CITATION:	*KMD v The Mental Health Review Tribunal & Anor* [2020] NTSC 13
PARTIES:	KMD v THE MENTAL HEALTH REVIEW TRIBUNAL and THE NORTHERN TERRITORY OF AUSTRALIA
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	APPEAL from MENTAL HEALTH REVIEW TRIBUNAL
FILE NO:	LCA No. 58 of 2018 (21847790)
DELIVERED:	31 March 2020
HEARING DATES:	17, 18 December 2018
JUDGMENT OF:	Barr J

CATCHWORDS:

APPEALS – HEALTH LAW – MENTAL ILLNESS – *Mental Health and Related Services Act 1998* (NT) – Criteria for involuntary admission – Appellant suffering delusional disorder – Appellant previously found not guilty by reason of mental impairment of serious criminal offences including attempted murder – Appellant subject to custodial supervision under Part IIA *Criminal Code* (NT) – Tribunal found the appellant satisfied all requirements for involuntary admission and treatment for delusional disorder – Appeal – Interpretation – Person without treatment "likely to cause serious harm" to self or someone else – Whether likelihood to cause harm to be assessed in the current institutional setting or in the community

after hypothetical eventual release – Held likelihood to be assessed in all the circumstances – Requires realistic consideration of person's overall situation – Risk highly unlikely to materialize while appellant remains in supervised custodial environment – Tribunal erred in assessment of risk – Failed to take into account circumstances in which appellant might be released under Part IIA *Criminal Code* (NT) and the role of the Supreme Court in relation thereto – Orders of Tribunal set aside

Mental Health and Related Services Act 1998, s 3(a), s 3(b), s 7, s 8(b), s 14(b)(ii), s 14(b)(iii), s 32A, s 33, s 34, s 130, s 142(4), s 143(a)

Criminal Code (NT), s 43ZG (6), s 43ZG (7), s 43ZH (2)(a), s 42ZN

CH v Mental Health Review Tribunal & Anor [2017] NTSC 43; *Hunter v Mental Health Review Tribunal* [2017] NTSC 92, 327 FLR 402; *JXC v Mental Health Review Tribunal* [2018] NTSC 62, followed

Re Bolton; ex parte Beane (1987) 162 CLR 514; *R v Secretary of State for the Home Department; ex parte Simms* [2000] 2 AC 115; *Electrolux Home Products v Australian Workers Union* (2004) 221 CLR 309; *X7 v Australian Crime Commission* [2013] HCA 29, 248 CLR 92; *Lee v New South Wales Crime Commission* [2013] HCA 39, 251 CLR 196; *Attorney-General (NSW) v XX* [2018] NSWCCA 198; 274 A Crim R 30, referred to

The Queen v Madrill (No 2) [2013] NTSC 42; *R v KMD* [2015] NTSC 31; *R v KMD [No 2]* [2017] NTSC 18, referred to

The United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the United Nations General Assembly resolution 46/119 of 17 December 1991, considered

REPRESENTATION:

Counsel:

Appellant	E Nekvapil, G Buchhorn
Second Respondent:	T Moses

Solicitors:

Appellant	North Australian Aboriginal Justice Agency
Second Respondent:	Solicitor for the Northern Territory

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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

KMD v The Mental Health Review Tribunal & Anor [2020] NTSC 13
No. LCA No. 58 of 2018 (21847790)

BETWEEN:

KMD
Appellant

AND:

THE MENTAL HEALTH REVIEW TRIBUNAL
First Respondent

AND:

NORTHERN TERRITORY OF AUSTRALIA
Second Respondent

CORAM: BARR J

REASONS FOR JUDGMENT

(Delivered 31 March 2020)

Introduction

[1] The appellant appeals from a decision of the first respondent ("the Tribunal"), which on 14 November 2018 determined that the appellant satisfied all requirements for involuntary admission under the *Mental Health and Related Services Act 1998* ('the *MHRSA*') and ordered that she be admitted to the Joan Ridley Unit (JRU), Royal Darwin Hospital, and be

subject to a management treatment plan involving the administration of antipsychotic medication.

[2] The nature of an appeal from the Tribunal was considered by Hiley J in *CH v Mental Health Review Tribunal & Anor*,[1] and subsequently affirmed in *Hunter v Mental Health Review Tribunal* and *JXC v Mental Health Review Tribunal*.[2] There has been no challenge to the correctness of those decisions in the present appeal. In brief, the appeal is by way of rehearing.[3] The purpose of the rehearing power is correction of error. This Court's jurisdiction depends on the existence of a legal, factual or discretionary error. The evidence permissibly adduced on appeal is confined to evidence which would assist this Court to determine whether there was any such error.

Background

[3] I have been assisted by the background chronology contained in the written submissions of the second respondent,[4] noting that the detail was not contested by the applicant.

[4] On 7 May 2013, the appellant committed acts which led to her being charged with eight serious criminal offences: unlawful entry, deprivation of liberty, attempted murder, reckless endangerment of life, reckless endangerment of

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1 *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43, at [15] – [32].

2 *Hunter v Mental Health Review Tribunal* [2017] NTSC 92; 327 FLR at [3]–[4]; *JXC v Mental Health Review Tribunal* [2018] NTSC 62 at [4].

3 *Mental Health and Related Services Act*, s 142(3).

4 Submissions of the second respondent, 11 December 2018, pars 2-14.

serious harm, unlawful use of a motor vehicle, removal of a child from lawful custody, and possession of a firearm for which the serial number had been defaced or altered.

