CITATION:	*CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43
PARTIES:	CH v MENTAL HEALTH REVIEW TRIBUNAL and NORTHERN TERRITORY OF AUSTRALIA
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	LCA 3 of 2017 (21703051)
DELIVERED ON:	9 June 2017
DELIVERED AT:	Darwin
HEARING DATE:	8 June 2017
JUDGMENT OF:	HILEY J

CATCHWORDS:

APPEAL AND NEW TRIAL – Mental Health Review Tribunal Appeal – Utility - Nature of appeal – Appeal by way of rehearing pursuant to s 142(3) of Mental Health Related Services Act (NT) - Held that s 142(3) does not involve an appeal de novo

APPEAL AND NEW TRIAL – Mental Health Review Tribunal Appeal– Jurisdiction – Power to make a declaration that the appellant is not mentally ill – Supreme Court does not have the power under Mental Health Related Services Act to make a determination to the effect that a person is or is not mentally ill

STATUTES - Acts of Parliament - Interpretation - Particular statutes – Mental Health Related Services Act ss 6(3) and 16(a) – determination that appellant has a mental illness - Meaning and effect of s 6(3)

APPEAL AND NEW TRIAL – Mental Health Review Tribunal – Mental Health and Related Services Act s 7(2) - Whether appellant was capable of giving informed consent – medical evidence indicates that unless appellant undergoes treatment he is likely to cause serious harm to himself or suffer serious mental deterioration – appellant's refusal to undergo treatment was unreasonable

Supreme Court Rules (NT) r 83.20

Mental Health and Related Services Act 1998 (NT) s 6(1), s 6(3), s 7(2), s 16, s 123, s 123(5)(c), s 123(11)(b), s 142(3), s 143(c), s 143(d),

R v KMD [No 2] [2017] NTSC 18, applied

Allesh v Maunz (2000) 203 CLR 172; *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* (2003) 230 CLR 194; *M v Mental Health Review Tribunal* [2015] NSWSC 1876; *Mio Art Pty Ltd v Brisbane City Council* (2010) 178 LGERA 387; *New South Wales v TD* [2013] NSWCA 32; *Thoroughbred Racing Board v Waterhouse* [2003] NSWCA 55; 56 NSWLR 691, referred to

Builders Licencing Board v Sperway Constructions (Syd) Pty Ltd [1975] 2 NSWLR 174; *Turnbull v New South Wales Medical Board* [1976] 2 NSWLR 281, *Z v Mental Health Review Tribunal* [2015] NSWSC 1943, distinguished

REPRESENTATION:

Counsel:

Appellant:	L Nguyen
Respondents:	R Brebner

Solicitors:

Appellant:	
Respondents:	Solicitor for the Northern Territory

Judgment category classification:	B
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

CH v Mental Health Review Tribunal & Anor [2017] NTSC 43
No. LCA 3 of 2017 (21703051)

BETWEEN:

CH
Appellant

AND:

MENTAL HEALTH REVIEW TRIBUNAL
First Respondent

AND:

NORTHERN TERRITORY OF AUSTRALIA
Second Respondent

CORAM: HILEY J

EX TEMPORE
REASONS FOR JUDGMENT

(Delivered 9 June 2017)

Introduction

[1] This is an appeal under s 142 of the *Mental Health and Related Services Act 1998* (NT) (**the Act**) against a decision of the Mental Health Review Tribunal (**the Tribunal**) on 4 January 2017 to order a Community Management Order (**CMO**) under s 123(5)(c) of the Act.

The CMO was made following a review by the Tribunal of an interim CMO made on 22 December 2016.

[2] The CMO operates for six months from the date of the order. It will therefore expire on 3 July 2017 unless it is extended following a further application of the kind contemplated by s 123(11)(b) of the Act. On 21 June 2016 the Tribunal will conduct another review for the purposes of determining whether it should make another CMO under s 123(5) which similarly would only operate for a further six months.

[3] In light of this, I queried the utility of pursuing this appeal. If the appeal was successful and I was to remit the matter to the Tribunal for further consideration under s 143(c) of the Act, there would be nothing to be achieved that cannot be dealt with by the Tribunal when it conducts the further review on 21 June 2017. That would seem to be an unnecessary duplication of the busy resources of the Tribunal and a waste of time and money.

[4] However, after hearing further submissions from counsel on the issue, I accept that there may be some utility in me deciding the appeal. That is because, if I were to conclude that the decision should be quashed, the appellant might have some kind of remedy arising out of that.[1] This is different to the situation considered in *Z v Mental Health*

[1] See for example the discussion about the significance of orders of this kind in *M v Mental Health Review Tribunal* [2015] NSWSC 1876 at [69] – [69] and possible remedies in circumstances where a person has been unlawfully detained in *State of New South Wales v TD* [2013] NSWCA 32.

