiring hospital presentations since 2012 each with persecutionary [sic] delusions." Section 53(5) requires a "relapse" after a refusal of "appropriate treatment". There was no express reference to what treatment had been provided prior to a particular relapse. The first hospitalisation of Z was on 1 August 2014. Z remained as an involuntary patient until discharged on 23 October 2014. What was required was a finding that Z had been given "appropriate treatment" during that time, that the treatment had then been "refused" and there had been "a relapse into an active phase of mental illness"

thereafter. That might well be satisfied by the history following release on 23 October 2014 and the later detention on 19 April 2015. However, Dr Chandrasekera did not identify the circumstances within that chronology as the basis of the relevant opinion.

32 Furthermore, there should have been a finding that the relapse was "followed by mental or physical deterioration" of a sufficient kind to justify involuntary admission to a mental health facility. Such a finding may be inferred from Dr Chandrasekera's explanation as to Z's treatment at Hornsby Hospital, under his supervision. But neither his opinion nor, importantly, any finding by the judge was expressed in those terms.

33 Fourthly, even accepting the final statement that "there is some material to justify the view that [Z] is a person who is unwilling to accept that [Z] has schizophrenia", that finding is itself only a step along the way to the statutory preconditions to the making of a community treatment order. Further, the conclusion to that sentence reinforces the first inference, namely that the judge approached the matter on the basis that he was reviewing the decision or order of the Tribunal, and not making his own findings in order to reach his own determination of the application.

34 Fifthly, the one factor which was a mandatory consideration in the circumstances of the case was the treatment plan: s 53(2)(a). The judge made no finding as to whether the treatment plan was appropriate, whether the period of six months was appropriate and, to that end, what time was required to stabilize Z's condition and establish a therapeutic relationship between Z and Z's psychiatric case manager: s 53(7).

Conclusions

35 The trial judge did conclude that "it would be best to infringe [Z's] civil liberties to the extent of ordering the treatment under the community treatment order." That language (which is not derived from the statute) appears to have been a reflection of parts of the reasoning of this Court in *Harry v Mental Health Review Tribunal*.[19] The question of intrusion on civil liberties was addressed in *Harry* in order to answer the question whether the Tribunal had power to make

[19] (1994) 33 NSWLR 315.

a community treatment order in respect of a person who was not a patient in a hospital, or a "mentally ill person".[20] No such question of statutory construction arose in the present case; respect for Z's civil liberties would have been achieved by the scrupulous application of the statutory scheme with respect to an application for a community treatment order. With great respect to the primary judge, who dealt with the matter as one of urgency on short notice, in my view the necessary findings to permit imposing a community treatment order were not made. It follows that the appeal must be allowed and the order made by the primary judge, dismissing the appeal under s 163, must be set aside.

36 There remains a real issue as to what consequential orders should follow. As a practical matter, Z remains the subject of the community treatment order made by the Tribunal, with the appeal from that order undetermined. However, that order is due to expire on 2 December 2015. It will not be practicable for any determination of the appeal to be completed prior to the expiration of the order.

37 One possibility is that one of the persons identified in s 51(2) will apply (or indeed may have applied) for a further community treatment order. Such an application may be made with respect to a person who is subject to a current community treatment order: s 51(4). Different procedural steps may need to be taken depending upon whether the person is, at the time of the further application, subject to an existing community treatment order: s 53(2)(b). The significant practical factor is that, if the person is not the subject of a current community treatment order when the application is heard by the Tribunal, and the person is not detained in a mental health facility, the applicant must be given 14 days' notice of the application: s 52(3), but now see s 52(4) which was not in force when the order under appeal was made.

38 There was a debate in this Court (as there was before the primary judge) as to whether the Court had jurisdiction to deal with appeals from what were described as "spent" orders. The primary judge did not find it necessary to determine that question. Nevertheless, the matter was pursued by the Attorney

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[20] See Harry at 321-323 (Kirby P) and 335 (Mahoney JA).

General in this Court; indeed, it was the only matter the Attorney sought to argue.

39 The question is not to be addressed in the abstract, as it might be if there were some express statutory limit on the right to appeal. The argument is rather based on an implied limitation derived from practical futility. However, to assess that argument requires consideration of the purpose for which the appeal may be brought. For example, if a tribunal had found that there was a diagnosis of mental illness in respect of a particular person for the purpose of making a community treatment order, which has run its course, the person may not wish to be precluded from submitting that there had been no such diagnosis when a further order is sought. In that sense, the applicant might contend that the earlier order, though no longer operative, was not "spent". The answer to that submission could be that the tribunal considering a fresh order must decide for itself whether there was such a diagnosis and would not be bound by an affirmative finding by an earlier tribunal. To reason in this way is to demonstrate the undesirability of deciding a question of jurisdiction in the abstract. In the present case, the point was lightly touched upon by the applicant and is best not considered further in circumstances where the earlier decisions of the Tribunal appear to have no relevance for the validity or otherwise of the present decision, but may do in ways not explored.

40 No doubt a similar question will be raised with respect to the present community treatment order, because it will be relevant if any further order is sought to know whether the applicant is subject to a community treatment order at a particular point in time. The answer to that question may depend upon a somewhat different issue, which was not addressed before this Court, namely the effect of setting aside a community treatment order on appeal. For example, it seems unlikely that, if, after a period during which the order had been acted upon, it was set aside on appeal, earlier actions would thereby become in some sense unlawful. It seems more likely, at least for some purposes, that the appeal would operate prospectively. Again, because the issues were not raised they should not be further addressed. Because the order is presently on foot (and was so at the time of the hearing in this Court)

no party invited the Court to dismiss the appeal on the grounds that this particular order was spent.

41 There remains a question as to whether this Court should seek to determine the appeal. For that purpose it would need to assess the evidence which was called before the primary judge, an exercise which was not addressed by the parties in any detail. Further, the applicant was critical in some respects of the way in which the primary judge dealt with the evidence before him. Given these factors, together with issues of timing, it is not appropriate for this Court to determine the merits of the appeal. It may well be that there is no further step which can usefully be taken in the appeal, but nevertheless, the appeal should be remitted to the Equity Division where its fate can be determined after the parties have given careful consideration to its utility in the light of whatever recent events may have occurred at the time it is listed for redetermination.

42 I propose the following orders:

(1) Grant the applicant leave to appeal from the judgment in the Equity Division given on 28 September 2015.

(2) Allow the appeal and set aside the order dismissing the appeal under s 163 of the *Mental Health Act 2007* (NSW).

(3) Remit the matter to the Equity Division.

(4) Pursuant to the *Court Suppression and Non-publication Orders Act 2010,* prohibit the disclosure of information tending to reveal the identity of the applicant, including by disclosure of information which might indirectly lead others to identify the applicant.

43 **BERGIN CJ in Eq**: This is an application for leave to appeal heard concurrently with the appeal from the decision of Young AJ on 28 September 2015 determining an appeal under s 163 of the *Mental Health Act* 2007 (the Act) brought by the applicant (referred to in the proceedings as "Z") against a community treatment order (CTO) made by the Mental Health Review Tribunal (Tribunal) on 3 June 2015.

44 The primary judge heard the appeal on 24 and 28 September 2015. Z was unrepresented and Ms K Richardson, of counsel, appeared for the second and third respondents to the appeal, the Attorney-General of New South Wales and the Northern Sydney Local Health District respectively. The Tribunal, as first respondent, filed a submitting appearance.

45 The CTO was made for a period expiring no later than 2 December 2015. The CTO was made in accordance with the terms and conditions of a Treatment Plan attached to the order. The goals of the Treatment Plan for Z were recorded as including "to better control symptoms of mental illness using medication, counselling, education, and promoting improved mental health in the least restrictive environment that is consistent with safe and effective care". It also recorded that this would allow Z to "establish connections in the community" and give Z "increased independence of taking medication and increased responsibility for taking oral medication with a view to discharge" from the CTO.

46 The CTO requires Z to attend regular appointments with a named professional for the purpose of implementing the CTO including the administration of appropriate medication. The Reasons of the Tribunal members on 3 June 2015 were recorded as follows:

> The Tribunal is satisfied that the requirements of s 53(3) are met. [Z] does not believe [Z] has a mental illness and the Tribunal is satisfied that without an order [Z] will not accept necessary treatment + will be at risk of relapse.

The legislation

47 In determining the application for leave and the appeal it will be necessary to have regard to various provisions of the Act. Section 4 of the Act includes the following definition:

> ***mental illness*** means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions,
>
> (b) hallucinations,
>
> (c) serious disorder of thought form,
>
> (d) a severe disturbance of mood,
>
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a) – (d).

48 The Act also provides:

> **12 General restrictions on detention of persons**
>
> (1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

(2) If an authorised medical officer is not of that opinion about a patient or other person at a mental health facility, the officer must refuse to detain, and must not continue to detain, the person.