[5] The events giving rise to the charges were, in brief, that the appellant unlawfully entered the home of her former partner armed with a firearm; threatened her former partner's mother with the firearm while detaining her in the mother's home, and later in the mother's car; discharged the firearm at her former partner, missing him; subsequently shot the mother in the arm before engaging in a car chase in pursuit of her former partner, firing at the vehicle in which he was travelling; rammed into that vehicle and shot into it, hitting her former partner in the thumb.[5]

[6] On 1 May 2014 the appellant was, by agreement between the prosecution and defence, declared unfit to stand trial in relation to those offences pursuant to s 43T and s 43R of the *Criminal Code*.[6]

[7] On 4 July 2014, following a special hearing, a jury found the appellant not guilty by reason of mental impairment of the eight offences charged. The basis for the verdict was expert evidence that the appellant suffered a delusional disorder, the most significant component of which was a delusion that her son was being sexually assaulted and was in danger of further

5 The sequence of events is described by Riley CJ in *R v KMD* [2015] NTSC 31 at [8]-[23].

6 *R v KMD* [2015] NTSC 31 at [1].

sexual assault by the appellant's former husband and other persons. As Riley CJ explained:

> The claims were investigated and found to have no foundation. Nevertheless, and sadly for all concerned, KMD persisted with, and acted upon, the intense but deluded belief that such assaults occurred and that her son was in grave danger.

[8] After the jury's verdict, the appellant was declared liable to supervision under Part IIA of the *Criminal Code*.[7] On 3 June 2015, a custodial supervision order was imposed. The Appellant remains in custody under that order. A term of 16 years was fixed under s 43ZG (2) of the *Criminal Code*, reflecting a hypothetical sentence for the disturbing and very dangerous conduct engaged in by the appellant.[8]

[9] The Tribunal was satisfied that the appellant had suffered and was still suffering from a mental illness, namely a delusional disorder.[9] A delusional disorder is a serious mental illness (psychosis), in which a person is unable to distinguish between what is real and what is imagined, resulting in an unshakeable belief in something which is not true. The appellant's core delusional belief was that her son had been sexually abused and was in danger of further sexual assault by her former partner, the child's father. The appellant's delusional disorder was the persecutory type, that is, she

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7 *R v KMD* [2015] NTSC 31 at [3]-[4].

8 As to the meaning of 'hypothetical sentence', see *The Queen v Madrill (No 2)* [2013] NTSC 42 at [37] – [39].

9 Tribunal's Reasons for Decision, pars 18, 19, 22 and 26 (esp. sub-paragraphs (b) and (c) of par 26).

believed that someone close to her was being harmed or mistreated.[10] This led to the dangerous violence described in [5] above. The insidious and potentially very dangerous aspect of a delusional disorder is that a person may function normally except in relation to the subject matter of the delusion.[11] In relation to the appellant's delusional beliefs, she is without insight. Further, a delusional disorder such as that suffered by the appellant is unlikely to resolve without treatment, as Dr Das explained in his evidence to the Tribunal:[12]

> … We know very well delusional disorders don't just fade away. The severity with which she presented – the severity can be judged by the extreme actions that she went to – would indicate that she does have an extremely deeply entrenched delusional system; that doesn't seem to have gone away. All the markers that we see in prison currently indicate the presence of this disorder. By that token, we can only assume that risk hasn't gone away.

[10] With the exception of a single depot injection (100 mg) of an antipsychotic drug in September 2014,[13] the appellant had never been given pharmacological treatment for her mental illness. Although she had been willing to engage in counselling and cognitive behavioural therapy focussed

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10 The appellant's diagnosis was described by Dr Das as a "delusional disorder with a well systematized persecutory theme" in the HCR 20, Version 3, April 2017, and HCR 20, Version 3, updated November 2018, respectively annexures MD-4 and MD-8 to the affidavit of Matthew Derrig sworn 4 December 2018.

11 A differential diagnosis made in relation to the appellant's mental illness was schizophrenia. A person suffering schizophrenia may experience delusions. However, a delusional disorder is distinguished from schizophrenia by the fact that delusions are present without other symptoms of psychosis such as hallucinations, disorganized speech and disorganized behavior.

12 Transcript of proceedings before the Tribunal, Affidavit of Matthew Derrig sworn 4 December 2018, par 2, Annexure MD-1, p. 9.

13 It is unclear whether the antipsychotic was Paliperidone or Risperidone. However that is immaterial for present purposes.

on anger management, she refused all treatment for her mental illness.[14] She refused to engage with the Top End Mental Health Service (TEMHS) with the result that her mental illness remained untreated.

[11] From 20 June 2016 to 18 July 2016,[15] the appellant was involuntarily admitted to the Joan Ridley Unit of the Royal Darwin hospital, pursuant to s 39 of the *MHRSA*. On review of that decision under s 123 of the *MHRSA*, the Tribunal was not satisfied that either limb of the requirement for involuntary admission under s 14(b)(ii) was met. The Tribunal revoked the appellant's involuntary admission and ordered that she be discharged back into custody.

[12] On 12 May 2016, on review of the appellant's custodial supervision order under s 43ZH of the *Criminal Code*, the CEO Health sought an order requiring the appellant to undergo pharmacological treatment.

[13] On 22 February 2017 the Supreme Court determined that it did not have power to order that the appellant undergo pharmacological treatment under Part IIA of the *Criminal Code*.[16] Hiley J found that there was nothing in s 43ZA (2A) or elsewhere in Part IIA of the *Criminal Code* that suggested, let alone expressed "with irresistible clearness", that the legislature intended to abrogate the common law right of a person, including a supervised

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14 Historical Clinical Risk Management guide (HCR-20, version 3) updated November 2018 pp 12, 15, Annexure MD-3 to the affidavit of Matthew Derrig affirmed 16 November 2018, pp 54, 57.

15 The second admission was because the Tribunal had insufficient time to review the first admission: Tribunal's Reasons for decision 18 July 2016 at [8]-[12] annexed to the affidavit of Matthew Derrig dated 16 November 2018 at MD-2 pp 12-13.

16 *R v KMD [No 2]* [2017] NTSC 18.

person, not to be subjected to medical treatment against the person's will.[17] On that basis, his Honour concluded that the Court did not have power to mandate pharmacological treatment of the appellant's mental illness.