Review Tribunal[2] where an appeal in similar circumstances was dismissed because there was no utility in the appeal proceeding. In that case, the appeal was an appeal *de novo*, and so, if it was successful, it would not have resulted in the quashing of the decision of the tribunal appealed from. None of that is to say that the reasoning in *Z v Mental Health Review Tribunal* would not apply if the Tribunal's decision was quashed, the matter remitted to it and the Tribunal reaches the same conclusion as the one under appeal. The Tribunal would be exercising jurisdiction *de novo*, albeit in relation to the circumstances as they existed at the time that they made the CMO.

Relevant Background

[5] CH was diagnosed with schizophrenia in January 2002, was admitted as an inpatient at St Vincent's Hospital, New South Wales and later absconded from hospital. In 2003, he broke into the Centrelink office in Darwin and set fire to a computer. He was subsequently charged with arson and found not guilty on account of mental impairment. He was placed on a custodial supervision order which remained in force until 2008. He was an inpatient at Royal Darwin Hospital for about three weeks in June 2003.

[6] After termination of the supervision order in 2008, CH continued to have contact with the forensic mental health team and was treated with

[2] [2015] NSWSC 1943.

oral antipsychotics. That contact ceased in 2011 when he went overseas. CH was jailed in Thailand and was deported in June 2013. He was then readmitted to Royal Darwin Hospital on 15 June 2013 where he remained until 9 August 2013. His diagnosis was a relapse of schizophrenia. He was then discharged on a CMO which continued until July 2014.

[7] On 22 December 2016 Dr William Taft, a Psychiatric practitioner, was satisfied that CH fulfilled the criteria for involuntary treatment in the community and made an interim CMO. Dr Taft prepared a Form 15 on 9 December 2016, which set out clinical details and a management plan for CH. This required CH to be given antipsychotic medication. In that document Dr Taft expressed opinions to the effect that each of the criteria for involuntary treatment in the community set out in s 16 of the Act was satisfied, and he gave brief reasons for those opinions.

[8] The Tribunal comprised Richard Bruxner, president of NTCAT, Jill Huck a community member, and Rosemary Howard, a psychiatrist. Also in attendance was Jagdish, a case manager for CH, Dr Taft, CH and his lawyer Lyma Nguyen.

[9] After explaining the proposed procedures to CH, including that he and his lawyer could ask questions and make submissions, the Tribunal heard from Dr Taft. Although Dr Taft was the person who had initiated the CMO process he had only seen CH once, about a month

earlier. At that time he thought that CH's mental state was relatively stable notwithstanding that the dosage of his medication had been reduced, and he did not think CH's risks to himself or others were high. Dr Taft subsequently spoke to Dr Parker, the Director of Psychiatry, and became aware of CH's history, extending as far back as 2003. He then reviewed further material including reports of forensic psychiatrists during the four or five years from 2003 when CH was under the supervision order imposed by this Court.

[10] Dr Taft was asked about the criteria in s 16(b)(ii) and in particular whether without the antipsychotic treatment CH was likely to cause serious harm to himself or someone else. He said, at page 17, line 479:

> 'Yeah. I suppose the way I think I have to answer that, is that without medications I think there is a high likelihood that CH's mental state will deteriorate, because I think that he does have a diagnosis of schizophrenia; and I think the symptoms of schizophrenia would have a high chance of recurring without medications. If that does occur, CH, I think, also has a likelihood of behaving in a way that could be harmful to himself or others, considering the historical evidence that when unwell in the past, without medications, in 2003 and in 2013, that has occurred'.

[11] Dr Taft was asked a number of questions by Ms Nguyen largely concerning the opinions that Dr Taft had expressed when he completed the initial interim CMO and concerning the opinions he had expressed about each of the s 16 criteria. During the Tribunal's hearing CH provided the Tribunal with a lot of detail, much of which challenged the accuracy of some of the opinions that had been formed by experts

and other people, including back in 2002, 2003 and in 2013 following his return from Thailand. At various stages members of the Tribunal asked questions of Dr Taft, and also of CH following some of his comments.

[12] The Tribunal expressed an interest in hearing from Dr Weerasundara, the psychiatrist who had had many more dealings with CH and who had previously agreed to reduce the dosage of his medication. That occurred later that day. Dr Weerasundara expressed strong support for the making of the CMO and gave detailed reasons for his opinions. In particular he was asked to address his views concerning the risk of deterioration. He said CH had a significant past history of harm to others and a risk to himself of becoming unwell. He explained why he considered that there had been a gradual deterioration in CH's mental state, and said that CH would have a relapse if he were taken off the medication. He said that as the dosage was reduced, CH's paranoia increased, to a point where he refused to comply with treatment. He said that CH's level of paranoia is slowly but surely increasing.

[13] Ms Nguyen asked Dr Weerasundara a number of questions and CH volunteered more detail including about the side-effects of the medication. Ms Nguyen then made final submissions, after which the Tribunal retired to consider its decision.