(3) An authorised medical officer may, immediately on discharging a patient or person who has been detained in a mental health facility, admit that person as a voluntary patient.

13 Criteria for involuntary admission etc as mentally ill person or mentally disordered person

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a mental health facility or the detention of the person in a facility under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a mental health facility,

if, and only if, the person satisfies the relevant criteria set out in this Part.

…

19 Detention on certificate of medical practitioner or accredited person

(1) A person may be taken to and detained in a declared mental health facility on the basis of a certificate about the person's condition issued by a medical practitioner or accredited person. The certificate is to be in the form set out in Part 1 of Schedule 1.

(2) A mental health certificate may be given about a person only if the medical practitioner or accredited person:

(a) has personally examined or observed the person's condition immediately before or shortly before completing the certificate, and

(b) is of the opinion that the person is a mentally ill person or a mentally disordered person, and

(c) is satisfied that no other appropriate means for dealing with the person is reasonably available, and that involuntary admission and detention are necessary, and

(d) is not a designated carer, the principal care provider or a near relative of the person.

(3) A mental health certificate may contain a police assistance endorsement that police assistance is required if the person giving the certificate is of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer. The endorsement is to be in the form set out in Part 2 of Schedule 1.

(4) A mental health certificate may not be used to admit or detain a person in a facility:

(a) in the case of a person certified to be a mentally ill person, more than 5 days after it is given, or

(b) in the case of a person certified to be a mentally disordered person, more than one day after it is given.

(5) In this section:

near relative of a person means a parent, brother, sister, child or spouse of the person and any other person prescribed for the purposes of this definition.

…

47 Leave of absence on compassionate grounds, medical grounds or other grounds

(1) An authorised medical officer may permit a person to be absent from a mental health facility for the period, and on the conditions, that the officer thinks fit.

(2) Permission may be given on compassionate grounds, on the ground that medical treatment is required or on any other ground the authorised medical officer thinks fit.

Note. A person may also be transferred from a mental health facility to another health facility on medical grounds (see section 80).

(3) An authorised medical officer may not grant leave of absence unless the officer is satisfied that, as far as is practicable, adequate measures have been taken to prevent the person concerned from causing harm to himself or herself or others.

49 The Act provides that certain persons may apply to the Tribunal for a CTO including an authorised medical officer of a mental health facility in which the affected person is detained or is a patient under the Act: s 51(2)(a); or a medical practitioner who is familiar with the clinical history of the affected person: s 51(2)(b). A CTO may be made in prescribed circumstances including on an application (otherwise than following a mental health inquiry under s 34 of the Act or a review of a patient by the Tribunal under s 44 of the Act): s 51(5).

50 Notice of an application for a CTO must be given to the affected person in writing and it must include a copy of the proposed treatment plan: s 52(1) and (2). Section 52 of the Act also provides:

(3) If the affected person is not detained in a mental health facility, the application must be heard not earlier than 14 days after the notice is given.

(4) Subsection (3) does not apply:

(a) to an application for a further community treatment order in respect of an affected person who was the subject of a current community treatment order when the notice was given, or

(b) if the Tribunal decides it is in the best interests of the affected person that the application be heard earlier than 14 days after the notice is given.

51 A pivotal section in this appeal is section 53 of the Act which provides:

53 Determination of applications for community treatment orders

(1) The Tribunal is, on an application for a community treatment order, to determine whether the affected person is a person who should be subject to the order.

(2) For that purpose, the Tribunal is to consider the following:

(a) a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order,

(b) if the affected person is subject to an existing community treatment order, a report by the psychiatric case manager of the person as to the efficacy of that order,

(c) a report as to the efficacy of any previous community treatment order for the affected person,

(d) any other information placed before the Tribunal.

(3) The Tribunal may make a community treatment order for an affected person if the Tribunal determines that:

(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and

(b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and

(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

(3A) If the affected person has within the last 12 months been a forensic patient or the subject of a community treatment order, the Tribunal is not required to make a determination under subsection (3) (c) but must be satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted.

(4) The Tribunal may not make a community treatment order at a mental health inquiry unless the Tribunal is of the opinion that the person is a mentally ill person.

(5) For the purposes of this section, a person has a ***previous history of refusing to accept appropriate treatment*** if the following are satisfied:

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

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

(c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility (whether or not there has been such an admission),

(d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery 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.

(6) The Tribunal must not specify a period longer than 12 months as the period for which a community treatment order is in force.

(7) In determining the duration of a community treatment order, the Tribunal must take into account the estimated time required:

(a) to stabilise the condition of the affected person, and

(b) to establish, or re-establish, a therapeutic relationship between the person and the person's psychiatric case manager.

(8) The Tribunal may order that the discharge of an involuntary patient for whom a community treatment order is made be deferred for a period of up to 14 days, if the Tribunal thinks it is in the best interests of the patient to do so.

52 The Act also provides:

163 Appeals to the Court

(1) A person may appeal to the Court against:

(a) a determination of the Tribunal made with respect to the person, or

(b) the failure or refusal of the Tribunal to make a determination with respect to the person in accordance with the provisions of this Act.

(2) An appeal is to be made subject to and in accordance with the rules of the Court.

164 Power of the Court on appeals

(1) The Court has, for the purposes of hearing and disposing of an appeal, all the functions and discretions of the Tribunal in respect of the subject-matter of the appeal, in addition to any other functions and discretions it has.

(2) An appeal is to be by way of a new hearing and new evidence or evidence in addition to, or in substitution for, the evidence given in relation to the determination of the Tribunal, or the failure or refusal of the Tribunal to make a determination, in respect of which the appeal is made may be given on the appeal.

(3) The Court is to have regard to the provisions of this Act and any other matters it considers to be relevant in determining an appeal.

(4) The decision of the Court on an appeal is, for the purposes of this or any other Act or instrument, taken to be, where appropriate, the final determination of the Tribunal and is to be given effect to accordingly.

(5) In hearing and deciding an appeal, the Court may be assisted by 2 assessors selected by the Court from the panel nominated for the purposes of this Chapter, if the Court considers it appropriate to do so.

(6) An assessor is to sit with the Court in the hearing of an appeal and has power to advise, but not to adjudicate, on any matter relating to the appeal.

Background

53 It is not in issue that Z was detained in various Mental Health Intensive Care Units (MHICU) during the periods 31 July 2014 to 23 October 2014 and 19 April 2015 to 3 June 2015. It is also not in issue that Z was the subject of a mental health inquiry under s 34 of the Act on 6 August 2014 when an order was made that Z be detained until 3 September 2014 as a "mentally ill person". Z's appeal under s 44 of the Act was dismissed on 14 August 2014. Z was also involved in a review under s 37 of the Act on 16 September 2014 when an order was made to detain Z until 9 December 2014. However Z was discharged on 23 October 2014 pursuant to s 12 of the Act.

54 On 26 November 2014 Z commenced proceedings by Summons challenging the decisions of the Tribunal in August and September 2014. On 24 June 2015 Z filed an Amended Summons continuing the challenge against the Tribunal's orders of August and September 2014 and including the challenge against the Tribunal's order on 3 June 2015 for the CTO.

55 On 19 April 2015 after a family fracas, Z was detained again at another MHICU, this time in accordance with a mental health certificate pursuant to s 19 of the Act.

56 On 6 May 2015 there was a further mental health inquiry under s 34 of the Act when an order was made that Z be detained until 4 June 2015 as a "mentally ill person". Z's appeal under s 44 of the Act was refused.

57 It was on 8 May 2015 that Z was first seen by Dr Ravinda Chandrasekera a consultant psychiatrist. Z was also seen subsequently by Dr Chandrasekera's Registrar Dr Jeremy Law, both separately and with Dr Chandrasekera. At some stage during May 2015 Z was granted leave of absence under s 47 of the Act. However Z accepted in cross-examination that discharge from the MHICU did not occur until 3 June 2015. It was also accepted on this appeal that on 11 May 2015 Z had requested a CTO and discharge. On 19 May 2015, whilst on leave, Z advised an intention to be available for hearing in respect of the CTO and to engage with community treatment. On 26 May 2015 Dr Law made the application for the hearing in respect of the CTO noting that the

"preferred time" was in the afternoon of 29 May 2015. On 29 May 2015 the Tribunal advised that the hearing would take place at 3.30 pm on 3 June 2015.

58 Z returned to the MHICU on the morning of 3 June 2015, it would appear by arrangement with Dr Law. Z was served with the notice of the application for the CTO at that time. The hearing took place at approximately 3.30 pm on that day.

59 On 20 October 2015 the CTO was varied to accommodate Z's change of residence by appointing a different mental health facility to implement the Treatment Plan.