[14] On 1 November 2018, the Appellant was again involuntarily admitted purportedly pursuant to s 39 of the *MHRSA*. On 12 November 2018 the Tribunal held a hearing to review that involuntary admission. The appellant was legally represented. The TEMHS appeared without legal representation. A large body of material relied on by TEMHS was put before the Tribunal at the hearing. That material included several reports which had been prepared for the purpose of, and tendered in, proceedings in this Court under Part IIA of the *Criminal Code*. On 14 November 2018, the Tribunal determined that the Appellant satisfied all requirements for involuntary admission under the *MHRSA* and ordered that she be admitted for a period of four weeks to commence pharmacological treatment.

[15] In its written reasons for decision, the Tribunal noted the evidence of psychiatrists Dr Lysenko and Dr Das that the appellant had consistently refused to engage in treatment by TEMHS for her mental illness, despite repeated attempts by health practitioners to encourage her to do so. The Tribunal referred to the expert opinion of those doctors that, without treatment, the appellant posed "too significant a risk of harm to others secondary to her delusional beliefs" and that she was "likely to suffer

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17 The reference to "irresistible clearness" was to the decision of Kiefel J in *X7 v Australian Crime Commission* [2013] HCA 29; 248 CLR 92 at [158], in relation to the principle of legality.

further mental deterioration if she [did] not receive psychiatric treatment, including antipsychotic medication".[18] The Tribunal also referred to the opinion expressed by Dr Das during the review hearing that, the longer the appellant went without treatment for her mental illness, the greater the likelihood not only that she would deteriorate but that she would become treatment resistant.[19]

[16] The opinion of Dr Das, given in evidence before the Tribunal, was that the appellant was unable to give informed consent to the proposed treatment because (1) she did not accept she was suffering from a mental illness linked to her unfounded belief that her son's father sexually molested him; (2) that unfounded belief prevented her from being able to properly appreciate the possible benefits that may result from the proposed treatment.[20] Even if she expressed apparently rational concerns about the possible side effects of drug treatment, she was not in a position to properly appreciate the benefits and could not rationally compare the benefits and detriments so as to be able to give informed consent (that is, consent based on a proper understanding of the pros and cons). The evidence of Dr Lysenko was to the same effect;

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18 Tribunal's Reasons for Decision, par 22.

19 Transcript of proceedings before the Tribunal, Annexure MD-1 to the affidavit of Matthew Derrig sworn 4 December 2018. At p. 16.5, Dr Das stated: "We do know, and this is something that I am very mindful of … that the longer we don't treat a schizophrenia spectrum illness, and this is well documented in literature, … We are causing the person a disservice because the treatment outcome becomes poorer with time; prognosis is adversely affected. … And the consequence of that is that we are making her illness more treatment resistant, less likely to respond to treatment in due course".

20 Extracted in par 40 of the Tribunal's Reasons for Decision.

when asked whether the appellant was capable of giving informed consent to the proposed treatment, he replied as follows:[21]

> I don't believe she is, owing to the fact that she doesn't perceive that she has an illness, and if she can't see that she has an illness, therefore she can't weigh up the risks versus benefits of treatment.

[17] The Tribunal accepted the assessment of Dr Das that the appellant was unable to give informed consent to the proposed treatment. The Tribunal found that she was suffering from a delusional disorder and that her lack of understanding of that illness (which was itself a direct result of the illness) resulted in her being unable to understand the benefit she might obtain from treatment. Her inability to weigh up the possible benefit was important in assessing her ability to give informed consent. The Tribunal further found that the appellant's view of the risks of the recommended treatment could be seen as extreme (and possibly affected by her illness).[22]

[18] The Tribunal ultimately held that all of the criteria for involuntary admission specified in s 14 of the *MHRSA* were satisfied. The Tribunal made an order that the appellant be admitted as an involuntary patient in the JRU for a period of four weeks and approved the management treatment plan proposed for her by Drs Lysenko and Das.[23]

[19] The Supreme Court has power to suspend the operation or effect of a decision being appealed against, pursuant to s 142(4) *MHRSA*. On

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21 MD-1, p.13.

22 Tribunal's Reasons for Decision, par 42.

23 Tribunal's Reasons for Decision, par 44.

19 November 2018, an order was made, by consent, that the Tribunal's orders be suspended pending the determination of this appeal.

Grounds of appeal

[20] The notice of appeal raises the following four grounds of appeal:

> **Ground 1**: The Tribunal erred in finding, pursuant to s 14(b)(ii)(A) of the *MHRSA*, that as a result of the mental illness without the treatment, the appellant is likely to cause serious harm to herself or to someone else.
>
> **Ground 2**: The Tribunal erred in finding, pursuant to s 14(b)(ii)(B) of the *MHRSA*, that as a result of the mental illness without the treatment, the appellant is likely to suffer serious mental or physical deterioration.
>
> **Ground 3**: The Tribunal erred in finding, pursuant to s 14(b)(iii) of the *MHRSA*, that as a result of the mental illness, the appellant is not capable of giving informed consent to the treatment and has unreasonably refused to consent to the treatment; and
>
> **Ground 4**: The Tribunal erred in finding, pursuant to s 14(a) of the *MHRSA*, that the appellant has a mental illness.

[21] In brief, the appellant denies that she has a mental illness and contends that the Tribunal erred in finding to the contrary (ground 4). However, she contends in the alternative that that the *MHRSA* "confines the scope for forcing a person to be detained and subjected to involuntary medical treatment by carefully confined statutory criteria, which were not met on the evidence before the Tribunal". As a result, the Tribunal erred in finding that she met the criteria in s 14(b)(ii) and (iii) of the *MHRSA*.

Ground 4 – whether the appellant has a mental illness

[22] It is clear that the appellant has a mental illness. She may well deny it, even on this appeal,[24] but the entirety of the expert psychiatric evidence before the Tribunal was to the effect that the appellant was suffering a mental illness. Counsel for the appellant made reference to and acknowledged that evidence in their submissions,[25] while still seeking to advance the appellant's contention that she does not have a mental illness. I reject the appellant's contention. I am satisfied that the Tribunal did not err in finding that appellant had suffered and was still suffering from a mental illness, namely a delusional disorder. The Tribunal's finding was clearly open and was not attended by error of law. Ground 4 must fail.