[14] The Tribunal returned and announced its decision to make the CMO. It said:

> We've decided that we're going to make the order that the doctors are seeking. We've listened very carefully to what you've had to say and what Ms Nguyen has said on your behalf. We are satisfied, though, that the criteria in the Act for the making of the order are satisfied and I just want to briefly deal with those. The first thing we have to be satisfied of is that you have mental illness. Now, we know what that you deny that. You've said, well, there's no evidence, I can't remember your exact words; but in the case of mental illness, the evidence often consists or nearly always consists just of the opinions of particular specialist, and we've got some very highly qualified doctors who've expressed the view that you are suffering from mental illness. There's also a history going back many years where plainly others have formed the same view. So we have to take that into account and we're satisfied, to the level that we need to be satisfied, that you are indeed suffering from a mental illness. We are also satisfied that you need treatment or care. And we also have, particularly having heard from Dr Weerasundara, we are satisfied that if you don't receive that care in the nature of treatment that's proposed, that you will suffer serious mental deterioration. It's not something that's going to happen in a huge hurry; but on the strength of what Dr Weerasundara has told us about the deterioration that he's observed, the fact that, and he has also told us that that deterioration is likely to escalate as the medication leaves the system, we are satisfied that there is a serious risk of mental deterioration if you don't get back onto the medication. And we also think that feeds into a risk that some of the more alarming events of the past might happen in some other way, so we also think that there is some risk that you might cause harm to yourself or to others. In terms of harm to yourself, we don't have to look at it in terms of physical harm. We look at it also in terms of the evidence that you're obviously doing pretty well and you've been doing pretty well for the last few years. But we are concerned on the strength of what we've heard that that good progress that you've made, academically and employment and that sort of stuff, will be jeopardised of you are off the medications. We've heard that Ms Nguyen has said about the matter of consent and being able to give informed consent. We are satisfied that at the moment you don't have the insight into your mental illness that would enable you to give the informed

> consent. And finally, we are satisfied that the Community Management Order is able to be implemented. So for all those reasons we are proposing to make the order. It will be a six month order that's reviewed on the 21st June 2017.

Nature of the appeal

[15] Section 142(1) of the Act provides that a person aggrieved by a decision of the Tribunal may appeal to the Supreme Court. Section 412(3) provides that: "An appeal is to be by way of a rehearing." The Court may suspend the operation or effect of a decision being appealed against pending the determination of the appeal,[3] and may refuse to hear an appeal where it is satisfied that it is frivolous, vexatious or has not been made in good faith.[4]

[16] Section 143 provides that the Supreme Court may make orders affirming, varying or setting aside the decision or order of the Tribunal, make any decision or order that the Tribunal may have made, remit the matter to the Tribunal for further consideration, or make any other order it thinks fit.

[17] It is well recognised that the language in s 142(3) might denote various forms of appeal. This would often depend upon provisions elsewhere in the relevant statute including the powers conferred on the appeal tribunal and the nature and functions of the tribunal being appealed from.

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3 *Mental Health and Related Services Act 1998* (NT) s 142(4).
4 *Mental Health and Related Services Act 1998* (NT) s 142(5).

[18] Counsel for the appellant contended that the appeal is an appeal *de novo.* All issues must be retried and fresh evidence may be adduced, including evidence that was not adduced before the original tribunal and evidence of events subsequent to the original decision. The relevant facts, are to be determined as at the date the appeal is heard. Counsel referred to Rule 83.20 of the *Supreme Court Rules* (NT), which states that "where an appeal is by way of rehearing, either party may call evidence at the hearing." Counsel contended that this means that the appeal is in the nature of an appeal *de novo*.

[19] Counsel for the Northern Territory (**the respondent**) disagreed with that conclusion and provided detailed written submissions in support of that disagreement. I agree with those submissions. The respondent observed that an appeal does not normally entail the issues and evidence being considered at large. Further, a provision that an appeal is to be by way of rehearing is well understood not to mean that the appeal is a complete rehearing.

[20] The respondent further submitted, and I agree, that an appeal by way of rehearing under s 142(3) is more restricted than a hearing *de novo* in two respects. Firstly, a rehearing is normally conducted on the basis of the material before the original decision maker. Secondly, a rehearing involves a search for errors in the original decision rather than instituting a completely fresh decision making process.

[21] The respondent cited the following passage from the High Court decision of *Allesh v Maunz* at 180-181.[5]

> The critical difference between an appeal by way of rehearing and a hearing *de novo* is that, in the former case, the powers of the appellate court are exercisable only where the appellant can demonstrate that, having regard to all the evidence now before the appellate court, the order that is the subject of the appeal is the result of some legal, factual or discretionary error, whereas, in the latter case, those powers may be exercised regardless of error. At least that is so unless, in the case of an appeal by way of rehearing, there is some statutory provision which indicates that the powers may be exercised whether or not there was error at first instance.