The hearing

60 The primary judge heard the appeal on Thursday 24 September 2015 and Monday 28 September 2015. The respondents relied upon the affidavit of Dr Chandrasekera affirmed on 10 August 2015. That affidavit addressed the relevant provisions of s 53 of the Act under the headings "Least restrictive care" (s 53(3)(a)) [pars 31-38]; "Appropriate treatment plan" (s 53(3)(b)) [pars 39-42]; and "Previous history of non-compliance with appropriate treatment" (s 53(3)(c) & 53(5)) [pars 43-50].

61 The respondents also relied upon the affidavit of Dr Law affirmed on 7 August 2015. Dr Law's evidence included detail of his analysis of his report prepared on 21 May 2015 and the process before the Tribunal on 3 June 2015. Dr Law also addressed the matters identified in s 53(3) of the Act under the headings "Ongoing mental illness" (s 53(3)(c)) [pars 38-41]; "Least restrictive care" (s 53(3)(a)) [pars 42-47]; "Appropriate treatment plan" (s 53(3)(b)) [pars 48-53]; and "Previous history of refusing to accept appropriate treatment" (s 53(3)(c) & 53(5)) [pars 55-58].

62 In respect of "Least restrictive care" Dr Chandrasekera's affidavit evidence included that: a CTO with a duration of six months was necessary and that no less restrictive care was appropriate and reasonably available; the prescribed medication was necessary but was unlikely to be taken voluntarily as Z had a history of non-compliance; Z believed that there was no mental illness and no need for medication; and there was a risk of relapse if the prescribed medication was not taken.

63 Dr Law's affidavit evidence on the "Least restrictive care" was that a CTO was necessary and that no less restrictive care was appropriate and reasonably available. Dr Law's evidence included that: he had "significant concerns" that Z would not take medication voluntarily; Z was not interested in any ongoing intervention or education about the mental illness; Z had "very poor insight"; however it would be of real benefit for Z to reside in the community under the regime in the Treatment Plan.

64 In dealing with the "Appropriate treatment plan" Dr Chandrasekera gave evidence that: the proposed medication under the CTO was appropriate; there were improvements in Z's condition after the first injection on 8 May 2015; and it had less side effects than other anti-psychotics used to treat schizophrenia. He also gave evidence that regular reviews by nurses and a psychiatrist at the relevant mental health facility were important so that treatment could be monitored and changed if necessary.

65 Dr Law's evidence on this topic was that the treatment plan proposed to the Tribunal on 3 June 2015 was appropriate. He recorded that the relevant mental health facility was suitable and capable of implementing the Treatment Plan. He also referred to the benefits of ongoing review by the health clinic and a psychiatrist.

66 Dr Chandrasekera gave evidence of "Previous history of non-compliance with appropriate treatment" by reference to a review of clinical notes, particularly Z's readmission to hospital on 19 April 2015. Dr Chandrasekera's evidence was that on 19 April 2015 Z presented to hospital in an active phase of schizophrenic illness. He expressed the opinion that, based on the improvements in Z's condition between 19 April 2015 and 3 June 2015 while taking the prescribed medication, Z's presentation on 19 April 2015 indicated that Z had not been taking the prescribed medication and suffered a relapse. Dr Chandrasekera also referred to clinical notes recording that Z had admitted non-compliance with the medication on 20 April 2015.

67 Dr Law's evidence on this topic was that Z had previously been diagnosed with suffering from a mental illness and that there was a history of refusing to accept appropriate treatment. Dr Law referred to his report of 21 May 2015 in

which he had noted that Z had expressed beliefs that there was no mental illness and therefore medication was not necessary; that Z was "now above the law" and that CTOs did not apply.

68 Z conceded both before the primary judge and on the appeal that there had been non-compliance with the medication regime.

69 Z cross-examined Dr Chandrasekera. During that cross-examination Z referred to a report that had been provided by a consultant psychiatrist from Western Australia in 2013 who had diagnosed Z as having an adjustment disorder with mixed anxiety and depressed mood. Z asked Dr Chandrasekera to explain why his diagnosis was "so far removed from this diagnosis". Dr Chandrasekera said:

> Yes, I can explain. There has been from 2012 to 2015, you have had about three to four admissions to psychiatric hospital with psychotic symptoms, which are paranoid ideas about people colluding with each other against you, and that includes your family, the doctors who treated you and the other features are there was some grandiosity in your thinking, where you believed that you have to be compensated for a lot of things and you are above the Mental Health Act, or mental health law. So that is paranoid and grandiose ideas. Those paranoid and grandiose ideas are part of the diagnosis of schizophrenia and it has been treated with medication and you respond well. If you are not on medication you relapse again. That has been the case.

70 Z cross-examined Dr Chandrasekera as follows:

> Q. And that you say during 2013 and 2014 I was suffering from schizophrenia?
>
> A. Yes, I still believe because schizophrenia is an enduring illness but people have relapses and remissions. So in periods of remissions, people can function well, but if they don't get treatment, they can relapse again and would have serious consequences, which I can elaborate if you want to.

71 Z challenged Dr Chandrasekera in respect of his diagnosis as follows:

> Q. I put it to you that there was no deterioration in my mental state?
>
> A. You are entitled to your opinions.
>
> Q. I put it to you that there was no relapse in my condition between the two hospitalisations?
>
> A. Documentation disagrees with that.
>
> …
>
> Q. I also deny that my grand-mother had schizophrenia, what do you say about that?
>
> A. That's historical evidence.

Q. When you say it's historical evidence, where did that evidence come from?

A. It's documented in your previous discharge summaries, previous notes.

Q. That evidence came from my father, that's right, isn't it?A. Mm.

Q. So if my father was lying, then that information wouldn't be correct, would it?

A. If he was lying, yes.

…

Q. So if that information that you had was incorrect, would your opinion change?

A. Probably not. I observed you, I looked after you in hospital for I think more than a month, so it's still, if I did have the other information, I would still go with my diagnosis.

Q. What do you say would happen if [I] came off medication now?

A. There's a high likelihood you would relapse, probably not immediately, but it can happen up to the next six months.

Q. And what do you mean by a relapse?

A. You would have paranoid ideas about people and you can get more disorganised, and you can get into arguments, disagreements.

72 The primary judge asked Dr Chandrasekera to comment upon the observation that Z presented well on the day, asking questions that seemed sensible and appearing "normal". In response Dr Chandrasekera agreed that Z was "normal" but had an "enduring condition" which if treated with medication would enable normal function. However Dr Chandrasekera said that if Z became unwell again treatment would be hard and there could be damage to cognitive function.

73 Dr Law prepared a report for the Tribunal hearing on 3 June 2015 in which he set out Z's diagnosis that Dr Chandrasekera and he had made jointly. That report included reference to the presence of persecutory delusions; grandiose delusions (spending large sums of money pursuing very large claims for compensation whilst being on Centrelink benefits); thought disorder; and decreased salience. The report included the opinion that Z remained insightless and that underlying persecutory delusions persisted. The report advised that therefore a CTO was the least restrictive option for Z's safe and effective care.

74 Z cross-examined Dr Law as follows:

Q. What steps did you take to arrive at your opinion of schizophrenia?

A. Essentially all of the standard clinical steps; review of past treatment, clinical care, past medications, past diagnoses, symptoms, present condition. Essentially nothing out of the ordinary.

…

Q. Can you provide an example of me being thought disordered?

…

A. Thank you... Here we go; there was one recorded from Royal North Shore Hospital that you claim because you were dedicated to your studies from the law that therefore the law in New South Wales did not apply to you and the New South Wales Mental Health Act did not apply to you.

Q. I deny making or expressing any of those ideas, all those ideas listed in the clinical note. Is it possible there was a miscommunication?

A. Obviously I was not there. I highly doubt that. The point of examining thought form is to look for linear thought flows to see if one idea flows from the other and so the mental health team is looking to examine exactly what the justification is for each claim so they are carefully recording what justifications for each claim are.

So I would find it to be a reliable record of the claims and what the justifications are because that is essential for making a determination on thought form and therefore making a determination on formal thought order.

…

Q. So why was I detained as an involuntary patient in the first place?

A. We believe your untreated schizophrenia was putting you at risk, that you did not have an appropriate insight to be able to seek treatment and adhere to that treatment and as such being in hospital was the least restrictive option for safe and effective care.

75 The respondent also relied on medical records including admission notes, transfer notes, clinical progress notes and reports from health professionals.

76 Z relied on three affidavits affirmed on 18 February 2015, 1 July 2015 and 27 August 2015. There was also an affidavit affirmed on 18 March 2015 that Z did not read. Z gave evidence-in-chief and was cross-examined. Z also gave additional evidence in reply. Z gave evidence of a number of side effects of the medication. In cross-examination Z agreed that no medication was being taken in April 2015 at the time of readmission to the MHICU. In cross-examination in respect of some of the claims in the affidavit that was not read, Z gave the following evidence:

Q. You say for example at paragraph 1 “The Plaintiff is of English, German and Greek origin. The Plaintiff does not submit to the New South Wales government”?