[23] Counsel for the appellant submitted that the Tribunal confined its findings about whether the appellant had a mental illness to the core aspects of her delusional disorder, that is, her delusional beliefs about sexual abuse perpetrated by her ex-husband, as distinct from previously noted 'satellite' delusional beliefs of a systematized nature about paedophile rings of which illuminati, Freemasons, police officers and judges were said to be members.[26] That 'confinement of findings' was said to have had cascading effects for the other criteria under s 14 *MHRSA*. It is correct that the Tribunal did not make findings as to the persistence and intensity of those satellite delusional beliefs, but that was probably because the appellant had

24 Appellant's outline of submissions, pars A1, 109 and 112.

25 Appellant's outline of submissions, pars 111, 113, and 114.

26 Appellant's outline of submissions, par 116 – 118.

refused to engage with mental health practitioners, as mentioned in [10] above, with the result that there was no evidence before the Tribunal as to the persistence (or otherwise) of those beliefs. However, it is not necessary for me to decide the contention as to cascading effects because of the view I take in relation to the interpretation of s 14(b)(ii) *MHRSA*.

Ground 1 – appellant likely to cause serious harm without treatment

[24] Given its relevance to Ground 1 and the remaining grounds argued on appeal, I set out below the text of s 14 *Mental Health and Related Services Act*:

> **14 Involuntary admission on grounds of mental illness**
>
> The ***criteria*** for the involuntary admission of a person on the grounds of mental illness are that:
>
> (a) the person has a mental illness; and
>
> (b) as a result of the mental illness:
>
> (i) the person requires treatment that is available at an approved treatment facility; and
>
> (ii) without the treatment, the person is likely to:
>
> (A) cause serious harm to himself or herself or to someone else; or
>
> (B) suffer serious mental or physical deterioration; and
>
> (iii) the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and
>
> (c) there is no less restrictive means of ensuring that the person receives the treatment.

[25] Although all three criteria in s 14(b) must be satisfied (there are alternative criteria within s 14(b)(ii)), and hence all are relevant, I consider that the central issue in the appeal is the interpretation of the phrase in s 14(b)(ii):

"is likely to", in relation to whether, without treatment, the appellant was likely to cause serious harm (to herself or to someone else) or suffer serious mental or physical deterioration. Leaving aside whether "likely" means probable or something less than probable (in my view its meaning is the same or substantially the same as 'probable'), the question is whether likelihood was to be assessed by the Tribunal not only with reference to the state of the appellant's mental health but also taking into consideration her general circumstances, which included the appellant's indefinite incarceration and the constraints imposed on her as a result of being subject to custodial supervision under Part IIA *Criminal Code*.[27]

[26] There are a number of circumstances described in Part IIA *Criminal Code* in which the Supreme Court may exercise power to unconditionally release a person subject to custodial supervision or non-custodial supervision from such supervision; and also to vary a person's custodial supervision order to a non-custodial supervision order, subject to conditions.[28] However, in relation to the making of any such orders, the Court is bound to take

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27 In an earlier decision, published 29 July 2016, a differently constituted Tribunal described the appellant's then-current circumstances as being in a "highly constrained and closely supervised custodial environment". Those circumstances had not materially changed at the time of the decision the subject of the present appeal.

28 *Criminal Code*, s 43ZG (6) provides for 'major review' of supervision orders, which must be conducted in the months before the expiry of the major review period. In the case of the appellant, this period is the 16-year period referred to in [8]. The subsection requires the Court to release the supervised person unconditionally unless the Court considers that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person were released. If the Court considers that the safety of the supervised person or of the public would be seriously at risk if the supervised person were released unconditionally, the Court may confirm an existing custodial supervision order or even vary a non-custodial supervision order to a custodial supervision order – see s 43ZG (7). The *Criminal Code*, s 43ZH, also provides for 'periodic review' by the Court of supervision orders, after receipt of periodic reports (which are usually annual reports) in relation to the treatment and management of the supervised person. On completion of the periodic review, the Court is required to vary the supervision order to a non-custodial supervision order unless satisfied that the safety of the supervised person or the public would be seriously at risk if the person were released on a non-custodial supervision order – see s 43ZH (2)(a).

specified matters into account, in accordance with s 43ZN *Criminal Code*, which I set out below (underline emphasis added):

> (1) In determining whether to make an order under this Part, the court must have regard to the following matters:
>
> (a) whether the accused person or supervised person concerned is likely to, or would if released be likely to, endanger himself or herself or another person because of his or her mental impairment, condition or disability;
>
> (b) the need to protect people from danger;
>
> (c) the nature of the mental impairment, condition or disability;
>
> (d) the relationship between the mental impairment, condition or disability and the offending conduct;
>
> (e) whether there are adequate resources available for the treatment and support of the supervised person in the community;
>
> (f) whether the accused person or supervised person is complying or is likely to comply with the conditions of the supervision order;
>
> (g) any other matters the court considers relevant.
>
> (2) The court must not make an order under this Part releasing a supervised person from custody (whether conditionally or otherwise) or significantly reducing the supervision to which a supervised person is subject unless:
>
> (a) the court has:
>
> (i) obtained and considered 2 reports, each report being prepared by a person who is a psychiatrist or other expert (but the same person must not prepare both reports); and
>
> (ii) considered the reports submitted to the court under sections 43ZJ and 43ZK and received by the court under section 43ZL, if any; and
>
> (b) subject to subsections (3) and (4), the court is satisfied that each of the following persons was given reasonable notice of the proceedings concerned:
>
> (i) the victim of the offence concerned;
>
> (ii) if the victim concerned is deceased – the victim's next of kin;
>
> (iia) the next of kin of the supervised person concerned;
>
> (iii) if the supervised person concerned is a member of an Aboriginal community – the Aboriginal community.