[22] As the respondent pointed out, there is no other statutory power conferred on the Supreme Court to simply review a decision of the Tribunal without regard to whether there was error in the first instance.[6]

[23] Counsel for the respondent also referred to the phrase "all the evidence now before the appellate court" in the passage in *Allesh v Maunz* quoted above. That phrase is to be construed in the context, again, of any contrary or different statutory discretion that is provided to the court.[7] The respondent then referred to rule 83.20 of the *Supreme Court Rules* and submitted that the conferral of such a power on the Court does not lead to the conclusion that the appeal is *de novo*. This

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5 (2000) 203 CLR 172 at pp 180-181.
6 Second Respondent's Written Submissions In Reply at [4].
7 Ibid at [5].

point was made by the High Court in *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission*[8] at 203:

> If an appellate tribunal can receive further evidence and its powers are not restricted to making the decision that should have been made at first instance, the appeal is usually and conveniently described as an appeal by way of re-hearing. Although further evidence may be admitted on an appeal of that kind the appeal is usually conducted by reference to the evidence given at first instance, and is to be contrasted with an appeal by way of hearing *de novo*.

[24] The respondent also submitted that the power in the *Supreme Court Rules* that allows evidence to be adduced, is conferred for the purpose of assisting the Court to determine whether there was some legal, factual or discretionary error that caused the decision of the tribunal to be in error.[9]

[25] For example, evidence may be adduced to show that the tribunal erred by failing to allow the appellant to appear or be represented, not permitting the appellant to give relevant evidence or make relevant submissions, or otherwise denying the appellant natural justice.

[26] The respondent quoted again from *Coal and Allied Operations* at p 203-204:

> Statutory provisions confirming appellant powers, even in the case of an appeal by way of a rehearing, are construed on the basis that, unless there is something to indicate otherwise, the power is to be exercised for the correction of error.

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8 (2003) 230 CLR 194 (***Coal and Allied Operations***).

9 Second Respondent's Written Submissions In Reply at [7] citing *Coal and Allied Operations* at 203-204.

[27] The respondent distinguished the present case from *Builders Licencing Board v Sperway Constructions (Syd) Pty Ltd*,[10] and *Turnbull v New South Wales Medical Board*.[11] Those decisions related to administrative decisions that were subject to appeal to a court, and held that the appeals in those matters would be hearings *de novo*. However, as the respondent points out, the Tribunal in the present case was exercising judicial functions.

[28] The decision of the Tribunal was made after certain executive functions had been performed, in this case, by Dr Taft, in satisfying himself that the s 16 criteria were met. The Tribunal was able to call witnesses to give evidence, hear submissions, and evaluate the evidence before deciding to make the CMO.

[29] It is relevant to add that the Mental Health Review Tribunal is a specialist tribunal which had as its members, not only a lawyer but also a psychiatrist and a community member, namely a representative of the community. It is very unlikely that Parliament would intend that, on appeal, a judge alone should perform the same evaluative kind of functions as those which would usually be better performed by such a specialist tribunal.

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10 [1975] 2 NSWLR 174 (***Sperway's Case***).
11 [1976] 2 NSWLR 281 (***Turnbull's case***).

[30] However, as the respondent submits,[12] this Court's jurisdiction is not confined to cases involving legal error. That would amount to an appeal in the strict sense, or an appeal in the nature of judicial review. This Court is able consider factual or discretionary errors, such as the placing of undue weight on a particular factor.[13] However, as the respondent noted, if there is no error the Court cannot alter the original decision, even if a better decision could have been made.[14]

[31] In conclusion, this Court's jurisdiction depends upon the existence of some kind of error – legal, factual or discretionary – having been committed by the Tribunal. Appeals from the Tribunal are not appeals *de novo*.

Power to make a declaration that the appellant is not mentally ill

[32] In the Notice of Appeal, the appellant's applied for a declaration that the appellant is not mentally ill.[15] The only powers that this Court has on appeal are those contained in s 143 of the Act. I do not consider this Court has a statutory power to make a determination to the effect that a person is or is not mentally ill.

[33] Counsel for the appellant referred me to s 143(d) of the Act, which enables the Court to make any other order it thinks fit. I do not

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12 Second Respondent's Written Submissions In Reply at [13].
13 See for example *Mio Art Pty Ltd v Brisbane City Council* (2010) 178 LGERA 387, 395-9.
14 Second Respondent's Written Submissions In Reply at [13] citing *Thoroughbred Racing Board v Waterhouse* [2003] NSWCA 55; 56 NSWLR 691.
15 Notice of Appeal (13 January 2017) at p 2.

consider that this section is intended to expand the powers of the Court. Rather it enables the Court to make other orders that may be incidental, necessary or appropriate when exercising the jurisdiction that the Court is given, namely to review the decision of the Tribunal by way of re-hearing. The Court's powers on appeal necessarily focus on the Tribunal's decision and whether or not the Tribunal erred.

[34] Even if the Court did consider that the Tribunal erred in concluding that the appellant was mentally ill at the time of the hearing before the Tribunal, and even if this Court or the Tribunal upon remitter reconsidered the evidence concerning that issue, all that the Court or Tribunal could decide would be whether or not it is satisfied that the appellant was mentally ill. Neither the Tribunal nor this Court has been given jurisdiction to make a determination or declaration that a person is not, in fact, mentally ill. Accordingly, I reject that application.