A. That is right.

Q. Is that something you still believe?

A. What I mean by that is it was my intention, it probably is not my intention now because it requires a great deal of effort, but it was my intention to take the New South Wales – No, actually, I am, I am still suing the State of New South Wales. Unfortunately I am suing the State of New South Wales in the New South Wales Supreme Court.

It was my intention to sue the State of New South Wales in the High Court or go to an international human rights forum because I was involved in several Federal Court cases and I was disabled and detained and prevented from attending my Federal Court cases. Now sexual harassment is actually a human rights matter so I was actually drugged and detained and prevented from appearing in my human rights hearing.

Q. Can I ask you to explain to his Honour in paragraph 1(B) why were you making a submission you were of English, German and Greek origin and you did not submit to the New South Wales government?

A. Because it is an entity like the Federal Government is an entity and WA State Government is an entity and I am a legal entity and I do not submit – well I have taken the State of New South Wales to court. It is one entity against the other. The reason I say I am of English, German and Greek origin is because the Royal family is of English and Greek origin and also Danish etcetera and the Royal family it could be said is the hallmark of a civilised family and I say I am a civilised.

Throughout the whole experience for example you can see Dr Chandra, he obtained his qualifications in Sri Lanka and countries like Sri Lanka and India do not have the same level of civilisation as this country and it came as a shock to me, a great shock, that in this day and age the New South Wales government is detaining people in cells saying they are trying to protect their reputation and so on and I say what happened to me is actually a great atrocity and comes from a lack of civilisation. I say that my background, I come from a civilised, I originate from civilised origins.

77 Z was taken to other claims made in that affidavit and in one instance indicated "regret" for making certain comments. Z was then cross-examined about the numerous cases that had been commenced involving claims for very large amounts of compensations and/or damages.

78 Z gave evidence in respect of the period of leave of absence and the CTO application as follows:

Q. And you were given extended leave, weren't you, because you understood that a CTO application would be made at some point when it could be arranged?

A. Yes.

Q. And so you knew that the CTO application was being organised while you were on leave with your father?

A. Yes.

> Q. And were you told that it was going to be on the morning of 3 June, and that's why you came back to the hospital that morning?
>
> A. I was told via telephone, not long before.
>
> Q. But you knew that the reason why you were going back to the facility on 3 June was that there would be a Mental Health Tribunal hearing later that day?
>
> A. Yes.

79 In re-examination Z indicated an embarrassment about the statements made in the affidavit that was not relied upon and said "I wish that I didn't make the second affidavit, and the best that I could do is say that I no longer rely on it".

80 At the conclusion of the hearing on 24 September 2015 the respondents handed up some written submissions and made oral submissions. As the matter had not concluded the primary judge listed it for a further day on Monday 28 September 2015. There was a need for further research in respect of the respondents' approach to the task that confronted the primary judge. Z sought an order staying the CTO until the appeal was determined. The primary judge expressed the view that the doctors' evidence had been "fairly clear" that unless Z had some treatment there would be a relapse. However the primary judge stayed the CTO up to and including 29 September 2015.

81 On 28 September 2015 the respondents completed their submissions. Z then made submissions and the respondents made submissions in reply. The primary judge then observed that a "completely new case" in some respects had been made by the respondents and that his attention had for the first time been drawn to the decision in *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315 which seemed to his Honour to be of particular importance. The primary judge also observed that Z had referred him to *Burnett v Mental Health Tribunal* [1997] ACTSC 94. His Honour then indicated his intention to reserve judgment for some weeks. However Z indicated that there was a preference to have a judgment that afternoon, the respondents having indicated to the primary judge when he asked whether judgment was required on 24 September 2015 that there was "an urgency to this matter". The primary judge indicated that "at the moment" he was inclined to dismiss the appeal and that this was why he was "worried about giving an unsatisfactory judgment this afternoon". However his Honour acceded to Z's request and stood the matter down to 2.30 pm.

The judgment

82 The primary judge delivered an ex tempore judgment on the afternoon of 28 September 2015. After setting out the relevant provisions of s 163 of the Act and a short history of the proceedings his Honour addressed or noted a number of "technical or legal questions". The first question was whether Z needed a tutor or guardian to mount the appeal. His Honour identified an issue as to whether the Act overrides the rules of court in respect of the necessity for a tutor, noting that the intention of the legislature that the appeal was to be dealt with in accordance with the ordinary procedures of the court was reinforced in s 163(2) of the Act. His Honour noted that "as I will consider in more detail later, the Court approaches the questions which affect a person's liberty in a very liberal manner". Ultimately his Honour dispensed with the need to appoint a tutor (J [5](1)).

83 The primary judge ignored the technical deficiency in the amendment of a Summons rather than the filing of a new Summons where a fresh challenge was raised in respect of the CTO (J [5](2)).

84 The respondents had sought a decision from the primary judge in respect of the competency of any appeal from orders that had expired or had become "spent". Although the respondents pressed the primary judge for a decision on this matter his Honour concluded that its determination "will not affect the outcome of this case, which has now become one which must be decided as a matter of some urgency" (J [5(3)]). His Honour said that it would be unsafe for him to decide the point because: it could be decided either way; it would be necessary to consider analogous legal situations; time did not permit counsel for the respondents to put a "full argument"; and the applicant was not in a position to put the arguments (J [5(3)]). Later his Honour concluded that it was not "in the community's interest" that he made a decision on this matter on the material before him and that it should await proper argument from both sides (J [33]).

85 In turning to "the facts and to the merits of the appeal" his Honour recorded that he had read "the lot" of over 450 pages in the Court Book. His Honour identified the bulk of the material in the Court Book as being reports from

psychiatric registrars, nurses, specialist psychiatrists, occupational therapists and other health professionals. His Honour recorded Z's criticism of the accuracy of some of the reports and the contention that they contained miscommunications and observations by unqualified persons repeated "over and over again by others". His Honour also recorded Z's criticism of the acceptance of observations some of which may well be reliable, others of which were disputed. His Honour concluded that it was appropriate to take into account the fact that the contents of these reports were "untested statements of alleged facts by various people" with the prospect that some of those people "might be malicious". His Honour also observed that there may be possible misinterpretations or misunderstandings. His Honour also said that although all of these matters were to be taken into account, when a consistent pattern of observations by people who could not be colluding is seen such evidence is most likely to be the truth (J [7]).

86 The primary judge recorded some of the details of the incident that resulted in Z's first period of detention in an MHICU (J [8]). His Honour noted that aspects of the cross-examination (on the affidavit that was not read) showed "some disordered thinking, to say the very least" (J [9]). His Honour recorded Z's version of the family fracas that resulted in the second period of detention in the MHICU commencing in April 2015. Z challenged the claims that had been made in respect of that fracas. His Honour proceeded on the basis that even if Z's claims were true there were "numerous other incidents" in respect of which Z had not given any reasonable explanation (J [10]).

87 His Honour recorded that Z had been assessed and treated by a number of doctors and was later transferred to the acute ward and came under the principal care of Dr Chandrasekera and Dr Law (J [11]). His Honour then said (J [11]):

> The records show – and also the affidavit and oral evidence of Drs Chandrasekera and Law – that the appellant is suffering from chronic schizophrenia. They reported this to the Tribunal when it sat on 3 June 2015. In his affidavit, Dr Chandrasekera said that schizophrenia is a chronic mental illness which is characterised by periods of relapse. The treatment that Z was given under his care, he says, was effective and the symptoms were diminished. However, Z did not have a good history of taking medication a point with which Z agrees, and unless Z was subject to a controlled treatment regime Z would relapse.

88 The primary judge referred to Z's cross-examination of Dr Chandrasekera and Dr Law (J [12] & [35]). His Honour recorded that Z produced very little medical evidence but tendered a letter from a Western Australian psychiatrist who had thought that in 2013 Z was suffering from mood swings. In dealing with this evidence the primary judge said (J [13]):

> This was put to Dr Chandrasekera. He acknowledged that that could well have been the diagnosis in 2013, but said that as more and more details emerged, the proper diagnosis was schizophrenia. Apart from that Western Australian doctor, all the medical evidence points in one direction and that is, that the appellant is suffering from chronic schizophrenia.

89 His Honour then referred to the decision in *McD v McD* [1983] 3 NSWLR 81 as authority for the proposition that a person suffering from schizophrenia was suffering from "a mental illness". The primary judge said that as the decision in *McD v McD* was under the *Mental Health Act* 1990 he would need to consider whether the proposition pertained under the Act (J [14]). His Honour also referred to the respondents' submission that the effect of s 164 of the Act was that the Court "makes a new decision" (J [16]). His Honour then said (J [16]):

> [T]he vital question is: what is this new decision that the Court is to make? Is it a decision as at today's date, or is it that the Tribunal was justified in making its decision, even taking into account material that has emerged since the decision was made?