[27] It can therefore be seen that the appellant could not be released from supervision unconditionally, or have her custodial supervision varied to non-custodial supervision, and in either case be returned to the community, unless the Supreme Court permitted that to take place. The Supreme Court is the gatekeeper of every pathway by which the appellant might transition from custodial supervision, and has a clear mandate to prevent serious risk to the public.[29]

[28] The Tribunal specifically adopted the proposition that "one should look at the likelihood of KMD causing harm to someone else when she is released back into the community at the end of her custodial supervision order".[30] Although the Tribunal referred to Part IIA of the *Criminal Code* in various parts of its decision,[31] it did not consider the legal consequences of the custodial supervision order made by the Supreme Court: nowhere did it make reference to the particular constraints to which the appellant was subject or to the role of the Supreme Court in relation to the lifting of those constraints.

[29] The second respondent submits that assessment of risk in the circumstances of the appellant's confinement to the Darwin Correctional Centre (rather

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29 In this context, it may be noted that on 26 July 2017, in the course of an annual (periodic) review under s 43ZH *Criminal Code*, Hiley J was satisfied on the evidence that the safety of the public would be seriously at risk if the appellant were released on a non-custodial supervision order. His Honour confirmed the existing custodial supervision order – see *The Queen v KMD and Ors (No 3)* [2017] NTSC 95 at [131].

30 Tribunal's Reasons for Decision, pars 29, 30.

31 See Tribunal's Reasons for Decision, pars 1, 3 (reference to the making of a final custodial supervision order by the Supreme Court), and 7 (reference to the Supreme Court's decision that it did not have jurisdiction to make an order for involuntary admission and treatment). The Tribunal was clearly aware that the appellant had been in custody, residing at the Darwin Correctional Precinct – see Reasons for Decision, pars 29, 30(b).

than in the community) would be an unnecessary and impermissible restriction of risk assessment,[32] and that the better view is that s 14(b)(ii)(A) requires "a risk assessment accommodating the range of potential living circumstances available to the person" which, for the appellant, "necessarily accommodates the prospect of future release into the community". This interpretation, if accepted, would justify the Tribunal's consideration of the risk of harm arising on the appellant's release at some unspecified future time.

[30] The second respondent further submits that an assessment of the criteria for the involuntary admission of a person would normally be made by a mental health practitioner or authorised psychiatric practitioner (and, on review, the Tribunal) in an approved treatment facility, a highly controlled and secure facility. If a risk assessment were limited to the person's 'extant location' and the circumstances prevailing in a treatment facility, the assessment would be artificially benign and arguably not relevant to the person's circumstances if at large in the community.

[31] In my opinion, the use of the present tense in the expression "is likely to" suggests that the focus of the risk assessment should be on the present, or at least the short term. However, the consideration should not be artificially confined; the expression "is likely to" still requires a realistic consideration of a person's overall situation. It requires a risk assessment in which

32 Submissions of the second respondent, 11 December 2018, pars 30, in reference to the 2016 decision of a differently constituted Tribunal.

likelihood is to be comprehensively assessed in all the circumstances. As a consequence, the Tribunal was required to assess likelihood on the basis that the appellant was subject to custodial supervision under Part IIA *Criminal Code*. That involved consideration not only of the supervised custodial environment in which the appellant was held, but also the provisions of Part IIA *Criminal Code*, under which the appellant (a supervised person subject to custodial supervision) could not be released if the Supreme Court considered that the safety of the public was "likely to be seriously at risk".[33]

[32] The second respondent's contentions summarised in [29] and [30] fail to take into account the significant improbability – if not the impossibility – of the appellant's early release into the community. The appellant's situation was not that of a person who had just been subject to urgent intervention. She had not been apprehended by police, brought to a psychiatrist for assessment as to whether she fulfilled the criteria for involuntary admission, recommended for psychiatric examination and then held in an approved treatment facility.[34] In such a case, the person's early return to the community could be assumed and the submission in [30] might be more

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33 *Criminal Code*, s 43ZG (6). The section provides for 'major review' of supervision orders, which must be conducted in the months before the expiry of the major review period. In the case of the appellant, this period is the 16-year period referred to in [8]. The subsection requires the Court to release the supervised person unconditionally unless the Court considers that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person were released. If the Court considers that the safety of the supervised person or of the public would be seriously at risk if the supervised person were released unconditionally, the Court may confirm an existing custodial supervision order or even vary a non-custodial supervision order to a custodial supervision order – see s 43ZG (7). The *Criminal Code*, s 43ZH, also provides for 'periodic review' by the Court of supervision orders, after receipt of periodic reports (which are usually annual reports) in relation to the treatment and management of the supervised person. On completion of the periodic review, the Court is required to vary the supervision order to a non-custodial supervision order unless satisfied that the safety of the supervised person or the public would be seriously at risk if the person is released on a non-custodial supervision order – see s 43ZH (2)(a).

34 *Mental Health and Related Services Act*, s 32A, s 33 and s 34.

relevant. The crucial difference in the case of the appellant was that she was subject to a custodial supervision order and thus her medium to long-term future circumstances could be ascertained with some level of precision.

[33] The interpretation I adopt, referred to in [31], and the approach based on that interpretation, are consistent with s 130 *MHRSA*, which provides that, in undertaking a review or deciding an involuntary detention application, the Tribunal must consider not only a person's current state in relation to the criteria for involuntary admission on the grounds of mental illness (a reference back to s 14 *MHRSA*), and the person's medical and psychiatric history, but also the person's "current social circumstances". Moreover, the approach is consistent with s 8 *MHRSA*, which sets out principles, not only in relation to the interpretation of the Act but also for the exercise or performance of any power or function conferred or imposed by the Act. I refer in particular to s 8(b), which reads as follows (italic emphasis added):

> (b) in providing for the care and treatment of a person who has a mental illness and the protection of members of the public, any restriction on the liberty of the person and any other person who has a mental illness, and any interference with their rights, dignity, privacy and self-respect is kept to the *minimum necessary in the circumstances*.