Power of this Court to determine other matters in s 16

[35] The appellant also contends that this Court can determine afresh the various matters referred to in the criteria set out in s 16.[16] By reference to the criteria in s 16 the appellant submitted that the disputed matters to be determined are:

(a) whether CH has a mental illness;

[16] Appellant's Outline of Written Submissions at [12

(b) whether, as a result of the mental illness, CH requires treatment;

(c) whether, without treatment, CH is likely to cause serious harm or suffer mental deterioration; and

(d) whether or not he is capable of giving informed consent or has unreasonably refused to consent.

[36] That submission, to the extent that this Court is able to determine those matters, misunderstands the primary function of this Court when deciding the appeal; namely, to consider whether the Tribunal was in error in reaching one or more of those conclusions. It is only once that threshold is passed that this Court would proceed to determine what action it should take under s 143.

[37] Where the error is similar to those alleged by the appellant in these proceedings, for example if the Tribunal erred in failing to take into account certain matters that it should have taken into account, or if it should have given CH further opportunity to be heard, the appropriate course would be for this Court to remit the matter to the Tribunal for further consideration, rather than to consider all of the evidence afresh and make its own determination. Although this Court does have the power to make any decision or order that the Tribunal may have made, it is likely that such a power would only be exercised in circumstances where such a remittal would not be appropriate. As I have already noted at [29] above, the Tribunal is a specialist tribunal which would

have greater experience and familiarity with matters of this nature, and, would be better placed to make the kind of value judgements that s 16 calls for.

Grounds of appeal

[38] The appellant raised four grounds of appeal in his Notice of Appeal:

1. The Tribunal came to conclusions of fact based on insufficient evidence and materials available to the Tribunal do not support the following matters, constituting part of the criteria for a Community Management Order:

    a. That the appellant has a mental illness, requiring treatment

    b. That without treatment, the appellant is likely to cause serious harm to himself or others

    c. That without treatment, the appellant is likely to suffer serious harm mental or physical deterioration

    d. That the appellant was not capable of giving informed consent, or had unreasonably refused consent to treatment

2. The Tribunal failed to take into account relevant considerations and took into consideration irrelevant considerations.

3. The Tribunal gave too much weight to treating team's evidence and insufficient weight to the applicant's evidence.

4. The decision was unreasonable in all the circumstances.

[39] There is a considerable overlap between the matters raised in these grounds. Accordingly it is convenient to deal with them as they were

during the hearing, rather than deal with them on a ground by ground basis.

[40] After discussion about the nature of the appeal, I accepted as read CH's affidavit of 13 January 2017. I accepted that on the limited basis of it showing what CH could have told the Tribunal if he had had the opportunity to do so. CH was cross-examined in relation to some of that material and there was some re-examination following that.

[41] The Tribunal's decision and this appeal focus primarily upon s 16 of the Act, which sets out the criteria for the involuntary treatment or care of a person in the community.

[42] Section 16 provides:

> **Involuntary treatment in community**
>
> The **criteria** for the involuntary treatment or care of a person in the community are:
>
> (a) the person has a mental illness; and
>
> (b) as a result of the mental illness:
>
> (i) the person requires treatment or care; and
>
> (ii) without the treatment or care, 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 inform consent to the treatment or care or has unreasonably refused to consent to the treatment or care; and

(c) the treatment or care is able to provide by a community management plan that has been prepared and is capable of being implemented.

[43] The third of these criteria, in s 16(c), is not relevant for the purposes of this appeal, however all the other criteria are.

Determination that CH has a mental illness – s 16(a)

[44] Section 6 of the Act provides:

Mental illness

(1) A mental illness is condition that serious impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:

(a) by the presence of at least one of the following symptoms:

(i) delusions;

(ii) hallucinations;

(iii) serious disorders of the stream of thought;

(iv) serious disorders of thought form;

(v) serious disturbances of mood; or

(b) by sustained or repeated irrational behaviour that may be taken to indicate that presence of at least one of the symptoms referred to in paragraph (a).

(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.

(3) A person is not to be considered to have a mental illness merely because he or she:

(a) expresses or refused or fails to express a particular political or religious opinion or belief, a particular philosophy or a particular sexual preference or sexual orientation; or

(b) engages, or refuses or fails to engage, in a particular political, religious or cultural activity; or

(c) engages, or has engaged, in sexual promiscuity, immoral or illegal conduct or anti-social behaviour; or

(d) has a sexual disorder; or

(e) is intellectually disabled; or

(f) uses alcohol or other drugs; or

(g) has a personality disorder or a habit or impulse disorder; or

(h) has, or has not, a particular political, economic or social status; or

(j) communicates or refuses or fails to communicate, or behaves or refuses of fails to behave, in a manner

consistent with his or her cultural beliefs, practices or mores; or

(k) is, or is not, a member of a particular cultural, racial or religious group; or

(m) is involved, or has been involved, in family or professional conflict; or

(n) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness; or

(p) has been admitted as an involuntary patient on the grounds of mental disturbance or complex cognitive impairment; or

(q) has acquired brain damage.