90 It is clear that some of the submissions made by the respondents were made in error and were corrected on the morning of 28 September 2015. His Honour said (J [17]):

> Work in chambers since Thursday and the fact that Ms Richardson has now withdrawn some of her submissions and replaced them with quite different ones, have made some matters clearer in my mind though other problems have now raised their head for the first time. I would have liked to have reserved my decision and studied the transcript of today's argument and read more. However, Z made it clear that [there was a preference for] a quick decision to one that was detailed and considered. Accordingly, though with some trepidation, I am now giving that decision.

91 The primary judge then embarked on an analysis of the definition of mental illness in s 4 of the Act. His Honour noted that it was virtually the same provision as that contained in the 1990 Act. His Honour was disturbed by the "two-pronged effect" of the definition: (1) that the condition must seriously impair mental functioning; and (2) the presence in the person of one or more of the symptoms identified in the definition and said (J [19]):

> The disturbance is that the appellant's condition as of today does not appear to be currently showing any of the prescribed symptoms, and unless both parts of the definition are fulfilled there is no mental illness. However, on consideration, I thought that the reference in the definition in the series of symptoms might be a reference, not to the sufferer, but to the medical condition – that is, the definition looks to a condition which is characterised by the presence of the prescribed symptoms – and on that construction schizophrenia falls within the definition.

92 His Honour then referred to the decision in *Burnett v Mental Health Tribunal* in which Crispin J referred to the significance of the expression "the presence in the person" in the corresponding definition in the ACT legislation. His Honour also referred to the decision in *Harry v Mental Health Review Tribunal* and dealt with the concept of a "mentally ill person" (J [19]-[22]). His Honour observed that the treatment was for the condition of chronic schizophrenia, which can be suffered without detrimental effect if it is treated (J [23]).

93 In addressing some of the matters identified in s 53(3)(c), (5)(a) and (b) of the Act his Honour said ([J 24]):

> Thus, so long as there has been a diagnosis of chronic schizophrenia and medical evidence that, unless treated, the condition will no longer lie dormant, and there is some evidence to suggest that a patient will not voluntarily take … medicine, a community treatment order may be made.

94 The primary judge then referred to further aspects of the decisions in *Harry v Mental Health Review Tribunal* and *Re S-C* [1996] 1 All ER 532 observing that the judges in those cases construed the Act to mean that "not only was personal liberty to be interfered with in cases where a person was mentally ill, but also in the case where" a person "had been mentally ill, might relapse into mental illness unless treated and was reluctant to take treatment voluntarily" (J [28]).

95 His Honour then extracted the relevant provisions of s 51 and s 53 of the Act (J [29]-[30]). His Honour accepted that in respect of a CTO under s 51(5)(a) it was only necessary to prove that at the time of the order the affected person had a mental illness (J [31]). This was a reference to the Tribunal's capacity to make a CTO on an "application otherwise" by a medical practitioner under s 51(2) where the prohibition in s 53(4) did not apply. In fact it was only necessary to prove that the person had previously been diagnosed with a mental illness. This was in contrast to the necessity of establishing that a person was a

"mentally ill person" where there is an application for a CTO following a mental health inquiry under s 34 of the Act or a review under s 44 of the Act.

96 In addressing the provisions of s 53(3) his Honour said (J [31]):

> However, the effect of the Act generally is that it is probably only the case where a person has previously been assessed with a mental illness and there is evidence that continued treatment is necessary to prevent reoccurrence of the symptoms and the person affected has a history of not voluntarily accepting treatment, that the Tribunal would be justified in making such an order. I do not need to go further because that is this case.

97 The primary judge also said (J [34]):

> The decision of 3 June 2015 was that Z needed treatment for chronic schizophrenia and the minimum appropriate treatment in all the circumstances was the community treatment order that was made. Now the basis of the decision can be found in the evidence in Dr Chandrasekera.

98 His Honour then extracted paragraphs 25 to 28 of Dr Chandrasekera's affidavit in which the doctor described the nature of schizophrenia and how it affects a person's thoughts, perceptions and mood and his conclusion that if Z did not take certain medication there was a real risk of deterioration of the mental illness and risk of harm (J [34]). There is no issue that this affidavit evidence was not before the Tribunal. However it seems to me that the primary judge was expressing the view that as of "now" the basis for the need for a CTO could be found in that evidence.

99 His Honour also referred to Z's closing submissions and reliance upon the decision in *Burnett v Mental Health Tribunal* in support of the proposition that the circumstances in that case were similar to those in the present case. His Honour concluded that the present case was not on all fours with *Burnett v Mental Health Tribunal* referring in particular to the fact that the reports of matters in respect of Z's conduct had been made over a considerable period of time by a number of different people.

100 His Honour then said (J [36]):

> Z had been under the care of Dr Chandrasekera and his colleagues for some months and that the evidence of Dr Chandrasekera really should be accepted and that that was the evidence on which the Tribunal made its decision, that is that in all the circumstances it would be best to infringe Z's civil liberties to the extent of ordering the treatment under the community treatment order.

101 His Honour's reference to the infringement of Z's civil liberties was clearly an observation with s 53(3)(a) in mind. In concluding, his Honour said:

> 37 I have to decide the matter on the balance of probabilities. I would have liked to have thought about it a bit more, but for the reasons I have outlined it seems to me that in the absence of any particular medical evidence produced by Z and on the background, that there is some material to justify the view that Z is a person who is unwilling to accept that [there is] schizophrenia that on the balance of probabilities the order made by the Mental Health Review Tribunal was the correct one for it to make.
>
> 38 Accordingly, the appeal is dismissed. The defendants do not ask for costs, so I do not need to make any other order.

102 Before considering the Grounds of Appeal, it is appropriate to say that it has been recognised that matters of complexity requiring judicial reflection do not usually lend themselves to *ex tempore* reasons for judgment: National Judicial College of Australia, *Oral Decisions – Delivering Clear Reasons*, (August 2011) at 50. In addition it has been said that ex tempore judgments "should not be picked over": *Maviglia v Maviglia* [1999] NSWCA 188 per Mason P at [1]; *Pollard v RRR Corporation Pty Ltd* [2009] NSWCA 110 at [56]; *Wyman on behalf of the Bidjara People v State of Queensland* [2015] FCAFC 108 at [57]. There were aspects to this case that prompted the primary judge, against his preference, to deliver ex tempore reasons. Z was under an operative CTO and the subject treatment was to be given on the day the judgment was delivered. The option of a reserved judgment was discussed and Z advised the primary judge that there was a preference for a judgment to be delivered that day. His Honour acceded to that request, as he said "with trepidation". That expressed emotion is understandable where it was necessary to draw together the facts and circumstances from oral evidence and a significant volume of documentary material aligned with medical opinions in respect of a person whose independence was constrained by the imposition of a compulsory treatment regime, compounded by the fact that the person did not accept the diagnosis of mental illness.

103 It is appropriate to view the reasons in light of the urgency and the circumstances in which they were delivered. However, that is not to say that this Court can read into the reasons findings or conclusions that were not expressly made or reached or findings or conclusions that cannot be implied on a reasonable reading of the reasons as a whole.

Grounds of Appeal

104 Z presented 15 grounds for leave to appeal and in the substantive appeal. Grounds 1 and 2 contend that Z did not receive a *de novo* hearing in relation to the findings of the Tribunal both in respect of the expired orders and the CTO.

105 Grounds 3 and 4 (and in part Ground 2) relate to the primary judge's refusal to determine the question of whether the Court had jurisdiction to deal with the challenge to the orders of the Tribunal that had expired.

106 Grounds 5, 6 and 9 relate to alleged errors by the primary judge in finding that Z was/is suffering from chronic schizophrenia; that all the medical evidence (apart from the opinion of the Western Australian doctor) pointed in the direction that Z is suffering from chronic schizophrenia; and in accepting and relying upon the evidence of Dr Chandrasekera.

107 Grounds 7, 8, and 11 relate to alleged errors by the primary judge in applying the decision in *Harry v Mental Health Review Tribunal* and in failing to apply *Burnett v Mental Health Tribunal*.

108 Grounds 10 and 14 relate to alleged errors by the primary judge in construing and applying or failing to apply the provisions of the Act.

109 In Ground 12 Z records a wish to present fresh medical evidence.

110 Ground 13 is expressed as a denial of "unsubstantiated allegations" and a claim that the Court accepted those allegations as correct without a hearing of those allegations.

111 Ground 15 relates to an alleged error by the primary judge in failing to hear the matter sitting with assessors.

Ground 12 – Fresh medical evidence

112 It is convenient to deal with Ground 12 before turning to the consideration of the other grounds of appeal. Although the ground was expressed to suggest Z wished to call fresh medical evidence it transpired that Z wished to call evidence as to why there was no fresh medical evidence in addition to evidence that there were particular side effects from the treatment the subject of the CTO and to give details of certain litigation in which Z is involved.