[34] The requirements that any restriction on a person's liberty and/or interference with a person's rights be kept to "the minimum necessary in the circumstances" emphasises the need for a risk assessment under s 14(b)(ii) in which likelihood is comprehensively assessed in all the circumstances.

[35] To the extent that the issue raised by Ground 1 on appeal is one of statutory interpretation,[35] I have also considered the principle of legality, an important principle of statutory interpretation, given that the involuntary administration of psychotropic drugs to treat a mental illness is a clear denial of patient autonomy as well as a significant infringement of the right to personal liberty. It has been held that any statute which purports to impair a right to personal liberty should be interpreted so as to respect that right.[36] The principle of legality was explained by Lord Hoffman in *R v Secretary of State for the Home Department; ex parte Simms* as follows:[37]

> [T]he principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual.

[36] In *Electrolux Home Products v Australian Workers Union*,[38] Gleeson CJ described the principal of legality as:

> … not merely a common sense guide to what a Parliament in a liberal democracy is likely to have intended; it is a working hypothesis, the existence of which is known both to Parliament and the courts, upon which statutory language will be interpreted. The hypothesis is an aspect of the rule of law.

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35 The second respondent contends that the issue is one of statutory construction: see the references to construction in Submissions pars 30, 32, 34 and 38. The appellant contends that the words of s 14(b)(ii)(A) are clear, and that no issue of construction arises: see Appellant's Outline of Submissions in Reply, par 3.

36 See, for example, *Re Bolton; ex parte Beane* (1987) 162 CLR 514 at 523.

37 *R v Secretary of State for the Home Department; ex parte Simms* [2000] 2 AC 115 at 131.

38 *Electrolux Home Products v Australian Workers Union* (2004) 221 CLR 309 at 329.

[37] In the general context of the *MHRSA*, which expressly authorizes involuntary admission for and treatment of mental illness, the principle of legality does not operate to frustrate the legislative intention,[39] and must be applied with care.[40] However, it does assist in determining the extent to which the legislation was intended to abrogate a person's rights where that does not otherwise appear clearly from the text or context of the statutory provision.

[38] The objects of the *MHRSA*, set out in s 5 of the Act, include as the first and second stated objects: (a) to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights; and (b) to establish provisions for the care, treatment and protection of people with mental illness that are consistent with the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care ("the UN Principles"),[41] the Australian Health Ministers' Mental Health Statement of Rights and Responsibilities and the National Mental Health Plan.

[39] Principle 11 of the UN Principles, Consent to Treatment, provides in par 1 that (subject to specific exceptions) no treatment shall be given to a patient without his or her informed consent. However, one exception is the situation of urgency, referred to in Principle 11, par 8:

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39 *Lee v New South Wales Crime Commission* (2013) 251 CLR 196 at [313] –[314], per Gageler and Keane JJ.

40 *Attorney-General (NSW) v XX* [2018] NSWCCA 198; 274 A Crim R 30 at [138].

41 Adopted by the United Nations General Assembly resolution 46/119 of 17 December 1991.

> 8. Except as provided in paragraphs 12, 13, 14 and 15 below [*not presently relevant*], treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose. [underline emphasis added]

[40] It should be noted that s 14(b) *MHRSA* does not expressly require that the proposed involuntary treatment be "urgently necessary" or that the harm the person is likely to cause without the treatment be "immediate or imminent harm". Nonetheless, when this Court is required to consider the meaning of the expression "is likely to", and the extent to which the likelihood need be immediate as distinct from medium-term or long-term, the Court should have regard to the objects of the Act, including object 5(b) above. That is not to say that the inclusion of, or reference to the UN Principles as an object means that they are thereby incorporated into Northern Territory Law; they are not.[42] However, to the extent that there is ambiguity in the legislation as to the meaning of "is likely to" in s 14(b)(ii), it is appropriate that this Court favour a construction (and approach) consistent with the international convention, in order to give effect to the stated object that provisions enacted for the care, treatment and protection of people with mental illness should be consistent with that convention.

[41] The interpretation and approach I have adopted promotes the purpose or object underlying the Act, which, as mentioned in [38], is expressly stated. I

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42 See, for example, *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273 at 286-287, per Mason CJ and Deane J.

mention also that s 62B (1) *Interpretation Act 1978* makes specific provision that, if material not forming part of an Act is capable of assisting in ascertaining the meaning of an ambiguous provision, the Court may consider such material. A specific example given in s 62B (2) is "any treaty or other international agreement that is referred to in the Act".[43] The UN Principles would not be characterized as a treaty or other international agreement; however, the examples in s 62B (2) *Interpretation Act 1978* are not intended to be exhaustive. The UN Principles are contained in an International Instrument adopted by the United Nations General Assembly; they are akin to an international agreement, and are specifically referred to in the *MHRSA*.

[42] Further to my consideration of Ground 1, I note that there had been no indication that the appellant was likely to cause harm – serious or otherwise – to any person within the custodial environment. Although she had been unpleasant in her behaviour towards others at times and had shown marked frustration, irritability and impatience, and a sense of entitlement, she was not considered a security risk. She had completed the University of Southern Queensland Tertiary Preparation Program (TPP) and had worked within the prison as a literacy and numeracy Quick Smart tutor to other prisoners. Moreover, having been subject to custodial supervision, she had been effectively quarantined from those persons who, she believed, posed a threat to her son. She was not exposed to the proximate triggers for her delusional disorder.

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43 *Interpretation Act 1978*, s 62B (2)(d).

[43] Finally, I mention that Ground 1 of appeal attributes to the Tribunal a finding which it did not make. The Tribunal did not find that, without treatment, the appellant was likely to cause serious harm to herself. To the contrary, the Tribunal appeared to accept that the appellant was not likely to cause serious harm to herself. This can be seen from the Tribunal's findings upon consideration of the criterion in s 14(b)(ii)(A), under the heading "Without the treatment, the person is likely to cause serious harm to himself or herself or to someone else".[44] There the Tribunal dealt only with the likelihood of the appellant causing harm to someone else, and in relation to such harm, only in the context of her release into the community.