[45] The respondent points out that CH was first diagnosed with schizophrenia in 2002 at the St Vincent's Hospital in New South Wales. His symptoms of "paranoid delusions, auditory hallucinations and ideas of reference" are consistent with that diagnosis.[17] The respondent submits that this indicates that the appellant suffers symptoms that seriously impair his mental functionality. This supports the conclusion that he has a mental illness.

[46] Counsel for the appellant placed much emphasis on s 6(3) of the Act, in particular on the matters referred to in subparagraphs 6(3)(c), (g), (j)

[17] Second Respondent's Written Submissions In Reply at [19] citing Dr William Taft, Clinical Details and Management Plan re Community Management Order, 9 December 2016 (**Interim Community Management Order**).

and (n). At [17] – [19] of her written submissions, counsel for the appellant submitted:

> [17] The Doctors did not assess CH's idiosyncrasies against the criteria under section 6(3) for assessing if there were any factors that warranted a finding that he *does not* have a mental illness.
>
> [18] For example, before concluding that CH has a mental illness, Doctors did not assess CH for whether he had a personality disorder or a habit or impulse disorder (which, being the case, would have excluded him from being deemed to have a mental illness) - or any of the other factors under s 6(3) aimed at assessing whether he *does not* have a mental illness.
>
> [19] Instead the Doctors based their assessment on incidents from 2003 and 2013 which constitute allegations of "illegal conduct or anti-social behaviour" on CH's part; as well as the fact that he "has been admitted as an involuntary patient" previously. Both of these factors are specifically set out in section 6(3) as being factors upon which a person "*is not to be considered to have a mental illness*" (my emphasis).

[47] Counsel for the appellant made similar submissions in support of Grounds 2 and 3, to the effect that the Tribunal erred in failing to properly consider the matters set out in s 6(3) when concluding that the appellant had a mental illness.

[48] I reject those contentions. They misunderstand the true meaning and effect of s 6(3). The contentions ignore the clear wording at the commencement of that subsection, namely:

> A person is **not** to be considered to have a mental illness **merely because** he or she …

(my emphasis)

[49] The words 'merely because' mean that a person is not to be considered to have a mental illness solely on the basis of one of the factors set out in s 6(3). Further, as I have already pointed out, each of those factors are expressed in the disjunctive. The meaning and effect of s 6(3) is that if a person meets only one of those criteria, he or she is not to be considered to have a mental illness solely for that reason. For example, and understandably, evidence that a person has been treated for mental illness in the past does not and should not of itself mean that the person still has a mental illness.

[50] However, it would be absurd to conclude that a doctor or the Tribunal is not entitled to take into account any of those matters in the process of deciding whether the person has a mental illness. It is self-evident that many of those matters will often be important for consideration. Obvious examples include a history of treatment for mental illness,[18] a history of admission as an involuntary patient on the grounds of mental disturbance or cognitive impairment,[19] a personality disorder,[20] and intellectual disability.[21]

[51] Secondly, the appellant's contention wrongly assumes that the words 'A person is not to be considered to have a mental illness' mean that a

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18 *Mental Health and Related Services Act 1998* (NT) s 6(3)(n).
19 *Mental Health and Related Services Act 1998* (NT) s 6(3)(p).
20 *Mental Health and Related Services Act 1998* (NT) s 6(3)(g)
21 *Mental Health and Related Services Act 1998* (NT) s 6(3)(e).

person does not have a mental illness if any of matters referred to in s 6(3) apply to that person. For example, on the appellant's argument, the fact that the person has been treated for mental illness in the past, namely factor (n), would not be a fact that can be taken into account for the purpose deciding whether the person has a mental illness but rather requires a finding that the person does not have a mental illness.

[52] I reject those arguments based on s 6(3).

Weight attached to the expert evidence of the treating team

[53] The appellant referred to Dr Taft's evidence concerning the initial opinions that he formed after he saw CH for the first time. I referred to these in [10] above.

[54] Counsel for the appellant submitted that because Dr Taft initially held those opinions he could not have considered that the relevant criteria in s 16 were satisfied. However those contentions ignore the fact that Dr Taft was subsequently able to reach firm conclusions on the topic, by the time he completed the Form 15. Soon after he had first seen CH, Dr Taft became aware that CH had a history which included a lengthy period of supervision following the fire at the Centrelink office in 2003.

[55] The appellant's submissions in relation to the weight that should have been given to Dr Weerasundara's evidence were also misplaced. It is

trite that one of the most important matters for a psychiatrist to have regard to is the patient's history. Counsel for the appellant submitted that Dr Weerasundara was wrong to rely on information where the treating team had no direct evidence, for example about incidents that allegedly occurred over a decade ago.[22] I disagree. It would be rare for there to be direct evidence about the facts underlying previous diagnoses by an expert. The absence of such evidence is not a basis for rejecting or attaching less weight to an opinion of a psychiatrist (in this case Dr Weerasundara). On the contrary, one would expect a psychiatrist to give substantial weight to opinions previously expressed by other experts. They would be assumed to have a better knowledge of the facts and diagnoses concerning the appellant's previous mental health issues in 2003, 2002 and 2013. Such knowledge would, rightly, have formed the basis of opinions that they formed at the time.