113 This Court is entitled to receive further evidence where “special grounds” are established: s 75A(8) *Supreme Court Act* 1970. Having regard to the fact that this is an appeal in the Protective List and that Z was unrepresented the Court decided to adopt the approach of permitting Z to outline the evidence that was intended to be called and to give the respondents the opportunity to indicate whether, if called, there would be any cross-examination. The respondents indicated that there was no desire to cross-examine. The Court received the claims made by Z from the Bar Table as further evidence on the appeal.

114 It is appropriate in the circumstances to refer to that evidence. Z referred to a consultation with a psychiatrist at the mental health facility that was charged with implementing the CTO in respect of whether he could provide a medical report. Z’s evidence was that the psychiatrist indicated that he could not do so without seeing Z and all the medical records and background material relevant to Z’s case. Z has in fact moved residence and now attends a different mental health facility. Z consulted another psychiatrist at that new facility and asked whether he would provide a medical report with his diagnosis of Z’s condition. That doctor also indicated that he would not be in a position to do so, certainly within the timeframe prior to the expiry of the CTO and in any event he would need to have access to Z’s relevant medical records.

115 Z also gave evidence in respect of a third psychiatrist who is presently administering the medication to Z in accordance with the CTO. That psychiatrist expressed the same view as the other two practitioners when asked whether he could provide a medical report and/or diagnosis.

116 The second area of evidence that Z gave related to the side effects of the medication. Z indicated that the dosage has been reduced but that there are still consequential side effects. Z had given evidence before the primary judge of a number of the side effects of the medication and was cross-examined about them. The evidence given in this Court was that there were “intimacy problems”. The example given by Z in this regard was there that had been a meeting with a member of the opposite sex who had in discussion elicited the fact of Z’s admission to a mental health facility. The relationship did not go forward because that person did not wish to have any “problems with intimacy”.

It is apparent from the medical records that any side effects that may affect Z's intimate life need to be addressed by the medical practitioners in balancing the control of Z's chronic schizophrenia and in trying to provide a more fulfilling life.

117 The third area of evidence was Z's involvement in the litigation referred to earlier. Z indicated that all of the cases upon which there was cross-examination were either resolved by settlement or withdrawn or discontinued. However Z indicated that there are two new proceedings which were then described.

Ground 15 – Assessors

118 It is also appropriate to address Ground 15 in which Z claimed that the primary judge fell into error by failing to hear the appeal "sitting with assessors".

119 Neither Z nor any other party asked the primary judge to sit with assessors. In the circumstances it is difficult to accept Z's contention that there was some error on the part of the primary judge particularly where he had voluminous records from a number of mental health facilities, psychiatrists, medical practitioners and other professionals together with progress notes which included observations made of Z by a range of health professionals.

120 It is also important to note that Z called no medical or expert evidence other than relying upon the 2013 report of the Western Australian psychiatrist.

121 This ground of appeal is not made out.

Grounds 1 and 2 – A de novo hearing

122 On appeal, Z contended that the primary judge did not conduct a *de novo* hearing. Z submitted that this was in breach of human rights principles. In support of this contention Z relied upon the primary judge's conclusions as expressed in [37] and [38] extracted above. It was submitted that rather than providing a hearing *de novo* the primary judge merely decided whether to uphold or dismiss the appeal.

123 It was necessary for the primary judge to hear the matter afresh and give a decision on the evidence presented at the hearing. Certainly the primary judge referred to the facts and the merits of the matter before him and that the relevant defendant bore the onus of proof.

124 His Honour analysed the new evidence before the Court together with that which was available to the Tribunal and retendered at the appeal. His Honour accepted that he was a "substitute" for the Tribunal (J [32]) and made a large number of factual findings. Notwithstanding the manner in which his Honour expressed his conclusion in [38] of his reasons I am satisfied that the process was in fact a hearing *de novo* or a fresh hearing.

125 These grounds of appeal are not made out.

Grounds 3 and 4 – Challenge to expired orders

126 The primary judge could see no utility in dealing with the challenge to the orders of the Tribunal, the operation of which had expired. The primary judge was met with urgent circumstances where time was running in respect of an order that was to expire on 2 December 2015. The challenges to the expired orders related to circumstances in which Z had been detained in various MHICUs. The periods of detention had concluded and Z had been discharged into the community.

127 The primary judge was not satisfied that the question of jurisdiction to deal with challenges to the expired orders had been properly ventilated by Z and was clearly concerned that should such a question require determination it should be the subject of proper argument. Although the primary judge took the view that in respect of the appeal relating to the CTO, it was not necessary for there to be the appointment of a tutor, it may be that if such complex jurisdictional questions were to be argued and determined, some form of representation may have been necessary for Z.

128 Clearly the Court had power to receive "any other information" in determining whether Z was a person who should be the subject of a CTO in accordance with s 53(1) and (2)(d). The fact of Z's previous detentions, treatment and the consequence of that treatment were clearly relevant matters to be taken into account by the Tribunal and by the primary judge in determining the issue under s 53(1) of the Act.

129 It appears that Z wished to challenge all of the factual background that resulted in the detentions and subsequent treatments. It also appeared that Z wished to claim that if those detentions were not justified then the CTO was not justified.

As recorded by the primary judge Z does not accept the diagnosis of chronic schizophrenia. Indeed this position is maintained on this appeal.

130 It was ultimately not necessary to decide whether the challenges to the orders that had expired could be made. The primary judge was asked to consider all of the material that was before him and on Z's case, was asked to accept that the bases of the detention (relapse and active symptoms of chronic schizophrenia) were in fact not present at the relevant times.

131 I am not satisfied that the primary judge fell into error in his conclusions as to why those challenges should not be determined.

132 Grounds 3 and 4 are not made out.

Grounds 5, 6 and 9 – Factual findings

133 Although Z's grounds of appeal were confined to alleged errors of findings as referred to above, in oral submissions Z also claimed that the primary judge erred in failing to determine those matters identified in s 53(3) of the Act.

134 Ground 5 alleges that the primary judge erred in finding that Z suffered from chronic schizophrenia. Ground 6 alleges that the primary judge erred in finding that apart from the Western Australian doctor all the medical evidence pointed in the one direction, that Z was suffering from chronic schizophrenia. Ground 9 alleges that the primary judge erred in accepting and relying upon the evidence of Dr Chandrasekera.

135 It was necessary for the primary judge to determine whether Z "had been previously diagnosed as suffering from a mental illness" (s 53(3)(c)); whether Z had previously refused to accept appropriate treatment and in consequence had relapsed into an active phase of mental illness followed by such deterioration that justified involuntary admission into a mental health facility (s 53(3)(c) & (5)).

136 Part of Z's challenge to the primary judge's findings and acceptance of Dr Chandrasekera's evidence was that there was no mention in the judgment of a portion of a record in the progress note made by Dr Veronica Rose Vass on 1 May 2015 in which was recorded "no thought disorder" and a portion of a record made by another health professional which recorded an impression

("imp") of "diagnostically unclear; ? delusional disorder". Dr Vass' record also included observations that Z lacked judgment and that the allegations that were being made by Z appeared "psychotic". The record of the other health professional included the impression that "paranoid schizophrenia is also possible but less likely as thought disorder is not prominent – although has been thought disordered in the past". In addition that record included, "thought content characterised by deep mistrust and paranoia about the world … Insight poor; Judgement impaired".

137 The only medical evidence that was relied upon by Z before the Tribunal was the medical report from the Western Australian doctor who expressed the view that in November 2013 Z was having "an Adjustment Disorder with Mixed Anxiety and Depressed Mood". Clearly the primary judge addressed this report and Dr Chandrasekera's response to it. The progress notes and other hospital records contain ample evidence, as the primary judge observed, pointing to the diagnosis of chronic schizophrenia. The primary judge was entitled in the circumstances to accept the evidence of Dr Chandrasekera (and indeed that of his Registrar, Dr Law). It is clear that the primary judge weighed up the claims made by Z that some of the underlying material upon which some health professionals based their conclusions in part may have contained errors and indeed malicious errors. However his Honour was satisfied on the evidence that the diagnosis of mental illness had been made.

138 There is no issue that the primary judge was obliged to address the provisions of s 53 of the Act in deciding whether Z was a person who should be subject to the CTO (ss 53(1) & 164). The primary judge was obliged to consider the Treatment Plan that was to implement the proposed order and any other information placed before him (s 53(2)). The Treatment Plan was part of the evidence before the primary judge. It is clear that his Honour considered it having regard to his statement that he had read the contents of the Court Book and noted that Z's civil liberties would be infringed to the extent of the treatment that was in the CTO (J [6] & [36]). The treatment that was in the CTO was that contained in the Treatment Plan attached to it.