[44] In the absence of any relevant finding by the Tribunal, however, the second respondent contends that this Court should make a finding that, without treatment, the appellant was likely to cause serious harm to herself: the harm being the effects of ongoing incarceration, effectively self-imposed ("the first contended finding"). The *MHRSA*, s 4, defines 'harm' to include "financial harm and loss of reputation". Counsel for the second respondent contends that 'serious harm' invites a value judgment as to the extent of loss and suffering; and that incarceration constitutes 'serious harm', being the most significant interference with a person's rights and liberties condoned by the law.[45] The underlying contention is that, if the appellant were to

44 Tribunal's Reasons for Decision, pars 28-30.

45 Submissions of the second respondent, pars 42, 43.

undergo the proposed treatment, she would be released from custody and the self-inflicted serious harm would cease.

[45] Additionally, the second respondent contends that "there was uncontested opinion evidence before the Tribunal that delayed pharmacological treatment of psychosis was likely to result in poorer outcomes in symptoms and relapse likelihood".[46] On the basis of that evidence, the respondent further contends – again in the absence of any relevant finding by the Tribunal – that this Court should find that, without treatment, the appellant "is likely to suffer serious mental deterioration" within s 14(b)(ii)(B) *MHRSA* ("the second contended finding").[47]

[46] I reject the second respondent's arguments summarized in [44] and [45] and decline to make either of the contended findings.

[47] As to the first contended finding, I will accept for the purposes of the argument that the significant detriments of ongoing incarceration are properly characterised as 'serious harm'. However, I am not satisfied on the balance of probabilities that the proposed treatment, if undergone by the appellant, would eliminate or significantly lessen the risk factors associated with her delusional disorder so as to enable her to be released unconditionally or made subject to non-custodial supervision. The position is quite unclear and, given the matters discussed in [53] below, it would be

46 Ibid, par 45.

47 Submissions of the second respondent, par 45.

inappropriate in the present appeal to speculate on the outcome of the considerations of another judge of this Court exercising jurisdiction under the mental impairment provisions contained in Part IIA *Criminal Code*.

[48] I explain in [49] – [54] below why I decline to make the second contended finding.

[49] The appellant had not only resisted pharmacological treatment but also refused to engage with her treating doctors by speaking with them about her delusional beliefs.[48] She was noted over time to have steadfastly refused to see her case manager and consultant psychiatrist, to the point of outright hostility. As a result, no proper assessment had been made as to the persistence and intensity of her beliefs. In the absence of any frank and honest 'two-way' discussion, her treating doctors had been unable to gauge her level of insight. This had left Dr Das to draw the conclusion that the appellant remained "completely entrenched in her belief system", and "completely of the view that there [was] a conspiracy going on".[49]

[50] The correctness of the conclusion of Dr Das was, in my assessment, substantially confirmed by the appellant's own statements to the Tribunal.[50] She asserted that a very early assessment (report dated 18 November 2013), carried out by specialist forensic psychiatrist Dr Kevin Smith, was flawed because Dr Smith had relied on information that was "not credible" and had

48 See, for example, the evidence of Dr Das at MD-1, pp. 19.9, 26.8.

49 MD-1, p. 27.3.

50 MD-1, p. 50.

not acknowledged the appellant's "very clear rational explanation". Consequently, she had not wanted to engage with Dr Smith because she did not consider that he was "ethical in his reporting".[51] The psychiatrists who followed Dr Smith "simply followed on from his report", and did not have regard to what she "very clearly explained". The appellant then said:

> They are just totally disregarding what I am saying, and the evidence from that, and maintaining very rigidly the firm belief that I have an untreated mental illness. And that's why I cannot engage ... I cannot engage because they are so rigid in the belief that I have a mental illness, and are not looking at all the evidence reasonably, that I can't put myself at risk of them making further reports that are based on a wrong premise.

[51] The extract in the previous paragraph indicates that it was the appellant who was "maintaining very rigidly" a firm belief: in her case, that she did not have an untreated mental illness. She would not engage with mental health practitioners because she did not want any further reports to be written and/or opinions given to the effect that she *did* have a mental illness. In his November 2013 report, Dr Kevin Smith expressed hope that the appellant might respond to medication, but qualified that statement by his observation

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51 Dr Smith, a senior forensic psychiatrist, held the position of Director of Forensic Psychiatry in the Northern Territory until October 2013. He was engaged by lawyers acting for the appellant in November 2013 to provide a psychiatric report in relation to a possible defence of mental impairment. He was provided with a police report in relation to the alleged offending, as well as a summary of the prosecution evidence and statements of relevant witnesses. He interviewed the appellant on three occasions, on 6, 12 and 14 November 2013. He spent over six hours with her. Dr Smith took a very detailed personal history, including a history of the appellant's past relationships. He also obtained specific (albeit incomplete) information from the appellant as to the circumstances leading up to her offending in May 2013. His report contained multiple direct quotes of statements made by the appellant to him. Dr Smith explained, "I have taken an extremely detailed history from Ms D, and quoted her exact words rather than simply interpreting their significance. It is a complex history, but Ms D is also a very driven and obsessive historian". The appellant's criticisms of Dr Smith appear to be that he recorded a detailed history which she denies having given and/or which she now disavows in substantial part, and that he expressed opinions with which she now disagrees.

that delusional disorders can sometimes be very resistant to medication.[52] In his evidence before the Tribunal in November 2018, Dr Das explained that the prognosis for mental illnesses on the schizophrenia spectrum (which includes delusional disorder) becomes poorer with the passing of time.[53] At a later point, after referring to the appellant's total lack of engagement and antipathy towards mental health professionals, Dr Das observed that those matters indicated "a continuation of the delusional system and … perhaps a worsening in many aspects of her delusional system". However, when asked by a Tribunal member about deterioration in the plaintiff's condition, he replied as follows:[54]

> Yes, possibly, but I do not wish for us to rely on the worsening or deterioration in mental state as the reason for wanting to treat her. Because if we were to sit down here and try to prove or disprove, either way, it's very difficult for us to do that. At the bare minimum, what we want to rely on is the evidence that she continues to suffer from this mental illness.