[56] Obviously the psychiatrist would take into account what the patient now says about his or her version of the facts surrounding his previous diagnoses, to the extent that they are relevant to the current diagnosis. However the psychiatrist would usually attach far greater weight to what the patient says about his current and more recent circumstances which resulted in him being treated or assessed by the psychiatrist.

[57] The appellant also criticised the Tribunal for cutting him off at one stage when he was anxious to say something. This is one of the bases

[22] Appellant's Outline of Written Submissions at [15].

for Ground 3. Counsel also complained that the Tribunal failed to take CH's evidence into account.

[58] In relation to these complaints counsel for the appellant referred to what the Chairman said in the following passages at page 12 of the transcript:

> We are not in a position though, today to go back and investigate and make findings about what did or didn't happen… It's very difficult for us to go back now and say, well, we're satisfied having heard from CH today that none of this happened. … [W]e can understand that you vehemently and strongly deny that the events happened in the way that has been described, but there is not a lot that we can do about that. We need to focus on you today.

[59] These passages need to be put in their proper context. After discussing the desirability of locating and calling Dr Weerasundara, the Chairman noted that CH had "indicated that he wanted to make a bit of a statement about the history." The Chairman said: "CH, does that relate to the events in 2003 or …". CH proceeded to talk about the events in 2002 and 2003 and to provide the Tribunal with a lot of detail about circumstances surrounding those events. He asserted that most of the information relied upon by the psychiatrists who treated him on those occasions was false.

[60] Then appeared the following exchange, which includes the passages quoted above.

C. CH, I don't want to appear disinterested in what you're saying but we need to focus really on what's proposed for you now.

CH. Well I mean, you're looking at a history and the history's false. I mean …

LN I think …

C We are not in a position, though, today where we can go back and investigate and make findings about what did or didn't happen. We have to look at that as part of the whole scenario that we are dealing with. And that obviously in the past, courts and presumably doctors, have taken a different view about the one that you're expressing about the relevant events. It's very difficult for us to go back now and say, well, we're satisfied having heard from CH today that none of this happened. Do you understand the difficulty we have?

CH Well, they've consistently built up a record of false …

C Well, we can understand that you definitely and strongly deny that the events happened in the way that has been described, but there's not a lot that we can do about that. We need to focus on you today.

CH Yes. I'll be taking this by my member for Parliament. I already have. And it's been escalated to the Minister of Health just recently.

C Might I just invite Ms Nguyen to say what she was going to say and if there is anything that you wanted to supplement from what she says, it might be that we can get to where we need to get a bit quicker that way.

[61] CH interrupted again, talking about his incarceration in Thailand in 2013 and explaining why he was misunderstood by various people on that occasion. Ms Nguyen then spoke for some time and addressed the

criteria in s 16. She referred to the previous incidents in 2002, 2003 and 2013 and CH's instructions in relation to those incidents. Even then CH interrupted Ms Nguyen and provided more detail about his time in Thailand.

[62] I allowed CH's affidavit to be read in this Court on the basis that it would inform me of the kind of additional information CH could have put to the Tribunal had he been given a further opportunity to do so. As I noted at [40] above, CH was cross-examined and re-examined on some of that material in this Court. I doubt that such additional information would have added anything relevant for the Tribunal's consideration. I do not consider that the provision of any of that additional information would have made any difference to the Tribunal's decision.

[63] CH interrupted the proceedings in the Tribunal on a number of occasions and provided information which he considered relevant. That occurred on several occasions, not only before, but also after the interruption referred to at page 12 of the transcript.

[64] Much of the information set out in CH's affidavit was in fact provided by him to the Tribunal. Moreover, he was assisted by counsel who was able to, and did, ask relevant questions of the witnesses and was able to make submissions on CH's behalf. There was never any suggestion that he or his counsel could not provide further information, if that was

relevant, apart from what might be read into that comment by the Chairman at page 12. That comment was made about a third of the way through the proceeding and before it was adjourned in order to locate Dr Weerasundara so he could give evidence. There were several subsequent occasions when CH and Ms Nguyen addressed the Tribunal further.

[65] Furthermore, there is no reason why CH and/or his counsel could not have provided a document like his affidavit to the experts prior to the hearing or to the Tribunal, had they thought that relevant. It is also open to assume that Dr Weerasundara, and other experts who have seen or treated CH over the past 15 years or so, would have received that kind of information from CH and would have taken that into account when reaching their diagnoses.

[66] Even if there was additional relevant information that CH could have provided, the Tribunal was well entitled to attach significant weight to the opinions of the experts who had previously seen CH. This is particularly so in matters such as this, which require medical opinions of the kind necessary for the purposes of making a CMO.

[67] As counsel for the respondent pointed out, there were no opinions advanced at the hearing before the Tribunal contrary to those provided by Dr Taft and Dr Weerasundara, apart, of course from CH's own opinions concerning his condition. Further, as the respondent pointed

out, the Tribunal itself had Dr Howard, a well-known psychologist, as one of its members. Dr Howard played an active part during the proceedings. He would have also been in a good position to assess not only the opinions of the doctors but also the relevance and weight that should be attached to CH's accounts.