139 The primary judge indicated to Z at the conclusion of the first day's hearing that the evidence was clear that unless Z had treatment there would be a relapse. The primary judge found that Z had previously been assessed with a mental illness, that there was evidence that continued treatment was necessary to prevent reoccurrence of the symptoms and that Z had a history of not voluntarily accepting treatment (J [31]). These were clear findings in accordance with s 53(3)(c). The primary judge also referred to and in my view was clearly satisfied in accordance with s 53(3)(c) & (5)(c) that Z had a relapse after discharge from the first detention and treatment followed by involuntary admission to an MHICU in April 2015 (J [11] & [36]). It is also clear that the primary judge found in accordance with s 53(3)(c) & (5)(d) that Z's care and treatment following the involuntary admission in April 2015 resulted in some amelioration of the symptoms of mental illness (J [11] & [36]).

140 In concluding that the making of the CTO was "correct" and in dismissing Z's appeal (J [37] & [38]) in circumstances where the primary judge was asked to make a determination because of the continued operation of the CTO, I am satisfied that his Honour determined that Z is a person who should be subject to the CTO.

141 Grounds 5, 6 and 9 are not made out.

Ground 13 – Unsubstantiated allegations

142 Although Ground 13 is expressed as a denial of unsubstantiated allegations, the real point made by Z on the appeal was that the medical practitioners, including Dr Chandrasekera and Dr Law, accepted without question allegations made by others including Z's relatives after the family fracas. The gravamen of Z's contention in respect of this ground of appeal is that the primary judge accepted the allegations without testing them.

143 The primary judge was acutely aware of Z's contention in this regard and referred to it in some detail in his reasons (J [6] & [7]). His Honour recounted Z's criticisms and made the additional observation that not only may some records contain inaccuracies but they may also have been reported by people with malicious intent. It does not seem to me that the primary judge accepted the "allegations" (unparticularised by Z on the appeal). Rather his Honour

assumed that such complaints may be justified and preferred the observations made by psychiatrists and other health workers irrespective of such allegations (J [7]).

144 Ground 13 is not made out.

Grounds 7, 8 and 11 – Application of authorities

145 Z claimed that the primary judge fell into error in applying *Harry v Mental Health Review Tribunal* and in distinguishing *Burnett v Mental Health Tribunal*.

146 The primary judge recognised that the applicable test in respect of the application for a CTO by a practitioner under s 51(2) & (5)(c) was not whether Z was a mentally ill person. This was the conclusion reached by Clarke JA in *Harry v Mental Health Review Tribunal* at 341F. In reliance on this case (and *Re S-C*) his Honour noted that notwithstanding the caution against putting too much power in the hands of mental health authorities, the judges in those cases accepted that on a true construction of the Act personal liberty might be interfered with in a case where mental illness had been diagnosed and the patient might relapse unless treated and where there was reluctance to take treatment voluntarily (J [28]).

147 The primary judge referred to Z's reliance on *Burnett v Mental Health Tribunal* (J [36]). The conclusion that his Honour reached that it was not "on all fours" with the present case was justified. There were differing medical opinions in that case; whereas in the present case, except for the view expressed by the Western Australian doctor in different circumstances, the evidence of the presence of the mental illness was, as the trial judge said, "clear".

148 I am not satisfied that the primary judge fell into error in his reference to *Harry v Mental Health Review Tribunal* or in distinguishing *Burnett v Mental Health Tribunal*.

149 Grounds 7, 8 and 11 are not made out.

Grounds 10 and 14 – Misapplication of the Act

150 Z claims that the primary judge failed to apply s 13 of the Act and misapplied s 53 of the Act.

151 There was a deal of confusion on the first day of the hearing when the third respondent submitted that the primary judge was required to determine whether Z was a "mentally ill person" within the meaning of s 13 of the Act. It is apparent that the third respondent did not appreciate at that time that the prohibition in s 53(4) (against making a CTO "at a mental health inquiry unless the Tribunal was of the opinion that the person was a mentally ill person") did not apply to a CTO that was made pursuant to an application under s 51(2) and s 51(5)(c)of the Act.

152 Those submissions were withdrawn subsequently and the third respondent submitted, correctly in my view, that it was not necessary to determine whether Z was a mentally ill person. Rather the requirement under s 53 of the Act was to determine whether Z had been previously diagnosed as suffering from a mental illness. The concepts of suffering from a mental illness and being a mentally ill person are distinct under the Act. His Honour analysed the Act and made the distinction between these two concepts.

153 I am satisfied that the primary judge did not misconstrue the Act. The provisions of s 13 did not apply to the determination of the appeal.

154 Z also claims that the primary judge misapplied s 53 of the Act. It seems to me that this ground is related to the previous ground. As I apprehend Z's submissions, it is contended that the primary judge in addressing matters under s 53 misapplied it by failing to apply s 13. For the reasons stated above I am satisfied that the primary judge did not fall into error in this regard.

155 Grounds 10 and 14 are not made out.

Another matter

156 The Grounds of Appeal dated 6 October 2015 did not include any contention that the CTO was liable to challenge on the basis of non-compliance with s 52 of the Act (holding a hearing earlier than fourteen days after written notice of the application: s 52(3)). However the respondents' written submissions referred to Z's complaint before the primary judge that there had been a failure to comply with s 52 of the Act. Those written submissions contended that as Z "was not detained in a facility and only received a few hours of Notice" there was no opportunity to receive any independent legal advice. The "few hours"

notice to which Z referred was clearly the receipt of the written notice. As stated earlier on 11 May 2015 Z requested a CTO and discharge. On the appeal to this Court Z accepted that such a request had been made. It is also clear that on 19 May 2015 there was discussion with Z about the CTO hearing and that Z would attend such hearing.

157 The third respondent submitted before the primary judge that fourteen days' notice was not needed because Z was detained at the time that written notice was given on the morning of 3 June 2015. In any event, although during the hearing of the appeal in this Court Z took issue with a statement made by Ms Richardson that Z returned to detention on the morning of 3 June 2015, the question of whether the hearing of the application for the CTO less than fourteen days after written notice was given was not pursued further.

Basten JA's analysis

158 Since circulating these reasons I have had the benefit of reading the draft judgment of Basten JA. His Honour identifies seven steps that must be taken to satisfy the provisions of s 53(3) and (5) of the Act.

159 The seven steps identified by Basten JA were taken by the primary judge. The primary judge accepted the evidence of Dr Chandrasekera. However Basten JA concluded that Dr Chandrasekera did not express his opinions "in terms of the statutory tests identified". Dr Chandrasekera addressed the provisions of s 53(3) albeit that he used the words "least restrictive care" whereas the Act refers to no other care of a "less restrictive kind". I do not see that as a significant difference. Dr Chandrasekera formed the view that the CTO was the "least restrictive care" for Z. The primary judge accepted that evidence (J [36]).

160 Dr Chandrasekera addressed the issue of whether there was other care of a less restrictive kind that Z would benefit from, other than the CTO Treatment Plan. He concluded that less restrictive treatment, for instance a period shorter than six months, would not be adequate for Z's progress, in other words for Z's safe and effective care. He concluded that the period of six months of the treatment in the Treatment Plan was necessary. The primary judge accepted that evidence (J [36]).

161 The primary judge took the first step referred to by Basten JA and identified that Z had been previously diagnosed as suffering from a mental illness. This finding is gleaned from his Honour's findings in J [31] and the acceptance of Dr Chandrasekera's evidence (J [36]).

162 The second, third and fourth steps were taken by the primary judge in his findings in J [31] and his acceptance of Dr Chandrasekera's evidence. The statutory test was whether Z had a previous history of refusing to accept appropriate treatment. Dr Chandrasekera's evidence established that Z had been discharged from the previous MHICU and had been prescribed a particular drug, obviously after diagnosis. The irresistible inference from Dr Chandrasekera's affidavit is that it was an appropriate treatment. There was no issue that there had been a refusal to accept that treatment. However Dr Chandrasekera's evidence was clear that Z had so refused. He concluded that had Z complied with the treatment there would not have been a relapse. The primary judge accepted this evidence and also made findings in J [31].

163 The fifth step was expressly referred to by Dr Chandrasekera in paragraph 46 of his affidavit when he expressed the view that in April 2015 Z was in an "active phase" of the relevant mental illness. This was part of the evidence accepted by the primary judge (J [36]).

164 The sixth step of identifying the relapse justifying involuntary admission was addressed by Dr Chandrasekera by reference to the involuntary admission on 19 April 2015 combined with his other evidence that Z would relapse unless treated. The primary judge accepted this evidence at J [11] and J [36].

165 The seventh step, the determination that the treatment and care after involuntary admission resulted in amelioration of the debilitating symptoms of a mental illness, was directly addressed by Dr Chandrasekera in paragraph 49 of his affidavit. Dr Chandrasekera did not use the words "following involuntary admission". However he referred to the treatment during the particular period from the date of involuntary admission to the date of discharge and said that it "resulted in an amelioration of the symptoms of Z's schizophrenia". I am satisfied that this specifically addressed the provisions of s 53(5)(d). The primary judge accepted this evidence (J [36]).