[52] Given the very appropriate concession made by Dr Das, I could not be satisfied that a serious deterioration in the plaintiff's condition, while she remained untreated, was any more than a possibility. It was an equal or even greater possibility that the plaintiff's condition had already deteriorated to a notional low point, with delusions firmly entrenched, and that although it was not getting better, it was not getting worse. Some evidence for the latter

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52 MD-10, pp. 345, 365.

53 MD-1, p. 16.5.

54 MD-1, p. 20.3.

possibility was provided by Dr Lysenko in his evidence to the Tribunal,[55] where he said that the plaintiff's risk profile at the time of a previous hearing in 2016 was "as bad it is as it has ever been", but that he did not believe that there had been a significant shift in the plaintiff's risk profile since then.

[53] In any event, whether or not the appellant's delusional disorder was deteriorating, there was a real possibility that her condition had become treatment resistant. Even if the condition were still susceptible to treatment, the proposed treatment would not bring about a "sea change in the delusional system", because, as Dr Das explained, it is very difficult to completely dissipate a delusional system in a delusional disorder.[56] The treating psychiatrists would nonetheless attempt to deal with the associated effects of the delusion: the appellant's conviction as to the delusion, her systematisation, her preoccupation with the delusion and the likelihood of her acting on her delusion. Treatment (which might not work) would be directed at reducing the associated risk factors as distinct from eliminating the delusion altogether.

[54] Given the state of the evidence, I cannot be satisfied on the balance of probabilities that, without the proposed treatment, the appellant was likely to suffer serious mental deterioration. The prospects of success of any pharmacological intervention were (and remain) unclear. Further, to the

55 MD-1, p. 9.

56 Evidence Dr Das, MD-1, p. 19.

extent that such treatment would be contrary to the wishes of the appellant, indeed, strongly opposed by her, the prospects of success are diminished.

Conclusion – Ground 1

[55] For reasons explained in [25] – [34], and supported by my further observations at [35] – [41], I am satisfied that the Tribunal erred in fact and law in finding that, without treatment, the appellant was likely to cause serious harm to someone else. The Tribunal erred in law because it assessed the likelihood that the appellant would cause serious harm on her release from custodial supervision into the community. In doing so, the Tribunal failed to apply the correct test and/or made findings that were not properly open to it.

Ground 2 – appellant likely to cause serious mental or physical deterioration without treatment

[56] A close reading of the Tribunal's findings indicates that no findings were made in relation to the alternative criterion, s 14(b)(ii)(B), that "without the treatment, the person is likely to suffer serious mental or physical deterioration". After considering the first criterion, s 14(b)(ii)(A), as described in [43] above, the Tribunal went on to consider the issues of the appellant's capacity to give informed consent and whether she had unreasonably refused to consent to the proposed treatment. Therefore, Ground 2 also attributed to the Tribunal a finding which it did not make.

[57] As explained in [54] above, I could not be satisfied on the balance of probabilities that, without the proposed treatment, the appellant was likely to suffer "serious mental deterioration" within s 14(b)(ii)(B) *MHRSA*.[57]

Conclusion

[58] I am not satisfied that the evidence before the Tribunal was sufficient to satisfy either of the alternative criteria in s 14(b)(ii). That disposes of the appeal, and it is not necessary for me to decide Ground 3.

[59] The appeal is allowed. Pursuant to s 143(a) *MHRSA*, I make an order setting aside the orders of the Tribunal: (1) that the appellant be admitted as an involuntary patient in the JRU for a period of four weeks and (2) approving the management treatment plan proposed by Drs Lysenko and Das.

[60] This decision may be seen as unsatisfactory by the dedicated psychiatrists and other metal health professionals who stand ready to assist the appellant and treat her serious delusional disorder. It is clear from my reading of the transcript that both Dr Lysenko and Dr Das had the best interests of the appellant firmly in mind when they gave evidence before the Tribunal. Dr Lysenko spoke with insight and compassion in the passage extracted below:[58]

> My view of [the appellant] is that she is a woman who suffers greatly owing to her illness. She has been detained and she is being detained, effectively indefinitely, owing to the circumstances relating to her

57 Physical deterioration has never been argued and does not arise for consideration on the evidence.

58 Affidavit of Matthew Derrig sworn 4 December 2018, par 2, annexure MD-1, p. 9, Transcript of proceedings before the Tribunal.

> offending and her illness. But in order for her to be released, there needs to be a significant shift with respect to her risk profile [given that] she has engaged in behaviours secondary to her illness which do represent serious risk of harm to specific members of the community. Without a trial of treatment, she will remain detained in prison, she will be separated from her family and her life will not progress. It is a miserable existence for her. We would like to see her treated and we would like to see some improvement in her mental state, and we would like to see her one day to be released into the community.

and subsequently:[59]

> She is a very intelligent and capable woman who has, despite being in prison, managed to make some achievements with respect to furthering her education. She has a good employment history and she would be a valuable member of the community if she were able to pursue a vocation. But that is not available to her, owing to her untreated illness. With respect to the treatment we propose, we are requesting that she be treated with antipsychotic medication. There is evidence for its use in the treatment of delusional disorder.
>
> It has been mentioned in previous reports that that treatment might not necessarily work. In my experience in using medications, antipsychotic medications for delusional disorder, often what you find is that the delusion remains but the intensity with which it is held and the associated risk does reduce. And in such an event, following a trial of treatment, we would hope that [the appellant's] risk profile would be diminished to an extent she should be able to be returned to the community.

[61] However, irrespective of the views held by the medical professionals as to the appellant's best interests, the *MHRSA* confines the scope for her involuntary medical treatment, and administration of drugs as part of such treatment, by carefully confined statutory criteria which were not met on the evidence before the Tribunal.

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59 MD-1, pp. 11.9 - 12.