Whether CH requires treatment or care – s 16(b)(i) and 16(b)(ii)

[68] I now turn to the next part of the appeal, which relates to s 16(b). That is, whether as a result of his mental illness, CH requires treatment or care,[23] and whether without such treatment or care he is likely to cause serious harm to himself or someone else,[24] or suffer serious mental deterioration.[25]

[69] The appellant's submissions referred to Dr Taft's initial views, which I have already discussed, and whether the doctors properly understood and applied the relevant parts of s 16(b)(ii). In particular, they canvass the meaning of the word 'likely' and the requirements of 'serious harm' in s 16(b)(ii)(A) and 'serious mental or physical deterioration' in s 16(b)(ii)(B).

[70] I have already referred to the careful questioning of the Tribunal in relation to those criteria and to the opinions provided by Dr Taft and Dr Weerasundara at [10] – [13] above. As noted, it was the concluded

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23 *Mental Health and Related Services Act 1998* (NT) s 16(b)(i).
24 *Mental Health and Related Services Act 1998* (NT) s 16(b)(ii)(A).
25 *Mental Health and Related Services Act 1998* (NT) s 16(b)(ii)(B).

view of both doctors that without treatment the appellant's mental condition would deteriorate, as has happened in the past. Dr Taft expressly addressed each of the criteria in s 16 when he made the Interim CMO. The Chairman of the Tribunal was also careful to remind both Dr Taft and Dr Weerasundara of the relevant definitions when they were giving their evidence.

[71] There is no basis for doubting their knowledge and understanding of these criteria and their ability to apply their knowledge to the relevant facts. Even if the experts did not use the exact words, such as 'likely to', in the context of 'causing serious harm' or, 'suffering mental deterioration', this was clearly, the effect of their evidence. The Tribunal was well entitled to be satisfied that either or both of those criteria in s 16(b)(ii) was met.

Whether CH is capable of giving informed consent – s 16(b)(iii)

[72] The next ground concerns s 16(b)(iii), that is, whether CH was capable of giving informed consent, or whether he unreasonably refused to consent to the treatment.

[73] Counsel for the appellant was critical of Dr Taft's reasoning because he took into account CH's denial of his mental illness and of his need for medical treatment when reaching the conclusion that he was not capable of giving informed consent. That argument must be premised upon the assumption that CH did not in fact have a mental illness and

did not need medical treatment. That is a false premise in light of the expert opinions which are to the effect that CH did have a mental illness, namely schizophrenia, and does require medical treatment. CH's denials of those matters were a legitimate basis upon which Dr Taft could form the view and express the opinion that CH was not capable of giving informed consent.

[74] Ms Nguyen also referred to s 7(2) of the Act. Section 7 of the Act provides:

> **Informed consent**
>
> (1) A person cannot give informed consent under this Act unless this section is complied with, and any attempt to waive or circumvent the requirements of this section is of no effect.
>
> (2) A person gives informed consent under this Act;
>
> (a) when the person's consent is freely and voluntarily given without any inducement being offered; and
>
> (b) the person is capable of understanding the effects of giving consent; and
>
> (c) the person communicates his or her consent on the approved form.
>
> (3) A person can give informed consent only when he or she has been given:
>
> (a) a clear explanation of the assessment and possible diagnosis, the nature if the proposed treatment, including sufficient information about the type of

treatment, its purpose and likely duration to permit the person to make a balances judgment regarding undertaking it ; and

“ ”

(4) A person must be given adequate time to consider the information provided under subsection (3) before being asked to give his or her informed consent.

(5) A person who is unable to communicate adequately in English but who is able to communicate adequately in another language is to be assisted, as far as is practicable, by a competent interpreter.

(6) A person whose informed consent is being sought may be request that another person be present while the informed consent is obtained.

(7) The person in-charge of the approved treatment facility or approved treatment agency at which treatment is proposed to be performed on a person must ensure that this section is complied with.

[75] Clearly this provision is designed to ensure that patients are given the extensive detail set out in s 7(3) before they are expected to give informed consent. It also gives medical practitioners greater clarity and protection against subsequent complaints about lack of informed consent.

[76] Those are not the questions that we are considering in the present matter. The relevant question for the purposes of s 16(b)(iii) is whether CH is capable of giving informed consent. The medical evidence is to the effect that he is not.

[77] Further, as counsel for the respondent pointed out, even if CH is capable of giving informed consent to the treatment, as he asserts, his refusal to give that consent would fall within the second part of s 16(b)(iii) if such refusal was unreasonable. The medical evidence is clearly to the effect that CH should have this medical treatment, and that unless he does he is likely to cause serious harm to himself or suffer serious mental deterioration. For him to refuse to have that treatment would be unreasonable. That ground is not made out.

[78] It follows from what I have said that the Tribunal did not commit the errors asserted in the grounds of appeal and the decision was not unreasonable in all the circumstances.

[79] I therefore affirm the decision of the Tribunal and dismiss the appeal.