166 Although the analysis of the Act is of significant importance not only to give guidance to those who are dealing with these matters on a daily basis but also having regard to the intrusion upon the liberty of the person the subject of orders under the Act, it is important to view the whole of the circumstances of these proceedings to decide whether there has been compliance with the Court's obligation notwithstanding the absence of use of particular expressions found in the Act.

167 The rather shorthand way of making the relevant findings by the process of accepting Dr Chandrasekera's evidence is not the ideal exemplar. However this must be viewed in the urgent circumstances with which the primary judge was dealing. Albeit that the primary judge expressed himself in the manner already described, I am satisfied that his Honour directed his attention to the determination of the necessary tests to be satisfied under the Act to justify the continuation of the CTO and determined that the statutory tests had been satisfied.

Conclusion

168 This Court may make any finding or assessment or give any judgment or make any order that ought to have been given or made or which the nature of the case requires: s 75A(10) *Supreme Court Act*.

169 The overwhelming evidence before the primary judge and in this Court establishes that Z is a person who should be subject to the CTO.

170 The orders I propose are:

(1) Leave to appeal is granted;

(2) The appeal is dismissed.

171 **EMMETT AJA:** These proceedings are concerned with orders made under the *Mental Health Act 2007* (NSW) (**the Act**) in relation to the applicant (**Z**). On 3 June 2015, the Mental Health Review Tribunal (**the Tribunal**) determined to make a community treatment order concerning Z. Z appealed to the Supreme Court under s 163 of the Act against the determination. The respondents to that appeal were the Tribunal, the Attorney-General of New South Wales and the Northern Sydney Local Health District (**the LHD**). It is difficult to see why the Tribunal was joined as a party to the proceedings, which were by way of

statutory appeal. A judge of the Equity Division (**the primary judge**) concluded that, on the balance of probabilities, the order made by the Tribunal was the correct one for it to make and ordered that the appeal be dismissed.[21]

172 By summons filed on 6 October 2015, Z seeks leave to appeal to this Court from the decision of the primary judge. The respondents to the summons are the Tribunal, the Attorney-General and the LHD. Both the Attorney-General and the LHD consent to the grant of leave to appeal if leave be required. The Tribunal should not be a party to the proceedings.

173 Section 163 of the Act relevantly provides that a person may appeal to the Supreme Court against a determination of the Tribunal made with respect to the person. Under s 164(1), the Supreme Court has, for the purposes of hearing and disposing of such an appeal, all the functions and discretions of the Tribunal in respect of the subject matter of the appeal. Importantly, under s 164(2), an appeal is to be by way of a new hearing. New evidence or evidence in addition to, or in substitution for, the evidence given in relation to the determination of the Tribunal in respect of which the appeal is made may be given on the appeal. The Supreme Court is to have regard to the provisions of the Act and any other matters it considers to be relevant in determining an appeal. The decision of the Supreme Court on an appeal is, for the purpose of any Act or instrument, taken to be the final determination of the Tribunal and is to be given effect to accordingly.

174 Thus, in exercising jurisdiction in an appeal under s 163 of the Act, it was incumbent upon the primary judge to conduct a hearing *de novo* in order to determine whether Z was, at the date of the hearing before his Honour, a person who should be subject to a community treatment order. That function does not entail making a decision as to whether the determination of the Tribunal was correct or incorrect. It requires the judge exercising jurisdiction to make his or her own determination as to whether or not an affected person is a person who should be subject to a community treatment order.

175 Section 51 of the Act relevantly provides that a community treatment order may be made by the Tribunal on an application being made to it. A community

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[21] Z v Mental Health Review Tribunal [2015] NSWSC 1425.

treatment order authorises the compulsory treatment in the community of a person. Under s 53(1), on an application for a community treatment order, the Tribunal is to determine whether the affected person is a person who should be subject to the order. Under s 53(2), in doing so, the Tribunal must consider the following:

(a) a treatment plan for the affected person;

(b) if the affected person is subject to an existing community treatment order, a report by the psychiatric case manager of the person as to the efficacy of that order;

(c) a report as to the efficacy of any previous community treatment order for the affected person;

(d) any other information placed before the Tribunal.

176 Under s 53(3), the Tribunal may make a community treatment order if the Tribunal determines that:

(a) no other care of a less restrictive kind, consistent with safe and effective care, is appropriate and reasonably available, and that the affected person would benefit from such an order;

(b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it; and

(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

Under s 53(5), for the purpose of s 53, a person has "a previous history of refusing to accept appropriate treatment" if:

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

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

(f) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility; and

(g) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of or recovery 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.

177 The basis of the complaint in ground 14 of Z's draft notice of appeal is that there is nothing in the primary judge's reasons to constitute a finding in terms of the matters and criteria described in s 53 of the Act. Counsel for the Attorney-General and the LHD made written submissions and oral submissions to the primary judge concerning the nature of the determination that his Honour was required to make. In particular, counsel took his Honour to each of the specific criteria just summarised. Further, the evidence of Dr Ravinda Chandrasekera, which is described by Bergin CJ in Eq, indicates that there was ample material upon which his Honour could conclude that the making of a community treatment order was appropriate, having regard to those criteria. However, notwithstanding that his Honour was taken to those criteria and detailed submissions were made as to why his Honour should be satisfied as to those criteria, his Honour did not make express findings in terms of all of the provisions of s 53(3) and s 53(5).

178 Z's complaint in grounds 1 and 2 of the draft notice of appeal is that Z did not receive a *de novo* hearing and that the primary judge did not make a new decision on the matters for determination. Significantly, there is nothing in the language used by his Honour to suggest that his Honour was deciding the question before him on the basis of a hearing *de novo*. His Honour referred to the fact that Z had been under the care of Dr Chandrasekera and his colleagues for some months and that the evidence of Dr Chandrasekera should be accepted.[22] Indeed, his Honour said that "that was the evidence on which the Tribunal made its decision" that, "in all the circumstances it would be best to infringe [Z's] civil liberties to the extent of ordering the treatment under the community treatment order".[23] That is incorrect insofar as his Honour was saying that the Tribunal based its decision on the evidence of Dr Chandrasekera, since Dr Chandrasekera did not give evidence before the Tribunal.

179 The primary judge then went on to say that he had to decide "the matter" on the balance of probabilities and said that, for the reasons he had outlined, it seemed to his Honour that, in the absence of any particular medical evidence

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22 [2015] NSWSC 1425 at [36].

23 Ibid.

produced by Z and, on the background that "there is some material to justify the view" that Z is a person who is unwilling to accept the diagnosis of schizophrenia, the order made by the Tribunal was, on the balance of probabilities, the correct one for it to make.[24] That language suggests that his Honour was engaged in a review of the decision of the Tribunal, rather than in the performance of all the functions and discretions of the Tribunal as to the question of whether there should be a community treatment order made in respect of Z. In other words, it suggests that his Honour was not engaged in a *de novo* hearing.

180 For the reasons explained by Bergin CJ in Eq, whose reasons I have had the advantage of reading in draft form, the reasons of the primary judge must be considered and understood in the light of the urgency and the circumstances in which they were delivered (on the same day on which the hearing concluded). Nevertheless, as her Honour says, it does not follow that this Court can read in to reasons findings or conclusions that cannot be implied on a reasonable reading, if they are not to be found in express terms.

181 I have also had the advantage of reading in draft form the proposed reasons of Basten JA. I agree with his Honour, for the reasons proposed, that it is not possible to find in the reasons of the primary judge the findings necessary to impose a community treatment order on Z. Although the evidence of Dr Chandrasekera, at least part of whose reasoning was apparently adopted by the primary judge,[25] addressed in substance the considerations that are to be considered pursuant to ss 53(3) and 53(5), it is not clear that the primary judge adopted the reasoning in the rest of the doctor's affidavit other than the four paragraphs quoted at [34], such as to constitute express findings as required by those subsections. Further, it remains that the primary judge did not consider the treatment plan as required by s 53(2)(a), nor the duration of the community treatment order as provided for in s 53(7). Perhaps most importantly, although there may be indicators pointing in both directions, it is difficult to be satisfied that the primary judge did indeed approach the hearing as a *de novo* hearing, and not a rehearing of the Tribunal's determination.

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[24] [2015] NSWSC 1425 at [37].

[25] [2015] NSWSC 1425 at [34].

Approaching the matter as a new hearing was, clearly, critical to the proper exercise of the appeal powers granted by s 164 of the Act. Accordingly, this appeal must be allowed. I agree with the orders proposed by Basten JA.

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Amendments

01 December 2015 - Typographical change in paragraphs [99], [107], [145], [147], [148]

01 December 2015 - Typographical change in paragraphs [99], [107], [145], [147], [148]